

SELECT MEDICAL HOLDINGS CORP
Form S-1/A
August 29, 2008

As filed with the Securities and Exchange Commission on August 29, 2008
Registration No. 333-152514

SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

**Amendment No. 1 to
Form S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933**

SELECT MEDICAL HOLDINGS CORPORATION
(Exact name of registrant as specified in its charter)

Delaware
*(State or Other Jurisdiction
of Incorporation or Organization)*

8060
*(Primary Standard Industrial
Classification Code Number)*

20-1764048
*(I.R.S. Employer
Identification No.)*

**4714 Gettysburg Road
Mechanicsburg, Pennsylvania 17055
(717) 972-1100**
(Address, including zip code, and telephone number, including area code, of registrant's principal executive offices)

**Michael E. Tarvin, Esq.
Executive Vice President, General Counsel and Secretary
4714 Gettysburg Road
P.O. Box 2034
Mechanicsburg, Pennsylvania 17055**

(717) 972-1100

(Name, address including zip code, and telephone number, including area code, of agent for service)

With copies to:

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Approximate date of commencement of proposed sale to the public: As soon as practicable after the effective date of this Registration Statement.

If any of the securities being registered on this Form are being offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933 check the following box:

If this Form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering.

If this Form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering.

If this Form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering.

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

Large accelerated
filer

Accelerated filer

Non-accelerated filer
(Do not check if a smaller
reporting company)

Smaller reporting
company

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Proposed Maximum Aggregate Offering Price(1)(2)	Amount of Registration Fee
Common Stock, par value \$0.001 per share	\$ 100,000,000	\$ 3,930

(1) Estimated solely for the purpose of calculating the registration fee pursuant to Rule 457(o) under the Securities Act of 1933, as amended.

(2) Including shares of common stock which may be purchased by the underwriters to cover over-allotments, if any.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until this Registration Statement shall become effective on such date as the Commission, acting pursuant to said Section 8(a), may determine.

The information in this prospectus is not complete and may be changed. A registration statement relating to these securities has been filed with the Securities and Exchange Commission. These securities may not be sold until the registration statement is effective. This preliminary prospectus is not an offer to sell nor does it seek an offer to buy these securities in any state where the offer or sale is not permitted.

Subject to Completion, Dated _____, 2008

Shares

Select Medical Holdings Corporation

Common Stock

This is an initial public offering of shares of common stock of Select Medical Holdings Corporation. We are offering _____ shares of our common stock and the selling stockholders are offering _____ shares of our common stock. We will not receive any proceeds from the sale of shares of common stock by the selling stockholders.

There is no existing public market for our common stock. It is currently estimated that the initial public offering price will be between \$ _____ and \$ _____ per share. We have applied to have our common stock approved for quotation on the New York Stock Exchange under the symbol SLC.

See Risk Factors beginning on page 13 to read about factors you should consider before buying shares of the common stock.

	Price to Public	Underwriting Discounts and Commissions	Proceeds to Select Medical Holdings Corporation	Proceeds to Selling Stockholders⁽¹⁾
Per Share	\$	\$	\$	\$
Total	\$	\$	\$	\$

(1) We have agreed to reimburse the selling stockholders for the underwriting discounts and commissions on the shares sold by them. This amount will be approximately \$ million.

To the extent the underwriters sell more than shares of common stock, the underwriters have the option to purchase up to an additional shares from Select Medical Holdings Corporation at the initial public offering price less the underwriting discount.

The underwriters expect to deliver the shares against payment in New York, New York on , 2008.

Neither the Securities and Exchange Commission nor any other regulatory body has approved or disapproved of these securities or passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

Morgan Stanley

Merrill Lynch & Co.

Goldman, Sachs & Co.

J.P. Morgan

Wachovia Securities

Credit Suisse

Jefferies & Company

Prospectus dated , 2008

TABLE OF CONTENTS

	Page
PROSPECTUS SUMMARY	1
RISK FACTORS	13
FORWARD-LOOKING STATEMENTS	29
USE OF PROCEEDS	30
DIVIDEND POLICY	31
CAPITALIZATION	32
DILUTION	33
SELECTED HISTORICAL CONSOLIDATED FINANCIAL DATA	35
UNAUDITED PRO FORMA CONSOLIDATED FINANCIAL INFORMATION	38
MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS	43
BUSINESS	77
MANAGEMENT	104
PRINCIPAL AND SELLING STOCKHOLDERS	134
CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS	136
DESCRIPTION OF CAPITAL STOCK	139
DESCRIPTION OF INDEBTEDNESS	143
SHARES ELIGIBLE FOR FUTURE SALE	148
MATERIAL U.S. FEDERAL TAX CONSIDERATIONS FOR NON-UNITED STATES HOLDERS	150
UNDERWRITERS	153
LEGAL MATTERS	158
EXPERTS	158
INDUSTRY DATA	158
WHERE YOU CAN FIND MORE INFORMATION	158
INDEX TO FINANCIAL STATEMENTS	F-1

You should rely only on the information contained in this prospectus. Neither we, the selling stockholders nor the underwriters have authorized any other person to provide you with different information. If anyone provides you with different or inconsistent information, you should not rely on it. Neither we, the selling stockholders nor the underwriters are making an offer to sell these securities in any jurisdiction where the offer or sale is not permitted. You should assume that the information appearing in this prospectus is accurate only as of the date on the front cover of this prospectus or other date stated in this prospectus. Our business, financial condition, results of operations and prospects may have changed since that date, and we have an obligation to provide updates to this prospectus only to the extent that the information contained in this prospectus becomes materially deficient or misleading after the date on the front cover.

As used in this prospectus, unless the context otherwise indicates, the references to Holdings refer to Select Medical Holdings Corporation, and the references to Select refer to Select Medical Corporation (a wholly-owned subsidiary of Holdings) and references to our company, us, we and our refer to Holdings together with Select and its subsidiaries.

Unless otherwise indicated or the context otherwise requires, financial data in this prospectus reflects the consolidated business and operations of Select Medical Holdings Corporation and its wholly-owned subsidiaries. Except where otherwise indicated, \$ indicates U.S. dollars.

Until , 2008 (25 days after the date of this prospectus), all dealers that buy, sell or trade our common stock, whether or not participating in this offering, may be required to deliver a prospectus. This is in addition to the dealers obligation to deliver a prospectus when acting as underwriters and with respect to their unsold allotments or subscriptions.

PROSPECTUS SUMMARY

The following summary highlights information contained elsewhere in this prospectus and is qualified in its entirety by more detailed information and consolidated financial statements included elsewhere in this prospectus. Because it is a summary, it does not contain all of the information that you should consider before investing in our common stock. You should read this prospectus carefully, including the section entitled Risk Factors and the consolidated financial statements and the related notes to those statements included elsewhere in this prospectus.

Our Business

Overview

We believe that we are one of the largest operators of both specialty hospitals and outpatient rehabilitation clinics in the United States based on number of facilities. As of June 30, 2008, we operated 88 long term acute care hospitals and four inpatient rehabilitation facilities in 25 states, and 970 outpatient rehabilitation clinics in 37 states and the District of Columbia. We also provide medical rehabilitation services on a contract basis at nursing homes, hospitals, assisted living and senior care centers, schools and worksites. We began operations in 1997 under the leadership of our current management team, including our co-founders, Rocco A. Ortenzio and Robert A. Ortenzio, who have a combined 66 years of experience in the healthcare industry. Under this leadership, we have grown our business from its founding to a business that generated net operating revenue of \$1,991.7 million for the year ended December 31, 2007.

Business Segments and Strategy

We manage our company through two business segments, our specialty hospital and our outpatient rehabilitation segments, which accounted for approximately 70% and 30%, respectively, of our net operating revenues for the year ended December 31, 2007. Our specialty hospital segment consists of hospitals designed to serve the needs of long term stay acute patients and hospitals designed to serve patients who require intensive inpatient medical rehabilitation. Our outpatient rehabilitation business consists of clinics and contract services that provide physical, occupational and speech rehabilitation services.

Specialty Hospitals

The key elements to our specialty hospital strategy are to:

Focus on Specialized Inpatient Services. We serve highly acute patients and patients with debilitating injuries that cannot be adequately cared for in a less medically intensive environment, such as a skilled nursing facility. Generally, patients in our specialty hospitals require longer stays and higher levels of clinical care than patients treated in general acute care hospitals. Our patients' average length of stay in our specialty hospitals is 25 days for the year ended December 31, 2007.

Provide High Quality Care and Service. We believe that our specialty hospitals serve a critical role in comprehensive healthcare delivery. Through our specialized treatment programs and staffing models, we treat patients with acute, complex and specialized medical needs who are typically referred to us by general acute care hospitals. Our specialized treatment programs focus on specific patient needs and medical conditions such as specific ventilator weaning programs and wound care protocols. Our responsive staffing models ensure that patients have the appropriate clinical resources over the course of their stay. We believe that we are recognized

for providing quality care and service, as evidenced by accreditation by The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities. We also believe we develop brand loyalty in the local areas we serve allowing us to strengthen our relationships with physicians and other referral sources and drive additional patient volume to our hospitals.

Reduce Operating Costs. We continually seek to improve operating efficiency and reduce costs at our hospitals by standardizing operations and centralizing key administrative functions. These initiatives include optimizing staffing based on our occupancy and the clinical needs of our patients, centralizing

administrative functions, standardizing management information systems and participating in group purchasing arrangements.

Increase Higher Margin Commercial Volume. With reimbursement rates from commercial insurers typically higher than the federal Medicare program, we have focused on continued expansion of our relationships with commercial insurers to increase our volume of patients with commercial insurance in our specialty hospitals. Although the level of care we provide is complex and staff intensive, we typically have lower relative operating expenses than a general acute care hospital because we provide a much narrower range of patient services at our hospitals. We believe that commercial payors seek to contract with our hospitals because we offer patients high quality, cost-effective care at more attractive rates than general acute care hospitals.

Develop New Inpatient Rehabilitation Facilities. By leveraging the experience of our senior management and dedicated development team, we intend to pursue new inpatient rehabilitation hospital development opportunities.

Pursue Opportunistic Acquisitions. In addition to our development initiatives, we may grow our network of specialty hospitals through opportunistic acquisitions. Our immediate focus is on acquisitions of inpatient rehabilitation facilities, although we will still consider acquisitions of long term acute care hospitals if they are at attractive valuations.

Outpatient Rehabilitation

The key elements to our outpatient rehabilitation strategy are to:

Provide High Quality Care and Service. We are focused on providing a high level of service to our patients throughout their entire course of treatment. This high quality of care and service allows us to strengthen our relationships with referring physicians, employers and health insurers and drive additional patient volume.

Increase Market Share. We strive to establish a leading presence within the local areas we serve. This allows us to realize economies of scale, heightened brand loyalty, workforce continuity and increased leverage when negotiating payor contracts.

Expand Rehabilitation Programs and Services. Through our local clinical directors of operations and clinic managers within their service areas, we assess the healthcare needs of the areas we serve. Based on these assessments, we implement additional programs and services specifically targeted to meet demand in the local community.

Optimize the Profitability of Our Payor Contracts. We rigorously review payor contracts up for renewal and potential new payor contracts to optimize our profitability. We believe that our size and our strong reputation enables us to negotiate favorable outpatient contracts with commercial insurers.

Maintain Strong Employee Relations. We seek to retain, motivate and educate our employees whose relationships with referral sources are key to our success.

Pursue Opportunistic Acquisitions. We may grow our network of outpatient rehabilitation facilities through opportunistic acquisitions. We significantly expanded our network with the 2007 acquisition of the outpatient rehabilitation division of HealthSouth Corporation, consisting of 569 clinics in 35 states and the District of Columbia, including eighteen states in which we did not previously have outpatient rehabilitation facilities. We believe our size and centralized infrastructure allow us to take advantage of operational efficiencies and

increase margins at acquired facilities.

Our Competitive Strengths

We believe that the success of our business model is based on a number of competitive strengths, including:

Leading Operator in Distinct but Complementary Lines of Business. We believe that we are a leading operator in each of our principal business segments, based on number of facilities in the United States. Our leadership position and reputation as a high quality, cost-effective health care provider in each of our

business segments allows us to attract patients and employees, aids us in our marketing efforts to payors and referral sources and helps us negotiate payor contracts.

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 an intense focus on free cash flow generation.

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. As a result, we have been able to minimize our general and administrative expense as a percentage of revenues, which was 2.2% for the year ended December 31, 2007.

Well-Positioned to Capitalize on Consolidation Opportunities. We believe that we are well-positioned to capitalize on consolidation opportunities within each of our business segments and selectively augment our internal growth. With our geographically diversified portfolio of facilities in the United States, we believe that our footprint provides us with a wide-ranging perspective on multiple potential acquisition opportunities.

Experience in Successfully Completing and Integrating Acquisitions. From our inception in 1997 through 2007, we completed six significant acquisitions for approximately \$894.8 million in aggregate consideration. We believe that we have improved the operating performance of these facilities over time by applying our standard operating practices and by realizing efficiencies from our centralized operations and management.

Experienced and Proven Management Team. Prior to co-founding our company with our current Chief Executive Officer, our Executive Chairman founded and operated three other healthcare companies focused on inpatient and outpatient rehabilitation services. In addition, our four senior operations executives have an average of over 30 years of experience in the healthcare industry, including extensive experience working together for our company and for past companies focused on operating acute rehabilitation hospitals and outpatient rehabilitation facilities.

Industry

In the United States, spending on healthcare accounted for approximately 16% of the gross domestic product in 2007, according to the Centers for Medicare & Medicaid Services. An important factor driving healthcare spending is increased consumption of services due to the aging of the population. The number of individuals age 65 and older has grown 1.2% compounded annually over the past twenty years and is expected to grow 2.9% compounded annually over the next twenty years, approximately three times faster than the overall population, according to the U.S. Census Bureau. We believe that an increasing number of individuals age 65 and older will drive demand for our specialized medical services.

For individuals age 65 and older, the primary source of health insurance is the federal Medicare program. Medicare utilizes distinct payment methodologies for services provided in long term acute hospitals, inpatient rehabilitation facilities and outpatient rehabilitation clinics. In the federal fiscal year 2006, Medicare payments for long term acute hospital services accounted for 1.1% of overall Medicare outlays and Medicare payments for inpatient rehabilitation services accounted for 1.5%, according to the Medicare Payment Advisory Commission.

Risk Factors

Before you invest in our shares, you should carefully consider all of the information in this prospectus, including matters set forth under the heading Risk Factors, such as:

Highly regulated industry. The healthcare services industry is subject to extensive federal, state and local laws and regulations. We conduct business in a heavily regulated industry and changes in regulations, new interpretations of existing regulations or violations of regulations could have a material adverse effect on our business, financial condition and results of operations.

Reliance on Medicare reimbursement. Approximately 48% and 46% of our net operating revenues for the year ended December 31, 2007 and the six months ended June 30, 2008, respectively, came from the highly

regulated federal Medicare program. If there are changes in the rates or methods of government reimbursements for our services, our business, financial condition and results of operations could decline.

Changes in federal regulations applicable to hospitals within hospitals. At June 30, 2008, 66 of our 88 long term acute care hospitals operated as hospitals within hospitals or as satellites. Recent federal regulations have lowered rates of reimbursement for services we provide to certain Medicare patients admitted to long term acute care hospitals operated as hospitals within hospitals or as satellites. Compliance with such changes in federal regulations may have an adverse effect on our future net operating revenues and profitability.

Changes in federal regulations applicable to free-standing hospitals and grandfathered long term acute care hospitals operated as hospitals within hospitals or satellites. At June 30, 2008, 22 of our 88 long term acute care hospitals operated as free-standing hospitals and two qualified as grandfathered long term acute care hospitals operated as hospitals within hospitals or satellites. Recent federal regulations have lowered rates of reimbursement for services we provide to certain Medicare patients admitted to free-standing long term acute care hospitals and grandfathered long term acute care hospitals operated as hospitals within hospitals or satellites. Significant aspects of these federal regulations have been postponed for a three year moratorium period. If these recent federal regulations are applied as currently written at the end of the three year moratorium, it would have an adverse effect on our future net operating revenues and profitability.

Failure to maintain certifications as long term acute care hospitals. At June 30, 2008, 84 of our 88 long term acute care hospitals were certified by Medicare as long term acute care hospitals, and four more were in the process of becoming certified as Medicare long term acute care hospitals. If our long term acute care hospitals fail to meet or maintain the standards for certification as long term acute care hospitals, such as minimum average length of patient stay, they will receive significantly less Medicare reimbursement than they currently receive for their patient services.

Modifications to the admissions policies for our inpatient rehabilitation facilities. At June 30, 2008, our four acute medical rehabilitation hospitals were certified by Medicare as inpatient rehabilitation facilities. Changes to federal regulations have made significant changes to the inpatient rehabilitation facilities certification process. In order to comply with the Medicare inpatient rehabilitation facility certification criteria, it may be necessary for us to implement more restrictive admissions policies at our inpatient rehabilitation facilities and not admit patients whose diagnoses fall outside the specified conditions. Such policies may result in a reduction of patient volume at these hospitals and, as a result, may reduce our future net operating revenues and profitability.

Company Information

Select was formed in December 1996 by Rocco A. Ortenzio and Robert A. Ortenzio and commenced operations during February 1997 upon the completion of its first acquisition. Holdings was formed in October 2004. On February 24, 2005, EGL Acquisition Corp., a wholly-owned subsidiary of Holdings, was merged with Select, with Select continuing as the surviving corporation and a wholly-owned subsidiary of Holdings. We refer to this merger and the related transactions collectively as the Merger Transactions. Holdings was formerly known as EGL Holding Company. Holdings primary asset is its investment in Select. Holdings is owned by an investor group that includes Welsh, Carson, Anderson & Stowe IX, L.P., WCAS Capital Partners IV, L.P. and WCAS Management Corporation, Thoma Cressey Bravo and members of our senior management. We refer to Welsh, Carson, Anderson & Stowe IX, L.P., WCAS Capital Partners IV, L.P. and WCAS Management Corporation, collectively as Welsh Carson and Thoma Cressey Bravo as Thoma Cressey.

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Select Medical Holdings Corporation was incorporated on October 14, 2004 as a Delaware corporation. Our principal executive office is located at 4714 Gettysburg Road, Mechanicsburg, Pennsylvania 17055 and our telephone number is (717) 972-1100.

Our website address is www.selectmedicalcorp.com. Our website and the information contained therein or connected thereto shall not be deemed to be incorporated into this prospectus or the registration statement of which it forms a part.

THE OFFERING

Shares of common stock offered by us shares, or shares if the underwriters exercise their over-allotment option in full.

Shares of common stock offered by the selling stockholders shares, or shares if the underwriters exercise their over-allotment option in full.

The number of shares offered by the selling stockholders includes shares of common stock into which the preferred stock held by them will convert immediately prior to the consummation of the offering.

Common stock to be outstanding after this offering shares, or shares if the underwriters exercise their over-allotment option in full.

Use of proceeds We estimate that we will receive net proceeds from the sale of shares of our common stock in this offering of \$ million, or \$ million if the underwriters exercise their over-allotment option in full, after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. We intend to use the net proceeds of this offering to:

 repay approximately \$ million of loans outstanding under our senior secured credit facilities, and any related prepayment costs;

 make payments under the Long Term Cash Incentive Plan in the amount of approximately \$ million;

 pay approximately \$ to the holders of our common stock who are not selling stockholders in this offering in payment for a portion of the common stock they received upon the conversion of our preferred stock immediately prior to the consummation of this offering at the public offering price; and

 pay approximately \$ to reimburse the selling stockholders for the underwriting discount incurred on shares sold by them in this offering.

Any remaining net proceeds will be used for general corporate purposes. Affiliates of J.P. Morgan Securities Inc., Wachovia Capital Markets, LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, underwriters in this offering, are parties to our senior secured credit facility and will receive a portion of the proceeds from this offering.

We will not receive any of the proceeds from the sale of shares of common stock by the selling stockholders. See Use of Proceeds, Principal and Selling Stockholders and Underwriters.

Dividend policy

We do not anticipate paying any dividends on our common stock in the foreseeable future. Any future determination relating to our dividend policy will be made at the discretion of our board of directors and will depend on then existing conditions, including our financial condition, results of operations, contractual restrictions, capital requirements, business prospects and other factors our board of directors may deem relevant. In addition, our ability to declare and pay dividends is

restricted by covenants in our senior secured credit facility and the indentures governing Select's senior subordinated notes due 2015, which we refer to as Select's 75/8% senior subordinated notes, and our senior floating rate notes due 2015, which we refer to as the senior floating rate notes. See Description of Indebtedness Senior Secured Credit Facility Restrictive Covenants and Other Matters and Risk Factors.

Proposed New York Stock Exchange symbol

SLC.

Risk factors

Investment in our common stock involves substantial risks. You should read this prospectus carefully, including the section entitled Risk Factors and the consolidated financial statements and the related notes to those statements included elsewhere in this prospectus before investing in our common stock.

It is anticipated that prior to the consummation of this offering, our stockholders will approve an amendment to our amended and restated certificate of incorporation that will provide that immediately prior to this offering, each share of our outstanding preferred stock will convert into a number of common shares to be determined by:

dividing the original cost of a share of the preferred stock (\$26.90 per share) plus all accrued and unpaid dividends thereon less the amount of any previously declared and paid special dividends, or the accreted value of such preferred stock by the initial public offering price per share in this offering; plus

one share of common stock for each share of participating preferred shares owned.

In this prospectus, unless otherwise indicated it is assumed that the conversion described above will be effected at \$ per share, the midpoint of the range set forth on the cover page of this prospectus. Unless otherwise indicated, references in this prospectus to the conversion of our preferred stock refer to the transactions contemplated by the amendment to our amended and restated certificate of incorporation that is described above.

The number of shares of our common stock to be outstanding after this offering is based on 204,859,489 shares outstanding as of June 30, 2008 and excludes:

120,000 shares of our common stock issuable upon exercise of options granted under our director stock option plan. See Management Compensation Discussion and Analysis Director Compensation Table Option Awards.

4,527,987 shares of our common stock issuable upon exercise of options granted under the Select Medical Holdings Corporation 2005 Equity Incentive Plan. See Management Compensation Discussion and Analysis Elements of Compensation Equity Compensation.

Unless otherwise noted, all information in this prospectus:

assumes that the underwriters do not exercise their over-allotment option; and

other than historical financial information, reflects the conversion of shares of our issued and outstanding preferred stock into shares of common stock at a conversion ratio of 1: immediately prior to the consummation of this offering, based upon an assumed public offering price of \$ per share, the midpoint

of the range set forth on the cover page of this prospectus.

SUMMARY HISTORICAL AND OTHER FINANCIAL DATA

The following table sets forth, for the periods and dates indicated, our summary historical and other financial data. We have derived the statements of operations data for the period from January 1 through February 24, 2005, or the Predecessor Period, and February 25 through December 31, 2005 and for the years ended December 31, 2006 and 2007, or the Successor Period, and the balance sheet data as of December 31, 2006 and 2007 from our audited consolidated financial statements appearing elsewhere in this prospectus. We have derived the statements of operations data for the six months ended June 30, 2007 and 2008 and balance sheet data as of June 30, 2008 from our unaudited consolidated financial statements appearing elsewhere in this prospectus. The summary financial data presented below represent portions of our financial statements and are not complete. You should read this information in conjunction with Use of Proceeds, Capitalization, Selected Historical Consolidated Financial Data, Management Discussion and Analysis of Financial Condition and Results of Operations and the consolidated financial statements and related notes included elsewhere in this prospectus.

The pro forma as adjusted consolidated financial statements of operations for the year ended December 31, 2007 and for the six months ended June 30, 2008 gives effect to the conversion of our preferred stock, based upon an assumed public offering price of \$ per share, the midpoint of the range set forth on the cover page of this prospectus, and the expected proceeds from this offering as if they had occurred on January 1, 2007. The balance sheet data as of June 30, 2008, gives effect to the conversion of our preferred stock, based upon an assumed public offering price of \$ per share, the midpoint of the range set forth on the cover page of this prospectus, and the expected use of proceeds from this offering as if they had occurred on June 30, 2008. The pro forma consolidated financial statement of operations excludes non-recurring charges directly attributable to the offering, including \$ million (net of tax) related to payments under the Long Term Cash Incentive Plan and \$ million (net of tax) related to reimbursing the selling stockholders for the underwriting discounts and commissions incurred on shares sold by them in this offering. You should read this information in conjunction with Unaudited Pro Forma Consolidated Financial Information included elsewhere in this prospectus.

	Predecessor Period Period from January 1 through February 24, 2005	Period from February 25 through December 31, 2005 (in thousands, except per share data)	Successor Period Year Ended December 31, 2006 2007		Pro Forma As Adjusted 2007
Statement of Operations Data:					
Net operating revenues	\$ 277,736	\$ 1,580,706	\$ 1,851,498	\$ 1,991,666	
Operating expenses ⁽¹⁾⁽²⁾	373,418	1,322,068	1,546,956	1,740,484	
Depreciation and amortization	5,933	37,922	46,668	57,297	
Income (loss) from operations	(101,615)	220,716	257,874	193,885	
Loss on early retirement of debt ⁽³⁾	(42,736)				
Merger related charges ⁽⁴⁾	(12,025)				
Other income (expense)	267	1,092		(167)	
Interest expense, net ⁽⁵⁾	(4,128)	(101,441)	(130,538)	(138,052)	
Income (loss) from continuing operations before minority interests and income taxes	(160,237)	120,367	127,336	55,666	
Minority interests in consolidated subsidiary companies ⁽⁶⁾	330	1,776	1,414	1,537	
Income (loss) from continuing operations before income taxes	(160,567)	118,591	125,922	54,129	
Income tax expense (benefit)	(59,794)	49,336	43,521	18,699	
Income (loss) from continuing operations	(100,773)	69,255	82,401	35,430	
Income from discontinued operations, net of tax	522	3,072	12,478		
Net income (loss)	(100,251)	72,327	94,879	35,430	
Less: Preferred dividends		23,519	22,663	23,807	
Net income (loss) available to common and preferred stockholders	\$ (100,251)	\$ 48,808	\$ 72,216	\$ 11,623	
Income (loss) per common share:					
Basic:					
Income (loss) from continuing operations	\$ (0.99) 0.01	\$ 0.23 0.02	\$ 0.30 0.06	\$ 0.05	

Income from discontinued operations,
net of tax

Net income (loss)	\$	(0.98)	\$	0.25	\$	0.36	\$	0.05
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Diluted:

Income (loss) from continuing operations	\$	(0.99)	\$	0.22	\$	0.28	\$	0.05
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Income from discontinued operations,
net of tax

		0.01		0.02		0.06		
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Net income (loss)	\$	(0.98)	\$	0.24	\$	0.34	\$	0.05
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Balance Sheet Data (at end of period):

Cash and cash equivalents		\$	35,861	\$	81,600	\$	4,529
Working capital			77,556		59,468		14,730
Total assets			2,168,385		2,182,524		2,495,046
Total debt			1,628,889		1,538,503		1,755,635
Preferred stock			444,765		467,395		491,194
Total stockholders' equity			(244,658)		(169,139)		(165,889)

Segment Data:

Specialty Hospitals⁽⁷⁾:

Net operating revenue	\$	202,781	\$	1,169,702	\$	1,378,543	\$	1,386,410
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Adjusted EBITDA ⁽⁸⁾		44,384		263,760		283,270		217,175
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Outpatient Rehabilitation:

Net operating revenue		73,344		407,367		470,339		603,413
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Adjusted EBITDA ⁽⁸⁾		9,848		56,109		64,823		75,437
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	Six Months Ended June 30,	
	Pro Forma	
	As Adjusted	
	2007	2008
	(in thousands, except per share data)	
Statement of Operations Data:		
Net operating revenues	\$ 973,313	\$ 1,087,084
Operating expenses ⁽¹⁾⁽²⁾	826,769	948,992
Depreciation and amortization	25,643	35,327
Income from operations	120,901	102,765
Other income	1,173	
Interest expense, net ⁽⁵⁾	(66,154)	(73,268)
Income from operations before minority interests and income taxes	55,920	29,497
Minority interests in consolidated subsidiary companies ⁽⁶⁾	1,136	1,071
Income from operations before income taxes	54,784	28,426
Income tax expense	22,998	13,973
Net income	31,786	14,453
Less: Preferred dividends	11,656	12,279
Net income available to common and preferred stockholders	\$ 20,130	\$ 2,174
Net income per common share:		
Basic	\$ 0.10	\$ 0.01
Diluted	0.10	0.01
Balance Sheet Data (at end of period):		
Cash and cash equivalents	\$ 25,610	\$ 7,534
Working capital surplus (deficit)	(3,985)	105,745
Total assets	2,457,840	2,544,037
Total debt	1,717,785	1,805,462
Preferred stock	479,044	503,179
Total stockholders' equity	(146,311)	(165,703)
Segment Data:		
Specialty Hospitals ⁽⁷⁾ :		
Net operating revenue	\$ 699,510	\$ 745,893
Adjusted EBITDA ⁽⁸⁾	126,721	118,480
Outpatient Rehabilitation:		
Net operating revenue	272,066	341,072
Adjusted EBITDA ⁽⁸⁾	42,171	43,843

Operating Statistics

The following tables set forth operating statistics for our specialty hospitals and our outpatient rehabilitation clinics for each of the periods presented. The data in the table reflect the changes in the number of specialty hospitals and outpatient rehabilitation clinics we operate that resulted from acquisitions, start-up activities, closures, sales and consolidations. The operating statistics reflect data for the period of time these operations were managed by us.

