SELECT MEDICAL HOLDINGS CORP
Form S-1/A
November 25, 2008

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As filed with the Securities and Exchange Commission on November 25, 2008
Registration No. 333-152514

SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Amendment No. 3 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	**8060**	**20-1764048**
(State or Other Jurisdiction of Incorporation or Organization)	*(Primary Standard Industrial Classification Code Number)*	*(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: o

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. o

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. o

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. o

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 o	Accelerated filer o	Non-accelerated filer þ (Do not check if a smaller reporting company)	Smaller reporting company o

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(3)

(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.

(3) Previously paid.

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.

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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 , 2009

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 Nasdaq Global Select Market under the symbol .

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 , 2009.

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 , 2009

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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 , 2009 (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.

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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. The information in this prospectus, other than historical financial information, gives effect to a reverse 1 to common stock split, which will be completed prior to the completion of this offering.

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 September 30, 2008, we operated 88 long term acute care hospitals and four inpatient rehabilitation facilities in 25 states, and 965 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

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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

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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 nine months ended September 30, 2008, respectively, came from the

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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 September 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 September 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 September 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 September 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.

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.

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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. 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 $ million 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 $ million 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

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	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 Nasdaq Global Select Market symbol	.
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.

Immediately prior to the consummation of 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 of preferred stock) 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

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 that are described above.

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

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.

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:

other than historical financial information, gives effect to a reverse 1 to common stock split, which will be completed prior to the consummation of this offering;

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 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.

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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 nine months ended September 30, 2007 and 2008 and balance sheet data as of September 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 s 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 nine months ended September 30, 2008 gives effect to (i) the assumed 1 for reverse split of our common stock, (ii) 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 (iii) the expected proceeds from this offering as if they had occurred on January 1, 2007. The pro forma as adjusted balance sheet data as of September 30, 2008 gives effect to (i) the assumed 1 for reverse split of our common stock, (ii) 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 (iii) the expected use of proceeds from this offering as if they had occurred on September 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.

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	Predecessor Period	Successor Period			
	Period from January 1 through February 24, 2005	Period from February 25 through December 31, 2005	Year Ended December 31, 2006	2007	Pro Forma As Adjusted 2007
	(in thousands, except per share data)				
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)	$ 0.23	$ 0.30	$ 0.05	
	0.01	0.02	0.06		

Income from discontinued operations, net of tax								
Net income (loss)	$	(0.98)	$	0.25	$	0.36	$	0.05
Diluted:								
Income (loss) from continuing operations	$	(0.99)	$	0.22	$	0.28	$	0.05
Income from discontinued operations, net of tax		0.01		0.02		0.06		
Net income (loss)	$	(0.98)	$	0.24	$	0.34	$	0.05
Income (loss) per common share assuming the reverse stock split contemplated by this offering:								
Basic:								
Income (loss) from continuing operations			$		$		$	
Income from discontinued operations, net of tax								
Net income (loss)			$		$		$	
Diluted:								
Income (loss) from continuing operations			$		$		$	
Income from discontinued operations, net of tax								
Net income (loss)			$		$		$	
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
Adjusted EBITDA[8]		44,384		263,760		283,270		217,175
Outpatient Rehabilitation:								
Net operating revenue		73,344		407,367		470,339		603,413
Adjusted EBITDA[8]		9,848		56,109		64,823		75,437

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	Nine Months Ended September 30,		
	2007	2008	Pro Forma As Adjusted 2008
	(in thousands, except per share data)		
Statement of Operations Data:			
Net operating revenues	$ 1,473,698	$ 1,606,263	$
Operating expenses[1][2]	1,279,463	1,414,165	
Depreciation and amortization	42,042	53,175	
Income from operations	152,193	138,923	
Other expense	(199)		
Interest expense, net[5]	(101,674)	(109,328)	
Income from operations before minority interests and income taxes	50,320	29,595	
Minority interests in consolidated subsidiary companies[6]	1,373	2,103	
Income from operations before income taxes	48,947	27,492	
Income tax expense	20,267	13,862	
Net income	28,680	13,630	
Less: Preferred dividends	17,696	18,569	
Net income (loss) available to common and preferred stockholders	$ 10,984	$ (4,939)	$
Net income (loss) per common share:			
Basic	$ 0.05	$ (0.02)	
Diluted	$ 0.05	$ (0.02)	
Net income per common share assuming the reverse stock split contemplated by this offering:			
Basic	$	$	$
Diluted	$	$	$
Balance Sheet Data (at end of period):			
Cash and cash equivalents	$ 10,103	$ 9,367	
Working capital surplus (deficit)	(17,521)	95,288	
Total assets	2,458,240	2,513,161	
Total debt	1,735,649	1,784,316	
Preferred stock	485,081	509,469	
Total stockholders equity	(160,782)	(171,978)	
Segment Data:			
Specialty Hospitals[7]:			
Net operating revenue	$ 1,033,533	$ 1,104,731	
Adjusted EBITDA[8]	168,367	167,617	
Outpatient Rehabilitation:			
Net operating revenue	438,356	501,375	

Adjusted EBITDA[8]	60,270	60,248

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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

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	Nine Months Ended September 30,	
	2007	2008
Specialty hospital data[7]:		
Number of hospitals start of period	96	87
Number of hospital start-ups	3	5
Number of hospitals acquired		2
Number of hospitals closed/sold	(4)	(1)
Number of hospitals consolidated	(4)	(1)
Number of hospitals end of period	91	92
Available licensed beds	3,934	4,144
Admissions	30,095	30,891
Patient days	741,959	756,093
Average length of stay (days)	25	25
Net revenue per patient day[9]	$ 1,367	$ 1,434
Occupancy rate	69%	68%
Percent patient days Medicare	70%	66%
Outpatient rehabilitation data:		
Number of clinics owned start of period	477	918
Number of clinics acquired	542	3
Number of clinic start-ups	6	12
Number of clinics closed/sold	(113)	(46)
Number of clinics owned end of period	912	887
Number of clinics managed end of period	109	78
Total number of clinics (all) end of period	1,021	965
Number of visits	2,887,134	3,430,138
Net revenue per visit[12]	$ 100	$ 102

(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 nine months ended September 30, 2007 and 2008.

(3) In connection with the Merger Transactions, Select completed tender offers for all of its 91/2% senior subordinated notes due 2009 and all of its 71/2% 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

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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 September 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.

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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 nine months ended September 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

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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.

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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 September 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.

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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.

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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 September 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 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. The Medical Payment Advisory Commission is an independent federal body that advises Congress on issues affecting the Medicare program. After the Medical Payment Advisory Commission s recommendation, CMS awarded a contract to Research Triangle Institute International to examine such recommendation. However, while acknowledging that Research Triangle Institute International 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 Research Triangle Institute International 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 the Medical Payment Advisory Commission 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 September 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

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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, which required the Secretary of Health and Human Services to respond within 60 days to a report by the Government Accountability Office 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. The Government Accountability Office 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 Government Accountability Office 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 the Government Accountability Office 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 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.

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. 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

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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 nine months ended September 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 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 the Health Insurance Portability and Accountability Act of 1996 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 the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. Our compliance officers and information security officers are responsible for implementing and monitoring compliance with our privacy and security policies and procedures at our facilities. We believe that the cost of our compliance with the Health Insurance Portability and Accountability Act of 1996 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.

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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, seven of our hospitals have physicians as minority owners. The aggregate revenue of these seven hospitals was $129.7 million for the year ended December 31, 2007, or approximately 6.5% of our revenues for the year ended December 31, 2007. The average minority ownership of these hospitals was approximately 10% 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.

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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

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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. 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 September 30, 2008 were $2,169.3 million, of which $1,784.3 million constituted indebtedness, including $808.2 million of indebtedness (excluding $29.0 million of letters of credit) under Select s senior secured credit facility, $660.0 million of Select s 75/8% senior subordinated notes, $135.2 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 $121.0 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

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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 September 30, 2008, we had approximately $1,784.3 million of total indebtedness. For the year ended December 31, 2007 and nine month period ended September 30, 2008, our total payments on our indebtedness were $336.9 million and $366.1 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 September 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 1.85 to 1.00 for such period. As of September 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 5.76 to 1.00 as of September 30, 2008. On a pro forma as adjusted basis, for the four

quarters ended September 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

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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 September 30, 2008, we had $121.0 million of revolving loan availability under our senior secured credit facility (after giving effect to $29.0 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.

We are exposed to the credit risk of our payors which in the future may cause us to make larger allowances for doubtful accounts or incur bad debt write-offs.

In the future, due to deteriorating economic conditions or other factors commercial payors may default on their payments to us, and individual patients may default on co-payments and deductibles for which they are responsible under the terms of either commercial insurance programs or Medicare. Although we review the credit risk of our commercial payors regularly, such risks will nevertheless arise from events or circumstances that are difficult to anticipate or control, such as a general economic downturn. As a result of the credit risk exposure of our payors defaulting on their payments to us in the future, we may have to make larger allowances for doubtful accounts or incur bad debt write-offs, both of which may have an adverse impact on our profitability.

Adverse economic conditions could materially adversely affect our net operating revenues in our outpatient rehabilitation segment from commercial payors.

Our net operating revenues may be materially adversely affected by adverse conditions in the general economy that could reduce the frequency of visits by patients of our outpatient rehabilitation clinics. While we believe that patient demand for the services provided by our outpatient rehabilitation clinics will not generally be impacted by the current state of the general economy, adverse economic conditions may result in some patients with commercial insurance electing to defer treatment or decrease the frequency of visits to our outpatient rehabilitation clinics in order to minimize their copay obligations. This could have a material adverse effect on the amount of our net operating revenues in our outpatient rehabilitation segment from commercial payors.

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;

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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.

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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 tangible 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 September 30, 2008, there were outstanding options to purchase shares of common stock at an average exercise price of $. 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;

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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 662/3% 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 10,000,000 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 net 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

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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 consumption 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 as payments under our Long Term Cash Incentive Plan.

	Proceeds from Common Stock Sold as Selling Stockholder	Proceeds from Common Stock Repurchased by the Company	Payments Under Long Term Cash Incentive Plan	Total Consideration
Welsh, Carson, Anderson & Stowe[1]	$	$	$	$
Thoma Cressey Bravo[2]				
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				

(1) Represents the portion of net proceeds Welsh, Carson, Anderson & Stowe IX, L.P., WCAS Management Corporation and WCAS Capital Partners IV, L.P. will receive in this offering as selling stockholders.

(2) Represents the portion of net proceeds Thoma Cressey Friends Fund VI, L.P., Thoma Cressey Friends Fund VII, L.P., Thoma Cressey Fund VI, L.P. and Thoma Cressey Fund VII, L.P. will receive in this offering as selling stockholders.

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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, sho 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;

the inability to draw funds under our senior secured credit facility because of lender defaults;

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.

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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 $ 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. If the underwriters option to purchase additional shares in this offering is exercised in full, we estimate that our net proceeds will be approximately $ million.

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 Merril 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 $ million will be paid to Rocco A. Ortenzio, approximately $ million will be paid to Robert A. Ortenzio, approximately $ million will be paid to Patricia A. Rice, approximately $ will be paid to Martin F. Jackson, approximately $ will be paid to S. Frank Fritsch, approximately $ million will be paid to David W. Cross, approximately $ million will be paid to James J. Talalai and approximately $ million will be paid to Michael E. Tarvin.

To pay approximately $ million 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 $ million 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.

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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.

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CAPITALIZATION

The following table sets forth our capitalization as of September 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 September 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 September 30, 2008		
	Actual	Pro Forma	Pro Forma As Adjusted[4]
Cash and cash equivalents	$ 9,367	$	$
Debt:			
Senior floating rate notes	175,000		
10% senior subordinated notes due 2015[1]	135,211		
Revolving credit facility[2]	150,000		
Term loan facility[3]	658,200		
75/8% senior subordinated notes due 2015	660,000		
Other debt	5,905		
Total debt	1,784,316		
Preferred stock	509,469		
Total stockholders equity	(171,978)		
Total capitalization	$ 2,121,807	$	$

(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 $14.8 million at September 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 $121.0 million was available as of September 30, 2008 for working capital and general corporate purposes (after giving effect to $29.0 million of outstanding letters of credit at September 30, 2008).

(3) We borrowed $680.0 million in term loans under our existing senior secured credit facility. Between February 24, 2005 and September 30, 2008 we repaid approximately $21.8 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.

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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 deficit as of September 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 mid point 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 deficit at September 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 deficit per share as of September 30, 2008	$
Increase attributable to conversion of preferred stock	
Increase per share attributable to this offering	
Pro forma net tangible book value per share after this offering as of September 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 , 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 existing investors would be $, the pro forma net tangible book deficit 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 decrease our pro forma net tangible book deficit by $ million, the pro forma net tangible book deficit 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.

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The following table summarizes, on the pro forma basis described above as of September 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		100.0%	$	100.0%	$

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 September 30, 2008. As of September 30, 2008, there were options outstanding to purchase shares of our common stock, with exercise prices ranging from $ to $ per share and a weighted average exercise price of $ 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.

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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 September 30, 2008 and for the nine months ended September 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,		Period from January 1 through February 24,	Period from February 25 through December 31,	Year Ended December 31,	
	2003	2004	2005	2005	2006	2007
	(in thousands, except per share data)			(in thousands, except per share data)		
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

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	Predecessor Period			Successor Period		
	Year Ended December 31,		Period from January 1 through February 24,	Period from February 25 through December 31,	Year Ended December 31,	
	2003	2004	2005	2005	2006	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

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)

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	Successor Period For the Nine Months Ended September 30,	
	2007	2008
	(in thousands, except per share data)	
Statement of Operations Data:		
Net operating revenues	$ 1,473,698	$ 1,606,263
Operating expenses[1][2]	1,279,463	1,414,165
Depreciation and amortization	42,042	53,175
Income from operations	152,193	138,923
Other expense	(199)	
Interest expense, net[5]	(101,674)	(109,328)
Income from operations before minority interests and income taxes	50,320	29,595
Minority interests in consolidated subsidiary companies[6]	1,373	2,103
Income from operations before income taxes	48,947	27,492
Income tax expense	20,267	13,862
Net income	28,680	13,630
Less: Preferred dividends	17,696	18,569
Net income (loss) available to common and preferred stockholders	$ 10,984	$ (4,939)
Net income (loss) per common share:		
Basic	$ 0.05	$ (0.02)
Diluted	0.05	(0.02)
Weighted average common shares outstanding:		
Basic	189,014	197,928
Diluted	189,014	197,928
Balance Sheet Data (at end of period):		
Cash and cash equivalents	$ 10,103	$ 9,367
Working capital (deficit)	(17,521)	95,288
Total assets	2,458,240	2,513,161
Total debt	1,735,649	1,784,316
Total stockholders equity	(160,782)	(171,978)

(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 nine months ended September 30, 2007 and 2008.

(3) In connection with the Merger, Select completed tender offers for all of its 91/2% senior subordinated notes due 2009 and all of its 71/2% 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.

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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 September 30, 2008 and our historical consolidated statement of operations for the year ended December 31, 2007 and the nine months ended September 30, 2008 to reflect (1) the assumed 1 for reverse split of our common stock to occur prior to the closing of this offering, (2) the issuance of shares of our common stock assuming this offering had occurred on September 30, 2008 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, (3) 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 (4) the application of the estimated net proceeds from this offering as if these events had occurred on September 30, 2008 for the unaudited pro forma consolidated balance sheet and on 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 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.

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.

