SELECT MEDICAL HOLDINGS CORP
Form S-1/A
October 06, 2008

As filed with the Securities and Exchange Commission on October 6, 2008

Registration No. 333-152514

SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Amendment No. 2 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.

Subject to Completion, Dated , 2008

Shares

Select Medical Holdings Corporation

Common Stock

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

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

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

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

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

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

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

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

Morgan Stanley	**Merrill Lynch & Co.**	**Goldman, Sachs & Co.**
J.P. Morgan	**Wachovia Securities**	**Credit Suisse**
	Jefferies & Company	

Prospectus dated , 2008

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

PROSPECTUS SUMMARY

The following summary highlights information contained elsewhere in this prospectus and is qualified in its entirety by more detailed information and consolidated financial statements included elsewhere in this prospectus. Because it is a summary, it does not contain all of the information that you should consider before investing in our common stock. You should read this prospectus carefully, including the section entitled Risk Factors and the consolidated financial statements and the related notes to those statements included elsewhere in this prospectus. 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 June 30, 2008, we operated 88 long term acute care hospitals and four inpatient rehabilitation facilities in 25 states, and 970 outpatient rehabilitation clinics in 37 states and the District of Columbia. We also provide medical rehabilitation services on a contract basis at nursing homes, hospitals, assisted living and senior care centers, schools and worksites. We began operations in 1997 under the leadership of our current management team, including our co-founders, Rocco A. Ortenzio and Robert A. Ortenzio, who have a combined 66 years of experience in the healthcare industry. Under this leadership, we have grown our business from its founding to a business that generated net operating revenue of $1,991.7 million for the year ended December 31, 2007.

Business Segments and Strategy

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

Specialty Hospitals

The key elements to our specialty hospital strategy are to:

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

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

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

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

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

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

Outpatient Rehabilitation

The key elements to our outpatient rehabilitation strategy are to:

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

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

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

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

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

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

Our Competitive Strengths

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

Leading Operator in Distinct but Complementary Lines of Business. We believe that we are a leading operator in each of our principal business segments, based on number of facilities in the United States. Our leadership position and reputation as a high quality, cost-effective health care provider in each of our business segments allows us to attract patients and employees, aids us in our marketing efforts to payors and referral sources and helps us negotiate payor contracts.

Proven Financial Performance and Strong Cash Flow. We have established a track record of improving the financial performance of our facilities due to our disciplined approach to revenue growth, expense management and an intense focus on free cash flow generation.

Significant Scale. By building significant scale in each of our business segments, we have been able to leverage our operating costs by centralizing administrative functions at our corporate office. As a result, we have been able to minimize our general and administrative expense as a percentage of revenues, which was 2.2% for the year ended December 31, 2007.

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

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

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

Industry

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

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

Risk Factors

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

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

Reliance on Medicare reimbursement. Approximately 48% and 46% of our net operating revenues for the year ended December 31, 2007 and the six months ended June 30, 2008, respectively, came from the highly regulated federal Medicare program. If there are changes in the rates or methods of government reimbursements for our services, our business, financial condition and results of operations could decline.

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

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

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

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

Company Information

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

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

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

THE OFFERING

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

	indentures governing Select s senior subordinated notes due 2015, which we refer to as Select s 75/8% senior subordinated notes, and our senior floating rate notes due 2015, which we refer to as the senior floating rate notes. See Description of Indebtedness Senior Secured Credit Facility Restrictive Covenants and Other Matters and Risk Factors.
Proposed New York Stock Exchange symbol	SLC.
Risk factors	Investment in our common stock involves substantial risks. You should read this prospectus carefully, including the section entitled Risk Factors and the consolidated financial statements and the related notes to those statements included elsewhere in this prospectus before investing in our common stock.

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.

SUMMARY HISTORICAL AND OTHER FINANCIAL DATA

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

The pro forma as adjusted consolidated financial statements of operations for the year ended December 31, 2007 and for the six months ended June 30, 2008 gives effect to (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 June 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 June 30, 2008. The pro forma consolidated financial statement of operations excludes non-recurring charges directly attributable to the offering, including $ million (net of tax) related to payments under the Long Term Cash Incentive Plan and $ million (net of tax) related to reimbursing the selling stockholders for the underwriting discounts and commissions incurred on shares sold by them in this offering. You should read this information in conjunction with Unaudited Pro Forma Consolidated Financial Information included elsewhere in this prospectus.