	Combined Year Ended December 31, 2005	Year Ended December 31, 2006	Year Ended December 31, 2007
Specialty hospital data⁽⁷⁾:			
Number of hospitals start of period	86	101	96
Number of hospital start-ups		3	3
Number of hospitals acquired	17		
Number of hospitals closed/sold	(2)	(4)	(8)
Number of hospitals consolidated		(4)	(4)
Number of hospitals end of period	101	96	87
Available licensed beds	3,829	3,867	3,819
Admissions	39,963	39,668	40,008
Patient days	985,025	969,590	987,624
Average length of stay (days)	25	24	25
Net revenue per patient day ⁽⁹⁾	\$ 1,370	\$ 1,392	\$ 1,378
Occupancy rate	70%	69%	69%
Percent patient days Medicare	75%	73%	69%
Outpatient rehabilitation data⁽¹⁰⁾:			
Number of clinics owned start of period	589	553	477
Number of clinics acquired			570
Number of clinic start-ups	22	12	15
Number of clinics closed/sold ⁽¹¹⁾	(58)	(88)	(144)
Number of clinics owned end of period	553	477	918
Number of clinics managed end of period	55	67	81
Total number of clinics (all) end of period	608	544	999
Number of visits	3,308,620	2,972,243	4,032,197
Net revenue per visit ⁽¹²⁾	\$ 89	\$ 94	\$ 100

	Six Months Ended June 30,	
	2007	2008
Specialty hospital data⁽⁷⁾:		
Number of hospitals start of period	96	87
Number of hospital start-ups	1	6
Number of hospitals closed/sold	(1)	
Number of hospitals consolidated	(4)	(1)
Number of hospitals end of period	92	92
Available licensed beds	3,983	4,126
Admissions	20,239	20,914
Patient days	499,844	512,286
Average length of stay (days)	25	25
Net revenue per patient day ⁽⁹⁾	\$ 1,374	\$ 1,428
Occupancy rate	71%	69%
Percent patient days Medicare	71%	66%
Outpatient rehabilitation data:		
Number of clinics owned start of period	477	918
Number of clinics acquired	541	
Number of clinic start-ups	5	9
Number of clinics closed/sold	(27)	(33)
Number of clinics owned end of period	996	894
Number of clinics managed end of period	110	76
Total number of clinics (all) end of period	1,106	970
Number of visits	1,726,264	2,323,609
Net revenue per visit ⁽¹²⁾	\$ 100	\$ 103

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- (1) Operating expenses include cost of services, general and administrative expenses, and bad debt expenses.
- (2) Includes stock compensation expense related to the repurchase of outstanding stock options in the Predecessor period from January 1 through February 24, 2005, compensation expense related to restricted stock, stock options and long term incentive compensation in the Successor Periods from February 25 through December 31, 2005, and for the years ended December 31, 2006 and 2007 and for the six months ended June 30, 2007 and 2008.
- (3) In connection with the Merger Transactions, Select completed tender offers for all of its 9 1/2% senior subordinated notes due 2009 and all of its 7 1/2% senior subordinated notes due 2013. The loss in the Predecessor period of January 1 through February 24, 2005 consists of the tender premium cost of \$34.8 million and the remaining write-off of unamortized deferred financing costs of \$7.9 million.
- (4) As a result of the Merger Transactions, Select incurred costs in the Predecessor period of January 1 through February 24, 2005 directly related to the Merger. This included the cost of the investment advisor hired by the special committee of Select's board of directors to evaluate the Merger, legal and accounting fees, costs

associated with the Hart-Scott-Rodino filing relating to the Merger, the cost associated with purchasing a six year extended reporting period under our directors and officers liability insurance policy and other associated expenses.

- (5) Net interest equals interest expense minus interest income.
- (6) Reflects interests held by other parties in subsidiaries, limited liability companies and limited partnerships owned and controlled by us.
- (7) Specialty hospitals consist of long term acute care hospitals and inpatient rehabilitation facilities.
- (8) We define Adjusted EBITDA as net income before interest, income taxes, depreciation and amortization, income from discontinued operations, loss on early retirement of debt, merger related charges, stock compensation expense, long term incentive compensation, other income/expense and minority interest. We believe that the presentation of Adjusted EBITDA 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 operating units. Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles. Items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to, or substitute for, net income, 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 generally accepted accounting principles and is thus susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies. See footnote 13 to our audited consolidated financial statements and footnote 7 to our interim unaudited consolidated financial statements for the period ended June 30, 2008 for a reconciliation of net income to Adjusted EBITDA as utilized by us in reporting our segment performance in accordance with SFAS No. 131.

- (9) Net revenue per patient day is calculated by dividing specialty hospital patient service revenues by the total number of patient days.
- (10) Clinic data has been restated to remove the clinics operated by Canadian Back Institute Limited, which we refer to as CBIL, which was sold on March 31, 2006 and is being reported as a discontinued operation in 2005 and 2006.
- (11) The number of clinics closed/sold for the year ended December 31, 2007 relate primarily to clinics closed in connection with the restructuring plan for integrating the acquisition of HealthSouth Corporation's outpatient rehabilitation division.
- (12) Net revenue per visit is calculated by dividing outpatient rehabilitation clinic revenue by the total number of visits. For purposes of this computation, outpatient rehabilitation clinic revenue does not include contract services revenue.

RISK FACTORS

Investing in our common stock involves a high degree of risk. You should consider carefully the following risk factors and the other information in this prospectus, including our consolidated financial statements and related notes, before you decide to purchase our common stock. If any of the following risks actually occur, our business, financial condition and operating results could be adversely affected. As a result, the trading price of our common stock could decline and you could lose part or all of your investment.

Risks Relating to Our Business and Industry

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

Approximately 48% and 46% of our net operating revenues for the year ended December 31, 2007 and the six months ended June 30, 2008, respectively, came from the highly regulated federal Medicare program. In recent years, through legislative and regulatory actions, the federal government has made substantial changes to various payment systems under the Medicare program. Additional changes to these payment systems, including modifications to the conditions on qualification for payment and the imposition of enrollment limitations on new providers, may be proposed or could be adopted, either by the U.S. Congress or by the Centers for Medicare & Medicaid Services, 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. Some of these changes and proposed changes could adversely affect our business strategy, operations and financial results. In addition, there can be no assurance that any increases in Medicare reimbursement rates established by CMS will fully reflect increases in our operating costs.

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

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to:

facility and professional licensure, including certificates of need;

conduct of operations, including financial relationships among healthcare providers, Medicare fraud and abuse, and physician self-referral;

addition of facilities and services and enrollment of newly developed facilities in the Medicare program;

payment for services; and

safeguarding protected health information.

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, cost reporting, billing practices, physician ownership and joint ventures involving hospitals. 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. See Business Government Regulations.

Compliance with changes in federal regulations applicable to long term acute care hospitals operated as hospitals within hospitals or as satellites may have an adverse effect on our future net operating revenues and profitability.

On August 11, 2004, CMS published final regulations applicable to long term acute care hospitals that are operated as hospitals within hospitals or as satellites. We collectively refer to hospitals within hospitals and

satellites as HIHs, and we refer to the CMS final regulations as the final regulations. HIHs are separate hospitals located in space leased from, and located in or on the same campus of, another hospital. We refer to such other hospitals as host hospitals.

Effective for hospital cost reporting periods beginning on or after October 1, 2004, the final regulations, subject to certain exceptions, provide lower rates of reimbursement to HIHs for those Medicare patients admitted from their host hospitals that are in excess of a specified percentage threshold. For HIHs opened after October 1, 2004, the Medicare admissions threshold has been established at 25% except for HIHs located in rural hospitals, metropolitan statistical area, or MSA dominant hospitals or single urban hospitals (as defined by the current regulations) where the percentage is no more than 50%, nor less than 25%. Certain grandfathered HIHs and satellites were also excluded from the Medicare admission threshold in the August 11, 2004 final regulations. Grandfathered HIHs refer to certain HIHs that were in existence on or before September 30, 1995, and satellite facilities refer to satellites of HIHs that were in existence on or before September 30, 1999.

For HIHs that meet specified criteria and were in existence as of October 1, 2004, including all but two of our then existing grandfathered HIHs, the Medicare admissions thresholds are phased in over a four year period starting with hospital cost reporting periods beginning on or after October 1, 2004, as follows: (1) for discharges during the cost reporting period beginning on or after October 1, 2004 and before October 1, 2005, the Medicare admissions threshold was the Fiscal 2004 Percentage (as defined below) of Medicare discharges admitted from the host hospital; (2) for discharges during the cost reporting period beginning on or after October 1, 2005 and before October 1, 2006, the Medicare admissions threshold was the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 75%; (3) for discharges during the cost reporting period beginning on or after October 1, 2006 and before October 1, 2007, the Medicare admissions threshold was the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 50%; and (4) for discharges during cost reporting periods beginning on or after October 1, 2007, the Medicare admissions threshold is 25%. The Medicare, Medicaid and SCHIP Extension Act of 2007, or the SCHIP Extension Act, generally limits the application of the Medicare admission threshold, however, to no lower than 50% for a three year period to commence on a long term acute care hospital s, or LTCH s, first cost reporting period to begin on or after December 29, 2007. Under the SCHIP Extension Act, for HIHs and satellite facilities located in rural areas and those which receive referrals from MSA dominant hospitals or single urban hospitals, the percentage threshold is no more than 75% during the same three year period. As of December 31, 2007, we had 66 LTCH HIHs, 11 of these HIHs were subject to a maximum 25% Medicare admissions threshold, 22 of these HIHs were subject to a Medicare admissions threshold between 25% and 50%, 31 of these HIHs were subject to a maximum 50% Medicare admissions threshold, and two of these HIHs were grandfathered HIHs and not subject to a Medicare admissions threshold.

With respect to any HIH, Fiscal 2004 Percentage means the percentage of all Medicare patients discharged by such HIH during its cost reporting period beginning on or after October 1, 2003 and before October 1, 2004 who were admitted to such HIH from its host hospital. In no event, however, is the Fiscal 2004 Percentage less than 25%.

During the year ended December 31, 2007, we recorded a reduction in our net operating revenues of approximately \$5.9 million related to estimated repayments to Medicare for host admissions exceeding an HIH s threshold. The liability has been recorded through a reduction in our net operating revenue. Additionally, changes in our admissions patterns may have further adversely impacted our potential revenues. Because these rules are complex and are based on the volume of Medicare admissions from our host hospitals as a percent of our overall Medicare admissions, we cannot predict with any certainty the impact on our future net operating revenues of compliance with these regulations. However, after the expiration of the three year moratorium provided by the SCHIP Extension Act, we expect the adverse financial impact to increase beginning for cost reporting periods on or after December 29, 2010 when the Medicare admissions thresholds decline to 25%, which may adversely affect our future net operating revenues and profitability.

Expiration of the three year moratorium imposed on certain federal regulations otherwise applicable to long term acute care hospitals operated as free-standing or grandfathered hospitals within hospitals or grandfathered satellites will have an adverse effect on our future net operating revenues and profitability.

All Medicare payments to our long term acute care hospitals are made in accordance with a prospective payment system specifically applicable to long term acute care hospitals, referred to as LTCH-PPS. On May 1, 2007, CMS published its annual payment rate update for the 2008 LTCH-PPS rate year, or RY 2008. We refer to such rate update as the May 2007 final rule. The May 2007 final rule makes several changes to LTCH-PPS payment methodologies and amounts during RY 2008. As described below, however, many of these changes have been postponed for a three year period by the SCHIP Extension Act.

For cost reporting periods beginning on or after July 1, 2007, the May 2007 final rule expanded the current Medicare HIH admissions threshold to apply to Medicare patients admitted from any individual hospital. Previously, the admissions threshold was applicable only to Medicare HIH admissions from hospitals co-located with an LTCH or satellite of an LTCH. Under the May 2007 final rule, free-standing LTCHs and grandfathered LTCH HIHs are subject to the Medicare admission thresholds, as well as HIHs and satellites that admit Medicare patients from non-co-located hospitals. To the extent that any LTCH's or LTCH satellite facility's discharges that are admitted from an individual hospital (regardless of whether the referring hospital is co-located with the LTCH or LTCH satellite) exceed the applicable percentage threshold during a particular cost reporting period, the payment rate for those discharges would be subject to a downward payment adjustment. Cases admitted in excess of the applicable threshold will be reimbursed at a rate comparable to that under general acute care inpatient prospective payment system, or IPPS. IPPS rates are generally lower than LTCH-PPS rates. Cases that reach outlier status in the discharging hospital would not count toward the limit and would be paid under LTCH-PPS.

The SCHIP Extension Act postpones the application of the percentage threshold to free-standing LTCHs and grandfathered satellites for a three year period commencing on an LTCH's first cost reporting period on or after December 29, 2007. However, the SCHIP Extension Act does not postpone the application of the percentage threshold, or the transition period stated above, to Medicare patients discharged from an LTCH HIH or satellite that were admitted from a non-co-located hospital. In addition, the SCHIP Extension Act, as interpreted by CMS, does not provide relief from the application of the threshold for patients admitted from a co-located hospital to certain nongrandfathered HIHs and satellites.

Of the 88 long term acute care hospitals we operated as of June 30, 2008, 22 were operated as free-standing hospitals and two qualified as grandfathered LTCH HIHs. If the May 2007 rule is applied as currently written, we expect the adverse financial impact to our net operating revenues and profitability to increase for cost reporting periods beginning on or after December 29, 2010.

The moratorium on the Medicare certification of new long term care hospitals and beds in existing long term care hospitals will limit our ability to increase long term acute care hospital bed capacity, expand into new areas or increase services in existing areas we serve.

The SCHIP Extension Act imposed a three year moratorium beginning on December 29, 2007 on the establishment and classification of new LTCHs, LTCH satellite facilities and LTCH beds in existing LTCH or satellite facilities. The moratorium does not apply to LTCHs that, before December 29, 2007, (1) began the qualifying period for payment under the LTCH-PPS, (2) had a written agreement with an unrelated party for the construction, renovation, lease or demolition for a LTCH and had expended at least 10% of the estimated cost of the project or \$2,500,000, or (3) had obtained an approved certificate of need. The moratorium also does not apply to an increase in beds in an existing hospital or satellite facility if the LTCH is located in a state where there is only one other LTCH and the LTCH requests an increase in beds following the closure or the decrease in the number of beds of the other LTCH. Since we

may still acquire LTCHs that were in existence prior to December 29, 2007, we do not expect this moratorium to materially impact our strategy to expand by acquiring additional LTCHs if such LTCHs can be acquired at attractive valuations. This moratorium, however, may still otherwise adversely affect our ability to increase long term acute care bed capacity, expand into new areas or increase bed capacity in existing areas we serve.

Government implementation of recent changes to Medicare's method of reimbursing our long term acute care hospitals will reduce our future net operating revenues and profitability.

The May 2007 final rule changed the 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 each long term care diagnosis-related group, or LTC-DRG (also referred to as short-stay outlier or SSO cases). Under this methodology, as a patient's length of stay increases, the percentage of the per diem amount based upon the IPPS component decreases and the percentage based on the LTC-DRG component increases. For the three year period beginning on December 29, 2007, the SCHIP Extension Act delays the SSO policy changes made in the May 2007 final rule. In an interim final rule dated May 6, 2008, CMS revised the regulations to provide that the change in the SSO policy adopted in the RY 2008 annual payment update does not apply for a three year period beginning with discharges occurring on or after December 29, 2007 and before December 29, 2010. The implementation of the payment methodology for short-stay outliers discharged after December 29, 2010 will reduce our future net operating revenues and profitability.

A long term acute care hospital is paid a pre-determined fixed amount under LTC-DRG depending upon the LTC-DRG to which each patient is assigned. LTCH-PPS includes special payment policies that adjust the payments for some patients based on a variety of factors. On May 2, 2006, CMS released its final annual payment rate updates for the 2007 LTCH-PPS rate year. We refer to such May 2006 rule as the May 2006 final rule. The May 2006 final rule made several changes to LTCH-PPS payment methodologies and amounts. For discharges occurring on or after July 1, 2006, the rule changed the payment methodology for SSO cases. Payment for these patients was previously based on the lesser of (1) 120% of the cost of the case, (2) 120% of the LTC-DRG specific per diem amount multiplied by the patient's length of stay or (3) the full LTC-DRG payment. The May 2006 final rule modified the limitation in clause (1) above to reduce payment for SSO cases to 100% (rather than 120%) of the cost of the case. The final rule also added a fourth limitation, capping payment for SSO cases at a per diem rate derived from blending 120% of the LTC-DRG specific per diem amount with a per diem rate based on the general acute care hospital IPPS. Under this methodology, as a patient's length of stay increases, the percentage of the per diem amount based upon the IPPS component decreases and the percentage based on the LTC-DRG component increases.

On May 1, 2007, CMS published its final annual payment rate updates for the 2007 LTCH-PPS rate year. The May 2007 final rule further revised the payment adjustment for SSO cases. Beginning with discharges on or after July 1, 2007, for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same diagnosis-related group, or DRG, under IPPS, referred to as the so-called IPPS comparable threshold, the rule effectively lowered the LTCH payment to a rate based on the general acute care hospital IPPS. SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the SSO payment policy described above under the May 2006 final rule. Cases with a covered length of stay less than or equal to the IPPS comparable threshold and less than five-sixths of the geometric average length of stay for that LTC-DRG would be paid at an amount comparable to the IPPS per diem. As previously stated, the SCHIP Extension Act delays the SSO policy changes made in the May 2007 final rule for the three year period beginning on December 29, 2007.

CMS estimated that the changes in the May 2006 final rule would result in an approximately 3.7% decrease in LTCH Medicare payments-per-discharge compared to the 2006 rate year, largely attributable to the revised SSO payment methodology. We estimated that the May 2006 final rule reduced Medicare revenues associated with SSO cases and high-cost outlier cases to our long term acute care hospitals by approximately \$29.3 million for the 2007 rate year (July 1, 2006 to June 30, 2007). Of this amount, we estimated an effect of approximately \$15.3 million on our Medicare payments for 2007 and \$14.0 million on our Medicare payments for 2006. Additionally, had CMS updated the LTCH-PPS standard federal rate by the 2007 estimated market basket index of 3.4% rather than applying the zero-percent update, we estimated that we would have received approximately \$31.0 million in additional annual Medicare revenues. We based this increase on our historical Medicare patient volumes and revenues (such revenues would have been paid to our hospitals for discharges beginning on or after July 1, 2006). See Business Government

Regulations Regulatory Changes and Business Government Regulations Overview of U.S. and State Government
Reimbursements Long term acute care hospital Medicare reimbursement.

If our long term acute care hospitals fail to maintain their certifications as long term acute care hospitals or if our facilities operated as HIHs fail to qualify as hospitals separate from their host hospitals, our net operating revenues and profitability may decline.

As of June 30, 2008, 84 of our 88 long term acute care hospitals were certified by Medicare as long term acute care hospitals. Our other long term acute care hospitals were in the process of becoming certified as Medicare long term acute care hospitals. Long term acute care hospitals must meet certain conditions of participation to enroll in, and seek payment from, the Medicare program as a long term acute care hospital, including, among other things, maintaining an average length of stay of 25 days or more. Similarly, our HIHs must meet conditions of participation in the Medicare program, which include additional criteria establishing separateness from the hospital with which the HIH shares space. If our long term acute care hospitals or HIHs fail to meet or maintain the standards for certification as long term acute care hospitals, they will receive payments under the general acute care hospitals IPPS rather than payment under the system applicable to long term acute care hospitals. Payments at rates applicable to general acute care hospitals would result in our long term acute care hospitals receiving significantly less Medicare reimbursement than they currently receive for their patient services.

Implementation of additional patient or facility criteria for LTCHs that limit the population of patients eligible for our hospitals' services or change the basis on which we are paid could adversely affect our net operating revenue and profitability.

CMS and industry stakeholders have, for a number of years, explored the development of facility and patient certification criteria for LTCHs, potentially as an alternative to the current specific payment adjustment features of LTCH-PPS. In its June 2004 Report to Congress, the Medical Payment Advisory Commission, or MedPAC, recommended the adoption by CMS of new facility staffing and services criteria and patient clinical characteristics and treatment requirements for LTCHs in order to ensure that only appropriate patients are admitted to these facilities. MedPac is an independent federal body that advises Congress on issues affecting the Medicare program. After MedPac's recommendation, CMS awarded a contract to Research Triangle Institute International, or RTI, to examine such recommendation. However, while acknowledging that RTI's findings are expected to have a substantial impact on future Medicare policy for LTCHs, CMS stated in the May 2006 final rule that many of the specific payment adjustment features of LTCH-PPS then in place may still be necessary and appropriate even with the development of patient- and facility-level criteria for LTCHs. In the preamble to the RY 2009 LTCH-PPS proposed rule, CMS indicated that RTI continues to work with the clinical community to make recommendations to CMS regarding payment and treatment of critically ill patients in LTCHs. The SCHIP Extension Act requires the Secretary of the Department of Health and Human Services to conduct a study and submit a report to Congress by June 29, 2009 on the establishment of national LTCH facility and patient criteria and to consider the recommendations contained in MedPAC's June 2004 report to Congress. Implementation of additional criteria that may limit the population of patients eligible for our hospitals' services or change the basis on which we are paid could adversely affect our net operating revenues and profitability. See Business Government Regulations Overview of U.S. and State Government Reimbursements Long term acute care hospital Medicare reimbursement.

Implementation of modifications to the admissions policies of our inpatient rehabilitation facilities as required in order to achieve compliance with Medicare regulations may result in a reduction of patient volume at these hospitals and, as a result, may reduce our future net operating revenues and profitability.

As of June 30, 2008, our four acute medical rehabilitation hospitals were certified by Medicare as inpatient rehabilitation facilities. Under the historic inpatient rehabilitation facility, or IRF, certification criteria that had been in effect since 1983, in order to qualify as an IRF, a hospital was required to satisfy certain operational criteria and demonstrate that, during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75% required intensive rehabilitation services for one or more of ten conditions specified in the regulations. We

refer to such 75% requirement as the 75% test. In 2002, CMS became aware that its various contractors were using inconsistent methods to assess compliance with the 75% test and that many inpatient rehabilitation facilities were not in compliance with the 75% test. In response, CMS suspended enforcement of the 75% test in June 2002. On September 9, 2003, CMS proposed modifications to the regulatory standards for

certification as an IRF. Notwithstanding concerns stated by the industry and Congress in late 2003 and early 2004 about the adverse impact that CMS's proposed changes and renewed enforcement efforts might have on access to inpatient rehabilitation facility services, and notwithstanding Congressional requests that CMS delay implementation of changes to the 75% test for additional study of clinically appropriate certification criteria, CMS adopted a final rule on May 7, 2004 that made significant changes to the certification standard. CMS temporarily lowered the 75% compliance threshold to 50%, with a gradual increase back to 75% over the course of a four year period. CMS also expanded from ten to 13 the number of medical conditions used to determine compliance with the 75% test (or any phase-in percentage) and finalized the conditions under which comorbidities may be used to satisfy the 75% test. Finally, CMS changed the timeframe used to determine a provider's compliance with the inpatient rehabilitation facility criteria including the 75% test so that any changes in a facility's certification based on compliance with the 75% test may be made effective in the cost reporting period immediately following the review period for determining compliance. Congress temporarily suspended enforcement of the 75% test when it enacted the Consolidated Appropriations Act, 2005, or CAA. CAA required the Secretary of Health and Human Services to respond within 60 days to a report by the Government Accountability Office, or GAO, on the standards for defining inpatient rehabilitation services before the Secretary may terminate a hospital's designation as an inpatient rehabilitation facility for failure to meet the 75% test. GAO issued its report on April 22, 2005 and recommended that CMS, based on further research, refine the 75% test to describe more thoroughly the subgroups of patients within the qualifying conditions that are appropriate for care in an inpatient rehabilitation facility. The Secretary issued a formal response to the GAO study on June 24, 2005 in which it concluded that the revised inpatient rehabilitation facility certification standards, including the 75% test, were consistent with the recommendations in GAO's report. In light of this determination, the Secretary announced that CMS would immediately begin enforcement of the revised certification standards.

Subsequently, under the Deficit Reduction Act of 2005 enacted on February 8, 2006, Congress extended the phase-in period for the 75% test by maintaining the compliance threshold at 60% (rather than increasing it to 65%) during the 12-month period beginning on July 1, 2006. The compliance threshold then increased to 65% for cost reporting periods beginning on or after July 1, 2007 and increased again to 75% for cost reporting periods beginning on or after July 1, 2008.

The SCHIP Extension Act includes a permanent freeze in the patient classification criteria compliance threshold at 60% (with comorbidities counting toward this threshold) and a rate freeze from April 1, 2008 through September 30, 2009. On April 25, 2008, CMS published the proposed rule for the inpatient rehabilitation facility prospective payment system, or IRF-PPS, for FY 2009. The proposed rule includes changes to the IRF-PPS regulations designed to implement portions of the SCHIP Extension Act. In particular, the patient classification criteria compliance threshold is established at 60% (with comorbidities counting toward this threshold). In the preamble discussion to the proposed rule, CMS notes that the President's FY 2009 budget proposes to repeal that portion of the SCHIP Extension Act that requires the compliance rate to be set no higher than 60% for cost reporting periods beginning on or after July 1, 2006. For this reason and others, CMS proposes to set the compliance rate at the highest level possible within current statutory authority.

In order to comply with Medicare inpatient rehabilitation facility certification criteria, it may be necessary for us to implement more restrictive admissions policies at our inpatient rehabilitation facilities and not admit patients whose diagnoses fall outside the specified conditions. Such policies may result in a reduction of patient volume at these hospitals and, as a result, may reduce our future net operating revenues and profitability. See Business Government Regulations Regulatory Changes Medicare Reimbursement of Inpatient Rehabilitation Facility Services.

Implementation of annual caps that limit the amount that can be paid for outpatient therapy services rendered to any Medicare beneficiary may reduce our future net operating revenues and profitability.

Our outpatient rehabilitation clinics receive payments from the Medicare program under a fee schedule. Congress has established annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for outpatient therapy services rendered to any Medicare beneficiary. These annual caps were to go into effect on January 1, 1999. After their adoption, however, Congress imposed a moratorium on the caps through 2002, and then re-imposed the moratorium for 2004 and 2005. Congress allowed the therapy caps to go back into effect on

January 1, 2006. Effective January 1, 2008, the annual limit on outpatient therapy services became \$1,810 for combined physical and speech language pathology services and \$1,810 for occupational therapy services. As directed by Congress in the Deficit Reduction Act of 2005, CMS implemented an exception process for therapy expenses incurred in 2006. Under this process, a Medicare enrollee (or person acting on behalf of the Medicare enrollee) was able to request an exception from the therapy caps if the provision of therapy services was deemed to be medically necessary. Therapy cap exceptions were available automatically for certain conditions and on a case-by-case basis upon submission of documentation of medical necessity. The SCHIP Extension Act extended the cap exception process through June 30, 2008. The Medicare Improvements for Patients and Providers Act of 2008 further extended the caps exceptions process through December 31, 2009. Elimination of the therapy cap exceptions may reduce our future net operating revenues and profitability.

To date, the implementation of the therapy caps has not had a material adverse effect on our business. If the exception process to therapy caps expires and is not renewed, our future net operating revenues and profitability may decline. For the year ended December 31, 2007 and the six months ended June 30, 2008, we received approximately 9.5% and 9.6%, respectively, of our outpatient rehabilitation net operating revenues from Medicare. See Business Government Regulations Regulatory Changes Medicare Reimbursement of Outpatient Rehabilitation Services.

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, required the United States Department of Health and Human Services to adopt standards to protect the privacy and security of individually identifiable health-related 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-related 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 health care providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically.

Violations of HIPAA could result in civil penalties of up to \$25,000 per type of violation in each calendar year and criminal penalties of up to \$250,000 per violation. In addition, 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 and could impose additional penalties. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy laws. Our compliance officers and information security officers are responsible for implementing and monitoring compliance with our HIPAA 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.

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 specialty hospitals, outpatient rehabilitation clinics and other related health care facilities and services. These acquisitions may involve significant cash expenditures, debt incurrence, additional operating losses and expenses that could have a material adverse effect on our financial condition and results of operations. Acquisitions (such as our acquisition of HealthSouth Corporation's outpatient rehabilitation division, which we are in the process of integrating into our business) involve numerous risks, including:

difficulty and expense of integrating acquired personnel into our business;

diversion of management's time from existing operations;

potential loss of key employees or customers of acquired companies; and

assumption of the liabilities and exposure to unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare regulations.

We cannot assure you that we will succeed in obtaining financing for acquisitions at a reasonable cost, or that such financing will not contain restrictive covenants that limit our operating flexibility. We also may be unable to operate acquired hospitals and outpatient rehabilitation clinics profitably or succeed in achieving improvements in their financial performance.

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

Initiatives undertaken by major insurers and managed care companies to contain healthcare costs affect the profitability of our specialty hospitals and outpatient rehabilitation clinics. 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 net operating revenues may decrease.

Our success is partially dependent upon the admissions and referral practices of the physicians in the communities our hospitals and our 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 clinics' businesses may decrease, and our net operating revenues may decline.

Changes in federal or state law limiting or prohibiting certain physician referrals may preclude physicians from investing in our hospitals or referring to hospitals in which they already own an interest.

The federal self-referral law, or Stark Law, 42 U.S.C. § 1395nn, prohibits a physician who has a financial relationship with an entity from referring his or her Medicare or Medicaid patients to that entity for certain designated health services, including inpatient and outpatient hospital services. Under current law, physicians who have a direct or indirect ownership interest in a hospital will not be prohibited from referring to the hospital because of the applicability of the whole hospital exception to the Stark Law. Various bills recently introduced in Congress have included provisions that further restrict physician ownership in hospitals to which the physician refers patients. These provisions would typically limit the Stark Law's whole hospital exception to existing hospitals with physician ownership. Physicians with ownership in new hospitals would be prohibited from referring. Certain requirements and limitations would also be placed on existing hospitals with physician ownership, such as limiting the expansion of any such hospital and limiting the amount and terms of physician investment. Furthermore, initiatives are underway in some states to restrict physician referrals to physician-owned hospitals. Currently, six of our hospitals have physicians as minority owners. The aggregate revenue of these six hospitals was \$113.0 million for the year ended December 31, 2007, or approximately 5.7% of our revenues for the year ended December 31, 2007. The average minority ownership of these hospitals was approximately 9% for the year ended December 31, 2007. There can be no assurance that new legislation or regulation prohibiting or limiting physician referrals to physician-owned hospitals will not be successfully enacted in the future. If such federal or state laws are adopted, among other outcomes, physicians who have invested in, or considered investing in, our hospitals could be precluded from referring to, investing in or

continuing to be physician owners of a hospital. In addition, expansion of our physician-owned hospitals may be limited, and the revenues, profitability and overall financial performance of our hospitals may be negatively affected.

Shortages in qualified nurses or therapists could increase our operating costs significantly.

Our specialty hospitals are highly dependent on nurses for patient care and our outpatient rehabilitation clinics are highly dependant on therapists for patient care. The availability of qualified nurses and therapists nationwide has declined in recent years, and the salaries for nurses and therapists have risen accordingly. We cannot assure you we will be able to attract and retain qualified nurses or therapists in the future. Additionally, the cost of attracting and retaining nurses and therapists may be higher than we anticipate, and as a result, our profitability could decline.

