SELECT MEDICAL CORP
Form 424B3
June 24, 2005

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Filed Pursuant to Rule 424B3
Registration No. 333-125846

PROSPECTUS

Select Medical Corporation
Offer to Exchange
$660,000,000 principal amount of our 7^{5}/8% Senior Subordinated Notes due 2015, which have been registered under the Securities Act, for our outstanding 7^{5}/8% Senior Subordinated Notes due 2015

We are offering to exchange new 7^{5}/8% Senior Subordinated Notes due 2015, or the senior subordinated exchange notes, for our currently outstanding 7^{5}/8% Senior Subordinated Notes due 2015, or the outstanding senior subordinated notes. We refer to the outstanding senior subordinated notes as the outstanding notes, the senior subordinated exchange notes as the exchange notes, and the outstanding notes and the exchange notes collectively as the notes. The exchange notes are substantially identical to the outstanding notes, except that the exchange notes have been registered under the federal securities laws, are not subject to transfer restrictions and are not entitled to certain registration rights relating to the outstanding notes. The exchange notes will represent the same debt as the outstanding notes and we will issue the exchange notes under the same indenture as the outstanding notes. We are also hereby offering the subsidiary guarantees of the exchange notes for guarantees of the outstanding notes described herein.

The principal features of the exchange offer are as follows:

- The exchange offer expires at 5:00 p.m., New York City time, on, July 26, 2005, unless extended. We do not currently intend to extend the expiration date of the exchange offer.
- The exchange offer is not subject to any condition other than that the exchange offer not violate applicable law or any applicable interpretation of the Staff of the Securities and Exchange Commission.
- We will exchange the exchange notes for all outstanding notes that are validly tendered and not validly withdrawn prior to the expiration of the exchange offer.
- You may withdraw tendered outstanding notes at any time prior to the expiration of the exchange offer.
- We do not intend to apply for listing of the exchange notes on any securities exchange or automated quotation system.
- We will not receive any proceeds from the exchange offer. We will pay all expenses incurred by us in connection with the exchange offer and the issuance of the exchange notes.

You should consider carefully the risk factors beginning on page 13 of this prospectus before participating in the exchange offer.

Neither the U.S. Securities and Exchange Commission nor any other federal or state agency has approved or disapproved of these securities to be distributed in the exchange offer, nor have any of these organizations determined that this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

The date of this Prospectus is June 24, 2005.

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[Inside Front Cover]

This prospectus incorporates important business and financial information about the company that is not included or delivered with this prospectus. This information is available without charge to security holders upon written or oral request.

Any requests for business and financial information incorporated but not included in this prospectus should be sent to Select Medical Corporation, 4716 Old Gettysburg Road, P.O. Box 2034, Mechanicsburg, Pennsylvania, 17055 Attn: General Counsel. To obtain timely delivery, holders of outstanding notes must request the information no later than five business days before July 26, 2005, the date they must make their investment decision.

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PROSPECTUS SUMMARY

This summary does not contain all of the information that is important to you. Please review this prospectus in its entirety, including the risk factors and our financial statements and the related notes included elsewhere herein, before you decide to invest.

Unless the context otherwise requires, the terms Select, our company, us, we and our refer to Select Medical Corporation together with its subsidiaries, and the terms Holdings and our parent refer to our parent company, Select Medical Holdings Corporation, a Delaware corporation which was formerly known as EGL Holding Company. Select Medical Corporation became a wholly owned subsidiary of Holdings on February 24, 2005 as a result of a merger of EGL Acquisition Corp., a subsidiary of Holdings, with and into Select Medical Corporation, with Select Medical Corporation continuing as the surviving corporation. Unless otherwise noted, references to pro forma and other financial terms have the meanings set forth under Summary Consolidated Financial and Other Data.

The Exchange Offer

On February 24, 2005, EGL Acquisition Corp. completed a private offering of $660.0 million in aggregate principal amount of 7 5/8% senior subordinated notes due 2015, referred to in this prospectus as the outstanding notes. The outstanding notes became our obligations when EGL Acquisition Corp. was merged into Select on February 24, 2005. We entered into an exchange and registration rights agreement with the initial purchasers in the private offering in which we agreed, among other things, to file the registration statement of which this prospectus forms a part within 150 days of the issuance of the outstanding notes. You are entitled to exchange in this exchange offer your outstanding notes for 7 5/8% senior subordinated notes due 2015 (referred to in this prospectus as the exchange notes), which have been registered under the federal securities laws and have substantially identical terms as the outstanding notes, except for the elimination of certain transfer restrictions and registration rights. You should read the discussion under the heading Summary Description of the Exchange Notes and Description of the Exchange Notes for further information regarding the exchange notes.

Our Business

Company Overview

We are a leading operator of specialty hospitals in the United States. We are also a leading operator of outpatient rehabilitation clinics in the United States and Canada. As of March 31, 2005, we operated 99 long-term acute care hospitals in 26 states, four acute medical rehabilitation hospitals, which are certified by Medicare as inpatient rehabilitation facilities, in New Jersey and 753 outpatient rehabilitation clinics in 25 states, the District of Columbia and seven Canadian provinces. 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, both of whom have significant experience in the healthcare industry. Under this leadership, we have grown our business through internal development initiatives and strategic acquisitions.