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UNAUDITED PRO FORMA CONSOLIDATED BALANCE SHEET

	September 30, 2008				
	Historical	Preferred Stock Conversion and Reverse Stock Split	Pro Forma	Adjustments for Offering	Pro Forma as Adjusted
			(in thousands)		
ASSETS					
Current Assets:					
Cash and cash equivalents	$ 9,367		$ 9,367		$ 9,367
Accounts receivable, net of allowance for doubtful accounts	311,352		311,352		311,352
Current deferred tax asset	44,135		44,135		44,135
Prepaid income taxes	9,325		9,325	(2)	
Other current assets	23,561		23,561		23,561
Total Current Assets	397,740		397,740		
Property and equipment, net	469,681		469,681		469,681
Goodwill	1,506,531		1,506,531		1,506,531
Other identifiable intangibles	74,026		74,026		74,026
Assets held for sale	15,343		15,343		15,343
Other assets	49,840		49,840		49,840
Total Assets	$ 2,513,161		$ 2,513,161		
LIABILITIES AND STOCKHOLDERS EQUITY					
Current Liabilities:					
Bank overdrafts	$ 13,907		$ 13,907		$ 13,907
Current portion of long term debt and notes payable	10,053		10,053		10,053
Accounts payable	68,932		68,932		68,932
Accrued payroll	64,769		64,769		64,769
Accrued vacation	34,813		34,813		34,813
Accrued interest	15,830		15,830		15,830
Accrued restructuring	9,344		9,344		9,344
Accrued other	79,060		79,060		79,060
Due to third party payors	5,744		5,744		5,744
Total Current Liabilities	302,452		302,452		302,452
Long term debt, net of current portion	1,774,263		1,774,263	(2)	
	24,611		24,611		24,611

Non-current deferred tax liability					
Other non-current liabilities	67,989		67,989		67,989
Total Liabilities	2,169,315		2,169,315		
Minority interest in consolidated subsidiary companies	6,355		6,355		6,355
Preferred stock	509,469	(1)		(2)	
Stockholders Equity:					
Common stock	205	(1)		(2)	
Capital in excess of par	(289,777)	(1)		(2)	
Retained earnings	125,777	(1)		(2)	
Accumulated other comprehensive loss	(8,183)		(8,183)		(8,183)
Total Stockholders Equity	(171,978)				
Total Liabilities and Stockholders Equity	$ 2,513,161				

(footnotes begin on page 42)

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UNAUDITED PRO FORMA CONSOLIDATED STATEMENT OF OPERATIONS

	Year Ended December 31, 2007				
	Historical	Preferred Stock Conversion and Reverse Stock Split	Pro Forma	Adjustments for Offering	Pro Forma As Adjusted
	(in thousands, except per share data)				
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			$		$
Weighted average basic common shares outstanding					
Diluted income per common share			$		$
Weighted average diluted common shares outstanding					

(footnotes begin on page 42)

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UNAUDITED PRO FORMA CONSOLIDATED STATEMENT OF OPERATIONS

	Nine Months Ended September 30, 2008				
	Historical	Preferred Stock Conversion and Reverse Stock Split	Pro Forma	Adjustments for Offering	Pro Forma As Adjusted
	(in thousands, except per share data)				
Net operating revenues	$ 1,606,263		$ 1,606,263		$ 1,606,263
Operating expenses	1,414,165		1,414,165		1,414,165
Depreciation and amortization	53,175		53,175		53,175
Total costs and expenses	1,467,340		1,467,340		1,467,340
Income from operations	138,923		138,923		138,923
Interest expense, net	(109,328)		(109,328)	(4)	
Income before minority interests and income taxes	29,595		29,595		
Minority interests in consolidated subsidiary companies	2,103		2,103		2,103
Income before income taxes	27,492		27,492		
Income tax expense	13,862		13,862	(4)	
Net income	13,630		13,630		
Less: Preferred dividends	18,569	(3)		(4)	
Net loss available to stockholders	$ (4,939)	$	$	$	$
Basic loss per common share			$		$
Weighted average basic common shares outstanding					
Diluted income per common share			$		$
Weighted average diluted common shares outstanding					

(footnotes begin on page 42)

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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:

(i) 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 $ million in cash upon the consummation of the offering;

(ii) a deemed dividend of $ million for the value of the contingent beneficial conversion feature associated with our preferred stock; and

(iii) the assumed 1 for reverse split for our common stock to occur prior to the closing of the offering.

(2) We reflected:

(i) our issuance of shares assuming this offering had occurred on September 30, 2008;

(ii) the repayment of $ million of loans outstanding under our senior secured credit facilities;

(iii) the payments under the Long Term Cash Incentive Plan in the amount of $ million reduced by $ million of income tax benefit;

(iv) the payment of $ million 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.

(3) We reflected the elimination of $ million and $ million for the year ended December 31, 2007 and the nine months ended September 30, 2008, respectively, 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.

(4) We reflected:

(i) the reduction in interest expense of $ million and $ million for the year ended December 31, 2007 and the nine months ended September 30, 2008 for the repayment of $ million 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 nine months ended September 30, 2008, respectively, related to the reduction in interest expense.

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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 September 30, 2008, we operated 88 long term acute care hospitals and four acute medical rehabilitation hospitals in 25 states, and 965 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 $1,606.3 million for the nine months ended September 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 nine months ended September 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.

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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 of $100.0 million under an incremental term loan, borrowings of $100.0 million under our revolving credit facility and the balance with 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.

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

Nine Months Ended September 30, 2008

For the nine months ended September 30, 2008, our net operating revenues increased 9.0% to $1,606.3 million compared to $1,473.7 million for the nine months ended September 30, 2007. This increase in net operating revenues resulted from a 6.9% increase in our specialty hospital net operating revenue and a 14.4% 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 nine months ended September 30, 2008 of $138.9 million compared to $152.2 million for the nine months ended September 30, 2007. The decline in income from operations is

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primarily attributable to the operating losses incurred in our specialty hospitals opened in 2007 and 2008 and a decline in the operating performance at the outpatient rehabilitation clinics acquired from HealthSouth Corporation. Our interest expense for the nine months ended September 30, 2008 was $109.6 million compared to $103.6 million for the nine months ended September 30, 2007. The increase in interest expense is related to higher average outstanding debt balances existing for the nine month period ended September 30, 2008 which resulted primarily from borrowings to finance the HealthSouth transaction, offset by the effect of declining interest rates in 2008. Cash flow from operations provided $34.0 million of cash for the nine months ended September 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 regulatory changes related to long term acute care hospitals, or LTCHs. 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 rulemaking procedures of the Centers for Medicare & Medicaid Services, or CMS. 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 rules related to the inpatient prospective payment system, or IPPS, that are typically proposed in May, finalized in August and effective on October 1st of each year. In

the annual payment rate update for the 2009 fiscal year, CMS consolidated the annual updates into one annual update. The final rule adopted a 15-month rate update for fiscal year 2009 and moves the LTCH-PPS from a July-June update cycle to an October-September cycle. Beginning fiscal year 2010 the LTCH rate year will begin October 1, coinciding with the start of the federal fiscal year.

August 2004 Final Rule. On August 11, 2004, CMS published final regulations applicable to LTCHs that are operated as hospital within hospitals or as satellites. We collectively refer to hospital 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, 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, metropolitan statistical areas, or 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 Medicare, Medicaid, and SCHIP Extension Act of 2007, or 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 relative weights for the long term care diagnosis-related group, or LTC-DRG. 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. 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 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 short stay outlier, or 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).

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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 diagnosis-related groups, or 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 average length of stay plus one standard deviation for

the same DRG under IPPS, referred to as the so-called 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

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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.

August 2008 Final Rule. On August 19, 2008, CMS published the IPPS final rule for FY 2009 (affecting discharges and cost reports beginning on or after October 1, 2008 and before October 1, 2009), which made limited revisions to the classifications of cases in Medicare severity long term care diagnosis-related groups (MS-LTC-DRGs). The final rule also includes a number of hospital ownership and physician referral provisions, including a proposal to expand a hospital s disclosure obligations by requiring physician-owned hospitals to disclose ownership or investment interests held by immediate family members of a referring physician. The final rule requires physician-owned hospitals to furnish to patients, on request, a list of physicians or immediate family members who own or invest in the hospital. Moreover, a physician-owned hospital must require all physician owners or investors who are also active members of the hospital s medical staff to disclose in writing their ownership or investment interests in the hospital to all patients they refer to the hospital. CMS can terminate the Medicare provider agreement of a physician-owned hospital if it fails to comply with these disclosure provisions or with the requirement that a hospital disclose in writing to all patients

whether there is a physician on-site at the hospital 24 hours per day, 7 days per week.

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 September 30, 2008, we have internally developed 59 specialty hospitals and

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258 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 new LTCH development, except for LTCHs currently under construction that are excluded from the moratorium. In addition, we will continue to evaluate opportunities to develop new inpatient rehabilitation hospitals. The moratorium will not, however, apply to LTCHs acquired by us in the future so long as those LTCHs were in existence prior to December 29, 2007. 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 49% of net operating revenues for the nine months ended September 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 66% of our specialty hospital revenues for the nine months ended September 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 nine months ended September 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 from Medicare instead of being paid on an individual claim basis. Under a periodic interim 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 periodic interim 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

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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 September 30, 2008, deductibles, co-payments and self-insured amounts owed by patients accounted for approximately 0.4% 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 September 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	$ 110,745	$ 14,738
Commercial insurance, and other	116,552	66,907	175,152	60,052	172,154	72,578
Total net accounts receivable	$ 173,110	$ 82,123	$ 252,079	$ 75,183	$ 282,899	$ 87,316

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 September 30,
	2006	2007	2008
0 to 90 days	67.8%	77.0%	76.4%
91 to 180 days	10.8%	10.0%	8.5%
181 to 365 days	8.4%	6.0%	8.5%
Over 365 days	13.0%	7.0%	6.6%
Total	100.0%	100.0%	100.0%

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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 September 30,
	2006	2007	2008
Insured receivables	99.1%	99.7%	99.6%
Self-pay receivables (including deductibles and copayments)	0.9%	0.3%	0.4%
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 September 30, 2008, December 31, 2007 and December 31, 2006, we have recorded a liability of $65.9 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 $2.6 million for the nine months ended September 30, 2008 and $1.7 million for the nine months ended September 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 September 30, 2008 amount to $46.4 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

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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 September 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 $17.3 million of valuation reserves related primarily to state and federal tax net operating losses that may not be realized at December 31, 2007 and September 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 September 30, 2008 was $ million, and the aggregate intrinsic value of our unvested outstanding stock options and restricted stock as of September 30, 2008 was $ million. 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. The fair value of the common stock has generally been determined contemporaneously with the grants. 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.

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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

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	Nine Months Ended September 30,	
	2007	2008
Specialty hospital data[1]:		
Number of hospitals start of period	96	87
Number of hospitals acquired		2
Number of hospital start-ups	3	5
Number of hospitals closed	(4)	(1)
Number of hospitals consolidated	(4)	(1)
Number of hospitals end of period	91	92
Available licensed beds	3,934	4,144
Admissions	30,095	30,891
Patient days	741,959	756,093
Average length of stay (days)	25	25
Net revenue per patient day[2]	$ 1,367	$ 1,434
Occupancy rate	69%	68%
Percent patient days Medicare	70%	66%
Outpatient rehabilitation data:		
Number of clinics owned start of period	477	918
Number of clinics acquired	542	3
Number of clinic start-ups	6	12
Number of clinics closed/sold	(113)	(46)
Number of clinics owned end of period	912	887
Number of clinics managed end of period	109	78
Total number of clinics (all) end of period	1,021	965
Number of visits	2,887,134	3,430,138
Net revenue per visit[5]	$ 100	$ 102

(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.

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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	Combined Year Ended December 31, 2005
		(in thousands)	
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)

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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%

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	Nine Months Ended September 30,	
	2007	2008
Net operating revenues	100.0%	100.0%
Cost of services[(2)]	82.7	83.6
General and administrative	2.4	2.2
Bad debt expense	1.7	2.2
Depreciation and amortization	2.9	3.3
Income from operations	10.3	8.7
Interest expense, net	(6.9)	(6.8)
Income from operations before minority interests and income taxes	3.4	1.9
Minority interests	0.1	0.1
Income from operations before income taxes	3.3	1.8
Income tax expense	1.4	0.9
Net income	1.9%	0.9%

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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		

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	Nine Months Ended September 30,		
	2007	2008	% Change
	(in thousands)		
Net operating revenues:			
Specialty hospitals	$ 1,033,533	$ 1,104,731	6.9%
Outpatient rehabilitation	438,356	501,375	14.4
Other[4]	1,809	157	(91.3)
Total company	$ 1,473,698	$ 1,606,263	9.0%
Income (loss) from operations:			
Specialty hospitals	$ 141,027	$ 134,985	(4.3)%
Outpatient rehabilitation	47,553	42,354	(10.9)
Other[4]	(36,387)	(38,416)	(5.6)
Total company	$ 152,193	$ 138,923	(8.7)%
Adjusted EBITDA:[3]			
Specialty hospitals	$ 168,367	$ 167,617	(0.4)%
Outpatient rehabilitation	60,270	60,248	0.0
Other[4]	(31,593)	(34,070)	(7.8)
Adjusted EBITDA margins:[3]			
Specialty hospitals	16.3%	15.2%	(6.7)%
Outpatient rehabilitation	13.7	12.0	(12.4)
Other[4]	N/M	N/M	N/M
Total assets:			
Specialty hospitals	$ 1,853,728	$ 1,900,485	
Outpatient rehabilitation	483,386	502,943	
Other[4]	121,126	109,733	
Total company	$ 2,458,240	$ 2,513,161	
Purchases of property and equipment, net:			
Specialty hospitals	$ 115,344	$ 23,385	
Outpatient rehabilitation	9,655	10,048	
Other[4]	2,898	2,337	
Total company	$ 127,897	$ 35,770	

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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%

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	Nine Months Ended September 30,	
	2007	2008
	(in thousands)	
Net operating revenue		
Specialty hospitals net operating revenue	$ 1,033,533	$ 1,104,731
Less: Specialty hospitals in development, opened or closed after 1/1/07	60,141	47,820
Specialty hospitals same store net operating revenue	$ 973,392	$ 1,056,911
Adjusted EBITDA(3)		
Specialty hospitals Adjusted EBITDA(3)	$ 168,367	$ 167,617
Less: Specialty hospitals in development, opened or closed after 1/1/07	(3,886)	(16,109)
Specialty hospitals same store Adjusted EBITDA(3)	$ 172,253	$ 183,726
All specialty hospitals Adjusted EBITDA margin(3)	16.3%	15.2%
Specialty hospitals same store Adjusted EBITDA margin(3)	17.7%	17.4%

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 September 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.

Nine Months Ended September 30, 2008 Compared to Nine Months Ended September 30, 2007

Net Operating Revenues

Our net operating revenues increased by 9.0% to $1,606.3 million for the nine months ended September 30, 2008 compared to $1,473.7 million for the nine months ended September 30, 2007.

Specialty Hospitals. Our specialty hospital net operating revenues increased 6.9% to $1,104.7 million for the nine months ended September 30, 2008 compared to $1,033.5 million for the nine months ended September 30, 2007. Net operating revenues for the specialty hospitals opened as of January 1, 2007 and operated by us throughout both periods increased 8.6% to $1,056.9 million for the nine months ended September 30, 2008 from $973.4 million for the nine months ended September 30, 2007. This increase was partially offset by the loss of revenues from closed hospitals, which accounted for $47.7 million of net operating revenues. Hospitals opened in 2007 and 2008 increased net operating revenues by $35.4 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 3.7% and was attributable to an increase in our non-Medicare patient days. The occupancy percentage in our same store hospitals remained constant at 70% for both the nine months ended

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September 30, 2008 and the nine months ended September 30, 2007. Our average net revenue per patient day in our same store hospitals increased 4.7% to $1,438 for the nine months ended September 30, 2008 from $1,374 for the nine months ended September 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 14.4% to $501.4 million for the nine months ended September 30, 2008 compared to $438.4 million for the nine months ended September 30, 2007. The number of patient visits in our outpatient rehabilitation clinics increased 18.8% for the nine months ended September 30, 2008 to 3,430,138 visits, compared to 2,887,134 visits for the nine months ended September 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 $102 for the nine months ended September 30, 2008 compared to $100 for the nine months ended September 30, 2007.

Other. Our other revenues were $0.2 million for the nine months ended September 30, 2008 compared to $1.8 million for the nine months ended September 30, 2007. These revenues relate to revenue from other non-healthcare services.

Operating Expenses

Our operating expenses increased by 10.5% to $1,414.2 million for the nine months ended September 30, 2008 compared to $1,279.5 million for the nine months ended September 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 88.0% for the nine months ended September 30, 2008 compared to 86.8% for the nine months ended September 30, 2007. Cost of services as a percentage of operating revenues was 83.6% for the nine months ended September 30, 2008 compared to 82.7% for the nine months ended September 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 opened in 2007 and 2008. Another component of cost of services is facility rent expense, which was $82.4 million for the nine months ended September 30, 2008 compared to $70.8 million for the nine months ended September 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 nine months ended September 30, 2008 compared to 2.4% for the nine months ended September 30, 2007. Our bad debt expense as a percentage of net operating revenues was 2.2% for the nine months ended September 30, 2008 compared to 1.7% for the nine months ended September 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 nine months ended September 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.

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA for our specialty hospitals decreased by 0.4% to $167.6 million for the nine months ended September 30, 2008 compared to $168.4 million for the nine months ended September 30, 2007. Our Adjusted EBITDA margins decreased to 15.2% for the nine months ended September 30, 2008 from 16.3% for the nine months ended September 30, 2007. The hospitals opened as of January 1, 2007 and operated by us throughout both periods had Adjusted EBITDA of $183.7 million for the nine months ended September 30, 2008, an increase of $11.5 million or 6.7% over the Adjusted EBITDA of these hospitals for the nine months ended September 30, 2007.

Our Adjusted EBITDA margin in these same store hospitals decreased to 17.4% for the nine months ended September 30, 2008 from 17.7% for the nine months ended September 30, 2007. The decrease in our adjusted EBITDA margin is principally related to the increase in bad debt expense. Our hospitals opened during

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2007 and 2008 incurred Adjusted EBITDA losses of $19.0 million and $6.7 million for the nine months ended September 30, 2008 and 2007, respectively.