Competition may limit our ability to acquire hospitals and clinics and adversely affect our growth.

We have historically faced limited competition in acquiring specialty hospitals and outpatient rehabilitation clinics, but we may face heightened competition in the future. Our competitors may acquire or seek to acquire many of the hospitals and clinics that would be suitable acquisition candidates for us. This increased competition could hamper our ability to acquire companies, or such increased competition may cause us to pay a higher price than we would otherwise pay in a less competitive environment. Increased competition from both strategic and financial buyers could limit our ability to grow by acquisitions or make our cost of acquisitions higher and therefore decrease our profitability.

If we fail to compete effectively with other hospitals, clinics and healthcare providers in our local areas, our net operating revenues 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 specialty hospital and outpatient rehabilitation businesses, our net operating revenues and profitability may decline. Many of our specialty hospitals operate in geographic areas where we compete with at least one other hospital that provides similar services. Our outpatient rehabilitation clinics face competition from a variety of local and national outpatient rehabilitation providers. Other outpatient rehabilitation clinics in local areas we serve may have greater name recognition and longer operating histories than our clinics. The managers of these clinics may also have stronger relationships with physicians in their communities, which could give them a competitive advantage for patient referrals.

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 key employees, both individually and as a group. Our future performance will be substantially dependent in particular on our ability to retain and motivate four key employees, Rocco A. Ortenzio, our Executive Chairman, Robert A. Ortenzio, our Chief Executive Officer, Patricia A. Rice, our President and Chief Operating Officer, and Martin F. Jackson, our Executive Vice President and Chief Financial Officer. We currently have an employment agreement in place with each of Messrs. Rocco and Robert Ortenzio and Ms. Rice and a change in control agreement with Mr. Jackson. Each of these individuals also has a significant equity ownership in our company. We have no reason to believe that we will lose the services of any of these individuals in the foreseeable future; however, we currently have no effective replacement for any of these individuals due to their experience, reputation in the industry and special role in our operations. We also do not maintain any key life insurance policies for any of our employees. The loss of the services of any of these individuals would disrupt significant aspects of our business, could prevent us from successfully executing our business strategy and could have a material adverse affect on our results of operations.

Significant legal actions as well as the cost and possible lack of available insurance could subject us to substantial uninsured liabilities.

Physicians, hospitals and other healthcare providers have become subject, in recent years, to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large claims and significant defense costs. We are also subject to lawsuits under federal and state whistleblower statutes designed to combat fraud and abuse in the healthcare industry. These whistleblower

lawsuits are not covered by insurance and can involve significant monetary damages and award bounties to private plaintiffs who successfully bring the suits.

We maintain professional malpractice liability insurance and general liability insurance coverages under a combination of policies with a total annual aggregate limit of \$30.0 million. Our insurance for the professional liability coverage is written on a claims-made basis and our commercial general liability coverage is maintained on an occurrence basis. These coverages are generally subject to a self-insured retention of \$2.0 million per medical incident for professional liability claims and \$2.0 million per occurrence for general liability claims. In recent years, many insurance underwriters have become more selective in the insurance limits and types of coverage they will provide as a result of rising settlement costs. Insurance underwriters, in some instances, will no longer underwrite risk in certain states that have a history of high medical malpractice awards. There can be no assurance that malpractice insurance will be available in certain states in the future nor that we will be able to obtain insurance coverage at a reasonable price. Since our professional liability insurance is on a claims-made basis, any failure to obtain malpractice insurance in any state in the future would increase our exposure not only to claims arising such state in the future but also to claims arising from injuries that may have already occurred but which had not been reported during the period in which we previously had insurance coverage in that state. In addition, our insurance coverage does not cover punitive damages and may not cover all claims against us. See Business Government Regulations Other Healthcare Regulations.

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

Upon completion of this offering, Welsh Carson and Thoma Cressey will beneficially own approximately % and %, respectively, of our outstanding common stock. Our executives, directors and principal stockholders, including Welsh Carson and Thoma Cressey, will beneficially own, in the aggregate, approximately % of our outstanding common stock in addition to % of our common stock issuable upon exercise of options. As a result, these stockholders will have significant control over our management and policies and will be 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 will be 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.

We are a holding company and therefore depend on our subsidiaries to service our obligations under our indebtedness and for any funds to pay dividends to our stockholders. Our ability to repay our indebtedness or pay dividends to our stockholders depends entirely upon the performance of our subsidiaries and their ability to make distributions.

We have no operations of our own and derive all of our revenues and cash flow from our subsidiaries. Our subsidiaries are separate and distinct legal entities and have no obligation, contingent or otherwise, to pay any amounts due under our 10% senior subordinated notes and senior floating rate notes, or to make any funds available therefore, whether by dividend, distribution, loan or other payments. In addition, any of our rights in the assets of any of our subsidiaries upon any liquidation or reorganization of any subsidiary will be subject to the prior claims of that subsidiary's creditors, including lenders under Select's senior secured credit facility and holders of Select's 75/8% senior subordinated notes. Our total consolidated balance sheet liabilities as of June 30, 2008 were \$2,201.2 million, of which \$1,805.5 million constituted indebtedness, including \$828.7 of indebtedness (excluding \$29.3 million of letters of credit) under Select's senior secured credit facility, \$660.0 million of Select's 75/8% senior subordinated notes, \$134.8 million of our 10% senior subordinated notes and \$175.0 million of our senior floating rate notes. In addition,

as of such date, Select would have been able to borrow up to an additional \$100.7 million under Select's senior secured credit facility. We and our restricted subsidiaries may incur additional debt in the future, including under Select's existing senior secured credit facility.

We depend on our subsidiaries, which conduct the operations of the business, for dividends and other payments to generate the funds necessary to meet our financial obligations, including payments of principal and interest on our indebtedness. We would also depend on our subsidiaries for any funds to pay dividends to our stockholders. In the event our subsidiaries are unable to pay dividends to us, we may not be able to service debt, pay obligations or pay dividends on common stock. The terms of Select's existing senior secured credit facility and the terms of the indentures governing Select's 75/8% senior subordinated notes restrict Select and its subsidiaries from, in each case, paying dividends or otherwise transferring its assets to us. Such restrictions include, among others, financial covenants, prohibition of dividends in the event of a default and limitations on the total amount of dividends. In addition, legal and contractual restrictions in agreements governing other current and future indebtedness, as well as financial condition and operating requirements of our subsidiaries, currently limit and may, in the future, limit our ability to obtain cash from our subsidiaries. The earnings from other available assets of our subsidiaries may not be sufficient to pay dividends or make distributions or loans to enable us to make payments in respect of our indebtedness when such payments are due. In addition, even if such earnings were sufficient, we cannot assure you that the agreements governing the current and future indebtedness of our subsidiaries will permit such subsidiaries to provide us with sufficient dividends, distributions or loans to fund interest and principal payments on our indebtedness when due. If our subsidiaries are unable to make dividends or otherwise distribute funds to us, we may not be able to satisfy the terms of our indebtedness, there will not be sufficient funds remaining to make distributions to our stockholders and the value of your investment in our common stock will be materially decreased.

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 June 30, 2008, we had approximately \$1,805.5 million of total indebtedness. For the year ended December 31, 2007 and six month period ended June 30, 2008, our total payments on our indebtedness were \$336.9 million and \$269.2 million, respectively.

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 facility and the senior floating rate notes, are at variable rates;

limits our ability to obtain additional financing in the future for working capital or other purposes, such as raising the funds necessary to repurchase all notes tendered to us upon the occurrence of specified changes of control in our ownership; and

places us at a competitive disadvantage compared to our competitors that have less indebtedness.

See Description of Indebtedness, Unaudited Pro Forma Consolidated Financial Information and Management's Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources.

Select's senior secured credit facility requires Select to comply with certain financial covenants, the default of which may result in the acceleration of certain of our indebtedness.

Select's senior secured credit facility requires Select to maintain certain interest expense coverage ratios and leverage ratios which become more restrictive over time. For the four consecutive fiscal quarters ended June 30,

2008, Select was required to maintain an interest expense coverage ratio (its ratio of consolidated EBITDA to cash interest expense) for the prior four consecutive quarters of at least 1.75 to 1.00. Select's interest expense coverage ratio was 1.78 to 1.00 for such period. As of June 30, 2008, Select was required to maintain its leverage ratio (its ratio of total indebtedness to consolidated EBITDA for the prior four consecutive fiscal quarters) at less than 6.00 to 1.00. Select's leverage ratio was 5.94 to 1.00 as of June 30, 2008. On a pro forma as adjusted basis, for the four quarters ended June 30, 2008, Select's interest expense coverage ratio was to 1.00 and Select's leverage ratio was to 1.00 based upon an assumed public offering price of \$ per share, the midpoint of the range set forth on the cover page of this prospectus.

While Select has never defaulted on compliance with any such financial covenants, its ability to comply with these ratios in the future may be affected by events beyond its control. Inability to comply with the required financial ratios could result in a default under Select's senior secured credit facility. In the event of any default under Select's senior secured credit facility, the lenders under Select's senior secured credit facility 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. Any default under Select's senior secured credit facility that results in the acceleration of the outstanding indebtedness under Select's senior secured credit facility would also constitute an event of default under Select's 75/8% senior subordinated notes and the senior floating rate notes, and the trustee or holders of each such notes could elect to declare such notes to be immediately due and payable.

See Description of Indebtedness.

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

We and our subsidiaries may be able to incur additional indebtedness in the future. Although our senior secured credit facility, the indentures governing each of Select's 75/8% senior subordinated notes and the senior floating rate notes each 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 June 30, 2008, we had \$100.7 million of revolving loan availability under our senior secured credit facility (after giving effect to \$29.3 million of outstanding letters of credit). To the extent new debt is added to our and our subsidiaries' current debt levels, the substantial leverage risks described above would increase. See Description of Indebtedness.

Risks Relating to this Offering

The price of our common stock may be volatile and you could lose all or part of your investment.

Volatility in the market price of our common stock may prevent you from being able to sell your shares at or above the price you paid for your shares. The market price of our common stock could fluctuate significantly for various reasons, which include:

our quarterly or annual earnings or those of other companies in our industry;

changes in laws or regulations, or new interpretations or applications of laws and regulations, that are applicable to our business;

the public's reaction to our press releases, our other public announcements and our filings with the SEC;

changes in accounting standards, policies, guidance, interpretations or principles;

additions or departures of our senior management personnel;

sales of common stock by our directors and executive officers;

sales or distribution of common stock by our sponsors;

adverse market reaction to any indebtedness we may incur or securities we may issue in the future;

downgrades of our stock or negative research reports published by securities or industry analysts;

actions by stockholders; and

changes in general conditions in the United States and global economies or financial markets, including those resulting from Acts of God, war, incidents of terrorism or responses to such events.

In addition, in recent years, the stock market has experienced extreme price and volume fluctuations. This volatility has had a significant impact on the market price of securities issued by many companies, including companies in our industry. The price of our common stock could fluctuate based upon factors that have little or nothing to do with our company, and these fluctuations could materially reduce our stock price.

In the past, following periods of market volatility in the price of a company's securities, security holders have often instituted class action litigation. If the market value of our common stock experiences adverse fluctuations and we become involved in this type of litigation, regardless of the outcome, we could incur substantial legal costs and our management's attention could be diverted from the operation of our business, causing our business to suffer.

There is no existing market for our common stock and we do not know if one will develop to provide you with adequate liquidity.

There is no existing public market for our common stock. An active market for our common stock may not develop following the completion of this offering, or if it does develop, may not be maintained. If an active trading market does not develop, you may have difficulty selling any of our common stock that you buy. The initial public offering price for the shares will be determined by negotiations between us, the selling stockholders and the representatives of the underwriters and may not be indicative of prices that will prevail in the open market following this offering. Consequently, you may not be able to sell shares of our common stock at prices equal to or greater than the price paid by you in this offering. In addition, our existing officers, directors and principal stockholders will maintain significant ownership interests in our stock following completion of this offering, which may restrict liquidity in the trading market for our stock.

Future sales of our common stock, including shares purchased in this offering, in the public market could lower our stock price.

Sales of substantial amounts of our common stock in the public market following this offering by our existing stockholders, upon the exercise of outstanding stock options or by persons who acquire shares in this offering may adversely affect the market price of our common stock. Such sales could also create public perception of difficulties or problems with our business. These sales might also make it more difficult for us to sell securities in the future at a time and price that we deem necessary or appropriate.

Upon the completion of this offering, we will have outstanding _____ shares of common stock, of which:

_____ shares are shares that we and the selling stockholders are selling in this offering and, unless purchased by affiliates, may be resold in the public market immediately after this offering; and

_____ shares will be restricted securities, as defined in Rule 144 under the Securities Act, and eligible for sale in the public market pursuant to the provisions of Rule 144, of which _____ shares are subject to lock-up agreements and will become available for resale in the public market beginning 180 days after the date of this prospectus.

With limited exceptions, as described under the caption Underwriters, these lock-up agreements prohibit a stockholder from selling, contracting to sell or otherwise disposing of any common stock or securities that are convertible or exchangeable for common stock or entering into any arrangement that transfers the economic consequences of ownership of our common stock for at least 180 days from the date of this prospectus. may, however in sole discretion and at any time without notice, release all or any portion of the securities subject to these lock-up agreements. has advised us that has no present intent or arrangement to release any shares subject to a lock-up and will consider the release of any lock-up on a case-by-case basis. Upon a request to release any shares subject to a lock-up, would consider the particular circumstances surrounding the request including, but not limited to, the length of time before the lock-up expires, the number of shares requested to be released, reasons for the request, the possible impact on the market for our

common stock and whether the holder of our shares requesting the release is an officer, director or other affiliate of ours. As a result of these lock-up agreements, notwithstanding earlier eligibility for sale under the provisions of Rule 144, none of these shares may be sold until at least 180 days after the date of this prospectus.

At our request, the underwriters have reserved up to _____ shares, or _____ % of our common stock offered by this prospectus, for sale under a directed share program to our officers, directors, employees, business associates and other individuals who have family or personal relationships with our employees. If any of our current directors or executive officers subject to lock-up agreements purchase these reserved shares, the shares will be restricted from sale under the lock-up agreements. If any of these shares are purchased by other persons, such shares will not be subject to lock-up agreements.

As restrictions on resale end, our stock price could drop significantly if the holders of these restricted shares sell them or are perceived by the market as intending to sell them. These sales might also make it more difficult for us to sell securities in the future at a time and at a price that we deem appropriate.

You will suffer immediate and substantial dilution.

The initial public offering price per share is substantially higher than the pro forma net tangible book value per share immediately after the offering. As a result, you will pay a price per share that substantially exceeds the book value of our assets after subtracting our liabilities. Assuming an offering price of \$ _____ per share, you will incur immediate and substantial dilution in the amount of \$ _____ per share. Purchasers of shares of our common stock in this offering will have contributed approximately _____ % of the aggregate price paid by all purchasers of our common stock, but will only own _____ % of the shares of our common stock outstanding after this offering. In addition, as of August 26, 2008, there were outstanding options to purchase 1,780,839 shares of common stock at an average exercise price of \$1.64. If the underwriters exercise their over-allotment option, or if outstanding options to purchase our common stock are exercised, you will experience additional dilution. Any future equity issuances will result in even further dilution to holders of our common stock.

Certain provisions of Delaware law and our certificate of incorporation and bylaws that will be in effect after this offering may deter takeover attempts, which may limit the opportunity of our stockholders to sell their shares at a favorable price, and may make it more difficult for our stockholders to remove our board of directors and management.

Provisions in our certificate of incorporation and bylaws, as they will be in effect upon the closing of this offering, may have the effect of delaying or preventing a change of control or changes in our management. These provisions include the following:

prohibition on stockholder action through written consents;

a requirement that special meetings of stockholders be called only by our board of directors;

advance notice requirements for stockholder proposals and nominations;

availability of blank check preferred stock;

establish a classified board of directors so that not all members of our board of directors are elected at one time;

the right of the board of directors to elect a director to fill a vacancy created by the expansion of the board of directors or due to the resignation or departure of an existing board member;

the prohibition of cumulative voting in the election of directors, which would otherwise allow less than a majority of stockholders to elect director candidates;

the ability of our board of directors to alter our bylaws without obtaining stockholder approval;

limitations on the removal of directors; and

the required approval of at least $66\frac{2}{3}\%$ of the shares entitled to vote at an election of directors to adopt, amend or repeal our bylaws or repeal the provisions of our amended and restated certificate of incorporation

regarding the election and removal of directors and the inability of stockholders to take action by written consent in lieu of a meeting.

In addition, because we are incorporated in Delaware, we are governed by the provisions of Section 203 of the Delaware General Corporation Law, or DGCL. These provisions may prohibit large stockholders, particularly those owning 15% or more of our outstanding voting stock, from merging or combining with us. These provisions in our certificate of incorporation and bylaws and under the DGCL could discourage potential takeover attempts, could reduce the price that investors are willing to pay for shares of our common stock in the future and could potentially result in the market price being lower than they would without these provisions.

Although no shares of preferred stock will be outstanding upon the completion of this offering and although we have no present plans to issue any preferred stock, our certificate of incorporation authorizes the board of directors to issue up to _____ shares of preferred stock. The preferred stock may be issued in one or more series, the terms of which will be determined at the time of issuance by our board of directors without further action by the stockholders. These terms may include voting rights, including the right to vote as a series on particular matters, preferences as to dividends and liquidation, conversion rights, redemption rights and sinking fund provisions. The issuance of any preferred stock could diminish the rights of holders of our common stock and, therefore, could reduce the value of our common stock. In addition, specific rights granted to future holders of preferred stock could be used to restrict our ability to merge with, or sell assets to, a third party. The ability of our board of directors to issue preferred stock and the foregoing anti-takeover provisions may prevent or frustrate attempts by a third party to acquire control of our company, even if some of our stockholders consider such change of control to be beneficial. See Description of Capital Stock.

Since we do not expect to pay any dividends for the foreseeable future, investors in this offering may be forced to sell their stock in order to realize a return on their investment.

We do not anticipate that we will pay any dividends to holders of our common stock for the foreseeable future. Any payment of cash dividends will be at the discretion of our board of directors and will depend on our financial condition, capital requirements, legal requirements, earnings and other factors. Our ability to pay dividends is restricted by the terms of our senior secured credit facilities and might be restricted by the terms of any indebtedness that we incur in the future. Consequently, you should not rely on dividends in order to receive a return on your investment. See Dividend Policy.

Affiliates of ours and affiliates of the underwriters will receive a significant portion of the proceeds from this offering.

We estimate that the net proceeds to us from this offering will be approximately \$ _____ million, assuming an initial public offering price of \$ _____ per share, which is the midpoint of the range listed on the cover page of this prospectus, and after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. The selling stockholders will receive \$ _____ million in proceeds from their sale of shares of common stock in the offering. We will not receive any proceeds from the sale of shares by the selling stockholders. We will apply approximately \$ _____ million of the proceeds to repay indebtedness under our senior secured credit facilities held by affiliates of the underwriters, approximately \$ _____ million of the proceeds to make payments to officers under the Long Term Cash Incentive Plan, approximately \$ _____ million of the proceeds to pay preferred stockholders who are not selling stockholders in payment for a portion of the value of their preferred shares and approximately \$ _____ million of the proceeds to reimburse the selling stockholders, all of whom are either sponsors, directors or officers of the Company, for the underwriting discount on the shares sold by them. To the extent the proceeds from this offering are used as described above, they will not be available for other corporate purposes.

The table below sets forth the portion of net proceeds, assuming an initial public offering price of \$ per share, which is the midpoint of the range set forth on the cover page of this prospectus, that our sponsors, directors and executive officers will receive in this offering for common stock received upon the conversion of our preferred stock immediately prior to the consummation of this offering at the public offering price that will be either (a) sold by selling stockholders in this offering or (b) repurchased by the Company with the proceeds of newly issued common stock. The table below also sets forth the portion of net proceeds that certain of our executive officers will receive in payments under our Long Term Cash Incentive Plan.

	Proceeds from Common Stock Sold as Selling Stockholder	Proceeds from Common Stock Repurchased by the Company	Proceeds from Long Term Cash Incentive Plan	Total Consideration
Welsh, Carson, Anderson & Stowe Thoma Cressey Bravo Rocco A. Ortenzio Robert A. Ortenzio Russell L. Carson Bryan C. Cressey David S. Chernow James E. Dalton, Jr. Thomas A. Scully Leopold Swergold Sean M. Traynor Patricia A. Rice S. Frank Fritsch Martin F. Jackson All other executive officers as a group				

FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements. These statements relate to future events or our future financial performance. We have attempted to identify forward-looking statements by terminology including anticipates, believes, can, continue, could, estimates, expects, intends, may, plans, potential, predicts, and similar terms, or the negative of these terms or other comparable terminology. These statements are only predictions and involve known and unknown risks, uncertainties, and other factors, including those discussed under Risk Factors. The following factors, among others, could cause our actual results and performance to differ materially from the results and performance projected in, or implied by, the forward-looking statements:

additional changes in government reimbursement for our services may result in a reduction in net operating revenues, an increase in costs and a reduction in profitability;

the failure of our long term acute care hospitals to maintain their status as such may cause our net operating revenues and profitability to decline;

the failure of our facilities operated as hospitals within hospitals to qualify as hospitals separate from their host hospitals may cause our net operating revenues and profitability to decline;

implementation of modifications to the admissions policies for our inpatient rehabilitation facilities, as required to achieve compliance with Medicare guidelines, may result in a loss of patient volume at these hospitals and, as a result, may reduce our future net operating revenues and profitability;

a government investigation or assertion that we have violated applicable regulations may result in sanctions or reputational harm and increased costs;

integration of acquired operations (such as the outpatient rehabilitation division of HealthSouth Corporation) and future acquisitions may prove difficult or unsuccessful, use significant resources or expose us to unforeseen liabilities;

private third-party payors for our services may undertake future cost containment initiatives that limit our future net operating revenues and profitability;

the failure to maintain established relationships with the physicians in the areas we serve could reduce our net operating revenues and profitability;

shortages in qualified nurses or therapists could increase our operating costs significantly;

competition may limit our ability to grow and result in a decrease in our net operating revenues and profitability;

the loss of key members of our management team could significantly disrupt our operations;

the effect of claims asserted against us or lack of adequate available insurance could subject us to substantial uninsured liabilities;

the ability to obtain any necessary or desired waiver or amendment from our existing lenders may be difficult due to the current uncertainty in the credit markets;

concentration of ownership among our existing executives, directors and principal stockholders may prevent new investors from influencing significant corporate decisions; and

other factors discussed under the headings Risk Factors, Management's Discussion and Analysis of Financial Condition and Results of Operations, and Business.

Although we believe that the expectations reflected in the forward-looking statements are reasonable based on our current knowledge of our business and operations, we cannot guarantee future results, levels of activity, performance or achievements. Forward-looking statements apply only as of the date of this prospectus and we assume no obligation to provide revisions to any forward-looking statements should circumstances change.

USE OF PROCEEDS

We estimate that the net proceeds to us from this offering will be approximately \$ million, assuming an initial public offering price of \$ per share, which is the midpoint of the range listed on the cover page of this prospectus, and after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. Each \$1.00 increase or decrease in the assumed initial public offering price of \$ per share would increase or decrease, as applicable, the net proceeds to us by approximately \$, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. If the underwriters' option to purchase additional shares in this offering is exercised in full, we estimate that our net proceeds will be approximately \$.

The selling stockholders will receive \$ million in proceeds from their sale of shares of common stock in the offering. We will not receive any proceeds from the sale of shares by the selling stockholders. The number of shares offered by the selling stockholders includes shares of common stock into which a portion of the preferred stock held by them will convert immediately prior to the consummation of the offering. See "Principal and Selling Stockholders" and "Underwriters."

We intend to use the net proceeds of this offering as follows:

To repay approximately \$ million of loans outstanding under our senior secured credit facilities, and any related prepayment costs. The average interest rate for the year ended December 31, 2007 of our indebtedness under our senior secured credit facilities was 6.9%. Our term loan facility matures on February 24, 2012. The revolving loan facility terminates on February 24, 2011. JPMorgan Chase Bank, N.A., an affiliate of J.P. Morgan Securities Inc., Wachovia Bank, National Association, an affiliate of Wachovia Capital Markets, LLC, and Merrill Lynch Capital Corporation, an affiliate of Merrill Lynch, Pierce, Fenner & Smith Incorporated are lenders under our senior secured credit facilities and therefore affiliates of these underwriters may receive more than 10% of the entire net proceeds from this offering. As of , 2008, the amounts to be repaid to affiliates of J.P. Morgan Securities Inc., Wachovia Capital Markets, LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated with the proceeds from this offering, assuming an initial public offering price of \$ per share, which is the midpoint of the range on the cover of this prospectus, are \$ million, \$ million and \$ million, respectively. See "Underwriters."

To make payments under the Long Term Cash Incentive Plan in the amount of approximately \$ million, which will be recognized as an expense in the quarter in which the offering occurs. We expect approximately \$ will be paid to Rocco A. Ortenzio, approximately \$ will be paid to Robert A. Ortenzio, approximately \$ will be paid to Patricia A. Rice, approximately \$ will be paid to Martin F. Jackson, approximately \$ will be paid to S. Frank Fritsch, approximately \$ will be paid to David W. Cross, approximately \$ will be paid to James J. Talalai and approximately \$ will be paid to Michael E. Tarvin.

To pay approximately \$ to the holders of our common stock who are not selling stockholders in this offering in payment for a portion of the common stock they received upon conversion of our preferred stock immediately prior to the consummation of this offering at the public offering price.

To reimburse the selling stockholders approximately \$ for the underwriting discount on the shares sold by them in this offering, which will be recognized as an expense in the quarter in which the offering occurs.

Any remaining net proceeds will be used for general corporate purposes.

DIVIDEND POLICY

Since its formation, Holdings has not declared or paid cash dividends on its common stock. Any payment of cash dividends on our common stock in the future will be at the discretion of our board of directors and will depend upon our results of operations, earnings, capital requirements, financial condition, future prospects, contractual restrictions and other factors deemed relevant by our board of directors. In addition, our ability to declare and pay dividends is restricted by covenants in our senior secured credit facility and the indentures governing Select's 75/8% senior subordinated notes and the senior floating rate notes. We currently intend to retain any future earnings to fund the operation, development and expansion of our business and repay outstanding indebtedness, and therefore we do not anticipate paying any cash dividends in the foreseeable future.

CAPITALIZATION

The following table sets forth our capitalization as of June 30, 2008:

on an actual basis; and

on a pro forma basis to give effect to the conversion of all shares of our issued and outstanding preferred stock into _____ shares of common stock immediately prior to the consummation of the offering based upon an assumed public offering price of \$ _____ per share, the midpoint of the range set forth on the cover page of this prospectus;

on a pro forma as adjusted basis to give effect to (1) the sale of shares of common stock in this offering at an assumed initial public offering price of \$ _____ per share, which is the midpoint of the range listed on the cover page of this prospectus, and after deducting underwriting discounts and commissions and estimated fees and expenses payable by us, (2) the conversion of all shares of our issued and outstanding preferred stock into _____ shares of common stock immediately prior to the consummation of the offering based upon an assumed public offering price of \$ _____ per share, the midpoint of the range set forth on the cover page of this prospectus, and (3) the application of the net proceeds of this offering as described under Use of Proceeds, as if the events had occurred on June 30, 2008.

You should read this information in conjunction with Prospectus Summary The Offering, Use of Proceeds, Selected Historical Consolidated Financial Data, Management's Discussion and Analysis of Financial Condition and Results of Operations, and with our consolidated financial statements and related notes included elsewhere in this prospectus.

	As of June 30, 2008		
	Actual	Pro Forma	Pro Forma As Adjusted⁽⁴⁾
Cash and cash equivalents	\$ 7,534	\$	\$
Debt:			
Senior floating rate notes	175,000		
10% senior subordinated notes due 2015 ⁽¹⁾	134,834		
Revolving credit facility ⁽²⁾	170,000		
Term loan facility ⁽³⁾	658,718		
75/8% senior subordinated notes due 2015	660,000		
Other debt	6,910		
Total debt	1,805,462		
Preferred stock	503,179		
Total stockholders' equity	(165,703)		
Total capitalization	\$ 2,142,938	\$	\$

- (1) Reflects the balance sheet liability of our 10% senior subordinated notes calculated in accordance with GAAP. The balance sheet liability so reflected is less than the \$150.0 million aggregate principal amount of such notes because such notes were issued with original issue discount. The remaining unamortized original issue discount is \$15.2 million at June 30, 2008. Interest on our 10% senior subordinated notes accrues on the full principal amount thereof, and we will be obligated to repay the full principal amount thereof at maturity or upon any mandatory or voluntary prepayment thereof. On any interest payment date on or after February 24, 2010, Holdings will be obligated to pay an amount of accrued original issue discount on the 10% senior subordinated notes if necessary to ensure that the notes will not be considered applicable high yield discount obligations within the meaning of the Internal Reserve Code of 1986, as amended. The \$150.0 million aggregate principal payable at maturity on our 10% senior subordinated notes would be reduced by prior payments of accrued original issue discount.
- (2) The revolving credit facility is a part of our senior secured credit facility and provides for borrowings of up to \$300.0 million of which \$100.7 million was available as of June 30, 2008 for working capital and general corporate purposes (after giving effect to \$29.3 million of outstanding letters of credit at June 30, 2008).
- (3) We borrowed \$680.0 million in term loans under our existing senior secured credit facility. Between February 24, 2005 and June 30, 2008 we repaid approximately \$21.3 million of our outstanding term loans.
- (4) A \$1.00 increase (decrease) in the assumed initial public offering price of \$ per share, which is the midpoint of the range set forth on the cover page of this prospectus, would increase (decrease) each of total stockholders equity and total capitalization by \$ million, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us.

DILUTION

Purchasers of shares of common stock in this offering will experience immediate and substantial dilution in the net tangible book value of the common stock from the initial public offering price. Net tangible book value per share represents the amount of our total tangible assets less our total liabilities, divided by the number of shares of our common stock outstanding. Dilution in net tangible book value per share represents the difference between the amount per share that you pay in this offering and the net tangible book value per share immediately after this offering. Our net tangible book value (deficit) as of June 30, 2008 was approximately \$ million, or \$ per share.