	Predecessor Period	Successor Period			
	Period from January 1 through February 24, 2005	Period from February 25 through December 31, 2005	Year Ended December 31, 2006	Year Ended December 31, 2007	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		

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

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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

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

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

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

(3) In connection with the Merger Transactions, Select completed tender offers for all of its 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 as an alternative to, or substitute for, net income, cash flows generated by operations, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because Adjusted

EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies. See footnote 13 to our audited consolidated financial statements and footnote 7 to our interim unaudited consolidated financial statements for the period ended June 30, 2008 for a reconciliation of net income to Adjusted EBITDA as utilized by us in reporting our segment performance in accordance with SFAS No. 131.

(9) Net revenue per patient day is calculated by dividing specialty hospital patient service revenues by the total number of patient days.

(10) Clinic data has been restated to remove the clinics operated by Canadian Back Institute Limited, which we refer to as CBIL, which was sold on March 31, 2006 and is being reported as a discontinued operation in 2005 and 2006.

(11) The number of clinics closed/sold for the year ended December 31, 2007 relate primarily to clinics closed in connection with the restructuring plan for integrating the acquisition of HealthSouth Corporation s outpatient rehabilitation division.

(12) Net revenue per visit is calculated by dividing outpatient rehabilitation clinic revenue by the total number of visits. For purposes of this computation, outpatient rehabilitation clinic revenue does not include contract services revenue.

RISK FACTORS

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

Risks Relating to Our Business and Industry

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

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

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

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

- facility and professional licensure, including certificates of need;
- conduct of operations, including financial relationships among healthcare providers, Medicare fraud and abuse, and physician self-referral;
- addition of facilities and services and enrollment of newly developed facilities in the Medicare program;
- payment for services; and
- safeguarding protected health information.

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

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

On August 11, 2004, CMS published final regulations applicable to long term acute care hospitals that are operated as hospitals within hospitals or as satellites. We collectively refer to hospitals within hospitals and satellites as HIHs, and we refer to the CMS final regulations as the final regulations. HIHs are separate hospitals located in space leased from, and located in or on the same campus of, another hospital. We refer to such other hospitals as host hospitals.

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

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

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

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

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

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

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

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

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

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

The SCHIP Extension Act imposed a three year moratorium beginning on December 29, 2007 on the establishment and classification of new LTCHs, LTCH satellite facilities and LTCH beds in existing LTCH or satellite facilities. The moratorium does not apply to LTCHs that, before December 29, 2007, (1) began the qualifying period for payment under the LTCH-PPS, (2) had a written agreement with an unrelated party for the construction, renovation, lease or demolition for a LTCH and had expended at least 10% of the estimated cost of the project or $2,500,000, or (3) had obtained an approved certificate of need. The moratorium also does not apply to an increase in beds in an existing hospital or satellite facility if the LTCH is located in a state where there is only one other LTCH and the LTCH requests an increase in beds following the closure or the decrease in the number of beds of the other LTCH. Since we may still acquire LTCHs that were in existence prior to December 29, 2007, we do not expect this moratorium to materially impact our strategy to expand by acquiring additional LTCHs if such LTCHs can be acquired at attractive valuations. This moratorium, however, may still otherwise adversely affect our ability to increase long term acute care bed capacity, expand into new areas or increase bed capacity in existing areas we serve.

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

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

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

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

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

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

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

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

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

CMS and industry stakeholders have, for a number of years, explored the development of facility and patient certification criteria for LTCHs, potentially as an alternative to the current specific payment adjustment features of LTCH-PPS. In its June 2004 Report to Congress, the Medical Payment Advisory Commission 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 June 30, 2008, our four acute medical rehabilitation hospitals were certified by Medicare as inpatient rehabilitation facilities. Under the historic inpatient rehabilitation facility, or IRF, certification criteria that had been in effect since 1983, in order to qualify as an IRF, a hospital was required to satisfy certain operational criteria and demonstrate that, during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75% required intensive rehabilitation services for one or more of ten conditions specified in the regulations. We refer to such 75% requirement as the 75% test. In 2002, CMS became aware that its various contractors were using inconsistent methods to assess compliance with the 75% test and that many inpatient rehabilitation facilities were not in compliance with the 75% test. In response, CMS suspended enforcement of the