Outpatient Rehabilitation. Adjusted EBITDA for our outpatient rehabilitation clinics was $60.2 million for the nine months ended September 30, 2008 compared to $60.3 million for the nine months ended September 30, 2007. Our Adjusted EBITDA margins decreased to 12.0% for the nine months ended September 30, 2008 from 13.7% for the nine months ended September 30, 2007. Our Adjusted EBITDA margins decreased for the nine months ended September 30, 2008 compared to the nine months ended September 30, 2007 due to lower margins generated by the outpatient rehabilitation clinics acquired from HealthSouth Corporation.

Other. The Adjusted EBITDA loss was $34.1 million for the nine months ended September 30, 2008 compared to an Adjusted EBITDA loss of $31.6 million for the nine months ended September 30, 2007 and was primarily related to our general and administrative expenses.

Income from Operations

For the nine months ended September 30, 2008 we had income from operations of $138.9 million compared to $152.2 million for the nine months ended September 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 $109.6 million for the nine months ended September 30, 2008 compared to $103.6 million for the nine months ended September 30, 2007. The increase in interest expense is related to higher average outstanding debt balances under Select s senior credit facility existing over the nine 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 $2.1 million for the nine months ended September 30, 2008 and $1.4 million for the nine months ended September 30, 2007.

Income Taxes

We recorded income tax expense of $13.9 million for the nine months ended September 30, 2008. The expense represented an effective tax rate of 50.4%. For the nine months ended September 30, 2007 we recorded income tax expense of $20.3 million. This expense represented an effective tax rate of 41.4%. The increase in the effective rate resulted from the accrual of additional reserves and interest related to the Company s uncertain tax positions. Additionally, for the nine months ended September 30, 2007 our rate was further reduced as a result of realizing greater than expected tax benefits on the sale of equipment and certain subsidiaries.

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

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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 HeathSouth 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

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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.

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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

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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

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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 91/2% senior subordinated notes due 2009 and all of its 71/2% senior subordinated notes due 2013. Upon completion of the tender offers on February 24, 2005, all $175.0 million of the 71/2% senior subordinated notes were tendered and $169.3 million of the $175.0 million of 91/2% 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.

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Liquidity and Capital Resources

Nine Months Ended September 30, 2007 and September 30, 2008

The following table summarizes the statement of cash flows of Holdings and Select for the nine months ended September 30, 2007 and 2008:

	Nine Months Ended September 30,	
	2007	2008
	(in thousands)	
Cash flows provided by operating activities	$ 55,020	$ 33,973
Cash flows used in investing activities	(326,045)	(40,578)
Cash flows provided by financing activities	199,528	11,443
Net increase (decrease) in cash and cash equivalents	(71,497)	4,838
Cash and cash equivalents at beginning of period	81,600	4,529
Cash and cash equivalents at end of period	$ 10,103	$ 9,367

Our operating activities provided $34.0 million and $55.0 million of cash flow for the nine months ended September 30, 2008 and September 30, 2007, respectively. The principal reason for the decline in our operating cash flow was the increase in our accounts receivable. Our days sales outstanding were 55 days at September 30, 2008 and 48 days at December 31, 2007. The increase in days sales outstanding between December 31, 2007 and September 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 $40.6 million of cash flow for the nine months ended September 30, 2008. The primary use of cash was $35.8 million related to the purchase of property and equipment and $7.4 million related to the acquisition of businesses and the final settlement of the purchase price for the acquisition of the outpatient rehabilitation division of HealthSouth Corporation. These cash outflows were offset by proceeds of $2.6 million related to the sale of a minority interest in a specialty hospital and sale of real property. Investing activities used $326.0 million of cash flow for the nine months ended September 30, 2007. The primary use of cash was for building improvements and equipment purchases of $127.9 million and acquisition payments of $214.0 million for the purchase of HealthSouth s outpatient rehabilitation division, offset in part by aggregate proceeds of $12.4 million from a sale of business units and a building.

Our financing activities provided $11.4 million of cash flow for the nine months ended September 30, 2008. The primary source of cash related to borrowings, net of repayments, on our senior secured credit facility of $24.9 million, offset by repayment of bank overdrafts of $7.2 million, principal payments on seller and other debt of $4.0 million, repurchase of common and preferred stock of $0.6 million and distributions to minority interests of $1.7 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. Our financing activities provided $199.5 million of cash for the nine months ended September 30, 2007. The primary source of cash related to borrowings on our senior credit facility net of repayments of $195.2 million and offset by distributions to minority interests of $1.5 million. The primary purpose of the borrowings under our senior credit facility was to fund the acquisition of

HealthSouth s outpatient rehabilitation division.

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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

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$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 $95.3 million at September 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

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September 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 1.85 to 1.00 for such period. As of September 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 5.76 to 1.00 as of September 30, 2008. On a pro forma as adjusted basis, for the four quarters ended September 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 September 30, 2008, we had $121.0 million of revolving loan availability under our senior secured credit facility (after giving effect to $29.0 million of outstanding letters of credit). On a pro forma as adjusted basis as of September 30, 2008 we had $ million of revolving loan availability under our senior secured credit facility (after giving effect to $29.0 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 8.8% and the fixed rate after the swap was 10.2% at September 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 may from time to time seek to retire or purchase our outstanding debt through cash purchases and/or exchanges for equity securities, in open market purchases, privately negotiated transactions or otherwise. Such repurchases or exchanges, if any, will depend on prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. The amounts involved may be material.

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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. Our lenders, including the lenders participating in our senior secured credit facility, may have suffered losses related to their lending and other financial relationships, especially because of the general weakening of the national economy and increased financial instability of many borrowers. As a result, lenders may become insolvent or tighten their lending standards, which could make it more difficult for us to borrow under our revolving credit facility or to obtain other financing on favorable terms or at all. Our financial condition and results of operations would be adversely affected if we were unable to draw funds under our senior secured credit facility because of a lender default or to obtain other cost-effective financing.

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.

		Payments Due by Year			
Contractual Obligations	**Total**	**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

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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 October 2008, the FASB issued FSP FAS 157-3, Determining the Fair Value of a Financial Asset When the Market for That Asset Is Not Active (FSP FAS 157-3). FSP FAS 157-3 clarifies the application of SFAS No. 157, Fair Value Measurements (SFAS No. 157), in a market that is not active and provides an example to illustrate key considerations in determining the fair value of a financial asset when the market for that financial asset is not active. FSP FAS 157-3 is effective upon issuance, including prior periods for which financial statements have not been issued. Revisions resulting from a change in the valuation technique or its application should be accounted for as a change in accounting estimate following the guidance in SFAS No. 154, Accounting Changes and Error Corrections. FSP FAS 157-3 is effective for the financial statements included in our quarterly report for the period ended September 30, 2008. The application of FSP FAS 157-3 had no impact on our consolidated financial statements.

In June 2008, the Financial Accounting Standards Board (FASB) issued FASB Staff Position (FSP) EITF 03-6-1, Determining Whether Instruments Granted in Share-Based Payment Transactions are Participating Securities (FSP EITF 03-6-1). This FSP addresses whether instruments granted in share-based payment transactions are participating securities prior to their vesting and therefore need to be included in the earnings per share calculation under the two-class method described in Statement of Financial Accounting Standards (SFAS) No. 128, Earnings per Share. FSP EITF 03-6-1 requires companies to treat unvested share-based payment awards that have non-forfeitable rights to dividends or dividend equivalents as participating securities and thus, include them in the calculation of basic earnings per share. FSP EITF 03-6-1 is effective for fiscal years beginning after December 15, 2008. Upon adoption of FSP EITF 03-6-1, we will be required to include its unvested restricted stock in its computation of basic earnings per share. The Company believes that the adoption of FSP EITF 03-6-1 will not materially impact its basic earnings per share computation.

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

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No. 133, or SFAS No. 161. 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

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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 September 30, 2008, we had $808.2 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.

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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 September 30, 2008, we operated 88 long term acute care hospitals, or LTCHs and four inpatient rehabilitation facilities, or IRFs in 25 states, and 965 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 76% of our income from operations from our specialty hospital segment; and approximately 30% and 31% of net operating revenues and 24% and 24% of our income from operations from our outpatient rehabilitation segment, for year ended December 31, 2007 and the nine months ended September 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 September 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 nine months ended September 30, 2008, approximately 65% and 63%, respectively, of the net operating revenues of our specialty hospital segment came from Medicare reimbursement. As of September 30, 2008, we operated a total of 4,144 available licensed beds and employed approximately 12,500 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 nine months ended September 30,

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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. The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities 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 as hospitals within hospitals or as satellites, which we collectively refer to as HIHs. 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

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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 September 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 long term acute care hospitals, referred to as LTCH-PPS. Under LTCH-PPS, a long term acute care hospital is paid a pre-determined fixed amount depending upon the long term care diagnosis-related group, or 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 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.

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 September 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 the Commission on Accreditation of Rehabilitation Facilities. One of our inpatient rehabilitation facilities has not yet been surveyed by the Commission on Accreditation of Rehabilitation Facilities. 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;

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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 Medicare, Medicaid, and SCHIP Extension Act of 2007, or 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 speciality 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 965 facilities throughout 37 states and the District of Columbia, as of September 30, 2008. Typically, each of our clinics is located in a medical complex or retail location. As of September 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

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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.

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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 nine months ended September 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 3,790 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 nine months ended September 30, 2008. In our outpatient rehabilitation segment, we operated 965 outpatient rehabilitation clinics in 37 states and the District of Columbia and derived approximately 31% of net operating revenues from these operations, for the nine months ended September 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.

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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 the Centers for Medicare & Medicaid Services, or 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 Medical Payment Advisory Commission. 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:

	Year Ended December 31,			Nine Months Ended September 30,	
Net Operating Revenues by Payor Source[1]	**2005[2]**	**2006**	**2007**	**2007**	**2008**
Medicare	56.4%	53.2%	48.0%	49.1%	45.9%
Commercial insurance[3]	36.8%	40.0%	44.2%	43.2%	46.6%
Private and other[4]	4.7%	5.0%	5.5%	5.4%	5.5%
Medicaid	2.1%	1.8%	2.3%	2.3%	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.

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(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 25 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 $ 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

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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.

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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 September 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 Management s Discussion and Analysis of Financial Condition and Results of Operations Recent Trends and Events Acquisition of HealthSouth Corporation s Outpatient Rehabilitation Division.

Employees

As of September 30, 2008, we employed approximately 21,500 people throughout the United States. A total of approximately 14,700 of our employees are full time and the remaining approximately 6,800 are part time employees. Outpatient, contract therapy and physical rehabilitation and occupational health employees totaled approximately 8,400 and specialty hospital employees totaled approximately 12,500. 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.

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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 three of our outpatient rehabilitation clinics and related offices, which, as of September 30, 2008, included 962 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 September 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 136,548 square feet and is located in Mechanicsburg, Pennsylvania. We lease several other administrative spaces related to administrative and operational support functions. As of September 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 September 30, 2008.

Hospital Name		City	State	Beds
Select Specialty Hospital	Birmingham	Birmingham	AL	38
Select Specialty Hospital	Fort Smith	Fort Smith	AR	34
Select Specialty Hospital	Little Rock	Little Rock	AR	43
Select Specialty Hospital	Arizona (Phoenix Downtown Campus)	Phoenix	AZ	33
Select Specialty Hospital	Phoenix	Phoenix	AZ	48
Select Specialty Hospital	Arizona (Scottsdale Campus)	Scottsdale	AZ	29
Select Specialty Hospital	Colorado Springs	Colorado Springs	CO	30
Select Specialty Hospital	Denver	Denver	CO	37
Select Specialty Hospital	Denver (South Campus)	Denver	CO	28
Select Specialty Hospital	Wilmington	Wilmington	DE	35
Select Specialty Hospital	Orlando (South Campus)	Edgewood	FL	40
Select Specialty Hospital	Gainesville	Gainesville	FL	44
Select Specialty Hospital	Palm Beach	Lake Worth	FL	60
Select Specialty Hospital	Miami	Miami	FL	47
Select Specialty Hospital	Orlando (North Campus)	Orlando	FL	35
Select Specialty Hospital	Panama City	Panama City	FL	30
Select Specialty Hospital	Pensacola	Pensacola	FL	54
Select Specialty Hospital	Tallahassee	Tallahassee	FL	29
Select Specialty Hospital	Atlanta	Atlanta	GA	27
Select Specialty Hospital	Augusta	Augusta	GA	80
Select Specialty Hospital	Savannah	Savannah	GA	40
Select Specialty Hospital	Quad Cities	Davenport	IA	50
Select Specialty Hospital	Beech Grove	Beech Grove	IN	40
Select Specialty Hospital	Evansville	Evansville	IN	60
Select Specialty Hospital	Fort Wayne	Fort Wayne	IN	32

Select Specialty Hospital	Indianapolis	Greenwood	IN	51

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Hospital Name		City	State	Beds
Select Specialty Hospital	Northwest Indiana	Hammond	IN	70
Select Specialty Hospital	Kansas City	Overland Park	KS	40
Select Specialty Hospital	Topeka	Topeka	KS	34
Select Specialty Hospital	Wichita	Wichita	KS	60
Select Specialty Hospital	Lexington	Lexington	KY	41
Select Specialty Hospital	Northwest Detroit	Detroit	MI	36
Select Specialty Hospital	Flint	Flint	MI	26
Select Specialty Hospital	Grosse Pointe	Grosse Pointe Farms	MI	30
Select Specialty Hospital	Kalamazoo	Kalamazoo	MI	25
Select Specialty Hospital	Macomb County	Mount Clemens	MI	36
Select Specialty Hospital	Western Michigan	Muskegon	MI	31
Select Specialty Hospital	Pontiac	Pontiac	MI	30
Select Specialty Hospital	Saginaw	Saginaw	MI	32
Select Specialty Hospital	Downriver	Taylor	MI	40
Select Specialty Hospital	Ann Arbor	Ypsilanti	MI	36
Select Specialty Hospital	Western Missouri	Kansas	MO	34
Select Specialty Hospital	Springfield	Springfield	MO	44
Select Specialty Hospital	St. Louis	St. Louis	MO	33
Select Specialty Hospital	Gulfport	Gulfport	MS	61
Select Specialty Hospital	Jackson	Jackson	MS	53
Select Specialty Hospital	Durham	Durham	NC	30
Select Specialty Hospital	Winston-Salem	Winston-Salem	NC	42
Select Specialty Hospital	Omaha (Central Campus)	Omaha	NE	52
Kessler Institute for Rehabilitation (Welkind Campus)		Chester	NJ	72
Select Specialty Hospital	Northeast New Jersey	Rochelle Park	NJ	62
Kessler Institute for Rehabilitation (North Campus)		Saddle Brook	NJ	102
Kessler Institute for Rehabilitation (West Campus)		West Orange	NJ	148
Select Specialty Hospital	Akron	Akron	OH	34
Select Specialty Hospital	Northeast Ohio (Canton Campus)	Canton	OH	30
Select Specialty Hospital	Cincinnati	Cincinnati	OH	36
Select Specialty Hospital	Columbus	Columbus	OH	152
Select Specialty Hospital	Columbus (Mt. Carmel Campus)	Columbus	OH	24
Select Specialty Hospital	Youngstown	Youngstown	OH	31
Select Specialty Hospital	Youngstown (Boardman Campus)	Youngstown	OH	20
Select Specialty Hospital	Zanesville	Zanesville	OH	35
Select Specialty Hospital	Oklahoma City	Oklahoma City	OK	72
Select Specialty Hospital	Tulsa	Tulsa	OK	30
Select Specialty Hospital	Tulsa/Midtown (Midtown Campus)	Tulsa	OK	56
Select Specialty Hospital	Tulsa/Midtown (Riverside Campus)	Tulsa	OK	44
Select Specialty Hospital	Central Pennsylvania (Camp Hill Campus)	Camp Hill	PA	31

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Hospital Name	City	State	Beds
Select Specialty Hospital Danville	Danville	PA	30
Select Specialty Hospital Erie	Erie	PA	50
Penn State Hershey Rehabilitation	Harrisburg	PA	32
Select Specialty Hospital Johnstown	Johnstown	PA	39
Select Specialty Hospital Laurel Highlands	Latrobe	PA	40
Select Specialty Hospital McKeesport	McKeesport	PA	30
Select Specialty Hospital Pittsburgh	Pittsburgh	PA	32
Select Specialty Hospital Central Pennsylvania (York Campus)	York	PA	23
Select Specialty Hospital Sioux Falls	Sioux Falls	SD	24
Select Specialty Hospital Tri-Cities	Bristol	TN	33
Select Specialty Hospital Knoxville	Knoxville	TN	35
Select Specialty Hospital North Knoxville	Knoxville	TN	33
Select Specialty Hospital Memphis	Memphis	TN	37
Select Specialty Hospital Nashville	Nashville	TN	47
Select Specialty Hospital Dallas/Ft Worth	Carrolton	TX	60
Select Specialty Hospital South Dallas	DeSoto	TX	100
Select Specialty Hospital Houston (Houston Heights)	Houston	TX	130
Select Specialty Hospital Houston (Houston Medical Center)	Houston	TX	86
Select Specialty Hospital Houston (Houston West)	Houston	TX	56
Select Specialty Hospital Longview	Longview	TX	32
Select Specialty Hospital Midland	Midland	TX	29
Select Specialty Hospital San Antonio	San Antonio	TX	44
Select Specialty Hospital Madison	Madison	WI	58
Select Specialty Hospital Milwaukee	Milwaukee	WI	34
Select Specialty Hospital Milwaukee (St Luke s Campus)	Milwaukee	WI	29
Select Specialty Hospital Charleston	Charleston	WV	32
Total Beds:			4,144

Legal Proceedings

On August 24, 2004, Clifford C. Marsden and Ming Xu filed a purported class action complaint in the United States District Court for the Eastern District of Pennsylvania on behalf of the public stockholders of Select against Martin F. Jackson, Robert A. Ortenzio, Rocco A. Ortenzio, Patricia A. Rice and Select. The complaint as later amended alleged, among other things, failure to disclose adverse information regarding a potential regulatory change affecting reimbursement for Select s services applicable to long term acute care hospitals operated as hospitals within hospitals. On October 25, 2007, the Court certified a class of investors who purchased Select stock between July 29, 2003 and May 11, 2004, inclusive. The Court also appointed class representatives and class counsel. On July 3, 2008, the parties reached a settlement in principle. The parties signed the settlement agreement on November 5, 2008 and it was filed with the Court on November 14, 2008. The settlement requires defendants to pay $5.0 million, which will be paid entirely by our insurer. The settlement is subject to both preliminary and final court approval.