After giving effect to the sale of shares of our common stock in this offering at an assumed initial public offering price of \$ per share, which is the midpoint of the range listed on the cover page of this prospectus, the conversion of all shares of our issued and outstanding preferred stock into shares of common stock based upon an assumed public offering price of \$ per share, the midpoint of the range set forth on the cover page of this prospectus, and after the deduction of estimated underwriting discounts and commissions and estimated fees and expenses payable by us, our pro forma net tangible book value at June 30, 2008 would have been approximately \$ million, or \$ per share. This represents an immediate increase in net tangible book value of \$ per share to existing stockholders and an immediate and substantial dilution of \$ per share to new investors. The following table illustrates this per share dilution:

	Per Share
Assumed public offering price per share (the midpoint of the range listed on the cover page of this prospectus)	\$
Actual net tangible book value per share as of June 30, 2008	\$
Increase attributable to conversion of preferred stock	
Increase per share attributable to new investors	
Pro forma net tangible book value per share after this offering as of June 30, 2008	\$
Dilution per share to new investors	\$

If the underwriters exercise in full their over-allotment option to purchase additional shares of our common stock in this offering at the assumed initial public offering price of \$ per share, which is the midpoint of the range listed on the cover page of this prospectus, the number of shares of common stock held by existing stockholders will be reduced to , or % of the aggregate number of shares of common stock outstanding after this offering, the number of shares of common stock held by new investors will be increased to , or % of the aggregate number of shares of common stock outstanding after this offering, the increase per share attributable to new investors would be \$, the pro forma net tangible book value per share after this offering would be \$, and the dilution per share to new investors would be \$.

Sales of shares of common stock by the selling stockholders in this offering will reduce the number of shares of common stock held by existing stockholders to , or approximately % of the total shares of common stock outstanding after this offering, and will increase the number of shares held by new investors to , or approximately % of the total shares of common stock outstanding after this offering.

A \$1.00 increase (decrease) in the assumed initial public offering price of \$ per share, which is the midpoint of the range listed on the cover page of this prospectus, would increase (decrease) our pro forma net tangible book value by \$ million, the pro forma net tangible book value per share after this offering by \$ per share, and the dilution per share to new investors by \$ per share, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting the underwriting discounts and commissions and estimated offering expenses payable by us.

The following table summarizes, on the pro forma basis described above as of June 30, 2008, after giving effect to the conversion of _____ shares of our issued and outstanding preferred stock into _____ shares of common stock immediately prior to the consummation of the offering based upon an assumed offering price of \$ _____ per share, the mid point of the range set forth on the cover page of this prospectus, the total number of shares of common stock purchased from us and the selling stockholders and the total consideration and the average price per share paid by existing holders and by investors participating in this offering. The calculation below is based on the assumed initial public offering price of \$ _____ per share, which is the midpoint of the range listed on the cover page of this prospectus, before deducting estimated underwriting discounts and commissions and estimated fees and expenses payable by us.

	Shares Purchased		Total Consideration		Average Price per Share
	Number	Percentage	Amount	Percentage	
Existing holders	\$	%	\$	%	\$
New investors		%		%	
Total		100%		100%	

Each \$1.00 increase (decrease) in the assumed offering price of \$ _____ per share, which is the midpoint of the range listed on the cover page of this prospectus, would increase (decrease) total consideration paid by new investors and total consideration paid by all stockholders by \$ _____ million, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same, and before deducting the underwriting discounts and commissions and estimated offering expenses payable by us.

The pro forma dilution information above is for illustration purposes only. Our net tangible book value following the completion of this offering is subject to adjustment based on the actual initial public offering price of our shares and other terms of this offering determined at pricing. The number of shares of our common stock outstanding after the offering as shown above is based on the number of shares outstanding as of June 30, 2008. As of June 30, 2008, there were options outstanding to purchase 4,647,987 shares of our common stock, with exercise prices ranging from \$1.00 to \$2.50 per share and a weighted average exercise price of \$1.92 per share. The tables and calculations above assume that those options have not been exercised. To the extent outstanding options are exercised, you would experience further dilution if the exercise price is less than our net tangible book value per share. In addition, if we grant options, warrants, preferred stock, or other convertible securities or rights to purchase our common stock in the future with exercise prices below the initial public offering price, new investors will incur additional dilution upon exercise of such securities or rights.

SELECTED HISTORICAL CONSOLIDATED FINANCIAL DATA

You should read the following selected historical consolidated financial data in conjunction with our consolidated financial statements and the accompanying notes. You should also read Management's Discussion and Analysis of Financial Condition and Results of Operations. All of these materials are contained elsewhere in this prospectus. The historical financial data as of December 31, 2003, 2004, 2005, 2006 and 2007 and for the years ended December 31, 2003 and 2004, for the period from January 1 through February 24, 2005 (Predecessor Period), for the period from February 25 through December 31, 2005 and for the years ended December 31, 2006 and 2007 (Successor Period) have been derived from consolidated financial statements audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm. The selected historical consolidated financial data as of December 31, 2006 and 2007, for the period from January 1 through February 24, 2005, for the period from February 25 through December 31, 2005 and for the years ended December 31, 2006 and 2007 have been derived from our consolidated financial information included elsewhere in this prospectus. The selected historical consolidated financial data as of December 31, 2003, 2004 and 2005 and for the years ended December 31, 2003 and 2004 have been derived from our audited consolidated financial information not included elsewhere in this prospectus. We derived the historical financial data as of June 30, 2008 and for the six months ended June 30, 2007 and 2008 from our unaudited interim consolidated financial statements, which are included elsewhere in this prospectus.

	Predecessor Period			Successor Period		
	Year Ended December 31, 2003 2004 (in thousands, except per share data)		Period from January 1 through February 24, 2005	Period from February 25 through December 31, 2005 (in thousands, except per share data)	Year Ended December 31, 2006 2007	
Statement of Operations Data:						
Net operating revenues	\$ 1,341,657	\$ 1,601,524	\$ 277,736	\$ 1,580,706	\$ 1,851,498	\$ 1,991,666
Operating expenses ⁽¹⁾⁽²⁾	1,165,814	1,340,068	373,418	1,322,068	1,546,956	1,740,484
Depreciation and amortization	33,663	38,951	5,933	37,922	46,668	57,297
Income (loss) from operations	142,180	222,505	(101,615)	220,716	257,874	193,885
Loss on early retirement of debt ⁽³⁾			(42,736)			
Merger related charges ⁽⁴⁾			(12,025)			
Equity in income from joint ventures	824					
Other income (expense)		1,096	267	1,092		(167)
Interest expense, net ⁽⁵⁾	(24,499)	(30,716)	(4,128)	(101,441)	(130,538)	(138,052)
Income (loss) from continuing operations before minority interests	118,505	192,885	(160,237)	120,367	127,336	55,666

and income taxes						
Minority interests in consolidated subsidiary companies ⁽⁶⁾	1,661	2,608	330	1,776	1,414	1,537
Income (loss) from continuing operations before income taxes	116,844	190,277	(160,567)	118,591	125,922	54,129
Income tax expense (benefit)	46,238	76,551	(59,794)	49,336	43,521	18,699
Income (loss) from continuing operations	70,606	113,726	(100,773)	69,255	82,401	35,430
Income from discontinued operations, net of tax	3,865	4,458	522	3,072	12,478	
Net income (loss)	74,471	118,184	(100,251)	72,327	94,879	35,430
Less: Preferred dividends				23,519	22,663	23,807
Net income (loss) available to common and preferred stockholders	\$ 74,471	\$ 118,184	\$ (100,251)	\$ 48,808	\$ 72,216	\$ 11,623

	Predecessor Period			Successor Period					
	Year Ended December 31, 2003		Year Ended December 31, 2004		Period from January 1 through February 24, 2005	Period from February 25 through December 31, 2005	Year Ended December 31, 2006		Year Ended December 31, 2007
	(in thousands, except per share data)			(in thousands, except per share data)					
Income (loss) per common share: Basic:									
Income (loss) from continuing operations	\$ 0.72	\$ 1.11	\$ (0.99)	\$ 0.23	\$ 0.30	\$ 0.05			
Income from discontinued operations, net of tax	0.04	0.04	0.01	0.02	0.06				
Net income (loss)	\$ 0.76	\$ 1.15	\$ (0.98)	\$ 0.25	\$ 0.36	\$ 0.05			
Diluted:									
Income (loss) from continuing operations	\$ 0.68	\$ 1.07	\$ (0.99)	\$ 0.22	\$ 0.28	\$ 0.05			
Income from discontinued operations, net of tax	0.04	0.04	0.01	0.02	0.06				
Net income (loss)	\$ 0.72	\$ 1.11	\$ (0.98)	\$ 0.24	\$ 0.34	\$ 0.05			
Weighted average common shares outstanding:									
Basic	97,452	102,165	102,026	171,330	180,183	190,286			
Diluted	103,991	106,529	102,026	181,070	188,287	192,748			
Balance Sheet Data (at end of period):									
Cash and cash equivalents	\$ 165,507	\$ 247,476		\$ 35,861	\$ 81,600	\$ 4,529			
Working capital	188,380	313,715		77,556	59,468	14,730			
Total assets	1,078,998	1,113,721		2,168,385	2,182,524	2,495,046			

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Total debt	367,503	354,590	1,628,889	1,538,503	1,755,635
Total stockholders equity	419,175	515,943	(244,658)	(169,139)	(165,889)

	Successor Period For the Six Months Ended June 30, 2007 2008 (in thousands, except per share data)	
Statement of Operations Data:		
Net operating revenues	\$ 973,313	\$ 1,087,084
Operating expenses ⁽¹⁾⁽²⁾	826,769	948,992
Depreciation and amortization	25,643	35,327
Income from operations	120,901	102,765
Other income	1,173	
Interest expense, net ⁽⁵⁾	(66,154)	(73,268)
Income from operations before minority interests and income taxes	55,920	29,497
Minority interests in consolidated subsidiary companies ⁽⁶⁾	1,136	1,071
Income from operations before income taxes	54,784	28,426
Income tax expense	22,998	13,973
Net income	31,786	14,453
Less: Preferred dividends	11,656	12,279
Net income available to common and preferred stockholders	\$ 20,130	\$ 2,174
Net income per common share:		
Basic	\$ 0.10	\$ 0.01
Diluted	0.10	0.01
Weighted average common shares outstanding:		
Basic	187,729	197,270
Diluted	187,729	202,260
Balance Sheet Data (at end of period):		
Cash and cash equivalents	\$ 25,610	\$ 7,534
Working capital	(3,985)	105,745
Total assets	2,457,840	2,544,037
Total debt	1,717,785	1,805,462
Total stockholders' equity	(146,311)	(165,703)

(1) Operating expenses include cost of services, general and administrative expenses, and bad debt expenses.

(2) Includes stock compensation expense related to the repurchase of outstanding stock options in the Predecessor Period from January 1 through February 24, 2005, compensation expense related to restricted stock, stock options and long term incentive compensation in the Successor Periods from February 25 through December 31, 2005, and for the years ended December 31, 2006 and 2007 and for the six months ended June 30, 2007 and 2008.

- (3) In connection with the Merger, Select completed tender offers for all of its 9 1/2% senior subordinated notes due 2009 and all of its 7 1/2% senior subordinated notes due 2013. The loss in the Predecessor Period of January 1 through February 24, 2005 consists of the tender premium cost of \$34.8 million and the remaining write-off of unamortized deferred financing costs of \$7.9 million.
- (4) As a result of the Merger, Select incurred costs in the Predecessor Period of January 1 through February 24, 2005 directly related to the Merger. This included the cost of the investment advisor hired by the special committee of Select's board of directors to evaluate the Merger, legal and accounting fees, costs associated with the Hart-Scott-Rodino filing relating to the Merger, the cost associated with purchasing a six year extended reporting period under our directors and officers liability insurance policy and other associated expenses.
- (5) Net interest equals interest expense minus interest income.
- (6) Reflects interests held by other parties in subsidiaries, limited liability companies and limited partnerships owned and controlled by us.

UNAUDITED PRO FORMA CONSOLIDATED FINANCIAL INFORMATION

Our consolidated financial statements are included elsewhere in this prospectus. The unaudited pro forma consolidated financial information presented here should be read together with these financial statements and related notes and Management's Discussion and Analysis of Financial Condition and Results of Operations.

We adjusted our historical consolidated balance sheet at June 30, 2008 and our historical consolidated statement of operations for the year ended December 31, 2007 and the six months ended June 30, 2008 to reflect (1) the issuance of _____ shares of our common stock in this offering at an assumed initial public offering price of \$ _____ per share, which is the midpoint of the range listed on the cover page of this prospectus, (2) the conversion of all shares of our issued and outstanding preferred stock into _____ shares of common stock immediately prior to the consummation of this offering based upon an assumed public offering price of \$ _____ per share, the midpoint of the range set forth on the cover page of this prospectus and (3) the application of the estimated net proceeds from this offering as if these events had occurred on June 30, 2008 for the unaudited pro forma consolidated balance sheet and at January 1, 2007 for the respective unaudited pro forma consolidated statement of operations. The pro forma consolidated financial statement of operations excludes non-recurring charges directly attributable to this offering, including \$ _____ million (net of tax) related to payments under the Long Term Cash Investment Plan and \$ _____ million (net of tax) related to reimbursing the selling stockholders for the underwriting discounts and commissions incurred on shares sold by them in this offering.

Certain information normally included in financial statements prepared in accordance with generally accepted accounting principles has been omitted pursuant to the rules and regulations of the Securities and Exchange Commission.

The pro forma consolidated balance sheet and pro forma consolidated statements of operations are not necessarily indicative of our financial position and results that would have occurred had the above events been completed on the above indicated dates and should not be construed as being representative of future results of operations.

UNAUDITED PRO FORMA CONSOLIDATED BALANCE SHEET

		June 30, 2008		
	Historical	Preferred Stock Conversion	Pro Forma (in thousands)	Adjustments for Offering
				Pro Forma as Adjusted
ASSETS				
Current Assets:				
Cash and cash equivalents	\$ 7,534		\$ 7,534	\$ 7,534
Accounts receivable, net of allowance for doubtful accounts	335,596		335,596	335,596
Current deferred tax asset	43,424		43,424	43,424
Prepaid income taxes	8,565		8,565	(2)
Other current assets	24,225		24,225	24,225
Total Current Assets	419,344		419,344	
Property and equipment, net	480,219		480,219	480,219
Goodwill	1,503,262		1,503,262	1,503,262
Other identifiable intangibles	76,229		76,229	76,229
Assets held for sale	13,953		13,953	13,953
Other assets	51,030		51,030	51,030
Total Assets	\$ 2,544,037		\$ 2,544,037	
LIABILITIES AND STOCKHOLDERS EQUITY				
Current Liabilities:				
Bank overdrafts	\$ 14,236		\$ 14,236	\$ 14,236
Current portion of long term debt and notes payable	10,408		10,408	10,408
Accounts payable	71,399		71,399	71,399
Accrued payroll	58,200		58,200	58,200
Accrued vacation	36,505		36,505	36,505
Accrued interest	37,281		37,281	37,281
Accrued restructuring	11,158		11,158	11,158
Accrued other	69,271		69,271	69,271
Due to third party payors	5,141		5,141	5,141
Total Current Liabilities	313,599		313,599	313,599
Long term debt, net of current portion	1,795,054		1,795,054	(2)
Non-current deferred tax liability	23,928		23,928	23,928
Other non-current liabilities	68,572		68,572	68,572

Total Liabilities	2,201,153		2,201,153	
Minority interest in consolidated subsidiary companies	5,408		5,408	5,408
Preferred stock	503,179	(1)		(2)
Stockholders' Equity:				
Common stock	205	(1)		(2)
Capital in excess of par	(290,347)	(1)		(2)
Retained earnings	132,890		132,890	(2)
Accumulated other comprehensive loss	(8,451)		(8,451)	(8,451)
Total Stockholders' Equity	(165,703)			
Total Liabilities and Stockholders' Equity	\$ 2,544,037			

(footnotes begin on page 42)

UNAUDITED PRO FORMA CONSOLIDATED STATEMENT OF OPERATIONS

	Year Ended December 31, 2007				Pro Forma As Adjusted
	Historical	Preferred Stock Conversion (in thousands, except per share data)	Pro Forma	Adjustments for Offering	
Net operating revenues	\$ 1,991,666		\$ 1,991,666		\$ 1,991,666
Operating expenses	1,740,484		1,740,484		1,740,484
Depreciation and amortization	57,297		57,297		57,297
Total cost and expenses	1,797,781		1,797,781		1,797,781
Income from operations	193,885		193,885		193,885
Other expense	(167)		(167)		
Interest expense, net	(138,052)		(138,052)	(4)	
Income before minority interests and income taxes	55,666		55,666		
Minority interests in consolidated subsidiary companies	1,537		1,537		1,537
Income before income taxes	54,129		54,129		
Income tax expense	18,699		18,699	(4)	
Net income	35,430		35,430		
Less: Preferred dividends	23,807	(3)		(4)	
Net income available to stockholders	\$ 11,623	\$	\$	\$	\$
Basic income per common share	\$ 0.05	\$	\$	\$	\$
Weighted average basic common shares outstanding	190,286	(3)		(4)	
Diluted income per common share	\$ 0.05	\$	\$	\$	\$
Weighted average diluted common shares outstanding	192,748	(3)		(4)	

(footnotes begin on page 42)

UNAUDITED PRO FORMA CONSOLIDATED STATEMENT OF OPERATIONS

	Six Months Ended June 30, 2008				
		Preferred Stock Conversion	Pro Forma	Adjustments for Offering	Pro Forma As Adjusted
	Historical	(in thousands, except per share data)			
Net operating revenues	\$ 1,087,084		\$ 1,087,084		\$ 1,087,084
Operating expenses	948,992		948,992		948,992
Depreciation and amortization	35,327		35,327		35,327
Total costs and expenses	984,319		984,319		984,319
Income from operations	102,765		102,765		102,765
Interest expense, net	(73,268)		(73,268)	(4)	
Income before minority interests and income taxes	29,497		29,497		
Minority interests in consolidated subsidiary companies	1,071		1,071		1,071
Income before income taxes	28,426		28,426		
Income tax expense	13,973		13,973	(4)	
Net income	14,453		14,453		
Less: Preferred dividends	12,279	(3)		(4)	
Net income available to stockholders	\$ 2,174	\$	\$	\$	\$
Basic income per common share	\$ 0.01	\$	\$	\$	\$
Weighted average basic common shares outstanding	197,270	(3)		(4)	
Diluted income per common share	\$ 0.01	\$	\$	\$	\$
Weighted average diluted common shares outstanding	202,260	(3)		(4)	

(footnotes begin on page 42)

NOTES TO UNAUDITED PRO FORMA CONSOLIDATED FINANCIAL INFORMATION

The following adjustments were applied to our Consolidated Balance Sheet to arrive at the Unaudited Pro Forma Consolidated Balance Sheet.

(1) We reflected the elimination of \$ million liquidation value of our preferred stock reflecting the conversion of all shares of our issued and outstanding preferred stock into shares of common stock immediately prior to the consummation of the offering and the right to receive \$ in cash upon the consummation of the offering.

(2) We reflected:

- (i) our issuance of shares in this offering;
- (ii) the repayment of \$ million of loans outstanding under our senior secured credit facilities;
- (iii) the payments under the Long Term Cash Investment Plan in the amount of \$ million reduced by \$ million of income tax benefit;
- (iv) the payment of \$ in cash to the holders of our common stock who are not selling stockholders in this offering in payment for a portion of the common stock they received upon the conversion of our preferred stock immediately prior to the consummation of this offering; and
- (v) the payment of \$ million to reimburse the selling stockholders for the underwriting discounts and commissions incurred on shares sold by them in this offering reduced by \$ million of income tax benefit.

The following adjustments were applied to our Consolidated Statement of Operations to arrive at the Unaudited Pro Forma Consolidated Statement of Operations.

(1) We reflected the elimination of \$ million of preferred dividends on the preferred stock reflecting the conversion of shares of our issued outstanding preferred stock into shares of common stock immediately prior to the consummation of the offering.

(2) We reflected:

- (i) the reduction in interest expense of \$ million and \$ million for the year ended December 31, 2007 and the six months ended June 30, 2008 for the repayment of \$ million of % senior debt under our bank credit facility;
- (ii) the issuance of shares in this offering; and
- (iii) additional tax expense of \$ million and \$ million for the year ended December 31, 2007 and the six months ended June 30, 2008, respectively, related to the reduction in interest expense.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read in conjunction with the Selected Historical Consolidated Financial Data, and our consolidated financial statements and the related notes included elsewhere in this prospectus. The following discussion contains, in addition to historical information, forward-looking statements that include risks and uncertainties. Our actual results may differ materially from those anticipated in these forward-looking statements as a result of certain factors, including those set forth under the heading Risk Factors and elsewhere in this prospectus.

Overview

We are a leading operator of specialty hospitals and outpatient rehabilitation clinics in the United States. As of June 30, 2008, we operated 88 long term acute care hospitals and four acute medical rehabilitation hospitals in 25 states, and 970 outpatient rehabilitation clinics in 37 states and the District of Columbia. We also provide medical rehabilitation services on a contracted basis to nursing homes, hospitals, assisted living and senior care centers, schools and work sites. We began operations in 1997 under the leadership of our current management team.

On February 24, 2005, Select merged with a wholly-owned subsidiary of Holdings pursuant to which Select became a wholly-owned subsidiary of Holdings. Holdings' primary asset is its investment in Select. Holdings is owned by an investor group that includes Welsh Carson, Thoma Cressey and members of our senior management. As a result of the Merger, Select's assets and liabilities have been adjusted to their fair value as of the closing. We have also experienced an increase in our aggregate outstanding indebtedness as a result of the financing transactions associated with the Merger. Accordingly, our amortization expense and interest expense are higher in periods following the Merger. The excess of the total purchase price over the fair value of our tangible and identifiable intangible assets of \$1.4 billion has been allocated to goodwill, which is subject to an annual impairment test. In determining the total economic consideration to use for financial accounting purposes, we have applied guidance found in Financial Accounting Standards Board Emerging Issues Task Force Issue No. 88-16 Basis in Leveraged Buyout Transactions. This has resulted in a portion of the equity related to our continuing stockholders being recorded at the stockholder's predecessor basis and a corresponding portion of the acquired assets being recorded likewise.

Although the Predecessor Period and Successor Period results are not comparable by definition due to the Merger Transactions and the resulting change in basis, for ease of comparison in the following discussion and to assist the reader in understanding our operating performance and operating trends, the financial data for the period after the Merger, February 25 through December 31, 2005 (Successor Period), have been added to the financial data for the period from January 1 through February 24, 2005 (Predecessor Period), to arrive at the combined year ended December 31, 2005. The combined data is referred to herein as the combined year ended December 31, 2005. As a result of the Merger, interest expense, loss on early retirement of debt, merger related charges, stock compensation expense, long term incentive compensation, depreciation and amortization have been impacted. We believe this combined presentation is a reasonable means of presenting our operating results.

We manage our company through two business segments, our specialty hospital segment and our outpatient rehabilitation segment. We had net operating revenues of \$1,991.7 million for the year ended December 31, 2007 and \$1,087.1 million for the six months ended June 30, 2008. Of these totals, we earned approximately 70% and 69% of our net operating revenues from our specialty hospitals and approximately 30% and 31% from our outpatient rehabilitation business for the year ended December 31, 2007 and the six months ended June 30, 2008, respectively.

Our specialty hospital segment consists of hospitals designed to serve the needs of long term stay acute patients and hospitals designed to serve patients who require intensive medical rehabilitation care. Patients in our long term acute care hospitals typically suffer from serious and often complex medical conditions that require a high degree of care. Patients in our inpatient rehabilitation facilities typically suffer from debilitating injuries, including traumatic brain and spinal cord injuries, and require rehabilitation care in the form of physical and vocational rehabilitation services. Our outpatient rehabilitation business consists of clinics and contract services that provide physical, occupational and speech rehabilitation services. Our outpatient rehabilitation patients are typically diagnosed with musculoskeletal impairments that restrict their ability to perform normal activities of daily living.

Recent Trends and Events

Acquisition of HealthSouth Corporation's Outpatient Rehabilitation Division

In 2007, we completed the acquisition of the outpatient rehabilitation division of HealthSouth Corporation. At the closing on May 1, 2007, we acquired 539 outpatient rehabilitation clinics. On June 20, 2007, one additional outpatient facility located in Washington, D.C. was acquired upon the receipt of regulatory approval. The closing of the purchase of 29 additional outpatient rehabilitation clinics that was deferred pending certain state regulatory approval was completed as of October 31, 2007 and resulted in the release of an additional \$23.4 million of the purchase price. The aggregate purchase price of \$245.0 million was reduced by approximately \$7.0 million at closing for assumed indebtedness and other matters. We funded the acquisition through borrowings under our senior secured credit facility and cash on hand.

Under the stock purchase agreement pursuant to which we acquired the outpatient rehabilitation division of HealthSouth Corporation, we have certain ongoing obligations to HealthSouth, including, (i) indemnification obligations for breaches of representations and warranties and covenants, post-closing taxes and certain other matters, (ii) to reasonably cooperate with HealthSouth regarding litigation and other liabilities retained by HealthSouth, including by providing access to books and records, (iii) to not solicit certain HealthSouth employees until January 27, 2009 and (iv) severance obligations for certain former employees of HealthSouth who worked in the facilities that were transferred to Select in connection with the acquisition.

In conjunction with the acquisition, we have recorded an estimated liability of \$18.7 million for restructuring costs associated with workforce reductions and lease termination costs resulting from our preliminary plans for integrating the acquired business. This estimated liability was accounted for as additional purchase price. We expect to pay the severance costs through 2008 and the lease termination costs through 2017.

Amendment to Credit Agreement

On March 19, 2007, we entered into an Amendment No. 2 and Waiver to our senior secured credit facility, or Amendment No. 2, and on March 28, 2007, we entered into an Incremental Facility Amendment with a group of lenders and JPMorgan Chase Bank, N.A. as administrative agent. Amendment No. 2 increased the general exception to the prohibition on asset sales under our senior secured credit facility from \$100.0 million to \$200.0 million, relaxed the interest expense coverage ratio and leverage ratio covenants starting March 31, 2007 in anticipation of the incurrence of additional indebtedness in connection with the HealthSouth acquisition and waived our requirement to prepay certain term loan borrowings following the year ended December 31, 2006. The Incremental Facility Amendment provided to our company an incremental term loan of \$100.0 million, the proceeds of which together with borrowings under our revolving credit facility and cash on hand we used to pay the purchase price for the HealthSouth transaction.

CBIL Sale

On March 1, 2006, we sold our wholly-owned subsidiary CBIL for approximately C\$89.8 million in cash (US\$79.0 million). At the time of the sale, CBIL operated 109 outpatient rehabilitation clinics in seven Canadian provinces and had approximately 1,000 employees. We conducted all of our Canadian operations through CBIL. The financial results of CBIL have been reclassified as discontinued operations for all periods presented in this report, and its assets and liabilities have been reclassified as held for sale on our December 31, 2005 balance sheet. As a result of this transaction, we have recognized a gain on sale (net of tax) of \$11.5 million in 2006.

Summary Financial Results

Six Months Ended June 30, 2008

For the six months ended June 30, 2008, our net operating revenues increased 11.7% to \$1,087.1 million compared to \$973.3 million for the six months ended June 30, 2007. This increase in net operating revenues resulted from a 6.6% increase in our specialty hospital net operating revenue and a 25.4% increase in our outpatient rehabilitation net operating revenue. The significant increase in our outpatient rehabilitation net operating revenue is primarily attributable to the net operating revenues generated by clinics acquired from HealthSouth Corporation

on May 1, 2007. We had income from operations for the six months ended June 30, 2008 of \$102.8 million compared to \$120.9 million for the six months ended June 30, 2007. The decline in income from operations is primarily attributable to the operating losses incurred in our specialty hospitals that were opened in 2007 and 2008. Our interest expense for the six months ended June 30, 2008 was \$73.5 million compared to \$68.0 million for the six months ended June 30, 2007. The increase in interest expense is related to higher average outstanding debt balances existing for the six month period ended June 30, 2008 which resulted primarily from the HealthSouth transaction. Cash flow from operations used \$1.0 million of cash for the six months ended June 30, 2008.

Year Ended December 31, 2007

For the year ended December 31, 2007, our net operating revenues increased 7.6% to \$1,991.7 million compared to \$1,851.5 million for the year ended December 31, 2006. This increase in net operating revenues resulted from a 0.6% increase in our specialty hospital net operating revenue and a 28.3% increase in our outpatient rehabilitation net operating revenue. The significant increase in our outpatient rehabilitation net operating revenue is primarily attributable to the net operating revenues generated by clinics acquired from HealthSouth Corporation in 2007. We had income from operations for the year ended December 31, 2007 of \$193.9 million compared to \$257.9 million for the year ended December 31, 2006. The decline in income from operations is principally related to a decline in the profitability of our specialty hospitals which resulted primarily from LTCH regulatory changes. Our interest expense for the year ended December 31, 2007 was \$140.2 million compared to \$131.8 million for the year ended December 31, 2006. The increase in interest expense resulted from higher average debt levels resulting primarily from the outpatient rehabilitation clinics acquired from HealthSouth Corporation and higher interest rates experienced during the year ended December 31, 2007. Our cash flow from operations provided \$86.0 million of cash for the year ended December 31, 2007.

Year Ended December 31, 2006

For the year ended December 31, 2006, our net operating revenues decreased 0.4% to \$1,851.5 million compared to \$1,858.4 million for the combined year ended December 31, 2005. This decrease in net operating revenues resulted from a 2.2% decrease in our outpatient rehabilitation net revenues offset by a 0.4% increase in our specialty hospital net operating revenue. The decline in our outpatient rehabilitation net revenues resulted from a decline in the number of clinics we operate and in the number of visits occurring at the operating clinics. We had income from operations for the year ended December 31, 2006 of \$257.9 million compared to \$119.1 million for the combined year ended December 31, 2005. For the combined year ended December 31, 2005, we incurred \$152.5 million of stock compensation costs as a result of the Merger Transactions and a non-recurring long term incentive compensation payment of \$14.5 million in September 2005. Interest expense for the year ended December 31, 2006 was \$131.8 million compared to \$106.9 million for the combined year ended December 31, 2005. This increase resulted from higher average debt levels and interest rates experienced during the year ended December 31, 2006. Our cash flow from operations provided \$227.7 million of cash for the year ended December 31, 2006.