The Transactions

On February 24, 2005, pursuant to a merger agreement among EGL Acquisition Corp., Holdings and Select, EGL Acquisition Corp. was merged with and into Select. Select continued as the surviving corporation in the merger and as a wholly owned subsidiary of Holdings. Holdings and EGL Acquisition Corp. were Delaware corporations formed at the direction of Welsh, Carson, Anderson & Stowe IX, L.P. (Welsh Carson) for purposes of engaging in the merger and related transactions. In the merger, Select s then-existing stockholders (other than rollover stockholders) and option holders were paid a total purchase price of

approximately $1,827.7 million. The merger and related transactions are collectively referred to in this prospectus as the Transactions and are more fully described below in The Transactions.

The merger was financed by:

- a cash equity investment in Holdings by an investor group lead by our sponsors Welsh Carson and Thoma Cressey Equity Partners Inc. (Thoma Cressey),
- a rollover investment in Holdings by our continuing investors including members of our senior management team and certain of our directors,
- Holdings issuance and sale of senior subordinated notes, preferred stock and common stock to WCAS Capital Partners IV, L.P., an investment fund affiliated with Welsh Carson, Rocco A. Ortenzio, Robert A. Ortenzio and certain other investors who are members of or affiliated with the Ortenzio family,
- borrowings by us under our new senior secured credit facility,
- a portion of our cash on hand, and
- the issuance of the outstanding notes.

In connection with the merger, we commenced tender offers to acquire all of our $9^{1}/2$% senior subordinated notes due 2009 and all of our $7^{1}/2$% senior subordinated notes due 2013. In connection with each such tender offer we sought consents to eliminate substantially all of the restrictive covenants and make other amendments to the indentures governing such notes. Upon the completion of the tender offers on February 24, 2005, holders of all of our $7^{1}/2$% senior subordinated notes and holders of approximately 96.7% of our $9^{1}/2$% senior subordinated notes had delivered consents and tendered their notes in connection with such tender offers and consent solicitations. See The Transactions.

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

Corporate Information

Select Medical Corporation is a corporation organized under the laws of the State of Delaware with principal executive offices located at 4716 Old Gettysburg Road, P.O. Box 2034, Mechanicsburg, Pennsylvania 17055. Our telephone number at our principal executive offices is (717) 972-1100. Our worldwide web address is www.selectmedicalcorp.com. The information on our website is not part of this prospectus.

Summary of the Terms of the Exchange Offer

On February 24, 2005, we completed an offering of $660.0 million in aggregate principal amount of 7 5/8% senior subordinated notes due 2015, which was exempt from registration under the Securities Act.

We sold the outstanding notes to certain initial purchasers, who subsequently resold the outstanding notes to qualified institutional buyers pursuant to Rule 144A under the Securities Act and to non-U.S. persons outside the United States in reliance on Regulation S under the Securities Act.

In connection with the sale of the outstanding notes, we and the subsidiary guarantors entered into an exchange and registration rights agreement with the initial purchasers of the outstanding notes. Under the terms of that agreement, we each agreed to use commercially reasonable efforts to consummate the exchange offer contemplated by this prospectus.

If we and the subsidiary guarantors are not able to effect the exchange offer contemplated by this prospectus, we and the subsidiary guarantors will use commercially reasonable efforts to file and cause to become effective a shelf registration statement relating to the resales of the outstanding notes.

The following is a brief summary of the terms of the exchange offer. Certain of the terms and conditions described below are subject to important limitations and exceptions. For a more complete description of the exchange offer, see The Exchange Offer .

Securities Offered	$660,000,000 in aggregate principal amount of 7 5/8% senior subordinated notes due 2015. We are also hereby offering to exchange the guarantees of the exchange notes for guarantees of outstanding notes as described herein.
Exchange Offer	The exchange notes are being offered in exchange for a like principal amount of outstanding notes. We will accept any and all outstanding notes validly tendered and not withdrawn prior to 5:00 p.m., New York City time, on July 26, 2005. Holders may tender some or all of their outstanding notes pursuant to the exchange offer. However, each of the outstanding notes may be tendered only in integral multiples of $1,000 in principal amount. The form and terms of each of the exchange notes are the same as the form and terms of each of the outstanding notes except that: the exchange notes have been registered under the federal securities laws and will not bear any legend restricting their transfer; each of the exchange notes bear different CUSIP numbers than the applicable outstanding notes; and the holders of the exchange notes will not be entitled to certain rights under the exchange and registration rights agreement, including the provisions for an increase in the interest rate on the applicable outstanding notes in some circumstances.
Resale	Based on an interpretation by the Staff of the SEC set forth in no-action letters issued to third parties, we believe that the exchange notes may be offered for resale, resold and otherwise transferred by you without compliance with the registration and prospectus delivery provisions of the Securities Act provided that: you are acquiring the exchange notes in the ordinary course of your business;