We are subject to legal proceedings and claims that arise in the ordinary course of our business, which include malpractice claims covered under insurance policies, subject to 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 our opinion,

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the outcome of these actions will not have a material adverse effect on our financial position or results of operations. See Risk Factors Significant legal actions as well as the cost and possible lack of available insurance could subject us to substantial uninsured liabilities.

To cover claims arising out of the operations of our specialty hospitals and outpatient rehabilitation facilities, we maintain professional malpractice liability insurance and general liability insurance. We also maintain umbrella liability insurance covering claims which, due to their nature or amount, are not covered by or not fully covered by our other insurance policies. These insurance policies also do not generally cover punitive damages and are subject to various deductibles and policy limits. Significant legal actions as well as the cost and possible lack of available insurance could subject us to substantial uninsured liabilities.

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

Government Regulations

General

The healthcare industry is required to comply with many laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals and outpatient rehabilitation clinics meet various requirements, including those relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, safeguarding protected health information, compliance with building codes and environmental protection and healthcare fraud and abuse. These laws and regulations are extremely complex and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation. If we fail to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in the Medicare, Medicaid and other federal and state healthcare programs.

Licensure

Facility Licensure. Our healthcare facilities are subject to state and local licensing regulations ranging from the adequacy of medical care to compliance with building codes and environmental protection laws. In order to assure continued compliance with these various regulations, governmental and other authorities periodically inspect our facilities.

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

Professional licensure and corporate practice. Healthcare professionals at our hospitals and outpatient rehabilitation clinics are required to be individually licensed or certified under applicable state law. We take steps to ensure that our employees and agents possess all necessary licenses and certifications.

Some states prohibit the corporate practice of therapy so that business corporations such as ours are restricted from practicing therapy through the direct employment of therapists. The laws relating to corporate practice vary from state to state and are not fully developed in each state in which we have clinics. We believe that each of our outpatient therapy clinics complies with any current corporate practice prohibition of the state in which it is located. For example, in those states that apply the corporate practice prohibition, we either contract to obtain therapy services from an entity permitted to employ therapists or we manage the physical therapy practice owned by licensed therapists through which the therapy services are provided. However, in those states where we furnish our

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services through business corporations, future interpretations of the corporate practice prohibition, enactment of new legislation or adoption of new regulations could cause us to have to restructure our business operations or close our clinics in any such state. If new legislation, regulations or interpretations establish that our clinics do not comply with state corporate practice prohibition, we could be subject to civil, and perhaps criminal, penalties. Any such restructuring or penalties could have a material adverse effect on our business.

Certification. In order to participate in the Medicare program and receive Medicare reimbursement, each facility must comply with the applicable regulations of the United States Department of Health and Human Services relating to, among other things, the type of facility, its equipment, its personnel and its standards of medical care, as well as compliance with all applicable state and local laws and regulations. All of our specialty hospitals participate in the Medicare program. In addition, we provide the majority of our outpatient rehabilitation services through clinics certified by Medicare as rehabilitation agencies or rehab agencies.

Accreditation. Our hospitals receive accreditation from The Joint Commission. As of September 30, 2008, The Joint Commission had accredited all but six of our hospitals. These six hospitals not accredited have not yet undergone a survey by The Joint Commission. Three of our four inpatient rehabilitation facilities have also received accreditation from the Commission on Accreditation of Rehabilitation Facilities, an independent, not-for-profit organization which reviews and grants accreditation for rehabilitation facilities that meet established standards for service and quality. One of our inpatient rehabilitation facilities has not yet undergone a Commission on Accreditation of Rehabilitation Facilities survey.

Overview of U.S. and State Government Reimbursements

Medicare. The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and CMS. Net operating revenues generated directly from the Medicare program represented approximately 56% of our consolidated net operating revenues for the combined year ended December 31, 2005, 53% for the year ended December 31, 2006, and 48% for the year ended December 31, 2007. For the nine months ended September 30, 2008, we generated approximately 46% of our consolidated net operating revenues from Medicare.

The Medicare program reimburses various types of providers, including long term acute care hospitals, inpatient rehabilitation facilities and outpatient rehabilitation providers, using different payment methodologies. The Medicare reimbursement systems for long term acute care hospitals, inpatient rehabilitation facilities and outpatient rehabilitation providers, as described below, are different than the system applicable to general acute care hospitals. For general acute care hospitals, Medicare payments are made under an inpatient prospective payment system, or IPPS, under which a hospital receives a fixed payment amount per discharge (adjusted for area wage differences) using diagnosis-related groups, or DRGs. The general acute care hospital DRG payment rate is based upon the national average cost of treating a Medicare patient s condition in that type of facility. Although the average length of stay varies for each DRG, the average stay of all Medicare patients in a general acute care hospital is approximately six days. Thus, the prospective payment system for general acute care hospitals creates an economic incentive for those hospitals to discharge medically complex Medicare patients as soon as clinically possible. Effective October 1, 2005, CMS expanded its post-acute care transfer policy under which general acute care hospitals are paid on a per diem basis rather than the full DRG rate if a patient is discharged early to certain post-acute care settings, including LTCHs and IRFs. When a patient is discharged from selected DRGs to, among other providers, an LTCH, the general acute care hospital is reimbursed below the full DRG payment if the patient s length of stay is short relative to the geometric mean length of stay for the DRG. This policy originally applied to ten DRGs beginning in fiscal year 1999 and was expanded to additional DRGs in FY 2004 and a total of 182 DRGs effective October 1, 2005. The expansion

of this policy to patients in a greater number of DRGs could cause general acute care hospitals to delay discharging those patients to our long term acute care hospitals.

Long Term Acute Care Hospital Medicare Reimbursement. The Medicare payment system for long term acute care hospitals is based on a prospective payment system specifically applicable to LTCH-PPS. LTCH-PPS was established by CMS final regulations, or final regulations, published on August 30, 2002 by CMS, and applies

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to long term acute care hospitals for their cost reporting periods beginning on or after October 1, 2002. Under LTCH-PPS, each patient discharged from a long term acute care hospital is assigned to a distinct LTC-DRG and a long term acute care hospital will generally be paid a pre-determined fixed amount applicable to the assigned LTC-DRG (adjusted for area wage differences). The payment amount for each LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that LTC-DRG in a long term acute care hospital. Cases with unusually high costs, referred to as high cost outliers, receive a payment adjustment to reflect the additional resources utilized. Conversely, cases with a stay that is considerably shorter than the average length of stay, a short-stay outlier receive a reduction in payment. LTCH-PPS also includes special payment policies that adjust the payments for some patients based on the patient s length of stay, the facility s costs, whether the patient was discharged and readmitted and other factors. Congress required that the LTC-DRG payment rates maintain budget neutrality during the first years of the prospective payment system with total expenditures that would have been made under the previous reasonable cost-based payment system. The LTCH-PPS regulations permit CMS to make a one-time adjustment to correct any error CMS made in estimating the federal rate in the first year of LTCH-PPS.

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. LTCHs that fail to exceed an average length of stay of greater than 25 days during any cost reporting period will be paid under the general acute care hospital DRG-based reimbursement.

Prior to qualifying under the payment system applicable to long term acute care hospitals, a new long term acute care hospital initially receives payments under the general acute care hospital DRG-based reimbursement system. The long term acute care hospital must continue to be paid under this system for a minimum of six months while meeting certain Medicare long term acute care hospital requirements, the most significant requirement being an average Medicare length of stay of more than 25 days.

Regulatory Changes

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. For discharges during the cost reporting period that began 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%. 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%. For discharges during cost reporting periods beginning on or after October 1, 2007, the Medicare admissions threshold is 25%; however, the SCHIP Extension Act generally limits the application of the Medicare admission threshold to no lower than 50% for a three year period to commence on an LTCHs 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 (as defined by current regulations), the percentage threshold is no more than 75% during the same three cost reporting years. As used above, Fiscal

2004 Percentage means, with respect to any HIH, 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, but in no event is the Fiscal 2004 Percentage less than 25%. The HIH regulations also established exceptions to the Medicare admissions thresholds with respect

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to patients who reach outlier status at the host hospital, HIHs located in MSA dominant hospitals or HIHs located in rural areas.

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 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 short stay outlier, or 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. Payment for these patients had been 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 will decrease and the percentage based on the LTC-DRG component will increase.

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 the 2007 LTCH-PPS rate year; (2) the elimination of the surgical case exception to the three day or less interruption of stay policy (under the 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. CMS created twenty new DRGs and modified 32 others, including LTC-DRGs. Prior to the August 2006 final rule, certain HIHs that were in existence on or before September 30, 1995, and certain satellite facilities that were in existence on or before September 30, 1999, referred to as grandfathered HIHs or satellites, were not subject to certain HIH separateness and control requirements as long as the grandfathered HIHs or satellites continued to operate under the same terms and conditions, including the number of beds and square footage, in effect on September 30, 2003 (for grandfathered HIHs) or September 30, 1999 (for grandfathered satellites). These grandfathered HIHs were also not subject to the

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payment adjustments for discharged Medicare patients admitted from their host hospitals in excess of the specified percentage threshold, as discussed in the August 2004 rule above. The August 2006 final rule revised the regulations to provide grandfathered HIHs and satellites more flexibility in adjusting square footage upward or downward, or decreasing the number of beds without being subject to the separateness and control requirements and payment adjustment provisions. As of September 30, 2008, we operated two grandfathered HIHs.

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 average length of stay plus one standard deviation for the same DRG under IPPS, referred to as the so-called 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.

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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 rules are complex and the SCHIP Extension Act has postponed the implementation of certain of the May 2007 final rules. 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 rules 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.

Previously, the statutory definition of an LTCH focused on the facility having an average length of stay of greater than 25 days. The SCHIP Extension Act adds to the statutory requirements by defining an LTCH as a hospital primarily engaged in providing inpatient services to Medicare beneficiaries with medically complex conditions that require a long hospital stay. In addition, by definition, LTCHs must meet certain facility criteria, including (1) instituting a review process that screens patients for appropriateness of an admission and validates the patient criteria within 48 hours of each patient s subsequent admission, evaluates regularly their patients for continuation of care and assesses the available discharge options; (2) having active physician involvement with patient care that includes a physician

available on-site daily and additional consulting physicians on call; and (3) having an interdisciplinary team of health care professionals to prepare and carry out an individualized treatment plan for each patient. We do not expect that these changes will have any impact on the designation of our hospitals as LTCHs.

The SCHIP Extension Act requires the Secretary of the Department of Health and Human Services to conduct a study on the establishment of national LTCH facility and patient criteria for the purpose of determining medical necessity, appropriateness of admissions and continued stay at, and discharge from, LTCHs. The Secretary must submit a report on the results of this study to Congress within eighteen months following enactment of the SCHIP

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Extension Act. Both the study and the report are required to consider recommendations on LTCH-specific facility and patient criteria contained in a June 2004 report to Congress by the Medical Payment Advisory Commission.

As described above, 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%. 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. Additionally, an LTCH located in a state with only two LTCHs, may request an increase in licensed beds following the closure or decrease in the number of licensed beds at the other LTCH located within the state. 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.

Beginning with LTCH discharges on or after October 1, 2007 and through September 30, 2010 (unless extended by the Secretary), the SCHIP Extension Act also requires the Secretary to significantly expand medical necessity review for patients admitted to LTCHs by instituting a review of the medical necessity of continued stays of patients admitted to LTCHs. The medical necessity reviews must include a representative sample that results in a 95% confidence interval and guarantees that at least 75% of overpayments received by LTCHs for medically unnecessary admissions and continued stays are recovered and not counted toward an LTCH s Medicare average length of stay. The Secretary may use up to 40% of the recouped overpayments to compensate the fiscal intermediaries and Medicare administrative contractors for the costs of conducting medical necessity reviews.

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.

As provided in the SCHIP Extension Act, for discharges beginning on or after December 29, 2007 and before December 29, 2010, the RY 2008 short-stay outlier rule based on the IPPS comparable threshold does not apply. The RY 2008 rule required that 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 DRG were paid at an amount comparable to the IPPS per diem. IPPS comparable threshold is defined as cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS. For discharges occurring on or after April 1, 2008 through June 30, 2008, the revised RY 2008 standard federal rate is $38,086.04. In the only interpretation of the SCHIP Extension Act in the interim rule, CMS states that it is interpreting the term base rate to be the standard federal rate because we believe Congress meant to eliminate the 0.71% update from the RY 2008 standard federal rate. Finally, the revised high cost outlier fixed-loss amount for discharges occurring on or after

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April 1, 2008 through June 30, 2008 is $20,707, a decrease of $31 per discharge. CMS indicates that the other issues addressed in the SCHIP Extension Act will be discussed in a forthcoming regulation, including instructions concerning (1) the moratorium on the certification of new LTCHs and satellites and the expansion of beds in existing facilities and (2) implementing changes to the 25% admission threshold adjustment for LTCH patients admitted from certain referring hospitals for a three year period.

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. As required by the SCHIP Extension Act, CMS made certain changes to the payment adjustment policy in the May 2008 Interim Final Rule. Effective for cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010, CMS delayed the extension of the 25% threshold payment adjustment to grandfathered HIHs and free-standing LTCHs. Furthermore, CMS increased the patient percentage thresholds from 25% to 50% for certain LTCH HIH and satellite discharges admitted from a co-located hospital, and from 50% to 75% for certain LTCH HIH and satellite discharges at rural HIHs or admitted from a co-located MSA dominant or urban single hospital.

The May 2008 Interim Final Rule is effective December 29, 2007 as required by the SCHIP Extension Act; however, CMS previously extended the percentage threshold rule for cost reporting periods beginning on or after July 1, 2007. Accordingly, grandfathered LTCH HIHs and free-standing LTCHs with cost reporting periods beginning on or after July 1, 2007 but before December 29, 2007 remain subject to the percentage threshold requirements until the start of the next cost reporting year. These particular LTCHs are subject to, for one cost reporting period, a percentage threshold equal to the lesser of 75% or the percentage of the grandfathered HIH s or free-standing LTCH s admissions discharged from the referring hospital during its cost reporting period beginning on or after July 1, 2004 and before July 1, 2005. CMS will continue to apply the percentage threshold to grandfathered satellites for patients admitted from any individual hospital with which they are not co-located. In addition, LTCH HIHs and LTCH satellites that are not grandfathered remain subject to the percentage threshold for patients admitted from non-co-located hospitals. The SCHIP Extension Act did not delay or exclude these facilities from the percentage threshold applicable for cost reporting periods beginning on or after July 1, 2007. For LTCHs subject to the expanded percentage threshold a 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 (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, LTCHs subject to the expanded percentage threshold will be subject to the 25% threshold (or applicable threshold for rural, urban-single, or

MSA dominant hospitals).

In accordance with the SCHIP Extension Act, the May 2008 Interim Final Rule provides an exception for new LTCHs that, on or before December 29, 2007, (1) began the qualifying period for payment under the LTCH PPS, (2) have a binding 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

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an approved certificate of need. The May 2008 Interim Final Rule implements a moratorium on any increase of LTCH beds in existing LTCHs or LTCH satellites beginning on December 29, 2007 and continuing through December 28, 2010. CMS interprets the moratorium on new beds to apply only to the number of Medicare-certified beds at the hospital at the beginning of the moratorium period. The May 2008 Interim Final Rule also implements a narrow exception for new beds. LTCHs located in a state with only two LTCHs may request an increase in Medicare-certified beds following the closure or decrease in the number of beds at the other LTCH located within the state. CMS noted that the exception for an increase in beds does not apply to the limit on the number of beds in grandfathered LTCH HIHs or grandfathered LTCH satellites. A grandfathered facility would not be allowed to maintain its grandfathered status if it increases its number of beds under the exception.