Regulatory Changes

A significant portion of our specialty hospital net operating revenues are generated directly from the Medicare program. For the years ended December 31, 2007 and 2006 and the combined year ended December 31, 2005, revenues from the federal Medicare program amounted to 65%, 69% and 73% of our specialty hospital net operating revenues, respectively. In the last few years, there have been significant regulatory changes affecting LTCHs that have affected our net operating revenues and, in some cases, caused us to change our operating models and strategies. The following is a summary of some of the more significant healthcare regulatory changes that have affected our financial performance in the past or are likely to affect our financial performance in the future. See Business Government Regulations.

We have been subject to regulatory changes that occur through the CMS rulemaking procedures. Generally, rule updates have occurred twice each year. Proposed rules specifically related to LTCHs are generally published in January, finalized in May and effective on July 1st of each year. Additionally, LTCHs are subject to annual updates to the IPPS rules that are typically proposed in May, finalized in August and effective on October 1st of each year.

August 2004 Final Rule. On August 11, 2004, CMS published final regulations applicable to LTCHs that are operated as HIHs. Effective for hospital cost reporting periods beginning on or after October 1, 2004, subject to certain exceptions, the final regulations provide lower rates of reimbursement to HIHs for those Medicare patients admitted from their host hospitals that are in excess of a specified percentage threshold. For HIHs opened after October 1, 2004, the Medicare admissions threshold has been established at 25% except for HIHs located in rural hospitals, MSA dominant hospitals or single urban hospitals where the percentage is no more than 50%, nor less than 25%. For HIHs that meet specified criteria and were in existence as of October 1, 2004, including all but two of our then existing HIHs, the Medicare admissions thresholds are phased in over a four year period starting with hospital cost reporting periods that began on or after October 1, 2004. However, as described below, many of these changes have been postponed for a three year period by the SCHIP Extension Act.

During the year ended December 31, 2007, we recorded a liability of approximately \$5.9 million related to estimated repayments to Medicare for host admissions exceeding HIH s applicable admission threshold. The liability has been recorded through a reduction in our net operating revenue.

August 2005 Final Rule. On August 12, 2005, CMS published the final rules for general acute care hospitals IPPS, for fiscal year 2006, which included an update of the LTC-DRG relative weights. CMS estimated the changes to the relative weights would reduce LTCH Medicare payments-per-discharge by approximately 4.2% in fiscal year 2006 (the period from October 1, 2005 through September 30, 2006).

May 2006 Final Rule. On May 2, 2006, CMS released its final annual payment rate updates for the 2007 LTCH-PPS rate year (affecting discharges and cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007), or RY 2007. The May 2006 final rule revised the payment adjustment formula for SSO patients. For discharges occurring on or after July 1, 2006, the rule changed the 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 each SSO case. In addition, for discharges occurring on or after July 1, 2006, the May 2006 final rule provided for (1) a zero-percent update to the LTCH-PPS standard federal rate used as a basis for LTCH-PPS payments for RY 2007; (2) the elimination of the surgical case exception to the three day or less interruption of stay policy, under which surgical exception Medicare reimburses a general acute care hospital directly for surgical services furnished to a long term acute care hospital patient during a brief interruption of stay from the long term acute care hospital, rather than requiring the long term acute care hospital to bear responsibility for such surgical services; and (3) increasing the costs that a long term acute care hospital must bear before Medicare will make additional payments for a case under its high-cost outlier policy for RY 2007.

CMS estimated that the changes in the May 2006 final rule would result in an approximately 3.7% decrease in LTCH Medicare payments-per-discharge compared to the 2006 rate year, largely attributable to the revised SSO payment methodology. We estimated that the May 2006 final rule reduced Medicare revenues associated with SSO cases and high-cost outlier cases to our long term acute care hospitals by approximately \$29.3 million for RY 2007.

Additionally, had CMS updated the LTCH-PPS standard federal rate by the 2007 estimated market basket index of 3.4% rather than applying the zero-percent update, we estimated that we would have received approximately \$31.0 million in additional annual Medicare revenues based on our historical Medicare patient volumes and revenues (such revenues would have been paid to our hospitals for discharges beginning on or after July 1, 2006).

August 2006 Final Rule. On August 18, 2006, CMS published the IPPS final rule for fiscal year 2007, which is the period from October 1, 2006 through September 30, 2007, that included an update of the LTC-DRG relative weights for fiscal year 2007. CMS estimated the changes to the relative weights would reduce LTCH Medicare payments-per-discharge by approximately 1.3% in fiscal year 2007. The August 2006 final rule also included changes to the DRGs in IPPS that apply to LTCHs, as the LTC-DRGs are based on the IPPS DRGs.

May 2007 Final Rule. On May 1, 2007, CMS published its annual payment rate update for the 2008 LTCH-PPS rate year, or RY 2008 (affecting discharges and cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008). The May 2007 final rule makes several changes to LTCH-PPS payment methodologies and amounts during RY 2008 although, as described below, many of these changes have been postponed for a three year period by the SCHIP Extension Act.

For cost reporting periods beginning on or after July 1, 2007, the May 2007 final rule expands the current Medicare HIH admissions threshold to apply to Medicare patients admitted from any individual hospital. Previously, the admissions threshold was applicable only to Medicare HIH admissions from hospitals co-located with an LTCH or satellite of an LTCH. Under the May 2007 final rule, free-standing LTCHs and grandfathered HIHs are subject to the Medicare admission thresholds, as well as HIHs and satellites that admit Medicare patients from non-co-located hospitals. To the extent that any LTCH's or LTCH satellite facility's discharges that are admitted from an individual hospital (regardless of whether the referring hospital is co-located with the LTCH or LTCH satellite) exceed the applicable percentage threshold during a particular cost reporting period, the payment rate for those discharges would be subject to a downward payment adjustment. Cases admitted in excess of the applicable threshold will be reimbursed at a rate comparable to that under general acute care IPPS, which is generally lower than LTCH-PPS rates. Cases that reach outlier status in the discharging hospital would not count toward the limit and would be paid under LTCH-PPS. CMS estimates the impact of the expansion of the Medicare admission thresholds will result in a reduction of 2.2% of the aggregate payments to all LTCHs in RY 2008.

The applicable percentage threshold is generally 25% after the completion of the phase-in period described below. The percentage threshold for LTCH discharges from a referring hospital that is an MSA dominant hospital or a single urban hospital is the percentage of total Medicare discharges in the MSA that are from the referring hospital, but no less than 25% nor more than 50%. For Medicare discharges from LTCHs or LTCH satellites located in rural areas, as defined by the Office of Management and Budget, the percentage threshold is 50% from any individual referring hospital. The expanded 25% rule is being phased in over a three year period. The three year transition period starts with cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, when the threshold is the lesser of 75% or the percentage of the LTCH's or LTCH satellite's admissions discharged from the referring hospital during its cost reporting period beginning on or after July 1, 2004 and before July 1, 2005, or RY 2005. For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the threshold will be the lesser of 50% or the percentage of the LTCH's or LTCH satellite's admissions from the referring hospital, during its RY 2005 cost reporting period. For cost reporting periods beginning on or after July 1, 2009, all LTCHs will be subject to the 25% threshold (or applicable threshold for rural, urban-single, or MSA dominant hospitals). The SCHIP Extension Act postpones the application of the percentage threshold to all free-standing and grandfathered HIHs for a three year period commencing on an LTCH's first cost reporting period on or after December 29, 2007. However, the SCHIP Extension Act does not postpone the application of the percentage threshold, or the transition period stated above, to those Medicare patients discharged from an LTCH HIH or HIH satellite that were admitted from a non-co-located hospital. The SCHIP Extension Act only postpones the expansion of the admission threshold in the May 2007 final rule to free-standing LTCHs and grandfathered HIHs.

The May 2007 final rule further revised the payment adjustment for SSO cases. Beginning with discharges on or after July 1, 2007, for cases with a length of stay that is less than the IPPS comparable threshold, the rule effectively lowers the LTCH payment to a rate based on the general acute care hospital IPPS. SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the SSO payment policy described above under the May 2006 final rule. Cases with a covered length of stay less than or equal to the IPPS comparable threshold and less than five-sixths of the geometric average length of stay for that LTC-DRG will be paid at an amount comparable to the IPPS per diem. The SCHIP Extension Act also postpones, for the three year period beginning on December 29, 2007, the SSO policy changes made in the May 2007 final rule.

The May 2007 final rule updated the standard federal rate by 0.71% for RY 2008. As a result, the federal rate for RY 2008 is equal to \$38,356.45, compared to \$38,086.04 for RY 2007. Subsequently, the SCHIP Extension Act eliminated the update to the standard federal rate that occurred for RY 2008 effective April 1, 2008. This adjustment to the standard federal rate was applied prospectively on April 1, 2008 and reduced the federal rate back to \$38,086.04. In a technical correction to the May 2007 final rule, CMS increased the fixed-loss amount for high cost outlier in RY 2008 to \$20,738, compared to \$14,887 in RY 2007. CMS projected an estimated 0.4% decrease in

LTCH payments in RY 2008 due to this change in the fixed-loss amount and the overall impact of the May 2007 final rule to be a 1.2% decrease in total estimated LTCH PPS payments for RY 2008.

The May 2007 final rule provides that beginning with the annual payment rate updates to the LTC-DRG classifications and relative weights for the fiscal year 2008, or FY 2008 (affecting discharges beginning on or after October 1, 2007 and before September 30, 2008), annual updates to the LTC-DRG classification and relative

weights are to have a budget neutral impact. Under the May 2007 final rule, future LTC-DRG reclassification and recalibrations, by themselves, should neither increase nor decrease the estimated aggregated LTCH PPS payments.

The May 2007 final rule is complex and the SCHIP Extension Act has postponed the implementation of certain portions of the May 2007 final rule. While we cannot predict the ultimate long term impact of LTCH-PPS because the payment system remains subject to significant change, if the May 2007 final rule become effective as currently written, after the expiration of the SCHIP Extension Act, our future net operating revenues and profitability will be adversely affected.

August 2007 Final Rule. On August 1, 2007, CMS published the IPPS final rule for FY 2008, which creates a new patient classification system with categories referred to as MS-DRGs and MS-LTC-DRGs, respectively, for hospitals reimbursed under IPPS and LTCH PPS. Beginning with discharges on or after October 1, 2007, the new classification categories take into account the severity of the patient's condition. CMS assigned proposed relative weights to each MS-DRG and MS-LTC-DRG to reflect their relative use of medical care resources. We believe that, because of the proposed relative weights and length of stay assigned to the MS-LTC-DRGs for the patient populations served by our hospitals, our long term acute care hospital payments may be adversely affected.

The August 2007 final rule published a budget neutral update to the MS-LTC-DRG classification and relative weights. In the preamble to the IPPS final rule for FY 2008 CMS restated that it intends to continue to update the LTC-DRG weights annually in the IPPS rulemaking and those weights would be modified by a budget neutrality adjustment factor to ensure that estimated aggregate LTCH payments after reweighting are equal to estimated aggregate LTCH payments before reweighting.

Medicare, Medicaid and SCHIP Extension Act of 2007. On December 29, 2007, the President signed into law the SCHIP Extension Act. Among other changes in the federal health care programs, the SCHIP Extension Act makes significant changes to Medicare policy for LTCHs including a new statutory definition of an LTCH, a report to Congress on new LTCH patient criteria, relief from certain LTCH-PPS payment policies for three years, a three year moratorium on the development of new LTCHs and LTCH beds, elimination of the payment update for the last quarter of RY 2008 and new medical necessity reviews by Medicare contractors through at least October 1, 2010.

The SCHIP Extension Act precludes the Secretary from implementing, during the three year moratorium period, the provisions added by the May 2007 final rule that extended the 25% rule to free-standing LTCHs, including grandfathered LTCHs. The SCHIP Extension Act also modifies, during the moratorium, the effect of the 25% rule for LTCHs that are co-located with other hospitals. For HIHs and satellite facilities, the applicable percentage threshold is set at 50% and not phased in to the 25% level. For HIHs and satellite facilities located in rural areas and those which receive referrals from MSA dominant hospitals or single urban hospitals, the percentage threshold is set at no more than 75%. These moratoria relating to LTCH admission thresholds extend for an LTCH's three cost reporting periods beginning on or after December 29, 2007.

The SCHIP Extension Act also precludes the Secretary from implementing, for the three year period beginning on December 29, 2007, a one-time adjustment to the LTCH standard federal rate. This rule, established in the original LTCH-PPS regulations, permits CMS to restate the standard federal rate to reflect the effect of changes in coding since the LTCH-PPS base year. In the preamble to the May 2007 final rule, CMS discussed making a one-time prospective adjustment to the LTCH-PPS rates for the 2009 rate year. In addition, the SCHIP Extension Act reduces the Medicare payment update for the portion of RY 2008 from April 1, 2008 to June 30, 2008 to the same base rate applied to LTCH discharges during RY 2007.

For the three years following December 29, 2007, the Secretary must impose a moratorium on the establishment and classification of new LTCHs, LTCH satellite facilities, and LTCH beds in existing LTCH or satellite facilities. This

moratorium does not apply to LTCHs that, before the date of enactment, (1) began the qualifying period for payment under the LTCH-PPS, (2) have a written agreement with an unrelated party for the construction, renovation, lease or demolition for a LTCH and have expended at least 10% of the estimated cost of the project or \$2,500,000, or (3) have obtained an approved certificate of need. As a result of the SCHIP Extension Act's three year moratorium on the development of new LTCHs, we have stopped all LTCH development, except for LTCHs currently under construction that are excluded from the moratorium.

May 6, 2008 Interim Final Rule. On May 6, 2008, CMS published an interim final rule with comment period, which implements portions of the SCHIP Extension Act. The interim final rule addresses: (1) the payment adjustment for very short-stay outliers, (2) the standard federal rate for the last three months of RY 2008, (3) adjustment of the high cost outlier fixed-loss amount for the last three months of RY 2008, and (4) references the SCHIP Extension Act in the discussion of the basis and scope of the LTCH-PPS rules.

May 9, 2008 Final Rule. On May 9, 2008, CMS published its annual payment rate update for the 2009 LTCH-PPS rate year, or RY 2009 (affecting discharges and cost reporting periods beginning on or after July 1, 2008). The final rule adopts a 15-month rate update, from July 1, 2008 through September 30, 2009 and moves LTCH-PPS from a July-June update cycle to the same update cycle as the general acute care hospital inpatient rule (October – September). For RY 2009, the rule establishes a 2.7% update to the standard federal rate. The rule increases the fixed-loss amount for high cost outlier cases to \$22,960, which is \$2,222 higher than the 2008 LTCH-PPS rate year. The final rule provides that CMS may make a one-time reduction in the LTCH-PPS rates to reflect a budget neutrality adjustment no earlier than December 29, 2010 and no later than October 1, 2012. CMS estimated this reduction will be approximately 3.75%.

May 2008 Interim Final Rule. On May 22, 2008, CMS published an interim final rule with comment period, which implements portions of the SCHIP Extension Act not addressed in the May 6, 2008 Interim Final Rule. Among other things, the second May 2008 Interim Final Rule establishes a definition for free-standing LTCHs as a hospital that: (1) has a Medicare provider agreement, (2) has an average length of stay of greater than 25 days, (3) does not occupy space in a building used by another hospital, (4) does not occupy space in one or more separate or entire buildings located on the same campus as buildings used by another hospital and (5) is not part of a hospital that provides inpatient services in a building also used by another hospital.

Development of New Specialty Hospitals and Clinics

In addition to the growth of our business through the acquisition and integration of other businesses, we have also grown our business through specialty hospital and outpatient rehabilitation facility development opportunities. Since our inception in 1997 through June 30, 2008, we have internally developed 60 specialty hospitals and 255 outpatient rehabilitation facilities. As a result of the SCHIP Extension Act however, which has a three year moratorium on the development of new LTCHs, we have stopped all LTCH development, except for LTCHs currently under construction that are excluded from the moratorium. We will continue to evaluate opportunities to develop inpatient rehabilitation hospitals. We also intend to open new outpatient rehabilitation clinics in the local areas that we currently serve where we can benefit from existing referral relationships and brand awareness to produce incremental growth.

Critical Accounting Matters

Sources of Revenue

Our net operating revenues are derived from a number of sources, including commercial, managed care, private and governmental payors. Our net operating revenues include amounts estimated by management to be reimbursable from each of the applicable payors and the federal Medicare program. Amounts we receive for treatment of patients are generally less than the standard billing rates. We account for the differences between the estimated reimbursement rates and the standard billing rates as contractual adjustments, which we deduct from gross revenues to arrive at net operating revenues.

Net operating revenues generated directly from the Medicare program from all segments represented approximately 48%, 53% and 56% of net operating revenues for the years ended December 31, 2007 and 2006, and the combined year ended December 31, 2005, respectively. Net operating revenues generated directly from the Medicare program

from all segments represented approximately 46% and 50% of net operating revenues for the six months ended June 30, 2008 and 2007, respectively. Approximately 65%, 69% and 73% of our specialty hospital revenues for the years ended December 31, 2007 and 2006, and the combined year ended December 31, 2005, respectively, were received for services provided to Medicare patients. Approximately 63% and 67% of our specialty hospital revenues for the six months ended June 30, 2008 and 2007, respectively, were received for services provided to Medicare patients. For the years ended December 31, 2006 and 2007 and the combined year

ended December 31, 2005 and the six months ended June 30, 2008, all of our Medicare payments were paid under prospective payment systems.

The LTCH-PPS regulations also refined the criteria that must be met in order for a hospital to be certified as a long term acute care hospital. For cost reporting periods beginning on or after October 1, 2002, a long term acute care hospital must have an average inpatient length of stay for Medicare patients (including both Medicare covered and non-covered days) of greater than 25 days. Previously, average lengths of stay were measured with respect to all patients.

Most of our specialty hospitals receive bi-weekly periodic interim payments, or PIP, from Medicare instead of being paid on an individual claim basis. Under a PIP payment methodology, Medicare estimates a hospital's claim volume based on historical trends and periodically reconciles the differences between the actual claim data and the estimated payments. At each balance sheet date, we record the difference between our actual claims and the PIP payments as a receivable or payable from third-party payors on our balance sheet.

Contractual Adjustments

Net operating revenues include amounts estimated by us to be reimbursable by Medicare and Medicaid under prospective payment systems and provisions of cost-reimbursement and other payment methods. In addition, we are reimbursed by non-governmental payors using a variety of payment methodologies. Amounts we receive for treatment of patients covered by these programs are generally less than standard billing rates. Contractual allowances are calculated and recorded through our internally developed systems. Within our hospital segment our billing system automatically calculates estimated Medicare reimbursement and associated contractual allowances. For non-governmental payors, we manually calculate the contractual allowance for each patient based upon the contractual provisions associated with the specific payor. In our outpatient segment, we perform provision testing, using internally developed systems, whereby we monitor a payor's historical paid claims data and compare it against the associated gross charges. This difference is determined as a percentage of gross charges and is applied against gross billing revenue to determine the contractual allowances for the period. Additionally, these contractual percentages are applied against the gross receivables on the balance sheet to determine that adequate contractual reserves are maintained for the gross accounts receivables reported on the balance sheet. We account for any difference as additional contractual adjustments deducted from gross revenues to arrive at net operating revenues in the period that the difference is determined. The estimation processes described above and used in recording our contractual adjustments have historically yielded consistent and reliable results.

Allowance for Doubtful Accounts

Substantially all of our accounts receivable are related to providing healthcare services to patients. Collection of these accounts receivable is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to non-governmental payors who insure these patients, and deductibles, co-payments and self-insured amounts owed by the patient. Deductibles, co-payments and self-insured amounts are an immaterial portion of our net accounts receivable balance. At June 30, 2008, deductibles, co-payments and self-insured amounts owed by patients accounted for approximately 0.3% of our net accounts receivable balance before doubtful accounts. Our general policy is to verify insurance coverage prior to the date of admission for a patient admitted to our hospitals or, in the case of our outpatient rehabilitation clinics, we verify insurance coverage prior to their first therapy visit. Our estimate for the allowance for doubtful accounts is calculated by generally reserving as uncollectible all governmental accounts over 365 days and non-governmental accounts over 180 days from discharge. This method is monitored based on our historical cash collections experience. Collections are impacted by the effectiveness of our collection efforts with non-governmental payors and regulatory or administrative disruptions with the fiscal intermediaries that pay our governmental receivables.

We estimate bad debts for total accounts receivable within each of our operating units. We believe our policies have resulted in reasonable estimates determined on a consistent basis. We believe that we collect substantially all of our third-party insured receivables (net of contractual allowances) which include receivables from governmental agencies. To date, we believe there has not been a material difference between our bad debt allowances and the ultimate historical collection rates on accounts receivable. We review our overall reserve adequacy by monitoring

historical cash collections as a percentage of net revenue less the provision for bad debts. Uncollected accounts are written off the balance sheet when they are turned over to an outside collection agency, or when management determines that the balance is uncollectible, whichever occurs first.

The following table is an aging of our net (after allowances for contractual adjustments but before doubtful accounts) accounts receivable (in thousands):

	Balance as of December 31,				Balance as of June 30,	
	2006		2007		2008	
	0-90 Days	Over 90 Days	0-90 Days	Over 90 Days	0-90 Days	Over 90 Days
Medicare and Medicaid	\$ 56,558	\$ 15,216	\$ 76,927	\$ 15,131	\$ 120,958	\$ 16,814
Commercial insurance, and other	116,552	66,907	175,152	60,052	181,398	71,945
Total net accounts receivable	\$ 173,110	\$ 82,123	\$ 252,079	\$ 75,183	\$ 302,356	\$ 88,759

The approximate percentage of total net accounts receivable (after allowance for contractual adjustments but before doubtful accounts) summarized by aging categories is as follows:

	As of December 31,		As of
	2006	2007	June 30, 2008
0 to 90 days	67.8%	77.0%	77.3%
91 to 180 days	10.8%	10.0%	10.5%
181 to 365 days	8.4%	6.0%	6.5%
Over 365 days	13.0%	7.0%	5.7%
Total	100.0%	100.0%	100.0%

The approximate percentage of total net accounts receivable (after allowance for contractual adjustments but before doubtful accounts) summarized by insured status is as follows:

	As of December 31,		As of
	2006	2007	June 30, 2008
Insured receivables	99.1%	99.7%	99.7%
Self-pay receivables (including deductibles and copayments)	0.9%	0.3%	0.3%
Total	100.0%	100.0%	100.0%

Insurance

Under a number of our insurance programs, which include our employee health insurance program and certain components under our property and casualty insurance program, we are liable for a portion of our losses. In these cases, we accrue for our losses under an occurrence-based principle whereby we estimate the losses that will be incurred by us in a given accounting period and accrue that estimated liability. Where we have substantial exposure, we utilize actuarial methods in estimating the losses. In cases where we have minimal exposure, we will estimate our losses by analyzing historical trends. We monitor these programs quarterly and revise our estimates as necessary to take into account additional information. At June 30, 2008, December 31, 2007 and December 31, 2006, we have recorded a liability of \$62.2 million, \$58.9 million and \$60.0 million, respectively, for our estimated losses under these insurance programs.

Related Party Transactions

We are party to various rental and other agreements with companies affiliated with us through common ownership. Our payments to these related parties amounted to \$2.3 million for both the year ended December 31, 2007 and the year ended December 31, 2006. Our payments to these related parties amounted to \$1.7 million for the six months ended June 30, 2008 and \$1.2 million for the six months ended June 30, 2007. Our future commitments are related to commercial office space we lease for our corporate headquarters in Mechanicsburg, Pennsylvania. These future commitments as of June 30, 2008 amount to \$47.3 million through 2023. These transactions and commitments are described more fully in the notes to our consolidated financial statements included herein. See also Certain Relationships and Related Transactions.

Consideration of Impairment Related to Goodwill and Other Intangible Assets

Goodwill and certain other indefinite-lived intangible assets are no longer amortized, but instead are subject to periodic impairment evaluations under Statement of Financial Accounting Standards, or SFAS, No. 142, Goodwill and Other Intangible Assets. Our most recent impairment assessment was completed during the fourth quarter of 2007, which indicated that there was no impairment with respect to goodwill or other recorded intangible assets. With the exception of goodwill, the majority of our intangible assets are subject to amortization. The majority of our goodwill resides in our specialty hospital reporting unit. In performing periodic impairment tests, the fair value of the reporting unit is compared to the carrying value, including goodwill and other intangible assets. If the carrying value exceeds the fair value, an impairment condition exists, which results in an impairment loss equal to the excess carrying value. Impairment tests are required to be conducted at least annually, or when events or conditions occur that might suggest a possible impairment. These events or conditions include, but are not limited to, a significant adverse change in the business environment, 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 occurrence of one of these events or conditions could significantly impact an impairment assessment, necessitating an impairment charge and adversely affecting our results of operations. For purposes of goodwill impairment assessment, we have defined our reporting units as specialty hospitals, outpatient rehabilitation clinics and contract therapy, with goodwill having been allocated among reporting units based on the relative fair value of those divisions when the Merger Transactions occurred in 2005 and based on subsequent acquisitions.

To determine the fair value of our reporting units, we use a discounted cash flow approach. Included in the discounted cash flow are assumptions regarding revenue growth rates, internal development of specialty hospitals and rehabilitation clinics, future EBITDA margin estimates, future selling, general and administrative expense rates and our weighted average cost of capital. We also must estimate residual values at the end of the forecast period and future capital expenditure requirements. Each of these assumptions requires us to use our knowledge of (1) our industry, (2) our recent transactions, and (3) reasonable performance expectations for our operations. If any one of the above assumptions changes or fails to materialize, the resulting decline in our estimated fair value could result in a material impairment charge to the goodwill associated with any one of the reporting units.

Realization of Deferred Tax Assets

We account for income taxes in accordance with SFAS No. 109, Accounting for Income Taxes, or SFAS No. 109, which requires that deferred tax assets and liabilities be recognized using enacted tax rates for the effect of temporary differences between the book and tax bases of recorded assets and liabilities. SFAS No. 109 also requires that deferred tax assets be reduced by a valuation allowance if it is more likely than not that some portion or all of the deferred tax asset will not be realized. As part of the process of preparing our consolidated financial statements, we estimate our income taxes based on our actual current tax exposure together with assessing temporary differences resulting from

differing treatment of items for tax and accounting purposes. We also recognize as deferred tax assets the future tax benefits from net operating loss carryforwards. We evaluate the realizability of these deferred tax assets by assessing their valuation allowances and by adjusting the amount of such allowances, if necessary. Among the factors used to assess the likelihood of realization are our 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. However,

changes in tax codes, statutory tax rates or future taxable income levels could materially impact our valuation of tax accruals and assets and could cause our provision for income taxes to vary significantly from period to period.

At December 31, 2007 and June 30, 2008, we had deferred tax assets in excess of deferred tax liabilities of approximately \$26.0 million and \$19.5 million, respectively. Those amounts are net of approximately \$16.8 million and \$16.9 million of valuation reserves related primarily to state and federal tax net operating losses that may not be realized at December 31, 2007 and June 30, 2008, respectively.

Uncertain Tax Positions

We record and review quarterly our uncertain tax positions. 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. While we believe that our reserves for uncertain tax positions are adequate, the settlement of any such exposures at amounts that differ from current reserves may require us to materially increase or decrease our reserves for uncertain tax positions.

Stock Based Compensation

Based on the midpoint of the price range set forth on the cover of this prospectus, the aggregate intrinsic value of our vested outstanding stock options and restricted stock as of June 30, 2008 was \$, and the aggregate intrinsic value of our unvested outstanding stock options and restricted stock as of June 30, 2008 was \$. Determining the fair value of our stock requires making complex and subjective judgments. Our approach to valuation is based on a discounted future cash flow approach that uses our estimates of revenue and estimated costs as well as appropriate discount rates. These estimates are consistent with the plans and estimates that we use to manage the business. There is inherent uncertainty in making these estimates. Although it is reasonable to expect that the completion of the registration process will add value to the shares because they will have increased liquidity and marketability, the amount of additional value cannot be measured with precision or certainty.

Operating Statistics

The following tables set forth operating statistics for our specialty hospitals and our outpatient rehabilitation clinics for each of the periods presented. The data in the table reflect the changes in the number of specialty hospitals and outpatient rehabilitation clinics we operate that resulted from acquisitions, start-up activities, closures, sales and consolidations. The operating statistics reflect data for the period of time these operations were managed by us.

	Combined Year Ended December 31, 2005	Year Ended December 31, 2006	Year Ended December 31, 2007
Specialty hospital data⁽¹⁾:			
Number of hospitals start of period	86	101	96
Number of hospital start-ups		3	3
Number of hospitals acquired	17		
Number of hospitals closed/sold	(2)	(4)	(8)
Number of hospitals consolidated		(4)	(4)
Number of hospitals end of period	101	96	87
Available licensed beds	3,829	3,867	3,819
Admissions	39,963	39,668	40,008
Patient days	985,025	969,590	987,624
Average length of stay (days)	25	24	25
Net revenue per patient day ⁽²⁾	\$ 1,370	\$ 1,392	\$ 1,378
Occupancy rate	70%	69%	69%
Percent patient days Medicare	75%	73%	69%
Outpatient rehabilitation data⁽³⁾:			
Number of clinics owned start of period	589	553	477
Number of clinics acquired			570
Number of clinic start-ups	22	12	15
Number of clinics closed/sold ⁽⁴⁾	(58)	(88)	(144)
Number of clinics owned end of period	553	477	918
Number of clinics managed end of period	55	67	81
Total number of clinics (all) end of period	608	544	999
Number of visits	3,308,620	2,972,243	4,032,197
Net revenue per visit ⁽⁵⁾	\$ 89	\$ 94	\$ 100

	Six Months Ended	
	June 30,	
	2007	2008
Specialty hospital data⁽¹⁾:		
Number of hospitals start of period	96	87
Number of hospital start-ups	1	6
Number of hospitals closed/sold	(1)	
Number of hospitals consolidated	(4)	(1)
Number of hospitals end of period	92	92
Available licensed beds	3,983	4,126
Admissions	20,239	20,914
Patient days	499,844	512,286
Average length of stay (days)	25	25
Net revenue per patient day ⁽²⁾	\$ 1,374	\$ 1,428
Occupancy rate	71%	69%
Percent patient days Medicare	71%	66%
Outpatient rehabilitation data:		
Number of clinics owned start of period	477	918
Number of clinics acquired	541	
Number of clinic start-ups	5	9
Number of clinics closed/sold	(27)	(33)
Number of clinics owned end of period	996	894
Number of clinics managed end of period	110	76
Total number of clinics (all) end of period	1,106	970
Number of visits	1,726,264	2,323,609
Net revenue per visit ⁽⁵⁾	\$ 100	\$ 103

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- (1) Specialty hospitals consist of long term acute care hospitals and inpatient rehabilitation facilities.
- (2) Net revenue per patient day is calculated by dividing specialty hospital patient service revenues by the total number of patient days.
- (3) Clinic data has been restated to remove the clinics operated by CBIL. CBIL was sold on March 31, 2006 and is being reported as a discontinued operation in 2005 and 2006.
- (4) The number of clinics closed/sold for the year ended December 31, 2007 relate primarily to clinics closed in connection with the restructuring plan for integrating the acquisition of HealthSouth Corporation's outpatient rehabilitation division.
- (5) Net revenue per visit is calculated by dividing outpatient rehabilitation clinic revenue by the total number of visits. For purposes of this computation, outpatient rehabilitation clinic revenue does not include contract services revenue.