	you have not participated in, do not intend to participate in, and have no arrangement or understanding with any person to participate in the distribution of exchange notes; and
	you are not an affiliate of Select, within the meaning of Rule 405 of the Securities Act.
	Each participating broker-dealer that receives exchange notes for its own account during the exchange offer in exchange for outstanding notes that were acquired as a result of market-making or other trading activity must acknowledge that it will deliver a prospectus in connection with any resale of the exchange notes. Prospectus delivery requirements are discussed in greater detail in the section captioned Plan of Distribution. Any holder of outstanding notes who:
	is an affiliate of Select,
	does not acquire exchange notes in the ordinary course of its business, or
	tenders in the exchange offer with the intention to participate, or for the purpose of participating, in a distribution of exchange notes,
	cannot rely on the aforementioned position of the Staff of the SEC enunciated in Exxon Capital Holdings Corporation, Morgan Stanley & Co. Incorporated or similar no-action letters and, in the absence of an exemption, must comply with the registration and prospectus delivery requirements of the Securities Act in connection with the resale of the exchange notes.
Expiration Date	The exchange offer will expire at 5:00 p.m., New York City time on July 26, 2005 unless we decide to extend the exchange offer. We may extend the exchange offer for the outstanding notes. Any outstanding notes not accepted for exchange for any reason will be returned without expense to the tendering holders promptly after expiration or termination of the exchange offer.
Conditions to the Exchange Offer	The exchange offer is subject to certain customary conditions, some of which may be waived by us.
Procedures for Tendering Outstanding Notes	If you wish to accept the exchange offer, you must complete, sign and date the letter of transmittal, or a facsimile of the letter of transmittal, in accordance with the instructions contained in this prospectus and in the letter of transmittal. You should then mail or otherwise deliver the letter of transmittal, or facsimile, together with the outstanding notes to be exchanged and any other required documentation, to the exchange agent at the address set forth in this prospectus and in the letter of transmittal. If you hold outstanding notes through The Depository Trust Company, or DTC, and wish to participate in the exchange offer, you must comply with the Automated Tender Offer Program procedures of DTC, by which you will agree to be bound by the applicable letter of transmittal.

By executing or agreeing to be bound by the letter of transmittal, you will represent to us that, among other things:

- any exchange notes to be received by you will be acquired in the ordinary course of business;
- you have no arrangement or understanding with any person to participate in the distribution (within the meaning of the Securities Act) of exchange notes in violation of the provisions of the Securities Act;
- you are not an affiliate (within the meaning of Rule 405 under the Securities Act) of Select, or if you are an affiliate, you will comply with any applicable registration and prospectus delivery requirements of the Securities Act; and
- if you are a broker-dealer that will receive exchange notes for your own account in exchange for applicable outstanding notes that were acquired as a result of market-making or other trading activities, then you will deliver a prospectus in connection with any resale of such exchange notes.

See The Exchange Offer Procedures for Tendering and Plan of Distribution.

Effect of Not Tendering in the Exchange Offer	Any outstanding notes that are not tendered or that are tendered but not accepted will remain subject to the restrictions on transfer. Since the outstanding notes have not been registered under the federal securities laws, they bear a legend restricting their transfer absent registration or the availability of a specific exemption from registration. Upon the completion of the exchange offer, we will have no further obligations to register, and we do not currently anticipate that we will register, the outstanding notes not exchanged in this exchange offer under the Securities Act.
Special Procedures for Beneficial Owners	If you are a beneficial owner of outstanding notes that are not registered in your name, and you wish to tender outstanding notes in the exchange offer, you should contact the registered holder promptly and instruct the registered holder to tender on your behalf. If you wish to tender on your own behalf, you must, prior to completing and executing the applicable letter of transmittal and delivering your outstanding notes, either make appropriate arrangements to register ownership of the outstanding notes in your name or obtain a properly completed bond power from the registered holder.
Guaranteed Delivery Procedures	If you wish to tender your outstanding notes and your outstanding notes are not immediately available or you cannot deliver your outstanding notes, the applicable letter of transmittal or any other documents required by the applicable letter of transmittal or comply with the applicable procedures under DTC s Automated Tender Offer Program prior to the expiration date, you must tender your outstanding notes according to the guaranteed delivery procedures set forth in this prospectus under The Exchange Offer Guaranteed Delivery Procedures.

Interest on the Exchange Notes and the Outstanding Notes	The exchange notes will bear interest at their respective interest rates from the most recent interest payment date to which interest has been paid on the outstanding notes or, if no interest has been paid, from February 24, 2005. Interest on the outstanding notes accepted for exchange will cease to accrue upon the issuance of the exchange notes.
Withdrawal Rights	Tenders of outstanding notes may be withdrawn at any time prior to 5:00 p.m., New York City time, on the expiration date.
Material United States Federal Income Tax Considerations	The exchange of outstanding notes for exchange notes in the exchange offer is not a taxable event for U.S. federal income tax purposes. Please read the section of this prospectus captioned Material U.S. Federal Income Tax Considerations for more information on tax consequences of the exchange offer.
Use of Proceeds	We will not receive any cash proceeds from the issuance of exchange notes pursuant to the exchange offer.
Exchange Agent	U.S. Bank Trust National Association, the trustee under the indenture governing the outstanding notes, is serving as exchange agent in connection with the exchange offer. The address and telephone number of the exchange agent are set forth under the heading The Exchange Offer Exchange Agent.

Summary Description of the Exchange Notes

The brief summary below describes the principal terms of the exchange notes. Some of the terms described below are subject to important limitations and exceptions. The Description of the Exchange Notes section of this prospectus contains a more detailed description of the terms of the exchange notes.