August 2008 Final Rule. On August 19, 2008, CMS published the IPPS final rule for FY 2009 (affecting discharges and cost reports beginning on or after October 1, 2008 and before October 1, 2009), which made limited revisions to the classifications of cases in Medicare severity long term care diagnosis-related groups (MS-LTC-DRGs). The final rule also includes a number of hospital ownership and physician referral provisions, including a proposal to expand a hospital s disclosure obligations by requiring physician-owned hospitals to disclose ownership or investment interests held by immediate family members of a referring physician. The final rule requires physician-owned hospitals to furnish to patients, on request, a list of physicians or immediate family members who own or invest in the hospital. Moreover, a physician-owned hospital must require all physician owners or investors who are also active members of the hospital s medical staff to disclose in writing their ownership or investment interests in the hospital to all patients they refer to the hospital. CMS can terminate the Medicare provider agreement of a physician-owned hospital if it fails to comply with these disclosure provisions or with the requirement that a hospital disclose in writing to all patients whether there is a physician on-site at the hospital 24 hours per day, 7 days per week.

Because the LTCH-PPS rules are complex and are based, in part, on the volume of Medicare admissions from our host hospitals and free-standing 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, we expect the financial impact to increase as the Medicare admissions thresholds decline during the phase-in of the regulations.

Medicare Reimbursement of Outpatient Rehabilitation Services. Beginning on January 1, 1999, the Balanced Budget Act of 1997 subjected certain outpatient therapy providers reimbursed under the Medicare physician fee schedule to annual limits for therapy expenses. Effective January 1, 2008, the annual limit on outpatient therapy services is $1,810 for combined physical and speech language pathology services and $1,810 for occupational therapy services. In the Deficit Reduction Act of 2005, Congress implemented an exceptions process to the annual limit for therapy expenses. Under this process, a Medicare enrollee (or person acting on behalf of the Medicare enrollee) is 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 exceptions process through June 30, 2008. The Medicare Improvements for Patients and Providers Act of 2008 further extended the cap exceptions process through December 31, 2009. CMS released the final rule for the 2009 Medicare physician fee schedule on October 30, 2008. The final rule increases the annual per beneficiary cap on outpatient therapy services for 2009 to $1,840 for combined physical therapy and speech language pathology services and $1,840 for occupational therapy services. The final rule also extends the exiting therapy cap exceptions process through December 31, 2009 as authorized by Congress, updates the conversion factor, and makes adjustments to the relative value units. Prior to implementing the exceptions process to the therapy caps, only hospitals could bill for outpatient rehabilitation services that exceeded the annual caps. Elimination of the therapy cap exceptions may reduce our future net operating revenues and profitability.

Historically, outpatient rehabilitation services have been subject to scrutiny by the Medicare program for, among other things, medical necessity for services, appropriate documentation for services, supervision of therapy aides and students and billing for group therapy. CMS has issued guidance to clarify that services performed by a student are not

reimbursed even if provided under line of sight supervision of the therapist. Likewise, CMS has reiterated that Medicare does not pay for services provided by aides regardless of the level of supervision. CMS also has issued instructions that outpatient physical and occupational therapy services provided simultaneously to two or more individuals by a practitioner should be billed as group therapy services.

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Medicare Reimbursement of Inpatient Rehabilitation Facility Services. Inpatient rehabilitation facilities are paid under a prospective payment system specifically applicable to this provider type, which is referred to as IRF-PPS. Under the IRF-PPS, each patient discharged from an inpatient rehabilitation facility is assigned to a case mix group or IRF-CMG containing patients with similar clinical problems that are expected to require similar amounts of resources. An inpatient rehabilitation facility is generally paid a pre-determined fixed amount applicable to the assigned IRF-CMG (subject to applicable case adjustments related to length of stay and facility level adjustments for location and low income patients). The payment amount for each IRF-CMG is intended to reflect the average cost of treating a Medicare patient s condition in an inpatient rehabilitation facility relative to patients with conditions described by other IRF-CMGs. The IRF-PPS also includes special payment policies that adjust the payments for some patients based on the patient s length of stay, the facility s costs, whether the patient was discharged and readmitted and other factors. As required by Congress, IRF-CMG payments rates have been set to maintain budget neutrality with total expenditures that would have been made under the previous reasonable cost based system. The IRF-PPS was phased in over a transition period in 2002. For cost reporting periods beginning on or after October 1, 2002, inpatient rehabilitation facilities are paid solely on the basis of the IRF-PPS payment rate.

Although the initial IRF-PPS regulations did not change the criteria that must be met in order for a hospital to be certified as an inpatient rehabilitation facility, CMS adopted a separate final rule on May 7, 2004 that made significant changes to those criteria. The new inpatient rehabilitation facility certification criteria became effective for cost reporting periods beginning on or after July 1, 2004. Under the historic 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 as well as 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 regulation. 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 the percentage of inpatient rehabilitation facilities in compliance with the 75% test might be low. In response, in June 2002, CMS suspended enforcement of the 75% test and, on September 9, 2003, proposed modifications to the regulatory standards for certification as an inpatient rehabilitation facility. In addition, during 2003, several CMS contractors, promulgated draft local medical review policies that would change the guidelines used to determine the medical necessity for inpatient rehabilitation care.

CMS adopted four major changes to the 75% test in its May 7, 2004 final rule. First, CMS temporarily lowered the 75% compliance threshold, as follows: (1) 50% for cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005; (2) 60% for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006; (3) 65% for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007; and (4) 75% for cost reporting periods beginning on or after July 1, 2007. Second, CMS modified and expanded from ten to thirteen the medical conditions used to determine whether a hospital qualifies as an inpatient rehabilitation facility. Third, the agency finalized the conditions under which comorbidities can be used to verify compliance with the 75% test. Fourth, CMS changed the timeframe used to determine compliance with the 75% test from the most recent 12-month cost reporting period to the most recent, consecutive, and appropriate 12-month period, with the result that a determination of non-compliance with the applicable compliance threshold will affect the facility s certification for its cost reporting period that begins immediately after the 12-month review period.

Congress temporarily suspended CMS enforcement of the 75% test under the Consolidated Appropriations Act, 2005, enacted on December 8, 2004, which required the Secretary to respond within 60 days to a study by the Government Accountability Office on the standards for defining inpatient rehabilitation services before the Secretary may use funds appropriated under the Act to redesignate as a general acute care hospital any hospital that was certified as an inpatient rehabilitation facility on or before June 30, 2004 as a result of the hospital s failure to meet the 75% test. The Government Accountability Office issued its study 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 Government Accountability Office study on June 24, 2005 in which it concluded that the revised inpatient rehabilitation facility certification standards, including the 75% test, were not inconsistent with the recommendations in the Government Accountability Office report. In light of this determination, the Secretary announced that CMS would immediately begin enforcement of the revised certification standards.

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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 increases to 65% for cost reporting periods beginning on or after July 1, 2007 and again to 75% for cost reporting periods beginning on or after July 1, 2008. The regulatory text was revised accordingly in the final rule updating the prospective payment rates for fiscal year 2007, as published by CMS on August 18, 2006. In the August 2006 final rule updating IRF-PPS, CMS also reduced the standard payment amount by 2.6% and updated the outlier threshold for fiscal year 2007 to $5,534. In the August 2007 final rule updating IRF-PPS, the compliance threshold increased to 65% for cost reporting periods beginning on or after July 1, 2007 and again to 75% for cost reporting periods beginning on or after July 1, 2008. As stipulated in the August 2007 final rule, for cost reporting periods beginning on or after July 1, 2008 comorbidities would not be used to determine whether an IRF meets the 75% test.

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 payment freeze from April 1, 2008 through September 30, 2009. In order to comply with Medicare inpatient rehabilitation facility certification criteria, it may be necessary for our IRFs to implement restrictive admissions policies and not admit patients whose diagnoses fall outside the thirteen specified conditions. Such policies may result in reduced patient volumes, which could have a negative effect on financial performance.

In addition to meeting the compliance threshold, a hospital must meet other facility criteria to be classified as an IRF, including: (1) a provider agreement to participate as a hospital in Medicare; (2) a preadmission screening procedure; (3) ensuring that patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services; (4) a full-time, qualified director of rehabilitation; (5) a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; (6) a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient s medical record to note the patient s status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment. Failure to comply with any of the classification criteria, including the compliance threshold, may cause a hospital to lose its exclusion from the prospective payment system that applies to general acute care hospitals and, as a result, no longer be eligible for payment at a higher rate.

The SCHIP Extension Act requires the Secretary, in consultation with providers, trade organizations and the Medical Payment Advisory Commission, to prepare an analysis of the compliance threshold for the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate. Among other things, the analysis must include the potential effect of the 75% rule on access to care, alternatives to the 75% rule policy for certifying inpatient rehabilitation hospitals, and the appropriate setting of care for conditions of patients commonly admitted to IRFs that are not one of the 13 specified conditions. In requiring the Secretary to produce a recommendation for classifying IRFs, Congress used the term 75% rule for the first time to describe the compliance threshold requirement, while at the same time freezing the threshold at 60%. The results of this analysis may impact future policies, regulations and statutes governing IRF-PPS.

August 2008 Final Rule. On August 8, 2008, CMS published the final rule for the inpatient rehabilitation facility prospective payment system (IRF PPS) for FY 2009. The final 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 percent (with comorbidities counting toward this threshold). In addition to updating the various values that compose the IRF-PPS, the final rule updates the outlier threshold amount to $10,250. CMS also updated the CMG relative weights and average length of stay values.

Specialty Hospital Medicaid Reimbursement. The Medicaid program is designed to provide medical assistance to individuals unable to afford care. The program is governed by the Social Security Act of 1965 and administered and funded jointly by each individual state government and CMS. Medicaid payments are made under a number of different systems, which include cost based reimbursement, prospective payment systems or programs that negotiate payment levels with individual hospitals. In addition, Medicaid programs are subject to

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statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may increase or decrease the level of program payments to our hospitals. Net operating revenues generated directly from the Medicaid program represented approximately 3.0% of our specialty hospital net operating revenues for the year ended December 31, 2007 and approximately 2.8% for the nine months ended September 30, 2008.

Workers Compensation. Net operating revenues generated directly from Workers compensation programs represented approximately 21.6% of our net operating revenue from outpatient rehabilitation services for the year ended December 31, 2007 and 20.3% for the nine months ended September 30, 2008. Workers compensation is a state mandated, comprehensive insurance program that requires employers to fund or insure medical expenses, lost wages and other costs resulting from work related injuries and illnesses. Workers compensation benefits and arrangements vary on a state-by-state basis and are often highly complex. In some states, payment for services covered by workers compensation programs are subject to cost containment features, such as requirements that all workers compensation injuries be treated through a managed care program, or the imposition of payment caps. In addition, these workers compensation programs may impose requirements that affect the operations of our outpatient rehabilitation services.

Other Healthcare Regulations

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

From time to time, various federal and state agencies, such as the Office of the Inspector General of the Department of Health and Human Services, issue a variety of pronouncements, including fraud alerts, the Office of Inspector General s Annual Work Plan and other reports, identifying practices that may be subject to heightened scrutiny. These pronouncements can identify issues relating to long term acute care hospitals, inpatient rehabilitation facilities or outpatient rehabilitation services or providers. For example, the Office of Inspector General s 2005 Work Plan describes plans to study whether patients in long term acute care hospitals are receiving acute-level services or could be cared for in skilled nursing facilities. The 2006 and 2007 Work Plans describe plans: (1) to study the accuracy of Medicare payment for inpatient rehabilitation stays when patient assessments are entered later than the required deadlines, (2) to study both inpatient rehabilitation facility and long term acute care hospital payments in order to determine whether they were made in accordance with applicable regulations, including policies on outlier payments and interrupted stays, and (3) to study physical and occupational therapy claims in order to determine whether the services were medically necessary, adequately documented and certified. The 2007 Work Plan describes plans to study the extent to which long term acute care hospitals admit patients from a sole general acute care hospital and whether hospitals currently reimbursed under LTCH-PPS are in compliance with the average length of stay criteria. We monitor government publications applicable to us and focus a portion of our compliance efforts towards these areas targeted for enforcement.

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

refund of monies to Medicare, Medicaid or other governmental health care programs.

Remuneration and Fraud Measures. The federal anti-kickback statute prohibits some business practices and relationships under Medicare, Medicaid and other federal healthcare programs. These practices include the payment, receipt, offer or solicitation of remuneration in connection with, to induce, or to arrange for, the referral of

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patients covered by a federal or state healthcare program. Violations of the anti-kickback law may be punished by a criminal fine of up to $50,000 or imprisonment for each violation, or both, civil monetary penalties of $50,000 and damages of up to three times the total amount of remuneration, and exclusion from participation in federal or state healthcare programs.

Section 1877 of the Social Security Act, commonly known as the Stark Law, prohibits referrals for designated health services by physicians under the Medicare and Medicaid programs to other healthcare providers in which the physicians have an ownership or compensation arrangement unless an exception applies. Sanctions for violating the Stark Law include civil monetary penalties of up to $15,000 per prohibited service provided, assessments equal to three times the dollar value of each such service provided and exclusion from the Medicare and Medicaid programs and other federal and state healthcare programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. In addition, many states have adopted or may adopt similar anti-kickback or anti-self-referral statutes. Some of these statutes prohibit the payment or receipt of remuneration for the referral of patients, regardless of the source of the payment for the care. While we do not believe our arrangements are in violation of these prohibitions, we cannot assure you that governmental officials charged with the responsibility for enforcing the provisions of these prohibitions will not assert that one or more of our arrangements are in violation of the provisions of such laws and regulations.

Provider-Based Status. The designation provider-based refers to circumstances in which a subordinate facility (e.g., a separately certified Medicare provider, a department of a provider or a satellite facility) is treated as part of a provider for Medicare payment purposes. In these cases, the services of the subordinate facility are included on the main provider s cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that they are shared. We operate 12 specialty hospitals that are treated as provider-based satellites of certain of our other facilities, certain of our outpatient rehabilitation services are operated as departments of our inpatient rehabilitation facilities, and we provide rehabilitation management and staffing services to hospital rehabilitation departments that may be treated as provider-based. These facilities are required to satisfy certain operational standards in order to retain their provider-based status.

Health Information Practices. In addition to broadening the scope of the fraud and abuse laws, the Health Insurance Portability and Accountability Act of 1996 also mandates, among other things, the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the healthcare industry. If we fail to comply with the standards, we could be subject to criminal penalties and civil sanctions. Among the standards that the Department of Health and Human Services has adopted or will adopt pursuant to the Health Insurance Portability and Accountability Act of 1996 are standards for electronic transactions and code sets, unique identifiers for providers (referred to as National Provider Identifier), employers, health plans and individuals, security and electronic signatures, privacy and enforcement.

The Department of Health and Human Services has adopted standards in three areas that most affect our operations.

Standards relating to the privacy of individually identifiable health information govern our use and disclosure of protected health information and require us to impose those rules, by contract, on any business associate to whom such information is disclosed. We were required to comply with these standards by April 14, 2003.

Standards relating to electronic transactions and code sets require the use of uniform standards for common healthcare transactions, including healthcare claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits. We were required to comply with these requirements by October 16, 2003.

Standards for the security of electronic health information require us to implement various administrative, physical and technical safeguards to ensure the integrity and confidentiality of electronic protected health information. We were required to comply with these security standards by April 20, 2005.

The National Provider Identifier will replace health care provider identifiers that are in use today in standard transactions. Implementation of the National Provider Identifier will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting standard transactions with multiple health plans. We were required to comply with the use of National Provider Identifiers in standard transactions by May 23, 2007.

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We maintain a HIPAA committee that is charged with evaluating and monitoring our compliance with the Health Insurance Portability and Accountability Act of 1996. The HIPAA committee monitors regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 as they have been adopted to date and as additional standards and modifications are adopted. Although health information standards have had a significant effect on the manner in which we handle health data and communicate with payors, the cost of our compliance has not had a material adverse effect on our business, financial condition or results of operations. We cannot estimate the cost of compliance with standards that have not been issued or finalized by the Department of Health and Human Services.

Compliance Program

Our Compliance Program

In late 1998, we voluntarily adopted our code of conduct. The code is reviewed and amended as necessary and is the basis for our company-wide compliance program. Our written code of conduct provides guidelines for principles and regulatory rules that are applicable to our patient care and business activities. These guidelines are implemented by a compliance officer, a compliance committee, and employee education and training. We also have established a reporting system, auditing and monitoring programs, and a disciplinary system as a means for enforcing the code s policies.