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

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

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

Our outpatient rehabilitation clinics receive payments from the Medicare program under a fee schedule. Congress has established annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for outpatient therapy services rendered to any Medicare beneficiary. These annual caps were to go into effect on January 1, 1999. After their adoption, however, Congress imposed a moratorium on the caps through 2002, and then re-imposed the moratorium for 2004 and 2005. Congress allowed the therapy caps to go back into effect on January 1, 2006. Effective January 1, 2008, the annual limit on outpatient therapy services became $1,810 for combined physical and speech language pathology services and $1,810 for occupational therapy services. As directed by Congress in the Deficit Reduction Act of 2005, CMS implemented an exception process for therapy expenses incurred in 2006. Under this process, a Medicare enrollee (or person acting on behalf of the Medicare enrollee) was able to request an exception from the therapy caps if the provision of therapy services was deemed to be medically necessary. Therapy cap exceptions were available automatically for certain conditions and on a case-by-case basis upon submission of documentation of medical necessity. The SCHIP Extension Act extended the cap exception process through June 30, 2008. The Medicare Improvements for Patients and Providers Act of 2008 further extended the caps exceptions process through December 31, 2009. Elimination of the therapy cap exceptions may reduce our future net operating revenues and profitability.

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

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

The Health Insurance Portability and Accountability Act of 1996 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.

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

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

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

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

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

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

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

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

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

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

If we fail to compete effectively with other hospitals, clinics and healthcare providers in our local areas, our net operating revenues and profitability may decline.

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

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

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

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

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

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

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

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

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

We have no operations of our own and derive all of our revenues and cash flow from our subsidiaries. Our subsidiaries are separate and distinct legal entities and have no obligation, contingent or otherwise, to pay any amounts due under our 10% senior subordinated notes and senior floating rate notes, or to make any funds available therefore, whether by dividend, distribution, loan or other payments. In addition, any of our rights in the assets of any of our subsidiaries upon any liquidation or reorganization of any subsidiary will be subject to the prior claims of that subsidiary s creditors, including lenders under Select s senior secured credit facility and holders of Select s 75/8% senior subordinated notes. Our total consolidated balance sheet liabilities as of June 30, 2008 were $2,201.2 million, of which $1,805.5 million constituted indebtedness, including $828.7 of indebtedness (excluding $29.3 million of letters of credit) under Select s senior secured credit facility, $660.0 million of Select s 75/8% senior subordinated notes, $134.8 million of our 10% senior subordinated notes and $175.0 million of our senior floating rate notes. In addition, as of such date, Select would have been able to borrow up to an additional $100.7 million under Select s senior secured credit facility. We and our restricted subsidiaries may incur additional debt in the future, including under Select s existing senior secured credit facility.

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

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

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

Our indebtedness could have important consequences to you. For example, it:

- requires us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, reducing the availability of our cash flow to fund working capital, capital expenditures, development activity, acquisitions and other general corporate purposes;

- increases our vulnerability to adverse general economic or industry conditions;

- limits our flexibility in planning for, or reacting to, changes in our business or the industries in which we operate;

- makes us more vulnerable to increases in interest rates, as borrowings under our senior secured credit facility and the senior floating rate notes, are at variable rates;

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

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

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

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

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

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

See Description of Indebtedness.

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

We and our subsidiaries may be able to incur additional indebtedness in the future. Although our senior secured credit facility, the indentures governing each of Select s 75/8% senior subordinated notes and the senior floating rate notes each contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. Also, these restrictions do not prevent us or our subsidiaries from incurring obligations that do not constitute indebtedness. As of June 30, 2008, we had $100.7 million of revolving loan availability under our senior secured credit facility (after giving effect to $29.3 million of outstanding letters of credit). To the extent new debt is added to our and our subsidiaries current debt levels, the substantial leverage risks described above would increase. See Description of Indebtedness.

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.