Issuer	Select Medical Corporation.
Exchange notes	$660,000,000 in aggregate principal amount of $7^5/8$% senior subordinated notes due 2015.
Maturity date	February 1, 2015.
Interest payment dates	February 1 and August 1, beginning August 1, 2005.
Optional redemption	We may redeem some or all of the notes prior to February 1, 2010 at a price equal to 100% of the principal amount thereof, plus accrued and unpaid interest and a make-whole premium. Thereafter, we may redeem some or all of the notes at the redemption prices set forth in this prospectus. See Description of the Exchange Notes Optional Redemption.
Equity offering optional redemption	At any time before February 1, 2008, we may redeem up to 35% of the aggregate principal amount of the notes at 107.625% of the principal amount thereof, plus accrued and unpaid interest, with the proceeds of one or more equity offerings so long as at least 65% of the originally issued aggregate principal amount of the notes remains outstanding after such redemption.
Change of control	Upon the occurrence of certain change of control events, we will be required to offer to repurchase all or a portion of the notes at a purchase price equal to 101% of the principal amount of the notes, plus accrued and unpaid interest. See Description of the Exchange Notes Repurchase at the Option of Holders Change of Control.
Guarantees	All of our existing and future restricted domestic subsidiaries, other than certain non-guarantor subsidiaries, guarantee the notes on an unsecured senior subordinated basis.
Ranking	The notes are our unsecured senior subordinated obligations and: rank junior to all of our existing and future senior indebtedness, which includes indebtedness under our new senior secured credit facility; rank equally with all of our existing and future senior subordinated indebtedness; rank senior to all of our existing and future subordinated indebtedness; and are effectively subordinated to all of our existing and future secured obligations to the extent of the value of the assets securing such obligations, including indebtedness under our new senior secured credit facility, and to all of the existing and future liabilities of our subsidiaries that do not guarantee the notes.

Similarly, the guarantees of the notes by our subsidiaries:

- rank junior to all of the existing and future senior indebtedness of such subsidiaries, which includes the subsidiary guarantees of our new senior secured credit facility;
- rank equally with all of the existing and future senior subordinated indebtedness of such subsidiaries;
- rank senior to all of the existing and future subordinated indebtedness of such subsidiaries; and
- are effectively subordinated to all of the existing and future secured obligations of such subsidiaries to the extent of the value of the assets securing such obligations, including the subsidiary guarantees of our new senior secured credit facility, and to all of the existing and future liabilities of our subsidiaries that do not guarantee the notes.

As of March 31, 2005, we and our subsidiaries that are guarantors of the notes had approximately $782.9 million of senior debt outstanding to which the notes were subordinated and our subsidiaries that are not guaranteeing the notes had total assets and total liabilities of $49.3 million and $10.3 million, respectively. See Description of the Exchange Notes Subordination.

Certain covenants

The indenture governing the notes contains covenants that, among other things, limit our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness and issue or sell preferred stock,
- pay dividends on, redeem or repurchase our capital stock,
- make investments,
- create certain liens,
- sell assets,
- incur obligations that restrict the ability of our subsidiaries to make dividend or other payments to us,
- guarantee indebtedness,
- engage in transactions with affiliates,
- create or designate unrestricted subsidiaries, and
- consolidate, merge or transfer all or substantially all of our assets and the assets of our subsidiaries on a consolidated basis.

	As of March 31, 2005, all of our subsidiaries were restricted subsidiaries, as defined in the indenture. These covenants are subject to important exceptions and qualifications. See Risk Factors Risks Related to the Notes and Description of the Exchange Notes.
No established market for the exchange notes	The exchange notes generally will be freely transferable but will also be new securities for which there will not initially be a market. Accordingly, we cannot assure you that a market for the exchange

	notes will develop or make any representation as to the liquidity of any market. We do not intend to apply for the listing of the exchange notes on any securities exchange or automated dealer quotation system. The initial purchasers advised us that they intend to make a market in the exchange notes. However, they are not obligated to do so, and any market making with respect to the exchange notes may be discontinued at any time without notice. See Plan of Distribution.
Tax consequences	For a discussion of certain U.S. federal income tax consequences of an investment in the exchange notes, see Material U.S. Federal Income Tax Considerations. You should consult your own tax advisor to determine the federal, state, local and other tax consequences of an investment in the exchange notes.
Risk factors	See Risk Factors beginning on page 13 of this prospectus for a discussion of factors you should carefully consider before deciding to invest in the exchange notes.