Operating Our Compliance Program

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

Compliance Committee

Our compliance committee is made up of members of our senior management and in-house counsel. The compliance committee meets on a quarterly basis and reviews the activities, reports and operation of our compliance program. In addition, the HIPAA committee meets on a regular basis to review compliance with regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and provides reports to the compliance committee.

Compliance Issue Reporting

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

Compliance Monitoring and Auditing / Comprehensive Training and Education

Monitoring reports and the results of compliance for each of our business segments are reported to the compliance committee on a quarterly basis. We train and educate our employees regarding the code of conduct, as well as the legal and regulatory requirements relevant to each employee s work environment. New and current employees are required to sign a compliance certification form certifying that the employee has read, understood and has agreed to

abide by the code of conduct. Additionally, all employees are required to re-certify compliance with the code on an annual basis.

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Policies and Procedures Reflecting Compliance Focus Areas

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

Internal Audit

In addition to and in support of the efforts of our compliance department, during 2001 we established an internal audit function. The compliance officer manages the combined Compliance and Audit Department and meets with the audit committee of the board of directors on a quarterly basis to discuss audit results.

Corporate Information

We are a corporation organized under the laws of the State of Delaware. Our principal executive offices are located at 4714 Gettysburg Road, Mechanicsburg, Pennsylvania 17055. Our telephone number at our principal executive offices is (717) 972-1100. Our company s website can be located at www.selectmedicalcorp.com. The information on our company s website is not part of this prospectus.

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MANAGEMENT

Executive Officers and Directors

The following table sets forth certain information with respect to our executive officers and directors as of , 2008.

Name	Age	Position
Rocco A. Ortenzio	75	Director and Executive Chairman
Robert A. Ortenzio	51	Director and Chief Executive Officer
Russell L. Carson	65	Director
David S. Chernow	51	Director
Bryan C. Cressey	59	Director
James E. Dalton, Jr.	66	Director
James S. Ely III	50	Director
Thomas A. Scully	51	Director
Leopold Swergold	68	Director
Sean M. Traynor	39	Director
Patricia A. Rice	61	President and Chief Operating Officer
David W. Cross	61	Executive Vice President and Chief Development Officer
S. Frank Fritsch	57	Executive Vice President and Chief Human Resources Officer
Martin F. Jackson	54	Executive Vice President and Chief Financial Officer
James J. Talalai	47	Executive Vice President and Chief Information Officer
Michael E. Tarvin	48	Executive Vice President, General Counsel and Secretary
Scott A. Romberger	48	Senior Vice President, Controller and Chief Accounting Officer
Robert G. Breighner, Jr.	39	Vice President, Compliance and Audit Services and Corporate Compliance Officer

Set forth below is a brief description of the business experience of each of our directors and executive officers:

Rocco A. Ortenzio co-founded our company and has served as Executive Chairman since September 2001. He became a director of ours upon consummation of the Merger Transactions. He served as Chairman and Chief Executive Officer from February 1997 until September 2001. In 1986, he co-founded Continental Medical Systems, Inc., and served as its Chairman and Chief Executive Officer until July 1995. In 1979, Mr. Ortenzio founded Rehab Hospital Services Corporation, and served as its Chairman and Chief Executive Officer until June 1986. In 1969, Mr. Ortenzio founded Rehab Corporation and served as its Chairman and Chief Executive Officer until 1974. Mr. Ortenzio is the father of Robert A. Ortenzio, our Chief Executive Officer.

Robert A. Ortenzio co-founded our company and has served as a director since February 1997. He became a director of ours upon consummation of the Merger Transactions. Mr. Ortenzio has served as our Chief Executive Officer since January 1, 2005 and as our President and Chief Executive Officer from September 2001 to January 1, 2005. Mr. Ortenzio also served as our President and Chief Operating Officer from February 1997 to September 2001. He was an Executive Vice President and a director of Horizon/CMS Healthcare Corporation from July 1995 until July

1996. In 1986, Mr. Ortenzio co-founded Continental Medical Systems, Inc., and served in a number of different capacities, including as a Senior Vice President from February 1986 until April 1988, as Chief

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Operating Officer from April 1988 until July 1995, as President from May 1989 until August 1996 and as Chief Executive Officer from July 1995 until August 1996. Before co-founding Continental Medical Systems, Inc., he was a Vice President of Rehab Hospital Services Corporation. He currently serves on the board of directors of Odyssey Healthcare, Inc., a hospice health care company, and U.S. Oncology, Inc. Mr. Ortenzio is the son of Rocco A. Ortenzio, our Executive Chairman.

Russell L. Carson has served as a director since February 1997, and became a director of ours upon consummation of the Merger Transactions. He co-founded Welsh, Carson, Anderson & Stowe in 1978 and has focused on healthcare investments. Mr. Carson has been a general partner of Welsh, Carson, Anderson & Stowe since 1979. Welsh, Carson, Anderson & Stowe has created fifteen institutionally funded limited partnerships with total capital of more than $18 billion and has invested in more than 200 companies. Before co-founding Welsh, Carson, Anderson & Stowe, Mr. Carson was employed by Citicorp Venture Capital Ltd., a subsidiary of Citigroup, Inc., and served as its Chairman and Chief Executive Officer from 1974 to 1978. He currently serves on the board of directors of U.S. Oncology, Inc.

David S. Chernow served as a director from January 2002 until the consummation of the Merger Transactions on February 24, 2005, and became a director of our company on August 10, 2005. Mr. Chernow is the President and Chief Executive Officer of OnCURE Medical Corp., one of the largest providers of free-standing radiation oncology care in the United States. From January 2004 to June 2007, Mr. Chernow served as the President and Chief Executive Officer of JA Worldwide, a nonprofit organization dedicated to the education of young people about business. From July 2001 to January 2004, he served as the President and Chief Executive Officer of Junior Achievement, Inc., a predecessor of JA Worldwide. From 1999 to 2001, he was the President of the Physician Services Group at US Oncology, Inc. Mr. Chernow co-founded American Oncology Resources in 1992 and served as its Chief Development Officer until the time of the merger with Physician Reliance Network, Inc., which created US Oncology, Inc. in 1999.

Bryan C. Cressey has served as a director since February 1997, and became a director of ours upon consummation of the Merger Transactions. He is a partner of Cressey & Company, which he founded in 2007. He is a managing partner of Thoma Cressey Bravo, which he co-founded in June 1998. Prior to that time he was a principal, partner and co-founder of Golder, Thoma, Cressey and Rauner, the predecessor of GTCR Golder Rauner, LLC, since 1980. Mr. Cressey also serves as a director and chairman of Belden Inc., Jazz Pharmaceuticals, Inc. and several private companies.

James E. Dalton, Jr. served as a director since December 2000 until the consummation of the Merger Transactions on February 24, 2005, and became a director of our company on August 10, 2005. Since January 1, 2006, Mr. Dalton has been Chairman of Signature Hospital Corporation. From 2001 to 2007, Mr. Dalton served as President of Edinburgh Associates, Inc. Mr. Dalton served as President, Chief Executive Officer and as a director of Quorum Health Group, Inc. from May 1, 1990 until it was acquired by Triad Hospitals, Inc. in April 2001. Prior to joining Quorum, he served as Regional Vice President, Southwest Region for HealthTrust, Inc., as division Vice President of HCA, and as Regional Vice President of HCA Management Company. Mr. Dalton also serves on the board of directors of U.S. Oncology, Inc. He serves as a Trustee for the Universal Health Services Realty Income Trust. Mr. Dalton is a Life Fellow of the American College of Healthcare Executives.

James S. Ely III was elected to our board of directors on November 13, 2008. From 2001 to 2008, Mr. Ely served as a Managing Director in the Syndicated and Leveraged Finance group at J.P. Morgan Securities Inc. From 1995 to 2000, Mr. Ely served as a Managing Director in the Global Syndicated Finance group of Chase Securities Inc. and its predecessor Chemical Securities Inc. In 1992, Mr. Ely co-founded the Healthcare Group of Chemical Securities Inc. where he served as a senior banker until 1995.

Thomas A. Scully has served as a director since February 2004, and became a director of ours upon consummation of the Merger Transactions. Since January 1, 2004, he has served as Senior Counsel to the law firm of Alston & Bird and as a General Partner with Welsh, Carson Anderson & Stowe. From May 2001 to December 2003, Mr. Scully served as Administrator of the Centers for Medicare & Medicaid Services, or CMS. CMS is responsible for the management of Medicare, Medicaid, SCHIP and other national healthcare initiatives. Before joining CMS, Mr. Scully served as President and Chief Executive Officer of the Federation of American Hospitals from January 1995 to May 2001. Mr. Scully also serves as a director of American Financial Corp.

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Leopold Swergold served as a director from May 2001 until the consummation of the Merger Transactions on February 24, 2005, and became a director of our company on August 10, 2005. In 1983, Mr. Swergold formed Swergold, Chefitz & Company, a healthcare investment banking firm. In 1989, Swergold, Chefitz & Company merged into Furman Selz, an investment banking firm, where Mr. Swergold served as Head of Healthcare Investment Banking and as a member of the board of directors. In 1997, Furman Selz was acquired by ING Groep N.V. of the Netherlands. From 1997 until 2004, Mr. Swergold was a Managing Director of ING Furman Selz Asset Management LLC, where he managed several healthcare investment funds. Mr. Swergold serves as a director of Financial Federal Corp., a New York Stock Exchange listed company, and is a trustee of the Freer and Sackler Galleries at the Smithsonian Institution.

Sean M. Traynor joined our board of directors following the consummation of the Merger Transactions, and has been a director of ours since October 2004. Mr. Traynor is a general partner of Welsh, Carson, Anderson & Stowe, where he focuses on investments in healthcare. Prior to joining Welsh Carson in April 1999, Mr. Traynor worked in the healthcare and financial services investment banking groups at BT Alex Brown after spending three years with Coopers & Lybrand. Mr. Traynor serves as a director of Renal Advantage Inc., AGA Medical Corporation, Ameripath, Inc., Amerisafe, Inc. and Universal American Corporation.

Patricia A. Rice has served as our President and Chief Operating Officer since January 1, 2005. Prior to this, she served as our Executive Vice President and Chief Operating Officer since January 2002 and as our Executive Vice President of Operations from November 1999 to January 2002. She served as Senior Vice President of Hospital Operations from December 1997 to November 1999. She was Executive Vice President of the Hospital Operations Division for Continental Medical Systems, Inc. from August 1996 until December 1997. Prior to that time, she served in various management positions at Continental Medical Systems, Inc. from 1987 to 1996.

David W. Cross has served as our Executive Vice President and Chief Development Officer since February 2007. He served as our Senior Vice President and Chief Development Officer from December 1998 to February 2007. Before joining us, he was President and Chief Executive Officer of Intensiva Healthcare Corporation from 1994 until we acquired it. Mr. Cross was a founder, the President and Chief Executive Officer, and a director of Advanced Rehabilitation Resources, Inc., and served in each of these capacities from 1990 to 1993. From 1987 to 1990, he was Senior Vice President of Business Development for RehabCare Group, Inc., a publicly traded rehabilitation care company, and in 1993 and 1994 served as Executive Vice President and Chief Development Officer of RehabCare Group, Inc. Mr. Cross currently serves on the board of directors of Odyssey Healthcare, Inc., a hospice health care company.

S. Frank Fritsch has served as our Executive Vice President and Chief Human Resources Officer since February 2007. He served as our Senior Vice President of Human Resources from November 1999 to February 2007. He served as our Vice President of Human Resources from June 1997 to November 1999. Prior to June 1997, he was Senior Vice President Human Resources for Integrated Health Services from May 1996 until June 1997. Prior to that time, Mr. Fritsch was Senior Vice President Human Resources for Continental Medical Systems, Inc. from August 1992 to April 1996. From 1980 to 1992, Mr. Fritsch held senior human resources positions with Mercy Health Systems, Rorer Pharmaceuticals, ARA Mark and American Hospital Supply Corporation.

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

James J. Talalai has served as our Executive Vice President and Chief Information Officer since February 2007. He served as our Senior Vice President and Chief Information Officer from August 2001 to February 2007. He joined our company in May 1997 and served in various leadership capacities within Information Services. Before joining us, Mr. Talalai was Director of Information Technology for Horizon/ CMS Healthcare Corporation from 1995 to 1997. He also served as Data Center Manager at Continental Medical Systems, Inc. in the

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mid-1990s. During his career, Mr. Talalai has held development positions with PHICO Insurance Company and with Harrisburg HealthCare.

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

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

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

Director Independence

Our board of directors currently consists of nine directors, Messrs. Rocco Ortenzio, Robert Ortenzio, Carson, Chernow, Cressey, Dalton, Ely, Scully, Swergold and Traynor. No later than twelve months after we list our common stock on the Nasdaq Global Select Market, a majority of our directors will be required to meet standards of independence. In 2008, our board of directors undertook a review of the independence of our directors and considered whether any director has a material relationship with us that could compromise his ability to exercise independent judgment in carrying out his responsibilities. We believe that Messrs. Chernow, Dalton, Ely, and Swergold currently meet these independence standards and that Mr. Cressey will meet these independence standards beginning on January 1, 2009.

Board Committees

Our board of directors will establish various committees to assist it with its responsibilities. Those committees are described below.

Audit Committee

The current audit committee members are Messrs. Cressey, Dalton, Ely, Swergold and Traynor. Upon the date our common stock is listed on the Nasdaq Global Select Market, our board of directors will reconstitute our audit committee to consist of at least three directors. The initial committee members will be Messrs. Cressey, Dalton, Ely, and Swergold. The composition of the audit committee will satisfy the independence and financial literacy requirements of the Nasdaq Global Select Market and the SEC. The independence standards require that the audit committee have at least one independent director on the date of listing, a majority of independent directors within 90 days after the date our registration statement is declared effective and fully independent audit committee within one year after that date. The financial literacy standards require that each member of our audit committee be able to read

and understand fundamental financial statements. In addition, at least one member of our audit committee must qualify as a financial expert, as defined by the SEC rules, and have financial sophistication in accordance with the rules of the Nasdaq Global Select Market. Our board of directors has determined that each of our audit committee members qualify as an audit committee financial expert.

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The primary function of the audit committee is to assist the board of directors in the oversight of the integrity of our financial statements, our compliance with legal and regulatory requirements, the independent accountant s qualifications and independence and the performance of our internal audit function and independent accountants. The audit committee also prepares an audit committee report required by the SEC to be included in our proxy statements.

The audit committee fulfills its oversight responsibilities by reviewing the following: (1) the financial reports and other financial information provided by us to our stockholders and others; (2) our systems of internal controls regarding finance, accounting, legal and regulatory compliance and business conduct established by management and the board; and (3) our auditing, accounting and financial processes generally. The audit committee s primary duties and responsibilities are to:

- serve as an independent and objective party to monitor our financial reporting process and internal control systems;
- review and appraise the audit efforts of our independent accountants and exercise ultimate authority over the relationship between us and our independent accountants; and
- provide an open avenue of communication among the independent accountants, financial and senior management and the board of directors.

To fulfill these duties and responsibilities, the audit committee will:

Documents/Reports Review

- discuss with management and the independent accountants our annual and interim financial statements, earnings press releases, earnings guidance and any reports or other financial information submitted to the stockholders, the SEC, analysts, rating agencies and others, including any certification, report, opinion or review rendered by the independent accountants;
- review the regular internal reports to management prepared by the internal auditors and management s response;
- discuss with management and the independent accountants the Quarterly Reports on Form 10-Q, the Annual Reports on Form 10-K, including our disclosures under Management s Discussion and Analysis of Financial Conditions and Results of Operations, and any related public disclosure prior to its filing;

Independent Accountants

- have sole authority for the appointment, compensation, retention, oversight, termination and replacement of our independent accountants (subject, if applicable, to stockholder ratification) and the independent accountants will report directly to the audit committee;
- pre-approve all auditing services and all non-audit services to be provided by the independent accountants;
- review the performance of the independent accountants with both management and the independent accountants;
- periodically meet with the independent accountants separately and privately to hear their views on the adequacy of our internal controls, any special audit steps adopted in light of material control deficiencies and

the qualitative aspects of our financial reporting, including the quality and consistency of both accounting policies and the underlying judgments, or any other matters raised by them;

obtain and review a report from the independent accountants at least annually regarding (1) the independent accountants internal quality-control procedures, (2) any material issues raised by the most recent quality-control review, or peer review, of the firm, or by any inquiry or investigation by governmental or professional authorities within the preceding five years respecting one or more independent audits carried out by the firm, (3) any steps taken to deal with any such issues, and (4) all relationships between the independent accountants and their related entities and us and our related entities;

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Financial Reporting Processes

review with financial management and the independent accountants the quality and consistency, not just the acceptability, of the judgments and appropriateness of the accounting principles and financial disclosure practices used by us, including an analysis of the effects of any alternative GAAP methods on the financial statements;

approve any significant changes to our auditing and accounting principles and practices after considering the advice of the independent accountants and management;

focus on the reasonableness of control processes for identifying and managing key business, financial and regulatory reporting risks;

discuss with management our major financial risk exposures and the steps management has taken to monitor and control such exposures, including our risk assessment and risk management policies;

periodically meet with appropriate representatives of management and the internal auditors separately and privately to consider any matters raised by them, including any audit problems or difficulties and management s response;

periodically review the effect of regulatory and accounting initiatives, as well as any off-balance sheet structures, on our financial statements;

Process Improvement

following the completion of the annual audit, review separately with management and the independent accountants any difficulties encountered during the course of the audit, including any restrictions on the scope of work or access to required information;

periodically review any processes and policies for communicating with investors and analysts;

review and resolve any disagreement between management and the independent accountants in connection with the annual audit or the preparation of the financial statements;

review with the independent accountants and management the extent to which changes or improvements in financial or accounting practices, as approved by the audit committee, have been implemented;

Business Conduct and Legal Compliance

review our code of conduct and review management s processes for communicating and enforcing this code of conduct;

review management s monitoring of our compliance with our code of conduct and ensure that management has the proper review system in place to ensure that our financial statements, reports, and other financial information disseminated to governmental organizations and to the public satisfy legal requirements;

review, with our counsel, any legal matter that could have a significant impact on our financial statements and any legal compliance matters;

review and approve all related-party transactions;

Other Responsibilities

establish and review periodically procedures for (1) the receipt, retention and treatment of complaints received by us regarding accounting, internal accounting controls or auditing matters and (2) the confidential, anonymous submission by our employees of concerns regarding questionable accounting or auditing matters;

review and reassess the audit committee s charter at least annually and submit any recommended changes to the board of directors for its consideration;

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provide the report for inclusion in our Annual Proxy Statement that is required by Item 306 of Regulation S-K of the Securities and Exchange Commission;

report periodically, as deemed necessary or desirable by the audit committee, but at least annually, to the full board of directors regarding the audit committee s actions and recommendations, if any;

establish policies for our hiring of employees or former employees of the independent accountants who were engaged on our account;

perform any other activities consistent with the audit committee s charter, our bylaws and governing law, as the audit committee or the board of directors deems necessary or appropriate; and

annually evaluate the audit committee s performance and report the results of such evaluation to the board of directors.