Risks Relating to this Offering

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

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

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

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

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

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

- additions or departures of our senior management personnel;

- sales of common stock by our directors and executive officers;

- sales or distribution of common stock by our sponsors;

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

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

- actions by stockholders; and

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

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

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

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

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

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

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

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

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

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

With limited exceptions, as described under the caption Underwriters, these lock-up agreements prohibit a stockholder from selling, contracting to sell or otherwise disposing of any common stock or securities that are convertible or exchangeable for common stock or entering into any arrangement that transfers the economic consequences of ownership of our common stock for at least 180 days from the date of this prospectus. may, however in sole discretion and at any time without notice, release all or any portion of the securities subject to these lock-up agreements. has advised us that has no present intent or arrangement to release any shares subject to a lock-up and will consider the release of any lock-up on a case-by-case basis. Upon a request to release any shares subject to a lock-up, would consider the particular circumstances surrounding the request including, but not limited to, the length of time before the lock-up expires, the number of shares requested to be released, reasons for the request, the possible impact on the market for our common stock and whether the holder of our shares requesting the release is an officer, director or other affiliate of ours. As a result of these lock-up agreements, notwithstanding earlier eligibility for sale under the provisions of Rule 144, none of these shares may be sold until at least 180 days after the date of this prospectus.

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

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

You will suffer immediate and substantial dilution.

The initial public offering price per share is substantially higher than the pro forma net tangible book value per share immediately after the offering. As a result, you will pay a price per share that substantially exceeds the book value of our 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;
- 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 approximately $ million of the proceeds to reimburse the selling stockholders, all of whom are either sponsors, directors or officers of the Company, for the underwriting discount on the shares sold by them. To the extent the proceeds from this offering are used as described above, they will not be available for other corporate purposes.

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

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(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.

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;

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

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

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

USE OF PROCEEDS

We estimate that the net proceeds to us from this offering will be approximately $ million, assuming an initial public offering price of $ per share, which is the midpoint of the range listed on the cover page of this prospectus, and after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. Each $1.00 increase or decrease in the assumed initial public offering price of $ per share would increase or decrease, as applicable, the net proceeds to us by approximately $ 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.

DIVIDEND POLICY

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

CAPITALIZATION

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

on an actual basis; and

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

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

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

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

(1) Reflects the balance sheet liability of our 10% senior subordinated notes calculated in accordance with GAAP. The balance sheet liability so reflected is less than the $150.0 million aggregate principal amount of such notes because such notes were issued with original issue discount. The remaining unamortized original issue discount is $15.2 million at June 30, 2008. Interest on our 10% senior subordinated notes accrues on the full principal amount thereof, and we will be obligated to repay the full principal amount thereof at maturity or upon any mandatory or voluntary prepayment thereof. On any interest payment date on or after February 24, 2010, Holdings will be obligated to pay an amount of accrued original issue discount on the 10% senior subordinated notes if necessary to ensure that the notes will not be considered applicable high yield discount obligations within the meaning of the Internal Reserve Code of 1986, as amended. The $150.0 million aggregate principal payable at maturity on our 10% senior subordinated notes would be reduced by prior payments of accrued original issue discount.

(2) The revolving credit facility is a part of our senior secured credit facility and provides for borrowings of up to $300.0 million of which $100.7 million was available as of June 30, 2008 for working capital and general corporate purposes (after giving effect to $29.3 million of outstanding letters of credit at June 30, 2008).

(3) We borrowed $680.0 million in term loans under our existing senior secured credit facility. Between February 24, 2005 and June 30, 2008 we repaid approximately $21.3 million of our outstanding term loans.

(4) A $1.00 increase (decrease) in the assumed initial public offering price of $ per share, which is the midpoint of the range set forth on the cover page of this prospectus, would increase (decrease) each of total stockholders equity and total capitalization by $ million, assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us.

DILUTION

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

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

		Per Share
Assumed public offering price per share (the midpoint of the range listed on the cover page of this prospectus)		$
Actual net tangible book deficit per share as of June 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 June 30, 2008		$
Dilution per share to new investors		$

If the underwriters exercise in full their over-allotment option to purchase additional shares of our common stock in this offering at the assumed initial public offering price of $ per share, which is the midpoint of the range listed on the cover page of this prospectus, the number of shares of common stock held by existing stockholders will be , 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.