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Summary Consolidated Financial and Other Data

You should read the summary consolidated financial and other data below in conjunction with our consolidated financial statements and the accompanying notes and Unaudited Pro Forma Condensed Consolidated Financial Information. All of these materials are contained later in this prospectus. We derived the historical financial data for the years ended December 31, 2002, 2003 and 2004, and as of December 31, 2002, 2003 and 2004 from our audited consolidated financial statements. We derived the historical financial data for the three months ended March 31, 2004, the period from January 1, 2005 through February 24, 2005 and the period from February 25, 2005 through March 31, 2005, and as of March 31, 2004 and 2005, from our unaudited interim consolidated financial statements. You should also read Selected Historical Consolidated Financial Data and the accompanying Management s Discussion and Analysis of Financial Condition and Results of Operations. The unaudited pro forma condensed consolidated statement of operations data for the three months ended March 31, 2005 present results of operations before cumulative effects of accounting changes and are pro forma for the Transactions as if the Transactions had been completed on January 1, 2005. The unaudited pro forma condensed consolidated statement of operations data for the year ended December 31, 2004 present results of operations before cumulative effects of accounting changes and are pro forma for the Transactions, as if the Transactions had been completed on January 1, 2004. By definition, our statements of financial position and results of operations subsequent to the Transactions are not comparable to the same statements for the periods prior to the Transactions due to the resulting change in basis.

	Predecessor						Successor	
	Year Ended December 31,				Three Months Ended March 31, 2004	Period from January 1, through February 24, 2005	Period from February 25, through March 31, 2005	Pro Forma Three Months Ended March 31, 2005(1)
	2002	2003	2004	2004 Pro Forma(1)				
	(Dollars in thousands)							
Statement of Operations Data:								
Net operating revenues	$ 1,126,559	$ 1,392,366	$ 1,660,791	$ 1,660,791	$ 418,469	$ 287,787	$ 195,112	$ 482,899
Operating expenses(2)	999,280	1,207,913	1,389,281	1,389,281	348,997	239,573	154,573	394,146
Stock compensation associated with the merger(3)						142,213	4,326	146,539
Depreciation and amortization	25,836	34,654	39,977	46,391	10,197	6,177	4,248	11,494
Income (loss) from operations	101,443	149,799	231,533	225,119	59,275	(100,176)	31,965	(69,280)
						(42,736)		(42,736)

Loss on early retirement of debt(4)								
Merger related charges(5)						(12,025)		(12,025)
Equity in income from joint ventures		824						
Interest expense, net(6)	(26,614)	(25,404)	(31,051)	(95,997)	(9,053)	(4,211)	(9,559)	(24,050)
Income (loss) from continuing operations before minority interests and income taxes	74,829	125,219	200,482	129,122	50,222	(159,148)	22,406	(148,091)
Minority interests(7)	2,022	2,402	3,448	3,448	1,006	469	462	931
Income (loss) from continuing operations before income taxes	72,807	122,817	197,034	125,674	49,216	(159,617)	21,944	(149,022)
Income tax provision (benefit)	28,576	48,597	79,602	50,772	19,793	(59,366)	8,871	(54,658)
Income (loss) from continuing operations	44,231	74,220	117,432	$ 74,902	29,423	(100,251)	13,073	$ (94,364)
Income from discontinued operations, net		251	752		147			
Net income (loss)	$ 44,231	$ 74,471	$ 118,184		$ 29,570	$ (100,251)	$ 13,073	
Other Financial Data:								
Capital expenditures	$ 43,183	$ 35,852	$ 32,626		$ 7,762	$ 2,586	$ 1,112	

Ratio of earnings to fixed charges(8)	2.3x	3.1x	3.9x	3.8x	n/a	2.7x
Cash Flow Data						
Net cash provided by (used in) operating activities	$ 120,812	$ 246,248	$ 174,276	$ 76,529	$ 19,056	$ (191,971)
Net cash used in investing activities	(54,048)	(261,452)	(21,928)	(11,177)	(110,865)	(3,327)
Net cash provided by (used in) financing activities	(21,423)	124,318	(70,990)	(20,042)	202	58,816
Balance Sheet Data (at end of period):						
Cash and cash equivalents	$ 56,062	$ 165,507	$ 247,476	$ 210,784		$ 19,343
Working capital	130,621	188,380	313,715	210,878		157,965
Total assets	739,059	1,078,998	1,113,721	1,116,986		2,169,424
Total debt	260,217	367,503	354,590	364,744		1,450,097
Total stockholders equity	286,418	419,175	515,943	440,760		449,584

Selected Operating Data

The following table sets forth operating statistics for our specialty hospitals and our outpatient rehabilitation business for each of the periods presented. The data in the table reflects the changes in the number of long-term acute care hospitals and outpatient rehabilitation clinics we operate that resulted from acquisitions, start-up activities and closures. The operating statistics reflect data for the period of time these operations were managed by us. Further information on our acquisition activities can be found in Management s Discussion and Analysis of Financial Condition and Results of Operations Operating Statistics and the notes to our consolidated financial statements.

	Year Ended December 31,			Three Months Ended March 31,	
	2002	2003	2004	2004	2005
	(Dollars in thousands)				
Specialty hospital data:					
Number of hospitals start of period	64	72	83	83	86
Number of hospital start-ups	8	8	4		
Number of hospitals acquired		4			17
Number of hospitals closed		(1)	(1)		
Number of hospitals end of period(9)	72	83	86	83	103
Available licensed beds(10)	2,594	3,204	3,403	3,256	3,907
Admissions(11)	21,065	27,620	33,523	8,738	10,336
Patient days(12)	619,322	722,231	816,898	212,727	250,839
Average length of stay (days)(13)	30	26	24	25	25
Occupancy rate(14)	71%	70%	67%	72%	71%
Percent patient days Medicare(15)	76%	76%	74%	75%	77%
Outpatient rehabilitation data:					
Number of clinics start of period	664	679	758	758	705
Number of clinics acquired	14	125	5	2	7
Number of clinics start-ups	49	30	20	4	9
Number of clinics closed/sold	(48)	(76)	(78)	(23)	(6)
Number of clinics owned end of period	679	758	705	741	715
Number of clinics managed end of period(16)	58	32	36	36	38
Total number of clinics	737	790	741	777	753

(1) Our recent acquisition of SemperCare, Inc. does not meet the significance thresholds under Rule S-X and accordingly is excluded from the Unaudited Pro Forma Condensed Consolidated Financial Information. See Management s Discussion and Analysis of Financial Condition and Results of Operations Recent Trends and Events SemperCare Acquisition.