The audit committee will hold regular meetings at least four times each year. The audit committee will report to the board of directors at each regularly scheduled meeting of the board of directors on significant results of its activities.

Prior to the consummation of this offering, our board of directors will amend and restate the charter for our audit committee. PricewatehouseCoopers LLP currently serves as our independent auditor.

Nominating and Corporate Governance Committee

Upon the date our common stock is listed on the Nasdaq Global Select Market, our board of directors will designate a nominating and corporate governance committee that will consist of at least two directors. The initial committee members will be Messrs. Dalton and Swergold. The composition of the nominating and corporate governance committee will satisfy the independence requirements of the Nasdaq Global Select Market that it have at least one independent director on the listing date, a majority of independent directors within 90 days after that date and full compliance within one year after that date. The nominating and corporate governance committee will:

identify individuals qualified to serve as our directors;

nominate qualified individuals for election to our board of directors at annual meetings of stockholders;

recommend to our board the directors to serve on each of our board committees; and

recommend to our board a set of corporate governance guidelines.

To fulfill these responsibilities, the nominating and governance committee will:

review periodically the composition of our board;

identify and recommend director candidates for our board;

recommend to our board nominees for election as directors;

recommend to our board the composition of the committees of the board;

review periodically our corporate governance guidelines and recommend governance issues that should be considered by our board;

review periodically our code of conduct and obtain confirmation from management that the policies included in the code of conduct are understood and implemented;

evaluate periodically the adequacy of our conflicts of interest policy;

review related party transactions;

consider with management public policy issues that may affect us;

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review periodically our committee structure and operations and the working relationship between each committee and the board; and

consider, discuss and recommend ways to improve our board s effectiveness.

Compensation Committee

The current compensation committee members are Russell L. Carson, David S. Chernow, Bryan C. Cressey, Rocco A. Ortenzio and Robert A. Ortenzio. Upon the date our common stock is listed on the Nasdaq Global Select Market, our board of directors will reconstitute our compensation committee to consist of at least two directors. The initial committee members will be Messrs. Chernow and Cressey. The composition of the compensation committee will satisfy the independence requirements of the Nasdaq Global Select Market that it have at least one independent director on the listing date, a majority of independent directors within 90 days after that date and full compliance within one year after that date. The primary responsibility of the compensation committee is to develop and oversee the implementation of our philosophy with respect to the compensation of our executive officers and directors. In that regard, the compensation committee will:

have the sole authority to retain and terminate any compensation consultant used to assist us, the board of directors or the compensation committee in the evaluation of the compensation of our executive officers and directors;

to the extent necessary or appropriate to carry out its responsibilities, have the authority to retain special legal, accounting, actuarial or other advisors;

review and approve annually corporate goals and objectives to serve as the basis for the compensation of our executive officers, evaluate the performance of our executive officers in light of such goals and objectives, and determine and approve the compensation level of our executive officers based on such evaluation;

interpret, implement, administer, review and approve all aspects of remuneration to our executive officers and other key officers, including their participation in incentive-compensation plans and equity-based compensation plans;

review and approve all employment agreements, consulting agreements, severance arrangements and change in control agreements for our executive officers;

develop, approve, administer and recommend to the board of directors and our stockholders for their approval (to the extent such approval is required by any applicable law, regulation or rule of the Nasdaq Global Select Market) all of our stock ownership, stock option and other equity-based compensation plans and all related policies and programs;

make individual determinations and grant any shares, stock options, or other equity-based awards under all equity-based compensation plans, and exercise such other power and authority as may be required or permitted under such plans, other than with respect to non-employee directors, which determinations are subject to the approval of our board of directors;

have the authority to form and delegate authority to subcommittees;

report regularly to our board of directors, but not less frequently than annually;

annually review and reassess the adequacy of its charter and recommend any proposed changes to our board of directors for its approval; and

annually review its own performance, and report the results of such review to our board of directors.

The Compensation Committee has the same authority with regard to all aspects of director compensation as it has been granted with regard to executive compensation, except that any ultimate decision regarding the compensation of any director is subject to the approval of our board of directors. The compensation committee will hold regular meetings at least two times each year.

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Effective upon the consummation of this offering, our board of directors will amend and restate the charter for our compensation committee.

Director Compensation

We do not pay directors fees to our employee directors; however they are reimbursed for the expenses they incur in attending meetings of our board of directors or board committees. Non-employee directors other than non-employee directors appointed by Welsh Carson and Thoma Cressey receive cash compensation in the amount of $6,000 per quarter, and the following for all meetings attended other than audit committee meetings: $1,500 per board meeting, $300 per telephonic board meeting, $500 per committee meeting held in conjunction with a board meeting and $1,000 per committee meeting held independent of a board meeting. For audit committee meetings attended, all members receive the following: $2,000 per audit committee meeting and $1,000 per telephonic audit committee meeting. All non-employee directors are also reimbursed for the expenses they incur in attending meetings of our board of directors or board committees.

Code of Ethics

We have adopted a written code of business conduct and ethics, known as our code of conduct, which applies to all of our directors, officers, and employees, including our chief executive officer, our chief financial officer and our chief accounting officer. Our code of conduct is available on our Internet website, www.selectmedicalcorp.com. Our code of conduct may also be obtained by contacting investor relations at (717) 972-1100. Any amendments to our code of conduct or waivers from the provisions of the code for our chief executive officer, our chief financial officer and our chief accounting officer will be disclosed on our Internet website promptly following the date of such amendment or waiver. The inclusion of our web address in this prospectus does not include or incorporate by reference the information on our web site into this prospectus.

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COMPENSATION DISCUSSION AND ANALYSIS

Introduction. This Compensation Discussion and Analysis (CD&A) provides an overview of our executive compensation program together with a description of the material factors underlying the decisions which resulted in the compensation provided for 2007 to our Executive Chairman, Chief Executive Officer, Chief Financial Officer and the two other executive officers who were the highest paid during 2007 (collectively, the named executive officers), as presented in the tables which follow this CD&A. This CD&A contains statements regarding our performance targets and goals. These targets and goals are disclosed in the limited context of our compensation program and should not be understood to be statements of management s expectations or estimates of financial results or other guidance. We specifically caution investors not to apply these statements to other contexts.

Compensation Philosophy. Our compensation philosophy for named executive officers is designed with the primary goals of rewarding the contributions of named executive officers to our financial performance and providing overall compensation sufficient to attract and retain highly skilled named executive officers who are properly motivated to contribute to our financial performance. We seek to achieve our goals with respect to named executive officers compensation by implementing and maintaining incentive plans for such executive officers that tie a substantial portion of each executive s overall compensation to pre-determined financial goals relating to our return on equity and earnings per share.

Committee Process. The compensation committee meets as often as necessary to perform its duties and responsibilities. During 2007, the committee met four times. The compensation committee s meeting agenda is normally established by our Chief Executive Officer in consultation with other members of the committee. Committee members receive the agenda and related materials in advance of each meeting. Depending on the meeting s agenda, such materials may include: financial reports regarding our performance, reports on achievement of individual and company objectives and information regarding our compensation programs.

The compensation committee periodically reviews overall compensation levels to ensure that performance-based compensation represents a sufficient portion of total compensation to promote and reward executive officers contributions to our performance. With respect to our named executive officers, the committee has determined to place increasing emphasis on performance-based compensation in lieu of paying higher base salaries. All members of our compensation committee have extensive experience in the health care industry, including a focus on structuring appropriate executive compensation for health care investment funds and their portfolio companies. In setting the compensation for the named executive officers, our compensation committee members draw on their collective experience in the health care industry and knowledge of investors goals. Accordingly, our compensation committee has not deemed it necessary to review formal compensation data or utilize a formal benchmarking process or the services of a compensation consultant to set the compensation levels of our named executive officers.

Role of Chief Executive Officer in Compensation Decisions. The Company s Chief Executive Officer and Executive Chairman abstain from voting on matters regarding their compensation or any compensation related plans in which they are participants. Our Chief Executive Officer recommends levels of compensation for the other named executive officers. However the compensation committee makes the final determination regarding the compensation of the named executive officers.

Elements of Compensation

Executive compensation consists of the following elements, each of which is discussed in further detail in the sections that follow:

Base Salary

Annual Performance-Based Bonuses

Annual Discretionary Bonuses

Long Term Cash Incentive Plan

Equity Compensation

Perquisites and Personal Benefits

General Benefits

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We have entered into employment contracts with certain of our named executive officers. In addition to the compensation components listed above, these contracts provide for post-employment severance payments and benefits in the event of employment termination under certain circumstances. The named executive officers who do not have employment contracts are party to change in control agreements with Select.

Base Salary

Base salaries are provided to our named executive officers to compensate them for services rendered during the year. Consistent with our philosophy of placing increasing emphasis on performance-based compensation, the compensation committee sets the base salaries for our named executive officers at levels which it believes are competitive for the health care industry when combined with our incentive programs. The compensation committee periodically reviews base salaries for the named executive officers. For 2007, the compensation committee determined that the base salaries of our named executive officers when combined with the bonus opportunities available under our incentive programs were at competitive levels and that no adjustments were required. The base salary for Ms. Rice, Mr. Jackson and Mr. Fritsch have been adjusted, effective January 1, 2008, to $750,000, $400,000 and $350,000 per year, respectively. Our board of directors determined that the adjustment in salary for these named executive officers was appropriate as each officer had not received a salary increase in a number of years.

2007 Annual Performance-Based Bonuses

Annual cash bonuses are included as part of the executive compensation program because the compensation committee believes that a significant portion of each named executive officer s compensation should be contingent on our financial performance. Accordingly, we maintain a bonus plan under which named executive officers are eligible to receive annual cash bonuses based upon the achievement of specific performance measures.

The compensation committee determines the range of bonus opportunities based on our philosophy that performance-based bonuses should represent a significant portion of overall compensation for the named executive officers. In order to further our philosophy that compensation should reward such executive officers contribution to our financial performance, the bonus plan for such executives is designed to determine bonuses based on measures directly related to our financial performance and the increase in stockholder value.

In 2007, the compensation committee established financial performance targets for the bonus plan for the named executive officers based on our return on equity and earnings per share, the achievement of which would have entitled the named executive officers to receive annual bonuses from 0% to 250% of a target bonus percentage multiplied by the named executive officer s base salary. If both of the performance goals were met, the participants would have received cash bonuses equal to their target bonus percentage listed below times the participant s base salary. If one or both of the performance goals are exceeded, the participants may receive bonuses greater than their target bonus percentage, up to a maximum of 250% of such target bonus percentage multiplied by such participant s base salary, depending upon the extent to which the performance goals were exceeded. For example, a participant whose target bonus percentage is 50% is eligible to receive a bonus equal to 125% of the participant s base salary if the maximum cash award of 250% is achieved (i.e., 250% times 50% equals 125%).

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For the 2007 fiscal year, the compensation committee established the following goals, both of which needed to be attained to entitle the executive to receive a cash payment equal to the stated bonus percentage times the executive s base salary: return on equity of at least 10.6% and earnings per share of at least $0.15. The targets were determined based on our annual budget, which our compensation committee determined was a desirable level of annual performance for our company. For 2007, the target bonus percentage for each of the named executive officers eligible to participate in the bonus plan is set forth in the table below. The target bonus percentage for Messrs. Rocco and Robert Ortenzio exceeds the target bonus percentages for the other named executive officers due to a higher level of responsibility.

Named Executive Officer	Target Bonus (% of Base Salary)
Rocco A. Ortenzio	80%
Robert A. Ortenzio	80%
Patricia A. Rice	50%
Martin F. Jackson	50%
S. Frank Fritsch	50%

Our financial performance goals for 2007 for return on equity and earnings per share were not attained. Accordingly, none of the named executive officers listed in the table above received bonuses for fiscal year 2007 under the bonus plan.

Discretionary Annual Bonus

The compensation committee has the authority to award bonuses to our executives on a purely discretionary basis. For 2007 the compensation committee determined that as a result of our 2007 financial results and other performance factors, a group of eight senior executives (including our named executive officers) should receive an aggregate bonus of $1.0 million dollars to be allocated among such executives pro rata based upon 2007 base salaries. Therefore, the compensation committee granted discretionary bonuses of $229,000 to Mr. Rocco Ortenzio, $229,000 to Mr. Robert Ortenzio, $164,645 to Ms. Rice, $103,225 to Mr. Jackson and $76,780 to Mr. Fritsch. These amounts were paid in 2008, even though each of the named executive officers are participants in the bonus plan described above, and no bonuses were awarded under that plan for 2007 as we failed to meet our performance goals. However, the compensation committee believed that our failure to meet such performance goals was, in part, based on changes in regulatory reimbursement rates that were beyond the control of our named executive officers.

Long Term Cash Incentive Plan

All of our named executive officers are eligible to participate in our Long Term Cash Incentive Plan, which we refer to as the Cash Plan. The Cash Plan was adopted to promote our long term financial interests and to enhance long term stockholder value. The Cash Plan achieves these goals by aligning the interests of the named executive officers with those of our stockholders through grants of notional units which are held in a bookkeeping account for each applicable participant until paid to such participant, generally upon the occurrence of certain liquidity events described below. Prior to payment, except in the event of death or disability, as discussed below, no participant has any right to receive any amount with respect to his or her account and the units held therein vested. Through the Cash Plan, we seek to provide an incentive to such officers and to motivate them to assist our current stockholders in achieving their long term goal, which is a liquidity event.

The Cash Plan originally provided a bonus pool of $100.0 million, to be paid on a pro rata basis to all participants according to the number of units held in their accounts. Fifty percent of the bonus pool may be allocated to participants accounts and paid upon the earlier to occur of a change in control of our company or an initial public offering of our company, in either case, that satisfies certain conditions (described below), neither of which are expected to be satisfied upon the consummation of this offering. In order for any portion of the bonus pool to be allocated and paid upon a change in control or an initial public offering, the value of one share of our preferred stock and 6.75 shares of our common stock, or a Strip of Securities, must be in excess of the greater of (1) $67.25 and (2) the value required for a Strip of Securities to yield a 25% average annual percentage return, compounded

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annually, from the adoption of the Cash Plan through the date of the initial public offering or change in control, as applicable. The remaining 50% of the bonus pool may be allocated and paid upon a redemption of our preferred stock, when special dividends are paid on our preferred stock or upon a sale of our outstanding preferred stock within the twelve-month period following an initial public offering. Payments to the holders of our preferred stock for shares of common stock received in conversion of our preferred stock with the proceeds of this offering (including via the sale of shares of common stock in this offering by the selling stockholders) are considered the equivalent of a redemption and will trigger payments under the cash plan. The amounts that may be payable under the Cash Plan in such event(s) are calculated by multiplying $50.0 million, less all prior amounts paid under the Cash Plan as a result of such special dividend or sale of preferred stock, by a percentage equal to the accreted value received by preferred stock holders divided by the total accreted value of preferred stock.