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

	Shares Purchased		Total Consideration		Average Price
	Number	**Percentage**	**Amount**	**Percentage**	**per Share**
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 June 30, 2008. As of June 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.

SELECTED HISTORICAL CONSOLIDATED FINANCIAL DATA

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

	Predecessor Period			Successor Period		
	Year Ended December 31,		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

	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)

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

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

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

(3) In connection with the Merger, Select completed tender offers for all of its 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.

UNAUDITED PRO FORMA CONSOLIDATED FINANCIAL INFORMATION

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

We adjusted our historical consolidated balance sheet at June 30, 2008 and our historical consolidated statement of operations for the year ended December 31, 2007 and the six months ended June 30, 2008 to reflect (1) the 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 June 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 June 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.

UNAUDITED PRO FORMA CONSOLIDATED BALANCE SHEET

	June 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	$ 7,534		$ 7,534		$ 7,534
Accounts receivable, net of allowance for doubtful accounts	335,596		335,596		335,596
Current deferred tax asset	43,424		43,424		43,424
Prepaid income taxes	8,565		8,565	(2)	
Other current assets	24,225		24,225		24,225
Total Current Assets	419,344		419,344		
Property and equipment, net	480,219		480,219		480,219
Goodwill	1,503,262		1,503,262		1,503,262
Other identifiable intangibles	76,229		76,229		76,229
Assets held for sale	13,953		13,953		13,953
Other assets	51,030		51,030		51,030
Total Assets	$ 2,544,037		$ 2,544,037		
LIABILITIES AND STOCKHOLDERS EQUITY					
Current Liabilities:					
Bank overdrafts	$ 14,236		$ 14,236		$ 14,236
Current portion of long term debt and notes payable	10,408		10,408		10,408
Accounts payable	71,399		71,399		71,399
Accrued payroll	58,200		58,200		58,200
Accrued vacation	36,505		36,505		36,505
Accrued interest	37,281		37,281		37,281
Accrued restructuring	11,158		11,158		11,158
Accrued other	69,271		69,271		69,271
Due to third party payors	5,141		5,141		5,141
Total Current Liabilities	313,599		313,599		313,599
	1,795,054		1,795,054	(2)	

Long term debt, net of current portion			
Non-current deferred tax liability	23,928	23,928	23,928
Other non-current liabilities	68,572	68,572	68,572
Total Liabilities	2,201,153	2,201,153	
Minority interest in consolidated subsidiary companies	5,408	5,408	5,408
Preferred stock	503,179	(1)	(2)
Stockholders Equity:			
Common stock	205	(1)	(2)
Capital in excess of par	(290,347)	(1)	(2)
Retained earnings	132,890	(1)	(2)
Accumulated other comprehensive loss	(8,451)	(8,451)	(8,451)
Total Stockholders Equity	(165,703)		
Total Liabilities and Stockholders Equity	$ 2,544,037		

(footnotes begin on page 42)

UNAUDITED PRO FORMA CONSOLIDATED STATEMENT OF OPERATIONS

	Year Ended December 31, 2007								
	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)

UNAUDITED PRO FORMA CONSOLIDATED STATEMENT OF OPERATIONS

	Six Months Ended June 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	$ 1,087,084			$ 1,087,084			$ 1,087,084
Operating expenses	948,992			948,992			948,992
Depreciation and amortization	35,327			35,327			35,327
Total costs and expenses	984,319			984,319			984,319
Income from operations	102,765			102,765			102,765
Interest expense, net	(73,268)			(73,268)		(4)	
Income before minority interests and income taxes	29,497			29,497			
Minority interests in consolidated subsidiary companies	1,071			1,071			1,071
Income before income taxes	28,426			28,426			
Income tax expense	13,973			13,973		(4)	
Net income	14,453			14,453			
Less: Preferred dividends	12,279		(3)			(4)	
Net income available to stockholders	$ 2,174	$		$	$		$
Basic income per common share				$			$
Weighted average basic common shares outstanding							
Diluted income per common share				$			$
Weighted average diluted common shares outstanding							

(footnotes begin on page 42)

NOTES TO UNAUDITED PRO FORMA CONSOLIDATED FINANCIAL INFORMATION

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

(1) We reflected:

(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 June 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 six months ended June 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 six months ended June 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 six months ended June 30, 2008, respectively, related to the reduction in interest expense.