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

(3) Consists of stock compensation expense related to the repurchase of outstanding stock options in the Predecessor period from January 1, 2005 through February 24, 2005 and compensation expense related to restricted stock and a warrant that were issued in the Successor period from February 25, 2005 through March 31, 2005.

(4) In connection with the merger, we tendered for all of our $9^{1}/2\%$ senior subordinated notes due 2009 and all of our $7^{1}/2\%$ senior subordinated notes due 2013. The loss in the Predecessor period of January 1, 2005 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.

(5) As a result of the merger, we incurred costs in the Predecessor period of January 1, 2005 through February 24, 2005 directly related to the merger. This included the cost of the investment advisor hired by the Special Committee of the Board of Directors to evaluate the merger, legal and accounting fees, costs associated with the Hart-Scott-Rodino filing relating to the merger, cost associated with purchasing a six year extended reporting period under our directors and officers liability insurance policy and other associated expenses.

(6) Net interest equals interest expense minus interest income.

(7) Reflects interests held by other parties in subsidiaries, limited liability companies and limited partnerships owned and controlled by us.

(8) For purposes of computing the ratio of earnings to fixed charges, earnings consist of income (loss) from continuing operations before income taxes, fixed charges, minority interest in income of subsidiaries, and income (loss) from unconsolidated joint ventures. Fixed charges include preferred dividend requirements of subsidiaries, deemed dividends on preferred stock conversion, interest expense, and the portion of operating rents that is deemed representative of an interest factor. For the period January 1, 2005 through February 24, 2005 (Predecessor period), the ratio coverage was less than 1:1. We would have had to generate additional earnings of approximately $159.1 million to achieve a coverage ratio of 1:1.

(9) As of March 31, 2005, we owned 100% of the equity interests in all of our hospitals except for two hospitals that had a 14% minority owner, three hospitals that had a 3% minority owner and two hospitals that had a 9% minority owner.

(10) Available licensed beds are the number of beds that are licensed with the appropriate state agency and which are readily available for patient use at the end of the period indicated.

(11) Admissions represent the number of patients admitted for treatment.

(12) Patient days represent the total number of days of care provided to patients.

(13) Average length of stay (days) represents the average number of days patients stay in our hospitals per admission, calculated by dividing total patient days by the number of discharges for the period.

(14) We calculate occupancy rate by dividing the average daily number of patients in our hospitals by the weighted average number of available licensed beds over the period indicated.

(15) We calculate percent patient days Medicare by dividing the number of Medicare patient days by the total number of patient days.

(16) Managed clinics are clinics that we operate through long-term management arrangements and clinics operated through unconsolidated joint ventures.

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RISK FACTORS

Investing in the notes involves a number of risks and uncertainties, many of which are beyond our control. You should carefully consider each of the risks and uncertainties we describe below and all of the other information in this prospectus before deciding to invest in the notes. The risks and uncertainties we describe below are not the only ones we face. Additional risks and uncertainties that we do not currently know about or that we currently believe to be immaterial may also adversely affect our business, operations, financial condition or financial results.

Risks Related to Our Businesses

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

On August 11, 2004, the Centers for Medicare & Medicaid Services, also known as CMS, published final regulations applicable to long-term acute care hospitals that are operated as hospitals within hospitals or as satellites (collectively referred to as HIHs). HIHs are separate hospitals located in space leased from, and located in, general acute care hospitals, known 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 hosts 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%. For HIHs that meet specified criteria and were in existence as of October 1, 2004, including all of our existing HIHs, the Medicare admissions thresholds will be phased-in over a four-year period starting with hospital cost reporting periods beginning on or after October 1, 2004, as follows: (i) for discharges during the cost reporting period beginning on or after October 1, 2004 and before October 1, 2005, the Medicare admissions threshold is the Fiscal 2004 Percentage (as defined below) of Medicare discharges admitted from the host hospital; (ii) for discharges during the cost reporting period beginning on or after October 1, 2005 and before October 1, 2006, the Medicare admissions threshold is the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 75%; (iii) for discharges during the cost reporting period beginning on or after October 1, 2006 and before October 1, 2007, the Medicare admissions threshold is the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 50%; and (iv) for discharges during cost reporting periods beginning on or after October 1, 2007, the Medicare admissions threshold is 25%. As used above, Fiscal 2004 Percentage means, with respect to any HIH, the percentage of all Medicare patients discharged by such HIH during its cost reporting period beginning on or after October 1, 2003 and before October 1, 2004 who were admitted to such HIH from its host hospital. As of December 31, 2004, 78 of our 82 long-term acute care hospitals operated as HIHs. For the year ended December 31, 2004, approximately 60% of the Medicare admissions to our HIHs were from host hospitals. For the year ended December 31, 2004, approximately 9% of our HIHs admitted 25% or fewer of their Medicare patients from their host hospitals, approximately 31% of our HIHs admitted 50% or fewer of their Medicare patients from their host hospitals, and approximately 78% of our HIHs admitted 75% or fewer of their Medicare patients from their host hospitals. There are several factors that should be taken into account in evaluating this admissions data. First, the admissions data for the year ended December 31, 2004 is not necessarily indicative of the admissions mix these hospitals will experience in the future. Second, admissions data for the year ended December 31, 2004 includes four hospitals that were open for less than one year, and the data from these hospitals may not be indicative of the admissions mix these hospitals will experience over a longer period of time. Third, admissions data for the year ended December 31, 2004 does not include admissions data for the hospitals recently acquired in the SemperCare acquisition. See Management s Discussion and Analysis of Financial Condition and Results of Operations Recent Trends and Events SemperCare Acquisition.