On September 29, 2005, we made a payment of $14.2 million, in the aggregate, to participants in the Cash Plan as a result of a special dividend paid to holders of our preferred stock with the proceeds of our $175.0 million senior floating rate notes. Following this payment, $85.8 million remained to be allocated to participants accounts. No other payments have been made under the Cash Plan.

The term change in control generally means (1) the disposition of all or substantially all of our assets, (2) the acquisition by any person of beneficial ownership of more than 40% of the voting power of our company or (3) a change in the majority of the members of our board of directors. The term initial public offering generally means an initial public offering in which we receive proceeds, which when combined with the proceeds received by our company in all prior public offerings, exceed $250,000,000. This offering will be considered an initial public offering for purposes of the Cash Plan.

Under the terms of the Cash Plan, all units held in a participant s account will be forfeited by the participant in the event of his or her termination of employment other than by reason of death or disability. However, in the event of a participant s termination of employment by reason of death or disability, 50% of the units in his or her account will be forfeited and the remaining units will remain in the account and be payable to the participant on January 31st of the second year following his or her disability or death.

Until the occurrence of an event that would trigger the payment of cash on any outstanding units held in participants accounts is deemed probable by us, no expense for any award under the Cash Plan will be reflected in our financial statements. Because we have not altered the allocation of units previously established and disclosed, and because no event entitling named executive officers to payment under the Cash Plan occurred in 2007, there is no amount reported in the Summary Compensation Table below regarding the Cash Plan.

The number of units allocated to the account of each of the named executive officers is set forth in the table below. The number of units allocated to the accounts of Messrs. Rocco and Robert Ortenzio exceeds the number of units allocated to the other named executive officers due to a higher level of responsibility.

Named Executive Officer	Cash Plan Units
Robert A. Ortenzio	35,000
Rocco A. Ortenzio	25,000
Patricia A. Rice	15,000
Martin F. Jackson	7,000
S. Frank Fritsch	5,000

As described more fully in the Section below entitled Potential Payments upon Termination or Change in Control the named executive officers would be entitled to approximately $74,608,212 under the Cash Plan upon completion of our initial public offering if the value of or return on a Strip of Securities equals or exceeds the targets stated in the Cash Plan and all of our preferred stock is redeemed for payment in full of its accreted value.

As discussed above, the targets stated in the Cash Plan are not expected to be satisfied however, and the $50.0 million bonus payable upon an initial public offering or change in control is not expected to be paid. Because this offering is, however, expected to result in a redemption (within the meaning of the Cash Plan) of a portion of our

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preferred stock, a percentage of the bonus pool may be payable based on the accreted value paid on preferred stock in connection therewith.

In addition, however, our board of directors amended the Cash Plan, effective August 20, 2008. This amendment provides for an additional payment from the bonus pool (not to exceed $10.0 million) upon the completion of an initial public offering occurring prior to March 31, 2009 if the amount of the bonus pool payable as a result of the redemption of preferred stock in connection with such offering does not result in full payment of the amount remaining in that bonus pool ($35.8 million). Accordingly, participants in the Cash Plan are entitled to receive the lesser of $35.8 million dollars or the amount that would otherwise be payable under the Cash Plan upon the redemption of preferred stock plus $10.0 million. Based on the redemption of preferred stock expected to occur in connection with the offering, $ will be payable under the Cash Plan upon the consummation of this offering, with the named executive officers expected to receive the amounts set forth below:

Upon consummation of this offering each of the named executive officers will receive the following payments under the Cash Plan:

Named Executive Officer	**Cash Plan Payment**
Robert A. Ortenzio	$
Rocco A. Ortenzio	$
Patricia A. Rice	$
Martin F. Jackson	$
S. Frank Fritsch	$

Following the consummation of this offering, none of the participants will have any further rights under the terms of the Cash Plan.

Equity Compensation

In connection with us becoming a privately owned corporation in 2005, described in Business The Merger Transactions, we sought to encourage meaningful long term contribution to our future financial success by our named executive officers. Accordingly, we established the 2005 Equity Incentive Plan, or Equity Plan, to provide certain of our employees, including our named executive officers, and employees of our subsidiaries with incentives to help align those employees interests with the interests of our stockholders. Awards under the Equity Plan vest over a period of time based on the applicable employee s continued employment.

Awards under the Equity Plan may be in the form of restricted stock, non-qualified stock options and incentive stock options. As of the end of our last completed fiscal year, the named executive officers have been granted only awards of restricted stock under the Equity Plan. The terms of each award granted under the Equity Plan are governed by the Equity Plan and the applicable award agreement between us and the recipient. Under the terms of the award agreements with each of our named executive officers, upon the occurrence of (1) a change in control, all unvested shares of restricted stock will immediately vest in full and (2) an initial public offering, 50% of the then unvested shares of restricted stock will immediately vest. The terms change in control and initial public offering have the same meanings as in Long Term Cash Incentive Plan, above.

Except with respect to Ms. Rice, all of the unvested shares of restricted stock granted to a named executive officer will be forfeited in the event of his or her termination of employment with us and all of our subsidiaries for any reason. Ms. Rice s award agreement was amended on February 13, 2008 to provide that in the event that her employment is

terminated by us without cause, or if she dies or becomes disabled while employed by us, all of her then unvested shares of restricted stock will immediately vest in full.

No grants were made to our named executive officers under the Equity Plan in 2007 based on the compensation committee s determination that the named executive officers possess a sufficient ownership interest in us and are sufficiently motivated by our bonus compensation programs to continue to contribute to our financial performance.

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Perquisites and Other Personal Benefits

We provide named executive officers with perquisites and other personal benefits that we and the compensation committee believe are reasonable and consistent with our overall compensation program to better enable us to attract and retain highly skilled named executive officers. The compensation committee periodically reviews the levels of perquisites and other personal benefits provided to named executive officers.

The primary perquisite and personal benefit the named executive officers are provided is the personal use of our aircraft at our expense. In recognition of their contributions to us, Messrs. Rocco and Robert Ortenzio and Ms. Rice are entitled to use our aircraft for personal reasons and may be accompanied by friends and family members. Messrs. Rocco and Robert Ortenzio and Ms. Rice must recognize taxable compensation for the value of the personal use of our aircraft by themselves and their friends and family members. Messrs. Jackson and Fritsch, along with other executive officers, may use our aircraft in connection with a personal emergency or bereavement matter with the prior approval of our Executive Chairman or Chief Executive Officer.

We offer full reimbursement for the costs associated with an annual comprehensive physical exam for certain executive officers, including travel and accommodations, so that an executive officer who makes use of our physical exam benefit can be evaluated and receive diagnostic and preventive medical care.

If Ms. Rice retires prior to age 65, we have agreed to provide continued health and dental insurance benefits to Ms. Rice and her eligible dependents following her retirement until she attains age 65. Ms. Rice would be required, during the period that we provide such health and dental insurance benefits, to make contributions toward the cost of such coverage at the same level required for employees who participate in our health and dental coverage.

Attributed costs of the perquisites and personal benefits described above for the named executive officers for the fiscal year ended December 31, 2007, are included in the Summary Compensation Table.

General Benefits

Our named executive officers are also eligible to participate in our group health and dental plans, including short term and long term disability, life insurance (at an amount up to 100% of base salary), and our 401(k) plan on the same terms and conditions as those plans are available to our employees generally.

Employment Agreements

It is our general philosophy that all our employees should be at will employees, thereby allowing both us and the employee to terminate the employment relationship at any time and without restriction or financial obligation. However, in certain cases, we have determined that as a retention device and as a means to obtain non-compete arrangements, employment agreements and change in control agreements are appropriate.

Messrs. Rocco and Robert Ortenzio and Ms. Rice each entered into an employment agreement with Select on March 1, 2000. Each of these employment agreements provides for a three year term which is automatically extended for an additional year on each anniversary of the effective date of the employment agreements unless a written notice of non-renewal is provided by either party at least three months prior to the applicable anniversary date. This automatic renewal provision has the effect of causing these employment agreements to have a continuous three year term. In addition to the compensation and benefits described above, these contracts provide for certain post-employment severance payments in the event of employment termination under certain circumstances.

Each agreement provides for severance upon termination of employment following a change in control, as described under the Section titled Potential Payments upon Termination or Change in Control below. In addition, upon a termination by us without cause or for good reason, such agreements require us to pay each such executive a pro-rated bonus for the year of termination and an amount equal to the base salary they would have received over the remainder of the term had no such termination occurred, provided that such executive adheres to the restrictive covenants contained in such agreement.

Prior to the consummation of this offering we intend to amend each of the executive s employment agreement to comply with recent changes to the tax laws. These amendments are expected to be approved by our board of directors and the executives no later than December 31, 2008 and will include (1) delaying commencement of severance benefits for six months following a termination of employment and (2) providing a pro-rated bonus in the event of certain terminations in connection with a change of control. The terms of these agreements, as are expected

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to be in effect following the amendments, including the severance benefits owed under these agreements, are described more fully in the section titled Potential Payments upon Termination or Change in Control below.

Messrs. Jackson and Fritsch are employees-at-will, and accordingly, elements of their annual compensation are subject to review and adjustment by the compensation committee. However, Messrs. Jackson and Fritsch are each a party to change in control agreements with Select which provide for severance upon the termination of employment in connection with a change in control.

Prior to the consummation of this offering we intend to amend each of the executive s change in control agreement to comply with recent changes to the tax laws. These amendments are expected to be approved by our board of directors and the executives no later than December 31, 2008 and will include delaying commencement of severance benefits for a period of six months following a termination of employment. The terms of these agreements, as are expected to be in effect following the amendments, including the payments owed thereunder, are described more fully in the section titled Potential Payments upon Termination or Change in Control below.

Rocco A. Ortenzio

Select and Mr. Rocco A. Ortenzio, our co-founder, are parties to an employment agreement, dated as of March 1, 2000, as subsequently amended, which is currently effective. Pursuant to the terms of his employment agreement, Mr. Rocco A. Ortenzio is entitled to an annual base salary of $800,000, subject to adjustment by our board of directors. Mr. Rocco A. Ortenzio s base salary was upwardly adjusted by the board of directors until 2003 and has not been increased since.

Mr. Rocco A. Ortenzio is also eligible for bonus compensation under his employment agreement, however our bonus plan for certain executive officers, described in the Compensation Discussion and Analysis section above, is the primary mechanism for determining bonus compensation from us for Mr. Rocco A. Ortenzio.

Mr. Rocco A. Ortenzio s employment agreement also provides that if he is terminated due to his disability, we must make salary continuation payments to him equal to 100% of his annual base salary for ten years after his date of termination or until he is physically able to become gainfully employed in an occupation consistent with his education, training and experience.

Mr. Rocco A. Ortenzio is entitled to up to six weeks paid vacation per year under the terms of his employment agreement.

Robert A. Ortenzio

Select and Mr. Robert A. Ortenzio, our co-founder, are parties to an employment agreement, dated as of March 1, 2000, as subsequently amended, which is currently effective. Pursuant to the terms of his employment agreement, Mr. Robert A. Ortenzio is entitled to an annual base salary of $800,000, subject to adjustment by our board of directors. Mr. Robert A. Ortenzio s base salary was upwardly adjusted by the board of directors until 2003 and has not been increased since.

Mr. Robert A. Ortenzio is also eligible for bonus compensation under his employment agreement, however our bonus plan for certain executive officers, described in the Compensation Discussion and Analysis section above, is the primary mechanism for determining bonus compensation from us for Mr. Robert A. Ortenzio.

Mr. Robert A. Ortenzio s employment agreement also provides that if he is terminated due to his disability, we must make salary continuation payments to him equal to 50% of his annual base salary for ten years after his date of

termination or until he is physically able to become gainfully employed in an occupation consistent with his education, training and experience.

Mr. Robert A. Ortenzio is entitled to up to six weeks paid vacation per year under the terms of his employment agreement.

Patricia A. Rice

Select and Ms. Rice are parties to an employment agreement, effective as of March 1, 2000, as subsequently amended, which is currently effective. Pursuant to the terms of her employment agreement, Ms. Rice serves as our President and Chief Operating Officer. Effective January 1, 2008, Ms. Rice s annual base salary was increased from $500,000 to $750,000.

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On February 13, 2008, Select entered into Amendment No. 6 to the Employment Agreement between Select and Ms. Rice. The amendment provides as follows: (1) Ms. Rice, in carrying out her duties, may use her office in Mechanicsburg, Pennsylvania and/or her home offices in Nicholasville or Lexington, Kentucky and St. Petersburg, Florida, (2) Ms. Rice s base salary was increased to $750,000 per year, (3) Ms. Rice will receive benefits under the Select s Paid Time Off (PTO) & Extended Illness Days (EID) policy in effect from time to time, and (4) Ms. Rice, following a change of control of Select, will be entitled to receive the change of control benefits provided for under the Employment Agreement if, within the one-year period immediately following such change of control, Ms. Rice s employment with Select (1) is terminated by Select without cause, or (2) is terminated by Ms. Rice for any reason. Also on February 13, 2008, we entered into Amendment No. 1 to Restricted Stock Award Agreement with Ms. Rice. The Award Agreement Amendment provides that if during the course of Ms. Rice s employment with Select, Ms. Rice shall die, become disabled or be terminated by Select without cause, then all restricted periods shall terminate, all restricted stock shall be vested in full and all limitations on the restricted stock shall automatically lapse.

Ms. Rice is also eligible for bonus compensation under her employment agreement, however our bonus plan for certain executive officers, described in the Compensation Discussion and Analysis section above, is the primary mechanism for determining bonus compensation from us for Ms. Rice.

Ms. Rice s employment agreement also provides that if she is terminated due to her disability, we must make salary continuation payments to her equal to 50% of her annual base salary for ten years after her date of termination or until she is physically able to become gainfully employed in an occupation consistent with her education, training and experience.

Finally, as described in the Compensation Discussion and Analysis section, above, if Ms. Rice retires before the age of 65, she is entitled to our health and dental insurance coverage for herself and her eligible dependents, following her retirement until she attains age 65. Ms. Rice would be required to contribute to the cost of such coverage at the same level required for employees who participate in our health and dental coverage.

Summary Compensation Table

This Summary Compensation Table summarizes the total compensation paid or earned by each named executive officer for the 2007 and 2006 fiscal year.

Name & Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards ($)[1]	Option Awards ($)	Non-Equity Incentive Plan Compensation ($)	Change in Pension Value ($)	All Other Compensation ($)[2]	Total Compensation ($)
Rocco A. Ortenzio	2007	824,000	229,000					132,451	1,185,451
Executive Chairman	2006	824,000						137,605	961,605
Robert A. Ortenzio	2007	824,000	229,000	2,604,033				108,077	3,765,110
Chief Executive Officer	2006	824,000		2,604,032				150,040	3,578,072
Patricia A. Rice	2007	592,250	164,645	444,618				234,555	1,436,068
President and Chief	2006	592,250		444,617				158,230	1,195,097
Operating Officer									
Martin F. Jackson	2007	371,315	103,225	222,309				28,216	725,065
	2006	371,315	50,000	222,309				6,600	650,224

Executive Vice President and Chief Financial Officer						
S. Frank Fritsch	2007	275,834	76,680	77,067	5,625	435,206
Executive Vice President and Chief Human Resources Officer	2006	275,834	50,000	77,067	5,500	408,401

(1) The dollar amounts reported in this column represent the expense recognized by us in accordance with Statements of Financial Accounting Standards No. 123R, Share-Based Payment (FAS 123R) on outstanding restricted stock awards granted pursuant to the 2005 Equity Incentive Plan. No such expense was recorded for Mr. Rocco Ortenzio s award because the restricted stock award was fully vested prior to 2006. See Note 10 to the Consolidated Financial Statements included in this prospectus for a discussion of the relevant assumptions used in

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calculating value pursuant to FAS 123R. See also the Option Exercises and Stock Vested Table, which shows the corresponding number of shares vesting under each such restricted stock award with respect to which we recognized an expense under FAS 123R.

(2) Mr. Robert A. Ortenzio, Ms. Rice and Mr. Jackson each received an employer matching contribution to our 401(k) plan in the amount of $6,750 in 2007 and $6,600 in 2006. Mr. Fritsch received a matching contribution of $5,625 in 2007 and $5,500 in 2006. The other items reported in this column include the value of personal use of our aircraft and the incremental cost to us of the executive s participation in our executive physical exam program, each in the amounts set forth in the Personal Benefits table below. The incremental cost to us of each of the personal benefits for Mr. Jackson in 2006 and for Mr. Fritsch in both 2006 and 2007 did not exceed $10,000, and accordingly, are not described below.

Personal Benefits

Name		Aircraft Usage ($)	Executive Physical ($)
Rocco A. Ortenzio	2007	132,451	
	2006	137,605	
Robert A. Ortenzio	2007	94,071	7,256
	2006	143,440	
Patricia A. Rice	2007	227,805	
	2006	149,023	2,607
Martin F. Jackson	2007	12,734	8,732
	2006		

Outstanding Equity Awards at Fiscal Year End Table

	Stock Awards