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

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

Overview

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

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

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

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

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

Recent Trends and Events

Acquisition of HealthSouth Corporation s Outpatient Rehabilitation Division

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

Six Months Ended June 30, 2008

For the six months ended June 30, 2008, our net operating revenues increased 11.7% to $1,087.1 million compared to $973.3 million for the six months ended June 30, 2007. This increase in net operating revenues resulted from a 6.6% increase in our specialty hospital net operating revenue and a 25.4% increase in our outpatient rehabilitation net operating revenue. The significant increase in our outpatient rehabilitation net operating revenue is primarily attributable to the net operating revenues generated by clinics acquired from HealthSouth Corporation on May 1, 2007. We had income from operations for the six months ended June 30, 2008 of $102.8 million compared to $120.9 million for the six months ended June 30, 2007. The decline in income from operations is primarily attributable to the operating losses incurred in our specialty hospitals that were opened in 2007 and 2008. Our interest expense for the six months ended June 30, 2008 was $73.5 million compared to $68.0 million for the six months ended June 30, 2007. The increase in interest expense is related to higher average outstanding debt balances existing for the six month period ended June 30, 2008 which resulted primarily from the HealthSouth transaction. Cash flow from operations used $1.0 million of cash for the six months ended June 30, 2008.

Year Ended December 31, 2007

For the year ended December 31, 2007, our net operating revenues increased 7.6% to $1,991.7 million compared to $1,851.5 million for the year ended December 31, 2006. This increase in net operating revenues resulted from a 0.6% increase in our specialty hospital net operating revenue and a 28.3% increase in our outpatient rehabilitation net operating revenue. The significant increase in our outpatient rehabilitation net operating revenue is primarily attributable to the net operating revenues generated by clinics acquired from HealthSouth Corporation in 2007. We had income from operations for the year ended December 31, 2007 of $193.9 million compared to $257.9 million for the year ended December 31, 2006. The decline in income from operations is principally related to a decline in the profitability of our specialty hospitals which resulted primarily from 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.

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).

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 LTC-DRG will be paid at an amount comparable to the IPPS per diem. The SCHIP Extension Act also postpones, for the three year period beginning on December 29, 2007, the SSO policy changes made in the May 2007 final rule.

The May 2007 final rule updated the standard federal rate by 0.71% for RY 2008. As a result, the federal rate for RY 2008 is equal to $38,356.45, compared to $38,086.04 for RY 2007. Subsequently, the SCHIP Extension Act eliminated the update to the standard federal rate that occurred for RY 2008 effective April 1, 2008. This adjustment to the standard federal rate was applied prospectively on April 1, 2008 and reduced the federal rate back to $38,086.04. In a technical correction to the May 2007 final rule, CMS increased the fixed-loss amount for high cost outlier in RY 2008 to $20,738, compared to $14,887 in RY 2007. CMS projected an estimated 0.4% decrease in LTCH payments in RY 2008 due to this change in the fixed-loss amount and the overall impact of the May 2007 final rule to be a 1.2% decrease in total estimated LTCH PPS payments for RY 2008.

The May 2007 final rule provides that beginning with the annual payment rate updates to the LTC-DRG classifications and relative weights for the fiscal year 2008, or FY 2008 (affecting discharges beginning on or after October 1, 2007 and before September 30, 2008), annual updates to the LTC-DRG classification and relative weights are to have a budget neutral impact. Under the May 2007 final rule, future LTC-DRG reclassification and recalibrations, by themselves, should neither increase nor decrease the estimated aggregated LTCH PPS payments.

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

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

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

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

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

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

For the three years following December 29, 2007, the Secretary must impose a moratorium on the establishment and classification of new LTCHs, LTCH satellite facilities, and LTCH beds in existing LTCH or satellite facilities. This moratorium does not apply to LTCHs that, before the date of enactment, (1) began the qualifying period for payment under the LTCH-PPS, (2) have a written agreement with an unrelated party for the construction, renovation, lease or demolition for a LTCH and have expended at least 10% of the estimated cost of the project or $2,500,000, or (3) have obtained an approved certificate of need. As a result of the SCHIP Extension Act s three year moratorium on the development of new LTCHs, we have stopped all LTCH development, except for LTCHs currently under construction that are excluded from the moratorium.