We currently anticipate that these new HIH regulations will have only a negligible impact on our 2005 financial results but could have a significant negative impact on our financial results thereafter. In order to minimize the more significant impact of the HIH regulations in 2006 and future years, we have developed a business plan and strategy in each of our markets to adapt to the HIH regulations and maintain our company s

current business. Our transition plan includes managing admissions at existing HIHs, relocating certain HIHs to leased spaces in smaller host hospitals in the same markets, consolidating HIHs in certain of our markets, relocating certain of our facilities to alternative settings, building or buying free-standing facilities and closing a small number of facilities. There can be no assurance that we can successfully implement such changes to our existing HIH business model or successfully control the capital expenditures associated with such changes. As a result, our ability to operate our long-term acute care hospitals effectively and our net operating revenues and profitably may be adversely affected. For example, because physicians generally direct the majority of hospital admissions, our net operating revenues and profitability may decline if the relocation efforts for certain of our HIHs adversely affect our relationships with the physicians in those communities. See Our Business Specialty Hospitals Recent HIH Regulatory Changes and Our Business Government Regulations Overview of U.S. and State Government Reimbursements Regulatory Changes.

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 March 31, 2005, 97 of our 99 long-term acute care hospitals were certified by Medicare as long-term acute care hospitals, and two 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, namely minimum average length of patient stay, they will receive payments under the prospective payment system applicable to general acute care hospitals rather than payment under the system applicable to long-term acute care hospitals. Payments at rates applicable to general acute care hospitals would likely result in our long-term acute care hospitals receiving less Medicare reimbursement than they currently receive for their patient services. In its preamble to the May 6, 2005 final rule updating the long-term acute care Medicare prospective payment system, CMS confirmed that it had awarded a contract to Research Triangle Institute, International (RTI) to examine recent recommendations made by the Medicare Payment Advisory Commission, or MedPAC, concerning how long-term acute care hospitals are defined and differentiated from other types of Medicare providers. MedPAC is an independent federal body that advises Congress on issues affecting the Medicare program. In its June 2004 Report to Congress, MedPAC recommended the adoption by CMS of new facility staffing and services criteria and patient clinical characteristics and treatment requirements for long-term acute care hospitals in order to ensure that only appropriate patients are admitted to these facilities. CMS anticipates making RTI s findings available in the proposed prospective payment system update to be published in early 2006. Although CMS has so far declined to impose the MedPAC recommended criteria, the agency has stated that if RTI s analysis suggests that changes should be made affecting long-term acute care hospital payments, discharges or certification criteria, statutory or regulatory modifications to implement these changes may be required. Failure to meet existing long-term acute care certification criteria or implementation of additional criteria that would limit the population of patients eligible for our hospitals services could adversely affect our net operating revenues and profitability.

Nearly all of our long-term acute care hospitals operate as HIHs and as a result are subject to additional Medicare criteria that require certain indications of separateness from the host hospital. If any of our long-term acute care HIHs fail to meet the separateness requirements, they will be reimbursed at the lower general acute care hospital rate, which would likely cause our net operating revenues and profitability to decrease. See Our 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 for our inpatient rehabilitation facilities as required in order to achieve compliance with Medicare regulations may result in a loss of patient volume at these hospitals and, as a result, may reduce our future net operating revenues and profitability.

As of March 31, 2005, 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

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certain operational criteria as well as demonstrate that, during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75% required intensive rehabilitation services for one or more of ten conditions specified in the regulations (referred to 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, in June 2002, CMS suspended enforcement of the 75% test and, on September 9, 2003, proposed modifications to the regulatory standards for certification as an 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 or changes to the 75% test for additional study of clinically appropriate certification criteria, on May 7, 2004, CMS adopted a final rule 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 10 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 requires the Secretary of Health and Human Services to respond within 60 days to a report by the Government Accountability Office, or GAO, on the standards for defining inpatient rehabilitation services before the Secretary may terminate a hospital s designation as an inpatient rehabilitation facility for failure to meet the 75% test. The GAO issued its report on April 22, 2005, and recommended that CMS, based on further research, refine the 75% test to describe more thoroughly the subgroups of patients within the qualifying conditions that are appropriate for care in an inpatient rehabilitation facility. The Secretary has not yet issued a formal response to the GAO report. The inpatient rehabilitation facilities we acquired as part of our Kessler acquisition in September 2003 may not have fully met the historic standard. If the revised 75% test is ultimately enforced without further modifications, in order to achieve compliance with the new certification standard, 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 decreased patient volumes, which could have a negative effect on the financial performance of these facilities. See Our Business Government Regulations Overview of U.S. and State Government Reimbursements Inpatient rehabilitation facility Medicare reimbursement.