Results of Operations

The following table presents the combined consolidated statement of operations for the combined year ended December 31, 2005. This data was derived by adding the financial data for the period after the Merger, February 25 through December 31, 2005 (Successor Period) to the financial data for the period from January 1 through February 24, 2005 (Predecessor Period).

	Predecessor Period from January 1 through February 24, 2005	Successor Period from February 25 through December 31, 2005 (in thousands)	Combined Year Ended December 31, 2005
Net operating revenues	\$ 277,736	\$ 1,580,706	\$ 1,858,442
Costs and expenses:			
Cost of services ⁽²⁾	244,321	1,244,361	1,488,682
General and administrative	122,509	59,494	182,003
Bad debt expense	6,588	18,213	24,801
Depreciation and amortization	5,933	37,922	43,855
Total costs and expenses	379,351	1,359,990	1,739,341
Income (loss) from operations	(101,615)	220,716	119,101
Other income and expense:			
Loss on early retirement of debt	(42,736)		(42,736)
Merger related charges	(12,025)		(12,025)
Other income	267	1,092	1,359
Interest income	523	767	1,290
Interest expense	(4,651)	(102,208)	(106,859)
Income (loss) from continuing operations before minority interests and income taxes	(160,237)	120,367	(39,870)
Minority interest in consolidated subsidiary companies	330	1,776	2,106
Income (loss) from continuing operations before income taxes	(160,567)	118,591	(41,976)
Income tax expense (benefit)	(59,794)	49,336	(10,458)
Income (loss) from continuing operations	(100,773)	69,255	(31,518)
Income from discontinued operations, net of tax	522	3,072	3,594
Net income (loss)	\$ (100,251)	\$ 72,327	\$ (27,924)

The following tables outline, for the periods indicated, selected operating data as a percentage of net operating revenues:

	Combined Year Ended December 31, 2005⁽¹⁾	Year Ended December 31, 2006	Year Ended December 31, 2007
Net operating revenues	100.0%	100.0%	100.0%
Cost of services ⁽²⁾	80.1	80.2	83.3
General and administrative	9.8	2.4	2.2
Bad debt expense	1.3	1.0	1.9
Depreciation and amortization	2.4	2.5	2.9
Income from operations	6.4	13.9	9.7
Loss on early retirement of debt	(2.3)		
Merger related charges	(0.7)		
Other income	0.1		
Interest expense, net	(5.7)	(7.1)	(6.9)
Income (loss) from continuing operations before minority interests and income taxes	(2.2)	6.8	2.8
Minority interests	0.1	0.1	0.1
Income (loss) from continuing operations before income taxes	(2.3)	6.7	2.7
Income tax expense (benefit)	(0.6)	2.4	0.9
Income (loss) from continuing operations	(1.7)	4.3	1.8
Income from discontinued operations, net of tax	0.2	0.7	
Net income (loss)	(1.5)%	5.0%	1.8%

	Six	
	Months Ended June 30,	
	2007	2008
Net operating revenues	100.0%	100.0%
Cost of services ⁽²⁾	81.0	82.9
General and administrative	2.4	2.2
Bad debt expense	1.5	2.1
Depreciation and amortization	2.6	3.3
Income from operations	12.5	9.5
Other income	0.1	
Interest expense, net	(6.8)	(6.8)
Income from operations before minority interests and income taxes	5.8	2.7
Minority interests	0.1	0.1
Income from operations before income taxes	5.7	2.6
Income tax expense	2.4	1.3
Net income	3.3%	1.3%

The following tables summarize selected financial data by business segment, for the periods indicated:

	Combined Year Ended December 31, 2005⁽¹⁾	Year Ended December 31, 2006	Year Ended December 31, 2007	% Change 2005- 2006	% Change 2006- 2007
	(in thousands)				
Net operating revenues:					
Specialty hospitals	\$ 1,372,483	\$ 1,378,543	\$ 1,386,410	0.4%	0.6%
Outpatient rehabilitation	480,711	470,339	603,413	(2.2)	28.3
Other ⁽⁴⁾	5,248	2,616	1,843	(50.2)	(29.5)
Total company	\$ 1,858,442	\$ 1,851,498	\$ 1,991,666	(0.4)%	7.6%
Income (loss) from operations:					
Specialty hospitals	\$ 280,789	\$ 252,539	\$ 180,090	(10.1)%	(28.7)%
Outpatient rehabilitation	56,052	51,859	57,979	(7.5)	11.8
Other ⁽⁴⁾	(217,740)	(46,524)	(44,184)	78.6	5.0
Total company	\$ 119,101	\$ 257,874	\$ 193,885	116.5%	(24.8)%
Adjusted EBITDA: ⁽³⁾					
Specialty hospitals	\$ 308,144	\$ 283,270	\$ 217,175	(8.1)%	(23.3)%
Outpatient rehabilitation	65,957	64,823	75,437	(1.7)	16.4
Other ⁽⁴⁾	(44,167)	(39,769)	(37,684)	10.0	5.2
Adjusted EBITDA margins: ⁽³⁾					
Specialty hospitals	22.5%	20.5%	15.7%	(8.9)%	(23.4)%
Outpatient rehabilitation	13.7	13.8	12.5	0.7	(9.4)
Other ⁽⁴⁾ :	N/M	N/M	N/M	N/M	N/M
Total assets:					
Specialty hospitals	\$ 1,656,224	\$ 1,742,803	\$ 1,882,476		
Outpatient rehabilitation	293,720	258,773	513,397		
Other ⁽⁴⁾	218,441	180,948	99,173		
Total company	\$ 2,168,385	\$ 2,182,524	\$ 2,495,046		
Purchases of property and equipment, net:					
Specialty hospitals	\$ 102,323	\$ 146,291	\$ 146,901		
Outpatient rehabilitation	3,750	6,527	14,737		
Other ⁽⁴⁾	3,873	2,278	4,436		
Total company	\$ 109,946	\$ 155,096	\$ 166,074		

	Six Months Ended June 30,		% Change
	2007	2008 (in thousands)	
Net operating revenues:			
Specialty hospitals	\$ 699,510	\$ 745,893	6.6%
Outpatient rehabilitation	272,066	341,072	25.4
Other ⁽⁴⁾	1,737	119	(93.1)
Total company	\$ 973,313	\$ 1,087,084	11.7%
Income (loss) from operations:			
Specialty hospitals	\$ 109,297	\$ 96,604	(11.6)%
Outpatient rehabilitation	35,211	32,142	(8.7)
Other ⁽⁴⁾	(23,607)	(25,981)	(10.1)
Total company	\$ 120,901	\$ 102,765	(15.0)%
Adjusted EBITDA: ⁽³⁾			
Specialty hospitals	\$ 126,721	\$ 118,480	(6.5)%
Outpatient rehabilitation	42,171	43,843	4.0
Other ⁽⁴⁾	(20,470)	(23,039)	(12.6)
Adjusted EBITDA margins: ⁽³⁾			
Specialty hospitals	18.1%	15.9%	(12.2)%
Outpatient rehabilitation	15.5	12.9	(16.8)
Other ⁽⁴⁾	N/M	N/M	N/M
Total assets:			
Specialty hospitals	\$ 1,832,312	\$ 1,925,514	
Outpatient rehabilitation	482,006	510,248	
Other ⁽⁴⁾	143,522	108,275	
Total company	\$ 2,457,840	\$ 2,544,037	
Purchases of property and equipment, net:			
Specialty hospitals	\$ 83,267	\$ 17,388	
Outpatient rehabilitation	4,645	6,813	
Other ⁽⁴⁾	1,920	1,906	
Total company	\$ 89,832	\$ 26,107	

The following tables reconcile same hospitals information:

	Year Ended December 31,	
	2005⁽¹⁾	2006
	(in thousands)	
Net operating revenue		
Specialty hospitals net operating revenue	\$ 1,372,483	\$ 1,378,543
Less: Specialty hospitals opened, acquired or closed after 1/1/05	49,046	23,764
Specialty hospitals same store net operating revenue	\$ 1,323,437	\$ 1,354,779
Adjusted EBITDA ⁽³⁾		
Specialty hospitals Adjusted EBITDA ⁽³⁾	\$ 308,144	\$ 283,270
Less: Specialty hospitals opened, acquired or closed after 1/1/05	5,404	(9,344)
Specialty hospitals same store Adjusted EBITDA ⁽³⁾	\$ 302,740	\$ 292,614
All specialty hospitals Adjusted EBITDA margin ⁽³⁾	22.5%	20.5%
Specialty hospitals same store Adjusted EBITDA margin ⁽³⁾	22.9%	21.6%

	Year Ended December 31,	
	2006	2007
Net operating revenue		
Specialty hospitals net operating revenue	\$ 1,378,543	\$ 1,386,410
Less: Specialty hospitals opened, acquired or closed after 1/1/06	106,940	81,514
Specialty hospitals same store net operating revenue	\$ 1,271,603	\$ 1,304,896
Adjusted EBITDA ⁽³⁾		
Specialty hospitals Adjusted EBITDA ⁽³⁾	\$ 283,270	\$ 217,175
Less: Specialty hospitals opened, acquired or closed after 1/1/06	5,867	(13,524)
Specialty hospitals same store Adjusted EBITDA ⁽³⁾	\$ 277,403	\$ 230,699
All specialty hospitals Adjusted EBITDA margin ⁽³⁾	20.5%	15.7%
Specialty hospitals same store Adjusted EBITDA margin ⁽³⁾	21.8%	17.7%

	Six Months Ended June 30,	
	2007	2008
	(in thousands)	
Net operating revenue		
Specialty hospitals net operating revenue	\$ 699,510	\$ 745,893
Less: Specialty hospitals in development, opened or closed after 1/1/07	35,872	21,512
Specialty hospitals same store net operating revenue	\$ 663,638	\$ 724,381
Adjusted EBITDA ⁽³⁾		
Specialty hospitals Adjusted EBITDA ⁽³⁾	\$ 126,721	\$ 118,480
Less: Specialty hospitals in development, opened or closed after 1/1/07	394	(12,406)
Specialty hospitals same store Adjusted EBITDA ⁽³⁾	\$ 126,327	\$ 130,886
All specialty hospitals Adjusted EBITDA margin ⁽³⁾	18.1%	15.9%
Specialty hospitals same store Adjusted EBITDA margin ⁽³⁾	19.0%	18.1%

N/M Not Meaningful.

- (1) The financial data for the period after the Merger, February 25 through December 31, 2005 (Successor Period), have been added to the financial data for the period from January 1 through February 24, 2005 (Predecessor Period) to arrive at the combined year ended December 31, 2005.
- (2) Cost of services includes salaries, wages and benefits, operating supplies, lease and rent expense and other operating costs.
- (3) We define Adjusted EBITDA as net income before interest, income taxes, depreciation and amortization, income from discontinued operations, loss on early retirement of debt, merger related charges, stock compensation expense, long term incentive compensation, other income/expense and minority interest. We believe that the presentation of Adjusted EBITDA 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 operating units. Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles. Items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to, or substitute for, net income, 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 generally accepted accounting principles and is thus susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies. See footnote 13 to our audited consolidated financial statements and footnote 7 to our interim unaudited consolidated financial statements for the period ended June 30, 2008 for a reconciliation of net income to Adjusted EBITDA as utilized by us in reporting our segment performance in accordance with SFAS No. 131.
- (4) Other includes our general and administrative services, as well as businesses associated with the sale of home medical equipment, infusion/intravenous services and non-healthcare services.

Six Months Ended June 30, 2008 Compared to Six Months Ended June 30, 2007

Net Operating Revenues

Our net operating revenues increased by 11.7% to \$1,087.1 million for the six months ended June 30, 2008 compared to \$973.3 million for the six months ended June 30, 2007.

Specialty Hospitals. Our specialty hospital net operating revenues increased 6.6% to \$745.9 million for the six months ended June 30, 2008 compared to \$699.5 million for the six months ended June 30, 2007. Net operating revenues for the specialty hospitals opened as of January 1, 2007 and operated by us throughout both periods increased 9.2% to \$724.4 million for the six months ended June 30, 2008 from \$663.6 million for the six months ended June 30, 2007. This increase was offset by the loss of revenues from closed hospitals, which accounted for \$34.7 million of net revenue. Hospitals opened in 2007 and 2008 increased net operating revenues by \$20.3 million. The increase in same store hospitals net operating revenues resulted from increases in our patient days and our average net revenue per patient day. Our patient days for these same store hospitals increased 4.7% and was attributable to an increase in our non-Medicare patient days. The occupancy percentage in our same store hospitals increased to 72% for the six months ended June 30, 2008 compared to 71% for the six months ended June 30, 2007. Our average net revenue per patient day in our same store hospitals increased 4.3% to \$1,461 for the six months ended June 30, 2008 from \$1,401 for the six months ended June 30, 2007. This increase in net revenue per patient

day occurred in our Medicare revenues and was primarily related to an increase in the severity of the cases we treated.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues increased 25.4% to \$341.1 million for the six months ended June 30, 2008 compared to \$272.1 million for the six months ended June 30, 2007. The number of patient visits in our outpatient rehabilitation clinics increased 34.6% for the six months ended June 30, 2008 to 2,323,609 visits, compared to 1,726,264 visits for the six months ended June 30, 2007. Substantially all of the increase in net operating revenues and patient visits was related to the acquisition of the outpatient rehabilitation division of HealthSouth Corporation. Net revenue per visit in our clinics was \$103 for the six months ended June 30, 2008 compared to \$100 for the six months ended June 30, 2007.

Other. Our other revenues were \$0.1 million for the six months ended June 30, 2008 compared to \$1.7 million for the six months ended June 30, 2007. These revenues relate to revenue from other non-healthcare services.

Operating Expenses

Our operating expenses increased by 14.8% to \$949.0 million for the six months ended June 30, 2008 compared to \$826.8 million for the six months ended June 30, 2007. Our operating expenses include our cost of services, general and administrative expense and bad debt expense. The increase in operating expenses was principally related to the acquisition of the outpatient division of HealthSouth Corporation and an increase in operating expenses at our specialty hospitals. As a percentage of our net operating revenues, our operating expenses were 87.2% for the six months ended June 30, 2008 compared to 84.9% for the six months ended June 30, 2007. Cost of services as a percentage of operating revenues was 82.9% for the six months ended June 30, 2008 compared to 81.0% for the six months ended June 30, 2007. These costs primarily reflect our labor expenses. The increase in cost of services as a percentage of net operating revenues was primarily related to higher relative costs incurred in the outpatient rehabilitation clinics acquired from HealthSouth Corporation and at our specialty hospitals. Another component of cost of services is facility rent expense, which was \$54.6 million for the six months ended June 30, 2008 compared to \$45.2 million for the six months ended June 30, 2007. The increase in rent expense is principally related to the acquisition of the outpatient rehabilitation division of HealthSouth Corporation and recently opened specialty hospitals that are leased. During the same time period, general and administrative expense declined as a percentage of net operating revenues. General and administrative expenses were 2.2% of net operating revenues for the six months ended June 30, 2008 compared to 2.4% for the six months ended June 30, 2007. Our bad debt expense as a percentage of net operating revenues was 2.1% for the six months ended June 30, 2008 compared to 1.5% for the six months ended June 30, 2007. This increase occurred principally in our specialty hospitals. In our specialty hospitals we experienced an aging of our accounts receivable which caused us to increase our reserves for doubtful accounts for the six months ended June 30, 2008. Additionally, we are experiencing an increase in the write-off of uncollectible Medicare co-payments and deductibles which has the effect of increasing our bad debt expense. Depreciation and amortization expenses were \$35.3 million for the six months ended June 30, 2008 compared to \$25.6 million for the six months ended June 30, 2007. Of the \$9.7 million increase, \$3.9 million is related to the outpatient rehabilitation clinics acquired from HealthSouth Corporation and the remaining increase is principally related to buildings and equipment associated with our hospital development and relocation activities.

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA for our specialty hospitals decreased by 6.5% to \$118.5 million for the six months ended June 30, 2008 compared to \$126.7 million for the six months ended June 30, 2007. Our Adjusted EBITDA margins decreased to 15.9% for the six months ended June 30, 2008 from 18.1% for the six months ended June 30, 2007. The hospitals opened as of January 1, 2007 and operated by us throughout both periods had Adjusted EBITDA of \$130.9 million for the six months ended June 30, 2008, an increase of \$4.6 million or 3.6% over the Adjusted EBITDA of these hospitals for the six months ended June 30, 2007. Our Adjusted EBITDA margin in these

same store hospitals decreased to 18.1% for the six months ended June 30, 2008 from 19.0% for the six months ended June 30, 2007. The decrease in our adjusted EBITDA margin is principally related to the increase in bad debt expense. Our hospitals opened during 2007 and 2008 incurred Adjusted EBITDA losses of \$14.5 million and \$3.1 million for the six months ended June 30, 2008 and 2007, respectively.

Outpatient Rehabilitation. Adjusted EBITDA for our outpatient rehabilitation clinics increased by 4.0% to \$43.8 million for the six months ended June 30, 2008 compared to \$42.2 million for the six months ended June 30, 2007. Our Adjusted EBITDA margins decreased to 12.9% for the six months ended June 30, 2008 from 15.5% for the six months ended June 30, 2007. The increase in Adjusted EBITDA was the result of Adjusted EBITDA contributed by the outpatient rehabilitation clinics acquired from HealthSouth Corporation. Our Adjusted EBITDA margins decreased due to lower margins generated by the outpatient rehabilitation clinics acquired from HealthSouth Corporation.

Other. The Adjusted EBITDA loss was \$23.0 million for the six months ended June 30, 2008 compared to an Adjusted EBITDA loss of \$20.5 million for the six months ended June 30, 2007 and was primarily related to our general and administrative expenses.

Income from Operations

For the six months ended June 30, 2008 we had income from operations of \$102.8 million compared to \$120.9 million for the six months ended June 30, 2007. The decrease in income from operations resulted primarily from operating losses incurred in our specialty hospitals opened in 2007 and 2008 and a decline in the operating profits of the clinics acquired from HealthSouth Corporation.

Interest Expense

Interest expense was \$73.5 million for the six months ended June 30, 2008 compared to \$68.0 million for the six months ended June 30, 2007. The increase in interest expense is related to higher average outstanding debt balances under our senior credit facility existing over the six month period. The increase in outstanding debt is principally related to the borrowings on our senior secured credit facility used to fund the acquisition of the outpatient rehabilitation division of HealthSouth Corporation.

Minority Interests

Minority interests in consolidated earnings were \$1.1 million for both the six months ended June 30, 2008 and June 30, 2007.

Income Taxes

We recorded income tax expense of \$14.0 million for the six months ended June 30, 2008. The expense represented an effective tax rate of 49.2%. For the six months ended June 30, 2007 we recorded income tax expense of \$23.0 million. This expense represented an effective tax rate of 42.0%. The increase in the effective rate resulted from the accrual of additional reserves and interest related to the Company's uncertain tax positions.

Year Ended December 31, 2007 Compared to Year Ended December 31, 2006

Net Operating Revenues

Our net operating revenues increased by 7.6% to \$1,991.7 million for the year ended December 31, 2007 compared to \$1,851.5 million for the year ended December 31, 2006.

Specialty Hospitals. Our specialty hospital net operating revenues increased 0.6% to \$1,386.4 million for the year ended December 31, 2007 compared to \$1,378.5 million for the year ended December 31, 2006. Net operating

revenues for the specialty hospitals opened before January 1, 2006 and operated by us throughout both years increased 2.6% to \$1,304.9 million for the year ended December 31, 2007 from \$1,271.6 million for the year ended December 31, 2006. This increase was offset by the effect of closed hospitals, which accounted for \$57.2 million of net revenue for the year ended December 31, 2006. Hospitals opened in 2006 and 2007 increased net operating revenues by \$31.8 million. The increase in same store hospitals net operating revenues resulted from an increase in our patient days. Our patient days for these same store hospitals increased 4.0% and our occupancy percentage remained constant at 71% for both the year ended December 31, 2007 and the year ended December 31, 2006. The \$33.3 million increase in our same store specialty hospitals net operating revenue was the result of a \$63.7 million increase in our non-Medicare net operating revenues that was offset by a reduction in our Medicare net operating

revenues of \$30.4 million. The reduction in Medicare net operating revenues has resulted from LTACH regulatory changes that have reduced the payment rates for Medicare cases and a reduction in our Medicare volume.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues increased 28.3% to \$603.4 million for the year ended December 31, 2007 compared to \$470.3 million for the year ended December 31, 2006. The number of patient visits in our outpatient rehabilitation clinics increased 35.7% for the year ended December 31, 2007 to 4,032,197 visits compared to 2,972,243 visits for the year ended December 31, 2006. Substantially all of the increase in net operating revenues and patient visits was related to the outpatient rehabilitation clinics acquired from HealthSouth Corporation, offset in part by a decrease in net operating revenues due to the sale of a group of clinics at the end of 2006. Net revenue per visit in our clinics was \$100 for the year ended December 31, 2007 compared to \$94 for the year ended December 31, 2006.

Other. Our other revenues were \$1.8 million for the year ended December 31, 2007 compared to \$2.6 million for the year ended December 31, 2006. These revenues were generated from non-healthcare related services.

Operating Expenses

Our operating expenses increased 12.5% to \$1,740.5 million for the year ended December 31, 2007 compared to \$1,547.0 million for the year ended December 31, 2006. Our operating expenses include our cost of services, general and administrative expense and bad debt expense. The increase in operating expenses was principally related to the outpatient rehabilitation clinics acquired from HealthSouth Corporation.

As a percentage of our net operating revenues, our operating expenses were 87.4% for the year ended December 31, 2007 compared to 83.6% for the year ended December 31, 2006. Cost of services as a percentage of operating revenues was 83.3% for the year ended December 31, 2007 compared to 80.2% for the year ended December 31, 2006. This increase in the relative percentage for cost of services is principally due to the significant decline in our specialty hospital Medicare revenue and an increase in labor costs at our specialty hospitals. We also experienced a higher relative labor component in the outpatient operations acquired from HealthSouth Corporation. Another component of cost of services is facility rent expense, which was \$98.5 million for the year ended December 31, 2007 compared to \$84.0 million for the year ended December 31, 2006. The increase in rent expense was principally related to the facility rent expense for the outpatient rehabilitation clinics acquired from HealthSouth Corporation. During the same period general and administrative expense decreased as a percentage of net operating revenue to 2.2% compared to 2.4% for the year ended December 31, 2006, principally due to the increase in our net operating revenues. Our bad debt expense as a percentage of net operating revenues was 1.9% for the year ended December 31, 2007 compared to 1.0% for the year ended December 31, 2006. This increase occurred across both business segments. In our specialty hospital segment we have experienced an increase in our bad debts associated with the write-off of uncollectible Medicare co-payments and deductibles. In our outpatient segment we have experienced an aging of our accounts receivable which has generated higher reserve requirements and an increase in bad debt expense under our reserve methodology.

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA decreased 23.3% to \$217.2 million for the year ended December 31, 2007 compared to \$283.3 million for the year ended December 31, 2006. Our Adjusted EBITDA margins decreased to 15.7% for the year ended December 31, 2007 from 20.5% for the year ended December 31, 2006. The hospitals opened before January 1, 2006 and operated throughout both years had Adjusted EBITDA of \$230.7 million, a decrease of 16.8% over the Adjusted EBITDA of these hospitals in 2006. Our Adjusted EBITDA margin in these same store hospitals decreased to 17.7% for the year ended December 31, 2007 from 21.8% for the year ended December 31, 2006. The decrease in our Adjusted EBITDA is principally due to a \$16.6 million decline in our

Medicare net operating revenues resulting from LTCH regulatory changes that reduced our payment rates for Medicare cases without any corresponding reduction in the cost of services associated with those cases. We also experienced a decline in our non-Medicare rate per patient day and an increase in our labor, bad debt and facility costs that contributed to the decrease in our Adjusted EBITDA. These contributors to the decline in our Adjusted EBITDA were offset by an increase in Adjusted EBITDA resulting from an increase in our non-Medicare volume.

Outpatient Rehabilitation. Adjusted EBITDA increased 16.4% to \$75.4 million for the year ended December 31, 2007 compared to \$64.8 million for the year ended December 31, 2006. Our Adjusted EBITDA margins decreased to 12.5% for the year ended December 31, 2007 from 13.8% for the year ended December 31, 2006. The increase in Adjusted EBITDA was the result of Adjusted EBITDA contributed by the outpatient rehabilitation clinics acquired from HealthSouth Corporation and an increase in the net revenue per visit at our existing clinics, offset in part by a reduction in Adjusted EBITDA due to the sale of a group of clinics at the end of 2006. Our Adjusted EBITDA margins decreased due to lower margins generated by the outpatient rehabilitation clinics acquired from HealthSouth Corporation.

Other. The Adjusted EBITDA loss, which primarily includes our general and administrative expenses, was \$37.7 million for the year ended December 31, 2007 compared to a loss of \$39.8 million for the year ended December 31, 2006.

Income from Operations

For the year ended December 31, 2007, we experienced income from operations of \$193.9 million compared to income from operations of \$257.9 million for the year ended December 31, 2006. The decrease in income from operations resulted from the Adjusted EBITDA changes described above and an increase in depreciation and amortization expense. The increase in depreciation and amortization expense resulted primarily from increased depreciation expense associated with free-standing hospitals we have placed in service and an increase in depreciation and amortization expense related to the outpatient rehabilitation clinics acquired from HealthSouth Corporation.

Interest Expense

Interest expense was \$140.2 million for the year ended December 31, 2007 compared to \$131.8 million for the year ended December 31, 2006. The increase in interest expense is related to higher outstanding debt balances and slightly higher interest rates under our senior secured credit facility. The increase in outstanding debt is principally related to the borrowings used to fund the acquisition of the outpatient rehabilitation division of HealthSouth Corporation.

Minority Interests

Minority interests in consolidated earnings were \$1.5 million for the year ended December 31, 2007 compared to \$1.4 million for the year ended December 31, 2006.

Income Taxes

We recorded income tax expense of \$18.7 million for the year ended December 31, 2007. This expense represented an effective tax rate of 34.5%. For the year ended December 31, 2006, we recorded income tax expense of \$43.5 million. This expense represented an effective tax rate of 34.6%. In both the years ended December 31, 2007 and December 31, 2006 we experienced an effective tax rate that was lower than our expected blended federal and state tax rate. For the year ended December 31, 2007 we recognized a lower effective tax rate as a result of greater than expected tax benefits generated on the sale of equipment and subsidiaries. For the year ended December 31, 2006 we recognized a lower effective tax rate as a result of a significant tax loss we recognized on the sale of a group of legal entities that operated outpatient rehabilitation clinics. These legal entities were sold at an amount that approximated their GAAP book value. However, the stock of these legal entities that were originally acquired as part of our acquisition of the NovaCare Physical Rehabilitation and Occupational Health Group in 1999 had a substantial tax basis.

Income from Discontinued Operations, Net of Tax

On March 1, 2006, we sold our wholly-owned subsidiary, CBIL, for approximately C\$89.8 million in cash (US\$79.0 million). We conducted all of our Canadian operations through CBIL. The financial results of CBIL have been reclassified as discontinued operations for all periods presented in this report. We recognized a gain on sale (net of tax) of \$9.1 million in the quarter ended March 31, 2006.

Year Ended December 31, 2006 Compared to Combined Year Ended December 31, 2005***Net Operating Revenues***

Our net operating revenues decreased 0.4% to \$1,851.5 million for the year ended December 31, 2006 compared to \$1,858.4 million for the combined year ended December 31, 2005.

Specialty Hospitals. Our specialty hospital net operating revenues increased 0.4% to \$1,378.5 million for the year ended December 31, 2006 compared to \$1,372.5 million for the combined year ended December 31, 2005. Net operating revenues for the specialty hospitals opened before January 1, 2005 and operated by us throughout both years increased 2.4% to \$1,354.8 million for the year ended December 31, 2006 from \$1,323.4 million for the combined year ended December 31, 2005. This increase was offset by the effect of closed hospitals, which amounted to \$28.0 million of net revenue. Hospitals opened in 2006 increased net operating revenues by \$2.6 million. The increase in same store hospitals net operating revenues resulted from both an increase in our patient days and higher net revenue per patient day. Our patient days for these same store hospitals increased 0.3% and our occupancy percentage remained constant at 70% for both the year ended December 31, 2006 and the combined year ended December 31, 2005. Although we have experienced a small increase in our same store specialty hospitals net operating revenue, we experienced a reduction in our Medicare net operating revenues of \$21.4 million that was offset by a \$52.8 million increase in our non-Medicare net operating revenues. The reduction in Medicare net operating revenues has resulted from LTCH regulatory changes that have reduced the payment rates for Medicare cases.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues declined 2.2% to \$470.3 million for the year ended December 31, 2006 compared to \$480.7 million for the combined year ended December 31, 2005. The number of patient visits in our outpatient rehabilitation clinics declined 10.2% for the year ended December 31, 2006 to 2,972,243 visits compared to 3,308,620 visits for the combined year ended December 31, 2005. The decrease in net operating revenues and patient visits was principally related to a decline in the volume of visits per clinic and in the number of clinics we own. Net revenue per visit in these clinics was \$94 for the year ended December 31, 2006 compared to \$89 for the combined year ended December 31, 2005.

Other. Our other revenues were \$2.6 million for the year ended December 31, 2006 compared to \$5.2 million for the combined year ended December 31, 2005. These revenues are principally related to the sales of home medical equipment, infusion/intravenous services, and non-healthcare services. In May 2005, we sold the assets of our home medical equipment and infusion/intravenous service business, which resulted in the reduction in our other revenues.