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

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

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

Development of New Specialty Hospitals and Clinics

In addition to the growth of our business through the acquisition and integration of other businesses, we have also grown our business through specialty hospital and outpatient rehabilitation facility development opportunities. Since our inception in 1997 through June 30, 2008, we have internally developed 60 specialty hospitals and 255 outpatient rehabilitation facilities. As a result of the SCHIP Extension Act however, which has a three year moratorium on the development of new LTCHs, we have stopped all 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 50% of net operating revenues for the six months ended June 30, 2008 and 2007, respectively. Approximately 65%, 69% and 73% of our specialty hospital revenues for the years ended December 31, 2007 and 2006, and the combined year ended December 31, 2005, respectively, were received for services provided to Medicare patients. Approximately 63% and 67% of our specialty hospital revenues for the six months ended June 30, 2008 and 2007, respectively, were received for services provided to Medicare patients. For the years ended December 31, 2006 and 2007 and the combined year ended December 31, 2005 and the six months ended June 30, 2008, all of our Medicare payments were paid under prospective payment systems.

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

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

Contractual Adjustments

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

Allowance for Doubtful Accounts

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

We estimate bad debts for total accounts receivable within each of our operating units. We believe our policies have resulted in reasonable estimates determined on a consistent basis. We believe that we collect substantially all of our third-party insured receivables (net of contractual allowances) which include receivables from governmental agencies. To date, we believe there has not been a material difference between our bad debt allowances and the ultimate historical collection rates on accounts receivable. We review our overall reserve adequacy by monitoring historical cash collections as a percentage of net revenue less the provision for bad debts. Uncollected accounts are written off the balance sheet when they are turned over to an outside collection agency, or when management determines that the balance is uncollectible, whichever occurs first.

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

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

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

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

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

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

Insurance

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

Related Party Transactions

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

Consideration of Impairment Related to Goodwill and Other Intangible Assets

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

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

Realization of Deferred Tax Assets

We account for income taxes in accordance with SFAS No. 109, Accounting for Income Taxes, or SFAS No. 109, which requires that deferred tax assets and liabilities be recognized using enacted tax rates for the effect of temporary differences between the book and tax bases of recorded assets and liabilities. SFAS No. 109 also requires that deferred tax assets be reduced by a valuation allowance if it is more likely than not that some portion or all of the deferred tax asset will not be realized. As part of the process of preparing our consolidated financial statements, we estimate our income taxes based on our actual current tax exposure together with assessing temporary differences resulting from differing treatment of items for tax and accounting purposes. We also recognize as deferred tax assets the future tax benefits from net operating loss carryforwards. We evaluate the realizability of these deferred tax assets by assessing their valuation allowances and by adjusting the amount of such allowances, if necessary. Among the factors used to assess the likelihood of realization are our projections of future taxable income streams, the expected timing of the reversals of existing temporary differences and the impact of tax planning strategies that could be implemented to avoid the potential loss of future tax benefits. However, changes in tax codes, statutory tax rates or future taxable income levels could materially impact our valuation of tax accruals and assets and could cause our provision for income taxes to vary significantly from period to period.

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

Uncertain Tax Positions

We record and review quarterly our uncertain tax positions. Reserves for uncertain tax positions are established for exposure items related to various federal and state tax matters. Income tax reserves are recorded when an exposure is identified and when, in the opinion of management, it is more likely than not that a tax position will not be sustained and the amount of the liability can be estimated. While we believe that our reserves for uncertain tax positions are adequate, the settlement of any such exposures at amounts that differ from current reserves may require us to materially increase or decrease our reserves for uncertain tax positions.

Stock Based Compensation

Based on the midpoint of the price range set forth on the cover of this prospectus, the aggregate intrinsic value of our vested outstanding stock options and restricted stock as of June 30, 2008 was $ million, and the aggregate intrinsic value of our unvested outstanding stock options and restricted stock as of June 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.

Operating Statistics

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

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

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

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

Results of Operations

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

	Predecessor Period from January 1 through February 24, 2005	Successor Period from February 25 through December 31, 2005	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