Operating Expenses

Our operating expenses decreased 8.8% to \$1,547.0 million for the year ended December 31, 2006 compared to \$1,695.5 million for the combined year ended December 31, 2005. Our operating expenses include our cost of services, general and administrative expense and bad debt expense. The principal reason for the decline in our operating expenses resulted from a significant decline in our general and administrative expenses. There were three major categories of expenses incurred during the combined year ended December 31, 2005 that do not exist for the year ended December 31, 2006. First, we granted restricted stock awards in connection with the Merger Transactions to certain key management employees. These awards generally vest over five years. Effective at the time of the Merger, we also granted stock options to certain other key employees that vest over five years. The fair value of restricted stock awards and stock options vesting and expensed during the Successor Period of February 25 through December 31, 2005 was \$10.3 million. Of this amount, \$10.1 million was included in general and administrative expense and \$0.2 million was included in cost of services. Second, during the Predecessor Period of January 1 through February 24, 2005, all of our then outstanding stock options were cancelled and cashed-out in accordance with the merger agreement. This resulted in a charge of \$142.2 million of which \$115.0 million is included in general and

administrative expense and \$27.2 million is included in cost of services. And third, as a result of the special dividend of \$175.0 million paid to our preferred stockholders on September 29, 2005, we incurred \$14.5 million of expense in connection with a payment to certain members of management under the terms of our long term incentive compensation plan that is included in general and administrative expense. Our general

and administrative cost for the combined year ended December 31, 2005 also contained costs associated with the SemperCare corporate office which were not eliminated until the second quarter of 2005.

During the year ended December 31, 2006, we recorded expense related to the vesting of restricted stock and stock options in the amount of \$3.8 million. Of this amount, \$3.6 million is included in general and administrative expense and \$0.2 million is included in cost of services.

As a percentage of our net operating revenues, our operating expenses were 83.6% for the year ended December 31, 2006 compared to 91.2% for the combined year ended December 31, 2005. Cost of services as a percentage of operating revenues was 80.2% for the year ended December 31, 2006 compared to 80.1% for the combined year ended December 31, 2005. These costs primarily reflect our labor expenses. Another component of cost of services is facility rent expense, which was \$84.0 million for the year ended December 31, 2006 compared to \$81.6 million for the combined year ended December 31, 2005. Our bad debt expense as a percentage of net operating revenues was 1.0% for the year ended December 31, 2006 compared to 1.3% for the combined year ended December 31, 2005. This decrease in bad debt expense resulted from continued improvement in the aging composition of our accounts receivable measured in absolute dollars which has resulted in a lower bad debt requirement and expense.

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA decreased 8.1% to \$283.3 million for the year ended December 31, 2006 compared to \$308.1 million for the combined year ended December 31, 2005. Our Adjusted EBITDA margins decreased to 20.5% for the year ended December 31, 2006 from 22.5% for the combined year ended December 31, 2005. The hospitals opened before January 1, 2005 and operated throughout both years had Adjusted EBITDA of \$292.6 million, a decrease of 3.3% over the Adjusted EBITDA of these hospitals in 2005. The decrease in same store hospitals Adjusted EBITDA resulted primarily from the reduction in our Medicare net operating revenues resulting from LTACH regulatory changes that have reduced our payment rates for Medicare cases. Additionally, during 2005 we recorded a one-time benefit of \$3.8 million due to the reversal of an accrued patient care liability as a result of the termination of this obligation. Our Adjusted EBITDA margin in these same store hospitals decreased to 21.6% for the year ended December 31, 2006 from 22.9% for the combined year ended December 31, 2005.

Outpatient Rehabilitation. Adjusted EBITDA decreased 1.7% to \$64.8 million for the year ended December 31, 2006 compared to \$66.0 million for the combined year ended December 31, 2005. Our Adjusted EBITDA margins increased to 13.8% for the year ended December 31, 2006 from 13.7% for the combined year ended December 31, 2005. The decline in Adjusted EBITDA was the result of the decline in clinic visit volumes, described under *Net Operating Revenues - Outpatient Rehabilitation* above.

Other. The Adjusted EBITDA loss, which primarily includes our general and administrative expenses, was \$39.8 million for the year ended December 31, 2006 compared to a loss of \$44.2 million for the combined year ended December 31, 2005. This reduction in the Adjusted EBITDA loss was primarily the result of the decline in our general and administrative expenses associated with the SemperCare corporate office which were eliminated in the second quarter of 2005 and losses incurred during 2005 related to our home medical equipment and infusion/intravenous service business which was sold in May 2005.

Income from Operations

For the year ended December 31, 2006, we experienced income from operations of \$257.9 million compared to income from operations of \$119.1 million for the combined year ended December 31, 2005. The increase in income from operations experienced for the year ended December 31, 2006 resulted from the higher expenses incurred during the combined year ended December 31, 2005 related to significant stock compensation costs associated with the

Merger Transactions of \$152.5 million and the payment of \$14.5 million under the terms of our long term incentive compensation plan offset by an increase in depreciation and amortization of \$2.8 million and the Adjusted EBITDA decreases described above. The stock compensation expense was comprised of \$142.2 million related to the redemption of all vested and unvested outstanding stock options in accordance with the terms of the merger agreement in the Predecessor Period of January 1 through February 24, 2005 and an additional \$10.3 million of

stock compensation expense related to shares of restricted stock that were issued in the Successor Period of February 25 through December 31, 2005.

Loss on Early Retirement of Debt

In connection with the Merger, Select commenced tender offers to acquire all of its 9 1/2% senior subordinated notes due 2009 and all of its 7 1/2% senior subordinated notes due 2013. Upon completion of the tender offers on February 24, 2005, all \$175.0 million of the 7 1/2% senior subordinated notes were tendered and \$169.3 million of the \$175.0 million of 9 1/2% notes were tendered. The loss consists of the tender premium cost of \$34.8 million and the remaining unamortized deferred financing costs of \$7.9 million.

Merger Related Charges

As a result of the Merger, we incurred costs of \$12.0 million in the Predecessor Period of January 1 through February 24, 2005 directly related to the Merger. This included the fees of the investment advisor hired by the special committee of Select's board of directors to evaluate the Merger, legal and accounting fees, costs associated with the Hart-Scott-Rodino filing related to the Merger, the cost associated with purchasing a six year extended reporting period under our directors and officers liability insurance policy and other associated expenses.

Interest Expense

Interest expense increased \$24.9 million to \$131.8 million for the year ended December 31, 2006 from \$106.9 million for the combined year ended December 31, 2005. The increase in interest expense was due to higher average debt levels and interest rates experienced during the year ended December 31, 2006.

Minority Interests

Minority interests in consolidated earnings were \$1.4 million for the year ended December 31, 2006 compared to \$2.1 million for the combined year ended December 31, 2005.

Income Taxes

For the year ended December 31, 2006, we recorded income tax expense of \$43.5 million. This expense represented an effective tax rate of 34.6%. We recognized a lower effective tax for the year ended December 31, 2006 as a result of a significant tax loss we recognized on the sale of a group of legal entities that operated outpatient rehabilitation clinics. These legal entities were sold at an amount that approximated their GAAP book value. However, these legal entities that were originally acquired as part of our acquisition of the NovaCare Physical and Occupational Health Group in 1999 had a substantial stock tax basis. We recorded an income tax benefit of \$59.8 million for the Predecessor Period of January 1 through February 24, 2005. The tax benefit represented an effective tax benefit rate of 37.2%. This effective tax benefit rate consisted of the statutory federal rate of 35% and a state rate of 2.2%. The federal tax benefit was carried forward and used to offset our federal tax throughout the remainder of 2005. Because of the differing state tax rules related to net operating losses, a portion of these state net operating losses were assigned valuation allowances. We recorded an income tax expense of \$49.3 million for the Successor Period of February 25 through December 31, 2005. The expense represented an effective tax rate of 41.6%.

Income from Discontinued Operations, Net of Tax

On March 1, 2006, we sold our wholly-owned subsidiary CBIL for approximately C\$89.8 million in cash (US\$79.0 million). We conducted all of our Canadian operations through CBIL. The financial results of CBIL have

been reclassified as discontinued operations for all periods presented in this report, and its assets and liabilities have been reclassified as held for sale on our December 31, 2005 balance sheet.

Liquidity and Capital Resources***Six Months Ended June 30, 2007 and June 30, 2008***

The following table summarizes the statement of cash flows for the six months ended June 30, 2007 and 2008:

	Six Months Ended June 30, 2007 2008 (in thousands)	
Cash flows provided by (used in) operating activities	\$ 55,304	\$ (993)
Cash flows used in investing activities	(293,851)	(30,353)
Cash flows provided by financing activities	182,557	34,351
Net increase (decrease) in cash and cash equivalents	(55,990)	3,005
Cash and cash equivalents at beginning of period	81,600	4,529
Cash and cash equivalents at end of period	\$ 25,610	\$ 7,534

Our operating activities used \$1.0 million and provided \$55.3 million of cash flow for the six months ended June 30, 2008 and June 30, 2007, respectively. The principal reason for the decline in our operating cash flow was the increase in our accounts receivable and a decline in our net income. Our days sales outstanding were 57 days at June 30, 2008 and 48 days at December 31, 2007. The increase in days sales outstanding between December 31, 2007 and June 30, 2008 is primarily related to the timing of the periodic interim payments we received from Medicare for the services provided at our specialty hospitals.

Our investing activities used \$30.4 million of cash flow for the six months ended June 30, 2008. The primary use of cash was \$26.1 million related to the purchase of property and equipment and \$4.2 million related to the acquisition of minority interests and the final settlement of the purchase price for the acquisition of the outpatient rehabilitation division of HealthSouth Corporation. Investing activities used \$293.9 million of cash flow for the six months ended June 30, 2007. The primary use of cash was for building improvements and equipment purchases of \$89.8 million and acquisition payments of \$214.1 million for the purchase of HealthSouth's outpatient rehabilitation division, offset in part by aggregate proceeds of \$9.5 million from a sale of business units and a building.

Our financing activities provided \$34.4 million of cash flow for the six months ended June 30, 2008. The primary source of cash related to borrowings, net of repayments, on our senior secured credit facility of \$45.4 million, offset by repayment of bank overdrafts of \$6.9 million, principal payments on seller and other debt of \$2.6 million, repurchase of common and preferred stock of \$0.6 million and distributions to minority interests of \$1.0 million. The net borrowings on our senior secured credit facility were used to fund the slow-down we experienced in our collection of accounts receivable and our purchase of property and equipment. Financing activities provided \$182.6 million of cash for the six months ended June 30, 2007. The primary sources of cash related to proceeds from bank overdrafts of \$6.8 million and by borrowings on our senior credit facility net of repayments of \$176.9 million and offset by distributions to minority interests of \$1.0 million. The primary purpose of the borrowings under our senior credit facility was to fund the acquisition of HealthSouth's outpatient rehabilitation division.

Year Ended December 31, 2007, Year Ended December 31, 2006 and Combined Year Ended December 31, 2005

The following table summarizes the statement of cash flows for the year ended December 31, 2007 and 2006, and combined year ended December 31, 2005:

	Year Ended December 31,		
	2005	2006	2007
	(in thousands)		
Cash flows provided by operating activities	\$ 57,211	\$ 227,651	\$ 86,013
Cash flows used in investing activities	(220,811)	(81,481)	(382,676)
Cash flows provided by (used in) financing activities	(48,510)	(100,466)	219,592
Effect of exchange rate changes on cash and cash equivalents	495	35	
Net increase (decrease) in cash and cash equivalents	(211,615)	45,739	(77,071)
Cash and cash equivalents at beginning of period	247,476	35,861	81,600
Cash and cash equivalents at end of period	\$ 35,861	\$ 81,600	\$ 4,529

Operating activities generated \$86.0 million in cash during the year ended December 31, 2007. Our days sales outstanding were 48 days at December 31, 2007 compared to 41 days at December 31, 2006. Our operating cash flow was negatively affected by a reduction in our operating earnings, an increase in interest expense and an increase in our accounts receivable.

Operating activities generated \$227.7 million in cash during the year ended December 31, 2006. Our operating cash flow was positively affected by a reduction in our accounts receivable and tax benefits we realized by changing our tax accounting method used for deducting bad debts. The tax accounting change had the effect of accelerating the tax deduction for bad debt reserves. Our days sales outstanding were 41 days at December 31, 2006 compared to 52 days at December 31, 2005. The significant reduction in days sales outstanding was the result of several factors. The timing of our periodic interim payments from Medicare received by our specialty hospitals resulted in a seven day decline in the days sales outstanding. The remaining decline was the result of improved cash collections.

For the combined year ended December 31, 2005, operating activities generated \$57.2 million of cash. Our operating cash flow includes \$186.0 million in cash expenses related to the Merger. Our days sales outstanding were 52 days at December 31, 2005 compared to 48 days at December 31, 2004. The increase in days sales outstanding is primarily the result of a change in the way Medicare calculated our periodic interim payments in our specialty hospitals. Medicare changed from a per day based calculation to a discharged based calculation to better align the periodic interim payment methodology with the current discharge based reimbursement system. As a result, we are no longer receiving a periodic payment for those patients that have not yet been discharged.

Investing activities used \$382.7 million, \$81.5 million, and \$220.8 million of cash flow for the year ended December 31, 2007, the year ended December 31, 2006, and the combined year ended December 31, 2005, respectively. Of these amounts, we incurred earnout and acquisition related payments of \$237.0 million, \$3.4 million, and \$111.6 million, respectively in 2007, 2006, and 2005. In 2007, the acquisition of the outpatient division of HealthSouth Corporation accounted for the \$236.9 million in acquisition payments. In 2005, the SemperCare acquisition accounted for \$105.1 million of the \$111.6 million in acquisition payments. The remaining acquisition payments relate primarily to small acquisitions of outpatient businesses. The earnout payments related principally to

obligations we assumed as part of our 1999 NovaCare acquisition. Investing activities also used cash for the purchases of property and equipment of \$166.1 million, \$155.1 million, and \$109.9 million in 2007, 2006, and 2005, respectively, which was related principally to construction and relocation of existing hospitals. During 2005 and 2006 we purchased properties that have been used to relocate existing hospitals and develop new free-standing hospitals. Each of these properties required additional improvements to be made before they become operational. Additionally during 2005 and 2006 we made major improvements and expanded our rehabilitation hospital in West Orange, New Jersey. During 2007 we sold business units and real property which generated

\$16.0 million in cash. During 2006, we sold all of our Canadian operations and a group of outpatient rehabilitation clinics. The cash flow from these transactions, net of operating cash transferred with the businesses, was \$75.0 million.

Financing activities provided \$219.6 million of cash for the year ended December 31, 2007. The cash resulted primarily from borrowings, net of repayments on our credit facility of \$213.5 million and proceeds from bank overdrafts of \$8.9 million. Approximately \$203.0 million of the borrowings from our credit facility were used to fund the acquisition of the outpatient division of HealthSouth Corporation. The remaining borrowings were used to fund our normal operations including our hospital construction activities.

Financing activities used \$100.5 million of cash for the year ended December 31, 2006. The cash usage resulted primarily from repayments, net of borrowings, on our credit facility of \$90.8 million and repayment of bank overdrafts of \$7.1 million.

Financing activities used \$48.5 million of cash for the combined year ended December 31, 2005. The principal financing activities were related to the financing of the Merger Transactions. The excess proceeds from the transactions were used to pay Merger Transactions related costs, which include the cancellation of outstanding stock options. Additionally, during 2005 we repaid \$115.0 million of debt under our revolving loans and \$4.4 million of our term loans. Bank overdrafts of \$19.4 million also provided additional financing cash.

Capital Resources

We had net working capital of \$105.7 million at June 30, 2008 compared to net working capital of \$14.7 million at December 31, 2007. This increase in working capital was principally related to an increase in our accounts receivable and the timing of the payments of our accounts payable and accrued liabilities.

On March 19, 2007, we entered into Amendment No. 2, and on March 28, 2007, we entered into an Incremental Facility Amendment with a group of lenders and JPMorgan Chase Bank, N.A. as administrative agent. Amendment No. 2 increased the general exception to the prohibition on asset sales under our senior secured credit facility from \$100.0 million to \$200.0 million, relaxed certain financial covenants starting March 31, 2007 and waived our requirement to prepay certain term loan borrowings following the year ended December 31, 2006. The Incremental Facility Amendment provided to our company an incremental term loan of \$100.0 million, the proceeds of which we used to pay a portion of the purchase price for the HealthSouth transaction.

After giving effect to the Incremental Facility Amendment, our senior secured credit facility provides for senior secured financing of up to \$980.0 million, consisting of:

- a \$300.0 million revolving loan facility that will terminate on February 24, 2011, including both a letter of credit sub-facility and a swingline loan sub-facility, and

- a \$680.0 million term loan facility that matures on February 24, 2012.

The interest rates per annum applicable to loans, other than swingline loans, under our senior secured credit facility are, at its option, equal to either an alternate base rate or an adjusted LIBOR rate for a one, two, three or six month interest period, or a 9 or 12 month period if available, in each case, plus an applicable margin percentage. The alternate base rate is the greater of (1) JPMorgan Chase Bank, N.A.'s prime rate and (2) one-half of 1% over the weighted average of rates on overnight Federal funds as published by the Federal Reserve Bank of New York. The adjusted LIBOR rate is determined by reference to settlement rates established for deposits in dollars in the London interbank market for a period equal to the interest period of the loan and the maximum reserve percentages established

by the Board of Governors of the United States Federal Reserve to which our lenders are subject. The applicable margin percentage for borrowings under our revolving loans is subject to change based upon the ratio of Select's total indebtedness to our consolidated EBITDA (as defined in the credit agreement). The applicable margin percentage for revolving loans is currently (1) 1.50% for alternate base rate loans and (2) 2.50% for adjusted LIBOR loans. The applicable margin percentages for the term loans are (1) 1.00% for alternate base rate loans and (2) 2.00% for adjusted LIBOR loans.

Our senior secured credit facility requires Select to maintain certain interest expense coverage ratios and leverage ratios which become more restrictive over time. For the four consecutive fiscal quarters ended June 30,

2008, Select was required to maintain an interest expense coverage ratio (its ratio of consolidated EBITDA (as defined in our senior secured credit facility) to cash interest expense) for the prior four consecutive quarters of at least 1.75 to 1.00. Select's interest expense coverage ratio was 1.78 to 1.00 for such period. As of June 30, 2008, Select was required to maintain its leverage ratio (its ratio of total indebtedness to consolidated EBITDA for the prior four consecutive fiscal quarters) at less than 6.00 to 1.00. Select's leverage ratio was 5.94 to 1.00 as of June 30, 2008. On a pro forma as adjusted basis, for the four quarters ended June 30, 2008, Select's interest expense coverage ratio was to 1.00 and Select's leverage ratio was to 1.00 based upon an assumed public offering price of \$ per share, the midpoint of the range set forth on the cover page of this prospectus.

Also, as of June 30, 2008, we had \$100.7 million of revolving loan availability under our senior secured credit facility (after giving effect to \$29.3 million of outstanding letters of credit). On a pro forma as adjusted basis as of June 30, 2008 we had \$ million of revolving loan availability under our senior secured credit facility (after giving effect to \$29.3 million of outstanding letters of credit) based upon an assumed public offering price of \$ per share, the midpoint of the range set forth on the cover page of this prospectus.

On June 13, 2005, Select entered into a five year interest rate swap transaction with an effective date of August 22, 2005. On March 8, 2007 and November 23, 2007, Select entered into two additional interest rate swap transactions for three years with effective dates of May 22, 2007 and November 23, 2007, respectively. The swaps are designated as a cash flow hedge of forecasted LIBOR-based variable rate interest payments. The underlying variable rate debt is \$500.0 million.

On February 24, 2005, EGL Acquisition Corp. issued and sold \$660.0 million in aggregate principal amount of 75/8% senior subordinated notes due 2015, which Select assumed in connection with the Merger. The net proceeds of the offering were used to finance a portion of the funds needed to consummate the Merger Transactions. The notes were issued under an indenture between EGL Acquisition Corp. and U.S. Bank Trust National Association, as trustee. Interest on the notes is payable semi-annually in arrears on February 1 and August 1 of each year. The notes are guaranteed by all of Select's wholly-owned subsidiaries, subject to certain exceptions. On or after February 1, 2010, the notes may be redeemed at Select's option, in whole or in part, at redemption prices that decline annually to 100% on and after February 1, 2013, plus accrued and unpaid interest. Upon a change of control of Holdings, each holder of notes may require us to repurchase all or any portion of the holder's notes at a purchase price equal to 101% of the principal amount plus accrued and unpaid interest to the date of purchase.

On September 29, 2005, we sold \$175.0 million of senior floating rate notes due 2015, which bear interest at a rate per annum, reset semi-annually, equal to the 6-month LIBOR plus 5.75%. Interest is payable semi-annually in arrears on March 15 and September 15 of each year, with the principal due in full on September 15, 2015. The senior floating rate notes are general unsecured obligations and are not guaranteed by us or any of our subsidiaries. In connection with the issuance of the senior floating rate notes, Select entered into an interest rate swap transaction. The notional amount of the interest rate swap is \$175.0 million. The variable interest rate of the debt was 8.4% and the fixed rate after the swap was 10.2% at June 30, 2008. The net proceeds of the issuance of the senior floating rate notes, together with cash was used to reduce the amount of our preferred stock, to make a payment to participants in our long term incentive plan and to pay related fees and expenses.

In connection with the issuance of our senior floating rate notes, we entered into an amendment to our senior secured credit facility. This amendment, among other things, permitted us to incur this indebtedness and permits Select to make distributions to us to service our indebtedness. The amendment also permitted us to use the net proceeds of the offering to make the \$175.0 million special dividend to our preferred stockholders and to incur \$14.5 million of expense in connection with a payment to certain members of management under the terms of our long term incentive compensation plan, which is included in general and administrative expense.

We believe internally generated cash flows and borrowing capacity under our senior secured credit facility will be sufficient to finance operations for the foreseeable future. We intend to amend or replace our senior secured credit facility prior to its maturity. Any significant acquisition may require us to restructure our senior secured credit facility prior to its maturity to either increase borrowing capacity or amend financial covenants, or both.

As a result of the SCHIP Extension Act, which has a three year moratorium on the development of new LTCHs, we have stopped all LTCH development, except for LTCHs currently under construction that are excluded from the

moratorium. However, we continue to evaluate opportunities to develop rehabilitation hospitals. We also intend to open new outpatient rehabilitation clinics in the local areas that we currently serve where we can benefit from existing referral relationships and brand awareness to produce incremental growth.

Commitments and Contingencies

The following table summarizes contractual obligations at December 31, 2007, and the effect such obligations are expected to have on liquidity and cash flow in future periods. Reserves for uncertain tax positions of \$21.4 million have been excluded from the table below as we cannot reasonably estimate the amounts or periods in which these liabilities will be paid.

Contractual Obligations	Total	Payments Due by Year			
		2008	2009-2011	2012-2013	After 2013
		(in thousands)			
75/8% senior subordinated notes	\$ 660,000	\$	\$	\$	\$ 660,000
Senior secured credit facility	783,300	6,800	615,775	160,725	
10% senior subordinated notes ⁽¹⁾	134,110				134,110
Senior floating rate notes	175,000				175,000
Seller notes	633	233	400		
Capital lease obligations	2,286	635	1,651		
Other debt obligations	306	81	225		
Total debt	1,755,635	7,749	618,051	160,725	969,110
Interest ⁽²⁾	805,678	137,812	386,410	166,245	115,211
Letters of credit outstanding	29,706		29,706		
Purchase obligations	6,244	3,903	2,169	172	
Construction contracts	8,689	8,689			
Naming, promotional and sponsorship agreement	56,382	2,559	8,040	5,676	40,107
Operating leases	473,348	100,215	171,536	46,937	154,660
Related party operating leases	35,918	3,069	9,237	6,433	17,179
Total contractual cash obligations	\$ 3,171,600	\$ 263,996	\$ 1,225,149	\$ 386,188	\$ 1,296,267

(1) Reflects the balance sheet liability of our 10% senior subordinated notes calculated in accordance with GAAP. The balance sheet liability so reflected is less than the \$150.0 million aggregate principal amount of such notes that were issued with an original issue discount. The remaining unamortized original issue discount was \$15.9 million at December 31, 2007. Interest on our 10% senior subordinated notes accrued on the full principal amount thereof, and Holdings will be obligated to repay the full principal thereof, at maturity or upon any mandatory or voluntary prepayment thereof. On any interest payment date on or after February 24, 2010, Holdings will be obligated to pay an amount of accrued original issued discount on the 10% senior subordinated notes if necessary to ensure that the notes will not be considered applicable high yield discount obligations within the meaning of the Internal Revenue Code of 1986, as amended. The \$150.0 million aggregate principal payable at maturity on our 10% senior subordinated notes would be reduced by prior payments of accrued original issue

discount.

- (2) The interest obligation was calculated using the average interest rate at December 31, 2007 of 6.8% for the senior secured credit facility, the stated interest rate for Select's 75/8% senior subordinated notes and our 10% senior subordinated notes, 10.2% for the senior floating rate notes and 6.0% for seller notes, capital lease obligations and other debt obligations.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program,

to curtail increases in operating costs and expenses. We cannot predict our ability to cover or offset future cost increases.

Recent Accounting Pronouncements

In April 2008, the Financial Accounting Standards Board (FASB) issued FASB Staff Position (FSP) No. 142-3, Determination of Useful Life of Intangible Assets (FSP 142-3). FSP 142-3 amends the factors that should be considered in developing renewal or extension assumptions used to determine the useful life of a recognized intangible asset under FASB Statement No. 142, Goodwill and Other Intangible Assets (SFAS No. 142). The intent of this FSP is to improve the consistency between the useful life of a recognized intangible asset under SFAS No. 142 and the period of expected cash flows used to measure the fair value of the asset under SFAS No. 141R, Business Combinations (SFAS No. 141R). FSP 142-3 is effective for financial statements issued for fiscal years beginning after December 15, 2008, and interim periods within those fiscal years. Early adoption is prohibited. The guidance for determining the useful life of a recognized intangible asset should be applied prospectively to intangible assets acquired after the effective date. The disclosure requirements should be applied prospectively to all intangible assets recognized as of, and subsequent to, the effective date. The adoption of FSP 142-3 will result in changes related to presentation and disclosure of our intangible assets but we believe that the adoption of this FSP will not materially impact our consolidated financial statements.

In March 2008, the FASB issued Statement of Financial Accounting Standards, or SFAS, No. 161, Disclosures about Derivative Instruments and Hedging Activities, an amendment of FASB Statement No. 133, or SFAS No. 133. This statement is intended to improve transparency in financial reporting by requiring enhanced disclosures of an entity's derivative instruments and hedging activities and their effects on the entity's financial position, financial performance, and cash flows. SFAS No. 161 applies to all derivative instruments within the scope of SFAS No. 133, Accounting for Derivative Instruments and Hedging Activities, or SFAS No. 133, as well as related hedged items, bifurcated derivatives, and nonderivative instruments that are designated and qualify as hedging instruments. Entities with instruments subject to SFAS No. 161 must provide more robust qualitative disclosures and expanded quantitative disclosures. SFAS No. 161 is effective prospectively for financial statements issued for years beginning after November 15, 2008, with early application permitted. Adoption of this statement will result in changes related to presentation and disclosure of our interest rate swaps but will not affect our results of operations.

In December 2007, the FASB issued SFAS No. 141 (Revised 2007), Business Combinations which replaces SFAS No. 141. SFAS No. 141R retains the purchase method of accounting for acquisitions, but requires a number of changes, including changes in the way assets and liabilities are recognized in the purchase accounting. It also changes the recognition of assets acquired and liabilities assumed arising from contingencies, requires the capitalization of in-process research and development at fair value and requires the expensing of acquisition-related costs as incurred. SFAS No. 141R is effective for business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. This statement will be applied prospectively and will not result in any changes to our historical financial statements.

In December 2007, FASB issued SFAS No. 160, Noncontrolling Interests in Consolidated Financial Statements, an amendment of ARB 51. SFAS No. 160 changes the accounting and reporting for minority interests. Minority interests will be recharacterized as noncontrolling interests and will be reported as a component of equity separate from the parent's equity, and purchases or sales of equity interests that do not result in a change in control will be accounted for as equity transactions. In addition, net income attributable to the noncontrolling interest will be included in consolidated net income on the face of the income statement and upon a loss of control, the interest sold, as well as any interest retained, will be recorded at fair value with any gain or loss recognized in earnings. SFAS No. 160 is effective for financial statements issued for years beginning after December 15, 2008, except for the presentation and disclosure requirements, which will apply retrospectively. Our adoption of this statement will result in changes related

to presentation and disclosure of our minority interest but will not affect our results of operations.

In February 2007, the FASB Issued SFAS No. 159, Establishing the Fair Value Option for Financial Assets and Liabilities, or SFAS No. 159. SFAS No. 159 was to permit all entities to choose to elect, at specified election

dates, to measure eligible financial instruments at fair value. An entity shall report unrealized gains and losses on items for which the fair value option has been elected in earnings at each subsequent reporting date, and recognize upfront costs and fees related to those items in earnings as incurred and not deferred. SFAS No. 159 applies to fiscal years beginning after November 15, 2007, with early adoption permitted for an entity that has also elected to apply the provisions of SFAS No. 157, Fair Value Measurements. An entity is prohibited from retrospectively applying SFAS No. 159, unless it chooses early adoption. SFAS No. 159 also applies to eligible items existing at November 15, 2007 (or early adoption date). Our adoption of SFAS No. 159 on January 1, 2008 did not impact our consolidated financial statements.

In September 2006, the FASB issued SFAS No. 157, Fair Value Measurements, or SFAS No. 157. SFAS No. 157 establishes a framework for measuring fair value and expands disclosures about fair value measurements. The changes to current practice resulting from the application of SFAS No. 157 relate to the definition of fair value, the methods used to measure fair value, and the expanded disclosures about fair value measurements. In February 2008, the FASB issued FSP 157-1, Application of FASB Statement No. 157 to FASB Statement No. 13 and Other Accounting Pronouncements That Address Fair Value Measurements for Purposes of Lease Classification or Measurement under Statement 13, or FSP 157-1, and FSP 157-2, Effective Date of FASB Statement No. 157, or FSP 157-2. FSP 157-1 amends SFAS No. 157 to remove certain leasing transactions from its scope. FSP 157-2 delays the effective date of SFAS No. 157 for all non-financial assets and non-financial liabilities, except for items that are recognized or disclosed at fair value in the financial statements on a recurring basis (at least annually), until the beginning of the first quarter of fiscal 2009. Effective for the first quarter 2008, we adopted SFAS No. 157 except as it applies to those nonfinancial assets and nonfinancial liabilities addressed in FSP 157-2. The adoption of SFAS No. 157 had no effect on our consolidated financial statements. We have evaluated the effect of FSP 157-2 and have determined that it will have no effect on our consolidated financial statements.

Quantitative and Qualitative Disclosures about Market Risk

We are subject to interest rate risk in connection with our long term indebtedness. Our principal interest rate exposure relates to the loans outstanding under our senior secured credit facility and the senior floating rate notes. As of June 30, 2008, we had \$828.7 million in term and revolving loans outstanding under our senior secured credit facility, which bear interest at variable rates. On June 13, 2005, Select entered into a five year interest rate swap transaction with an effective date of August 22, 2005. On March 8, 2007 and November 16, 2007, Select entered into two additional interest rate swap transactions for three years with effective dates of May 22, 2007 and November 23, 2007, respectively. Select entered into the swap transactions to mitigate the risks of future variable rate interest payments. The notional amount of the interest rate swaps are \$500.0 million and the underlying variable rate debt is associated with the senior secured credit facility. Each eighth point change in interest rates on the variable rate portion of our long term indebtedness would result in a \$0.4 million change in interest expense on our term loans.

In conjunction with the issuance of the senior floating rate notes, on September 29, 2005, Select entered into a swap transaction to mitigate the risks of future variable rate interest payments associated with this debt. The notional amount of the interest rate swap is \$175.0 million and the swap is for a period of five years.

BUSINESS

Overview

We believe that we are one of the largest operators of both specialty hospitals and outpatient rehabilitation clinics in the United States based on number of facilities. As of June 30, 2008, we operated 88 long term acute care hospitals, or LTCHs and four inpatient rehabilitation facilities, or IRFs in 25 states, and 970 outpatient rehabilitation clinics in 37 states and the District of Columbia. We also provide medical rehabilitation services on a contract basis at nursing homes, hospitals, assisted living and senior care centers, schools and worksites. We began operations in 1997 under the leadership of our current management team, including our co-founders, Rocco A. Ortenzio and Robert A. Ortenzio, who have a combined 66 years of experience in the healthcare industry. Under this leadership, we have grown our business from its founding to a business that generated net operating revenue of \$1,991.7 million for the year ended December 31, 2007.

Business Segments and Strategy

We manage our company through two business segments, our specialty hospital and our outpatient rehabilitation segments. We derived approximately 70% and 69% of net operating revenues and 76% and 75% of our income from operations from our specialty hospital segment; and approximately 30% and 31% of net operating revenues and 24% and 25% of our income from operations from our outpatient rehabilitation segment, for year ended December 31, 2007 and the six months ended June 30, 2008, respectively. Our specialty hospital segment consists of hospitals designed to serve the needs of long term stay acute patients and hospitals designed to serve patients who require intensive inpatient medical rehabilitation. Our outpatient rehabilitation business consists of clinics and contract services that provide physical, occupational and speech rehabilitation services.

Specialty Hospitals

We are a leading operator of specialty hospitals in the United States, with 92 facilities throughout 25 states, as of June 30, 2008. Of this total, 88 operated as long term acute care hospitals, 84 of which were certified by the federal Medicare program as long term acute care hospitals, and four additional specialty hospitals were in the process of becoming certified as Medicare long term acute care hospitals. The remaining four specialty hospitals are certified by the federal Medicare program as inpatient rehabilitation facilities. For the year ended December 31, 2007 and the six months ended June 30, 2008, approximately 65% and 63%, respectively, of the net operating revenues of our specialty hospital segment came from Medicare reimbursement. As of June 30, 2008, we operated a total of 4,126 available licensed beds and employed approximately 12,700 people in our specialty hospital segment, consisting primarily of registered or licensed nurses, respiratory therapists, physical therapists, occupational therapists and speech therapists.

Patients are typically admitted to our specialty hospitals from general acute care hospitals. These patients have specialized needs, and serious and often complex medical conditions such as respiratory failure, neuromuscular disorders, traumatic brain and spinal cord injuries, strokes, non-healing wounds, cardiac disorders, renal disorders and cancer. Given their complex medical needs, these patients generally require a longer length of stay than patients in a general acute care hospital and benefit from being treated in a specialty hospital that is designed to meet their unique medical needs. The average length of stay for patients in our specialty hospitals is 26 days in our long term acute care hospitals and 16 days in our inpatient rehabilitation facilities, for the six months ended June 30, 2008.

Below is a table that shows the distribution by medical condition (based on primary diagnosis) of patients in our hospitals for the year ended December 31, 2007:

Medical Condition	Distribution of Patients
Respiratory disorders	38%
Neuromuscular disorders	23
Wound care	11
Cardiac disorders	7
Other	21
Total	100%

We believe that we provide our services on a more cost-effective basis than a typical general acute care hospital because we provide a much narrower range of services. We believe that our services are therefore attractive to healthcare payors who are seeking to provide the most cost-effective level of care to their enrollees. Additionally, we continually seek to increase our admissions by expanding and improving our relationships with the physicians and general acute care hospitals that refer patients to our facilities. We also maintain a strong focus on the provision of high-quality medical care within our facilities and believe that this operational focus is in part reflected in our specialty hospital accreditation by The Joint Commission, previously known as the Joint Commission on Accreditation of Healthcare Organizations, and the Commission on Accreditation of Rehabilitation Facilities, commonly known as CARF. The Joint Commission and CARF are independent, not-for-profit organizations that establish standards related to the operation and management of health care facilities. Each of our accredited facilities must regularly demonstrate to a survey team conformance to the applicable standards. When a survey is completed, the facility receives a survey report that acknowledges best practices, contains suggestions for improving services, and makes recommendations for improvement based on conformance to the standards.

When a patient is referred to one of our hospitals by a physician, case manager, discharge planner, health maintenance organization or insurance company, a clinical liaison along with a case manager from our company makes an assessment to determine the care required. Based on the determinations reached in this clinical assessment, an admission decision is made by the attending physician.

Upon admission, an interdisciplinary team reviews a new patient's condition. The interdisciplinary team is comprised of a number of clinicians and may include any or all of the following: an attending physician; a specialty nurse; a physical, occupational or speech therapist; a respiratory therapist; a dietician; 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 specialty hospitals has an onsite management team consisting of a chief executive officer, a director of clinical services and a director of provider relations. 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 specialty hospitals. We provide our hospitals with centralized accounting, payroll, legal, reimbursement, human resources, compliance, management information systems and billing and collection services. The centralization of

these services improves efficiency and permits hospital staff to spend more time on patient care.

We operate the majority of our long term acute care hospitals using an HIH model. A long term acute care hospital that operates as an HIH leases space from a general acute care 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 long term acute care hospital does not operate on a host hospital campus. As a result of the HIH regulatory changes discussed in further detail in Government Regulations, we developed and implemented a plan that included,

among other things, relocating certain facilities to alternative settings, building or buying additional free-standing hospitals and closing some of our facilities. The significant changes associated with this plan have been completed. As a result of this plan, of the 88 long term acute care hospitals we operated as of June 30, 2008, 66 were operated as HIHs and 22 were operated as free-standing hospitals.

All Medicare payments to our long term acute care hospitals are made in accordance with the prospective payment system specifically applicable to LTCH-PPS. Under LTCH-PPS, a long term acute care hospital is paid a pre-determined fixed amount depending upon the LTC-DRG to which each patient is assigned. LTCH-PPS includes special payment policies that adjust the payments for some patients based on a variety of factors. Some of these special payment policies have been the subject of recent regulatory developments. See Government Regulations and Management's Discussion and Analysis of Financial Condition and Results of Operations Regulatory Changes.

Specialty Hospital Strategy

Focus on Specialized Inpatient Services. We serve highly acute patients and patients with debilitating injuries that cannot be adequately cared for in a less medically intensive environment, such as a skilled nursing facility. Generally, patients in our specialty hospitals require longer stays and higher levels of clinical care than patients treated in general acute care hospitals. Our patients' average length of stay in our specialty hospitals is 25 days for the year ended December 31, 2007.

Provide High Quality Care and Service. We believe that our specialty hospitals serve a critical role in comprehensive healthcare delivery. Through our specialized treatment programs and staffing models, we treat patients with acute, complex and specialized medical needs who are typically referred to us by general acute care hospitals. Our specialized treatment programs focus on specific patient needs and medical conditions such as specific ventilator weaning programs and wound care protocols. Our responsive staffing models ensure that patients have the appropriate clinical resources over the course of their stay. We believe that we are recognized for providing quality care and service, as evidenced by accreditation by The Joint Commission and CARF. We also believe we develop brand loyalty in the local areas we serve allowing us to strengthen our relationships with physicians and other referral sources and drive additional patient volume to our hospitals.

Our treatment and staffing programs benefit patients because they give our clinicians access to the regimens that we have found to be most effective in treating various conditions such as respiratory failure, non-healing wounds, 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.

The quality of the patient care we provide is continually monitored using several measures, including patient, payor and physician satisfaction surveys, as well as clinical outcomes analyses. Quality measures are collected monthly and reported quarterly and annually. In order to benchmark ourselves against other healthcare organizations, we have contracted with outside vendors to collect our clinical and patient satisfaction information and compare it to other healthcare organizations. The information collected is reported back to each hospital, to our corporate office, and directly to The Joint Commission. As of June 30, 2008, The Joint Commission had accredited all but six of our hospitals. These six hospitals have not yet undergone a survey by The Joint Commission. Three of our four inpatient rehabilitation facilities have also received accreditation from CARF. One of our inpatient rehabilitation facilities has not yet been surveyed by CARF. See Government Regulations Licensure Accreditation.

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

optimizing staffing based on our occupancy and the clinical needs of our patients;

centralizing administrative functions such as accounting, finance, payroll, legal, reimbursement, compliance, human resources and billing and collection;

standardizing management information systems to aid in financial reporting as well as billing and collecting; and

participating in group purchasing arrangements to receive discounted prices for pharmaceuticals and medical supplies.

Increase Higher Margin Commercial Volume. With reimbursement rates from commercial insurers typically higher than the federal Medicare program, we have focused on continued expansion of our relationships with commercial insurers to increase our volume of patients with commercial insurance in our specialty hospitals. Although the level of care we provide is complex and staff intensive, we typically have lower relative operating expenses than a general acute care hospital because we provide a much narrower range of patient services at our hospitals. We believe that commercial payors seek to contract with our hospitals because we offer 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.

Develop New Inpatient Rehabilitation Facilities. As a result of the SCHIP Extension Act, which has a three year moratorium on the development of new LTCHs, we have stopped all LTCH development, except for LTCHs currently under construction that are excluded from the moratorium. We expect to continue evaluating opportunities to develop new inpatient rehabilitation facilities. We have a dedicated development team with significant experience in specialty hospital development. In addition, three predecessor companies founded by our Executive Chairman and/or co-founded by our Chief Executive Officer focused on the development and operation of inpatient rehabilitation hospitals.

By leveraging the experience of our senior management and dedicated development team, we believe that we are well positioned to capitalize on development opportunities. When we target a new local area to serve, our development team conducts an extensive review of the area's referral patterns and commercial insurance to determine the general reimbursement trends and payor mix. Ultimately, when we determine a location for the development of a new specialty hospital, we evaluate the opportunities in the area for the construction of new space or the leasing and renovation of existing space. During construction or renovation, the project is transitioned to our start-up team, which is experienced in preparing a specialty hospital for opening. The start-up team oversees equipment purchases, licensure procedures and the recruitment of a full-time management team. After the facility is opened, responsibility for its management is transitioned to this new management team and our corporate operations group.

Pursue Opportunistic Acquisitions. In addition to our development initiatives, we may grow our network of specialty hospitals through opportunistic acquisitions. Our immediate focus is on acquisitions of inpatient rehabilitation facilities, although we will still consider acquisitions of long term acute care hospitals if they are at attractive valuations. We believe we have historically been able to obtain assets for what we believe are attractive valuations. When we acquire a hospital or a group of hospitals, a team of our professionals is responsible for formulating and executing an integration plan. We have generally been able to increase margins at acquired facilities by adding clinical programs that attract commercial payors, centralizing administrative functions and implementing our standardized staffing models and resource management programs. Since our founding in 1997, we have made a total of four significant specialty hospital acquisitions comprising 54 long term acute care hospitals and four inpatient rehabilitation facilities for a total of \$496.4 million in aggregate consideration.

Outpatient Rehabilitation

We believe that we are the largest operator of outpatient rehabilitation clinics in the United States based on number of facilities, with 970 facilities throughout 37 states and the District of Columbia, as of June 30, 2008. Typically, each of our clinics is located in a medical complex or retail location. As of June 30, 2008, our outpatient rehabilitation segment employed approximately 8,400 people.

In our clinics and through our contractual relationships, we provide physical, occupational and speech rehabilitation programs and services. We also provide certain specialized programs such as hand therapy or sports performance enhancement that treat sports and work related injuries, musculoskeletal disorders, chronic or acute pain and orthopedic conditions. The typical patient in one of our 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, strokes, heart attacks 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, speech-language pathologists and respiratory therapists.

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. We believe that our services are attractive to healthcare payors who are seeking to provide the most cost-effective level of care to their enrollees. In addition to providing therapy in our outpatient clinics, we provide medical rehabilitation management services on a contract basis at nursing homes, hospitals, schools, assisted living and senior care centers and worksites. In our outpatient rehabilitation segment, approximately 90% of our net operating revenues come from commercial payors, including healthcare insurers, managed care organizations and workers compensation programs, contract management services and private pay sources. The balance of our reimbursement is derived from Medicare and other government sponsored programs.

Outpatient Rehabilitation Strategy

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

Increase Market Share. We strive to establish a leading presence within the local areas we serve. To increase our presence, we seek to expand our services and programs and to continue to provide high quality care and strong customer service. This allows us to realize economies of scale, heightened brand loyalty, workforce continuity and increased leverage when negotiating payor contracts.

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

Optimize the Profitability of our Payor Contracts. We rigorously review payor contracts up for renewal and potential new payor contracts to optimize our profitability. Before we enter into a new contract with a commercial payor, we evaluate it with the aid of our contract management system. We assess potential profitability by evaluating past and projected patient volume, clinic capacity, and expense trends. 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 size and our strong reputation enables us to negotiate favorable outpatient contracts with commercial insurers.

Maintain Strong 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 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. 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 performance.

Pursue Opportunistic Acquisitions. We may grow our network of outpatient rehabilitation facilities through opportunistic acquisitions. We significantly expanded our network with the 2007 acquisition of the outpatient rehabilitation division of HealthSouth Corporation, consisting of 569 clinics in 35 states and the District of

Columbia, including eighteen states in which we did not previously have outpatient rehabilitation facilities. We believe our size and centralized infrastructure allow us to take advantage of operational efficiencies and increase margins at acquired facilities.

Other Services

Other services (which accounted for less than 1% of our net operating revenues for the six months ended June 30, 2008) include corporate services and certain non-healthcare 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, proven financial performance and strong cash flow, significant scale, experience in completing and integrating acquisitions, ability to capitalize on consolidation opportunities and an experienced management team.

Leading Operator in Distinct but Complementary Lines of Business. We believe that we are a leading operator in each of our principal business segments, based on number of facilities in the United States. Our leadership position and reputation as a high quality, cost-effective health care provider in each of our business segments allows us to attract patients and employees, aids us in our marketing efforts to payors and referral sources and helps us negotiate payor contracts. In our specialty hospital segment, we operated 88 long term acute care hospitals with 3,772 available licensed beds in 25 states and four inpatient rehabilitation facilities with 354 beds in two states and derived approximately 69% of net operating revenues from these operations, for the six months ended June 30, 2008. In our outpatient rehabilitation segment, we operated 970 outpatient rehabilitation clinics in 37 states and the District of Columbia and derived approximately 31% of net operating revenues from these operations, for the six months ended June 30, 2008. 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 lines.

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 an intense 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. As a result, we have been able to minimize our general and administrative expense as a percentage of revenues, which was 2.2% for the year ended December 31, 2007.

Well-Positioned to Capitalize on Consolidation Opportunities. We believe that we are well-positioned to capitalize on consolidation opportunities within each of our business segments and selectively augment our internal growth. We believe that each of our business segments is highly fragmented, with many of the nation's long term acute care hospitals, inpatient rehabilitation facilities and outpatient rehabilitation facilities being operated by independent operators lacking national or broad regional scope. With our geographically diversified portfolio of facilities in the United States, we believe that our footprint provides us with a wide-ranging perspective on multiple potential acquisition opportunities.

Experience in Successfully Completing and Integrating Acquisitions. From our inception in 1997 through 2007, we completed six significant acquisitions for approximately \$894.8 million in aggregate consideration. We believe that we have improved the operating performance of these facilities over time by applying our standard operating practices and by realizing efficiencies from our centralized operations and management.

Experienced and Proven Management Team. Prior to co-founding our company with our current Chief Executive Officer, our Executive Chairman founded and operated three other healthcare companies focused on inpatient and outpatient rehabilitation services. In addition, our four senior operations executives have an average of over 30 years of experience in the healthcare industry, including extensive experience working together for our

company and for past companies focused on operating acute rehabilitation hospitals and outpatient rehabilitation facilities. Eleven of our 17 corporate officers worked together at Continental Medical Systems, Inc., a developer and operator of inpatient rehabilitation facilities that was managed under the leadership of Rocco A. Ortenzio and Robert A. Ortenzio from its inception in 1986 until it was sold in 1995. Over the course of their operating history, our senior management team has received national recognition for its management and business operations, including selection for the Forbes Platinum 400 List, as one of America's Best Managed Companies.

Industry

In the United States, spending on healthcare accounted for approximately 16% of the gross domestic product in 2007 and is projected to grow at 6.7% compounded annually over the next ten years, according to CMS. An important factor driving healthcare spending is increased consumption of services due to the aging of the population. The number of individuals age 65 and older has grown 1.2% compounded annually over the past twenty years and is expected to grow 2.9% compounded annually over the next twenty years, approximately three times faster than the overall population, according to the U.S. Census Bureau. We believe that an increasing number of individuals age 65 and older will drive demand for our specialized medical services.

For individuals age 65 and older, the primary source of health insurance is the federal Medicare program. Medicare utilizes distinct payment methodologies for services provided in long term acute hospitals, inpatient rehabilitation facilities and outpatient rehabilitation clinics. In the federal fiscal year 2006, Medicare payments for long term acute hospitals services accounted for 1.1% of overall Medicare outlays and Medicare payments for inpatient rehabilitation services accounted for 1.5% according to MedPAC. Due to recent regulatory changes enacted in part to slow growth, over the next five years Medicare payments for long term acute care hospital services are projected to grow approximately 4% compounded annually and Medicare payments for inpatient rehabilitation services are projected to grow approximately 3% compounded annually, which compares with approximately 7% compound annual growth projected for the overall Medicare program, according to information provided by the Office of the Actuary of the U.S. Department of Health and Human Services.

Sources of Net Operating Revenues

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

Net Operating Revenues by Payor Source ⁽¹⁾	Year Ended December 31,			Six Months Ended June 30,	
	2005 ⁽²⁾	2006	2007	2007	2008
Medicare	56.4%	53.2%	48.0%	50.4%	46.0%
Commercial insurance ⁽³⁾	36.8%	40.0%	44.2%	42.3%	46.5%
Private and other ⁽⁴⁾	4.7%	5.0%	5.5%	5.2%	5.5%
Medicaid	2.1%	1.8%	2.3%	2.1%	2.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

- (1) This table excludes the net operating revenues of our Canadian operations which were sold on March 1, 2006 and are now reported as a discontinued operation.
- (2) The net operating revenues for the period after the Merger, February 25 through December 31, 2005 (Successor Period), has been added to the net operating revenues for the period from January 1 through February 24, 2005 (Predecessor Period), to arrive at the combined year ended December 31, 2005.
- (3) Includes commercial healthcare insurance carriers, health maintenance organizations, preferred provider organizations, workers compensation and managed care programs.
- (4) Includes self payors, contract management services and non-patient related payments. Self pay revenues represent less than 1% of total net operating revenues.

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. All of our hospitals are currently certified as Medicare providers. Our outpatient rehabilitation clinics regularly receive Medicare payments for their services. Additionally, our specialty hospitals participate in 23 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 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

An increasing amount of our net operating revenues continue to come from commercial and private payor sources. These sources include insurance companies, workers compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies and employers, as well as by patients directly. Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs, insurance companies, workers compensation companies, health maintenance organizations, preferred provider organizations and other managed care companies, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors.

The Merger Transactions

On February 24, 2005, EGL Acquisition Corp. was merged with and into Select, with Select continuing as the surviving corporation and a wholly owned subsidiary of Holdings. The merger was completed pursuant to an agreement and plan of merger, dated as of October 17, 2004, among EGL Acquisition Corp., Holdings and Select. Holdings and EGL Acquisition Corp. were Delaware corporations formed by Welsh Carson for purposes of engaging in the merger and the related transactions described below.

Upon the consummation of the merger, Select became a wholly owned subsidiary of Holdings and all of the capital stock of Holdings was owned by an investor group that includes Welsh Carson and Thoma Cressey, and certain other rollover investors that participated in the merger. We refer to those other investors as the continuing investors. Our continuing investors include Rocco A. Ortenzio, our Executive Chairman and the chairman of our board of directors, Robert A. Ortenzio, our Chief Executive Officer and a member of our board of directors, certain other investors who are members of or affiliated with the Ortenzio family, certain individuals affiliated with Welsh Carson, including Russell L. Carson, a member of our board of directors and a founding general partner of Welsh, Carson, Anderson & Stowe, Bryan C. Cressey, a member of our board of directors and a founding partner of Thoma Cressey, various investment funds affiliated with Thoma Cressey, Patricia A. Rice, our President and Chief Operating Officer, Martin F. Jackson, our Executive Vice President and Chief Financial Officer, S. Frank Fritsch, our Executive Vice President and Chief Human Resources Officer, Michael E. Tarvin, our Executive Vice President, General Counsel and Secretary, James J. Talalai, our Executive Vice President and Chief Information Officer, and Scott A. Romberger, our Senior Vice President, Controller and Chief Accounting Officer. The continuing investors purchased our common stock at a price of \$1.00 per share and our preferred stock at a price of \$26.90 per share. Immediately prior to the merger, shares of common stock of Select which were owned by our continuing investors were contributed to

Holdings in exchange for equity securities of Holdings. For purposes of such exchange, these rollover shares were valued at \$152.0 million in the aggregate, or \$18.00 per share (the per share merger consideration). Upon consummation of the merger, these rollover shares were cancelled without payment of any merger consideration.

The amount of funds and rollover equity used to consummate the Merger Transactions was \$2,443.1 million, including:

\$1,827.7 million to pay Select's then existing stockholders (other than rollover stockholders) and option holders all amounts due under the merger agreement;

\$152.0 million of rollover equity from our continuing investors;

\$344.2 million to repay existing indebtedness; and

\$119.2 million to pay related fees and expenses, including premiums, consent fees and interest payable in connection with the tender offers and consent solicitations for Select's existing senior subordinated notes.

The Merger Transactions were financed by:

a cash equity investment in Holdings of \$570.0 million by an investor group led by Welsh Carson and Thoma Cressey (the net proceeds of which were contributed by Holdings to Select) and a rollover equity investment in Holdings of \$152.0 million by our continuing investors;

Holdings' issuance and sale of senior subordinated notes, preferred stock and common stock to WCAS Capital Partners IV, L.P., an investment fund affiliated with Welsh Carson, Rocco A. Ortenzio, Robert A. Ortenzio and certain other investors who are members of or affiliated with the Ortenzio family, for an aggregate purchase price of \$150.0 million (the net proceeds of which were contributed by Holdings to Select);

borrowings by us of \$580.0 million in term loans and \$200.0 million in revolving loans under Select's senior secured credit facility;

existing cash on hand of \$131.1 million; and

the issuance of \$660.0 million in aggregate principal amount of Select's 75/8% senior subordinated notes.

In connection with the merger, Select commenced tender offers to acquire all of its 91/2% senior subordinated notes due 2009 and all of its 71/2% senior subordinated notes due 2013. In connection with each such tender offer Select sought consents to eliminate substantially all of the restrictive covenants and make other amendments to the indentures governing such notes. Upon completion of the tender offers on February 24, 2005, holders of all of Select's 71/2% senior subordinated notes and holders of approximately 96.7% of Select's 91/2% senior subordinated notes had delivered consents and tendered their notes in connection with such tender offers and consent solicitations.

As a result of the Merger Transactions, the majority of Select's assets and liabilities were adjusted to their fair value as of February 25, 2005. The excess of the total purchase price over the fair value of Select's tangible and identifiable intangible assets was allocated to goodwill, which is the subject of an annual impairment test. Additionally, pursuant to Financial Accounting Standards Board Emerging Issues Task Force Issue No. 88-16 Basis in Leveraged Buyout Transactions, a portion of the equity related to our continuing stockholders was recorded at the stockholder's predecessor basis and a corresponding portion of the fair value of the acquired assets was reduced accordingly. By definition, our statements of financial position and results of operations subsequent to the Merger Transactions are not comparable to the same statements for the periods prior to the Merger Transactions due to the resulting change in basis.

In recommending the approval of the merger agreement and the merger to the board of directors, the special committee of our board of directors considered the material factors that it believed supported its recommendation, the most significant factor being that the merger consideration of \$18.00 per share was payable in cash and represented a substantial premium over the market price of common stock of Select before the public announcement of the execution of the merger agreement.

Material Acquisitions

The growth of our business also has been attributable to our ability to successfully acquire and integrate other businesses. Since our inception in 1997 through June 30, 2008, we have completed six significant acquisitions for approximately \$894.8 million in aggregate consideration. On June 30, 1998, we acquired American Transitional

Hospitals, a wholly-owned subsidiary of Beverly Enterprises, Inc. and a provider of long term acute care hospital services, for approximately \$62.8 million in cash and approximately \$14.9 million in assumed liabilities. The American Transitional Hospital acquisition added 15 long term acute care hospitals. On December 16, 1998, we acquired Intensiva Healthcare Corporation, a provider of long term acute care hospital services, for approximately \$103.6 million in cash and approximately \$56.5 million in assumed liabilities. The Intensiva Healthcare Corporation acquisition added 22 long term acute care hospitals. On November 19, 1999, we acquired the Physical Rehabilitation and Occupational Health Division of NovaCare, Inc., for approximately \$160.4 million consisting of cash and the assumption of seller notes. The NovaCare acquisition added 513 outpatient rehabilitation clinics. On September 2, 2003, we acquired Kessler Rehabilitation Corporation for approximately \$230.0 million in cash and approximately \$1.7 million of assumed indebtedness. The Kessler acquisition added four inpatient rehabilitation hospitals and 92 outpatient rehabilitation clinics. On January 1, 2005, we acquired SemperCare, Inc. for approximately \$100.0 million in cash. The SemperCare acquisition added 17 long term acute care hospitals. Finally, on May 1, 2007, we acquired HealthSouth Corporation's outpatient rehabilitation division for approximately \$245.0 million, reduced by approximately \$7.0 million at closing for assumed indebtedness and other matters. We significantly expanded our network with the HealthSouth acquisition, consisting of 569 outpatient rehabilitation clinics in 35 states and the District of Columbia, including eighteen states in which we did not previously have outpatient rehabilitation clinics. See Recent Trends and Events Acquisition of HealthSouth Corporation's Outpatient Rehabilitation Division.

Employees

As of June 30, 2008, we employed approximately 21,700 people throughout the United States. A total of approximately 14,600 of our employees are full time and the remaining approximately 7,100 are part time employees. Outpatient, contract therapy and physical rehabilitation and occupational health employees totaled approximately 8,400 and specialty hospital employees totaled approximately 12,700. The remaining approximately 600 employees were in corporate management, administration and other services.

Competition

We compete on the basis of pricing, the quality of the patient services we provide and the results that we achieve for our patients. The primary competitive factors in the long term acute care and inpatient rehabilitation businesses include quality of services, charges for services and responsiveness to the needs of patients, families, payors and physicians. Other companies operate long term acute care hospitals and inpatient rehabilitation facilities that compete with our hospitals, including large operators of similar facilities, such as Kindred Healthcare Inc. and HealthSouth Corporation. The competitive position of any 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 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 hospital's competitive position, vary from area to area, depending on the number and strength of such organizations.

Our outpatient rehabilitation clinics face competition principally from locally owned and managed outpatient rehabilitation clinics in the communities they serve and from selected national providers such as Physiotherapy Associates and U.S. Physical Therapy in selected local areas. Many of these clinics have longer operating histories and greater name recognition in these communities than our clinics, and they may have stronger relations with physicians in these communities on whom we rely for patient referrals.

Facilities

We currently lease most of our facilities, including clinics, offices, specialty hospitals and our corporate headquarters. We own three of our four inpatient rehabilitation facilities and 13 of our long term acute care hospitals. We also own one facility currently undergoing renovations that will house a future specialty hospital.

We lease all but four of our outpatient rehabilitation clinics and related offices, which, as of June 30, 2008, included 966 leased outpatient rehabilitation clinics throughout the United States. The outpatient rehabilitation clinics generally have a five year lease term and include options to renew. We also lease the majority of our long term acute care hospital facilities except for the facilities described above. As of June 30, 2008, in our LTCHs we had 65 hospital within hospital leases and ten free-standing building leases.

We generally seek a five year lease for our long term acute care hospitals operated as HIHs, with an additional five year renewal at our option. We lease our corporate headquarters from companies owned by a related party affiliated with us through common ownership or management. Our corporate headquarters is approximately 139,179 square feet and is located in Mechanicsburg, Pennsylvania. We lease several other administrative spaces related to administrative and operational support functions. As of June 30, 2008, this comprised 12 locations throughout the United States with approximately 82,121 square feet in total.

The following is a list of our hospitals and the number of beds at each hospital as of June 30, 2008.

Hospital Name	City	State	Beds
Select Specialty Hospital	Birmingham	AL	38
Select Specialty Hospital	Fort Smith	AR	34
Select Specialty Hospital	Little Rock	AR	43
Select Specialty Hospital	Arizona (Phoenix Downtown Campus)	AZ	33
Select Specialty Hospital	Phoenix	AZ	48
Select Specialty Hospital	Arizona (Scottsdale Campus)		