Implementation of annual caps that limit the amounts 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 amounts 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, however, after their adoption, Congress imposed a moratorium on the caps through 2002, and then re-imposed the moratorium for 2004 and 2005. Upon the expiration of the moratorium, we believe these therapy caps could have an adverse effect on the net operating revenues we generate from providing outpatient rehabilitation services to Medicare beneficiaries, to the extent that such patients receive services for which total payments would exceed the annual caps. For the year ended December 31, 2004, we received approximately 9% of our outpatient rehabilitation net operating revenues from Medicare. See Our Business Government Regulations Overview of U.S. and State Government Reimbursements Outpatient rehabilitation services Medicare reimbursement.

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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% of our net operating revenues for the year ended December 31, 2004 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 in Congress or by CMS. Because of the possibility of adoption of these kinds of proposals, the availability, methods and rates of Medicare reimbursements for services of the type furnished at our facilities could change at any time. 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 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; and
- payment for services.

Recently, 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 our current practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services and capital expenditure programs, 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 an investigation or other enforcement action under these laws or regulations. See Our Business Government Regulations.

Integrating SemperCare into our company structure may strain our resources and prove to be difficult.

On January 1, 2005, we acquired SemperCare, Inc., or SemperCare, which operated 17 long-term acute care hospitals in 11 states. Six of the SemperCare facilities are in markets that overlapped with other Select hospital markets. The expansion of our business and operations resulting from the recent SemperCare acquisition may strain our administrative, operational and financial resources. The continued integration of SemperCare into our business will require substantial time, effort, attention and dedication of management resources and may distract our management from our existing business in unpredictable ways and may take longer than anticipated. The integration process could create a number of potential challenges and adverse consequences for us, including the difficulty and expense of integrating acquired personnel into our existing business, the difficulty and expense of integrating SemperCare s billing and information systems with ours, the possible unexpected loss of key employees, customers or suppliers, a possible loss of net operating revenues or an increase in operating or other costs and the assumption of liabilities and exposure to unforeseen liabilities of SemperCare. Additionally, all of the SemperCare facilities are HIHs, and while we expect to transition these facilities to adapt to the new HIH regulations within a similar timeframe and using strategies similar to those

that we will use to transition our existing hospitals, there can be no assurance that such transition will be successful. These types of challenges and uncertainties could have an adverse effect on our business, financial condition and results of operations. We may not be able to manage the combined operations and assets effectively or realize any anticipated benefits of the SemperCare acquisition, including a reduction of corporate overhead expenses.

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 and outpatient rehabilitation clinics. 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 involve numerous risks, including:

- the 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 our markets, our net operating revenues may decrease.

Our success is, in part, 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 markets 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.

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 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, 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 markets 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 on our ability to retain and motivate these individuals. The loss of the services of any of our senior officers or key employees, particularly our executive officers named in Management Executive Officers and Directors, 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.

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large claims and significant defense costs. We are also subject to lawsuits under a federal whistleblower statute designed to combat fraud and abuse in the healthcare industry. These lawsuits can involve significant monetary damages and award bounties to private plaintiffs who successfully bring the suits. See Our Business Legal Proceedings Other Legal Proceedings.

We maintain professional malpractice liability insurance and general liability insurance coverage. As a result of unfavorable pricing and availability trends in the professional liability insurance market and the insurance market in general, the cost and risk sharing components of professional liability coverage have changed dramatically. 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 and the significant failures of some nationally known insurance underwriters. In some instances, insurance underwriters will no longer issue new policies in certain states that have a history of high medical malpractice awards. As a result, we have experienced substantial changes in our medical and professional malpractice insurance program. Among other things, in order to obtain malpractice insurance at a reasonable cost, we are required to assume substantial self-insured retentions for our professional liability claims. A self-insured retention is a minimum amount of damages and expenses (including legal fees) that we must pay for each claim. We use actuarial methods to

determine the value of the losses that may occur within this self-insured retention level. Our insurance agreements require us to post letters of credit or set aside cash in a trust arrangement in an amount equal to the estimated losses that we assumed for previous policy years. Because of the high retention levels, we cannot predict with certainty the actual amount of the losses we will assume and pay. To the extent that subsequent claims information varies from loss estimates, the liabilities will be adjusted to reflect current loss data. There can be no assurance that in the future malpractice insurance will be available at a reasonable price or that we will not have to further increase our levels of self-insurance. In addition, our insurance coverage does not cover punitive damages and may not cover all claims against us. See Our Business Government Regulations Other Healthcare Regulations and Management s Discussion and Analysis of Financial Condition and Results of Operations Medical and Professional Malpractice Insurance.

Risks Related to the Notes

Our substantial indebtedness may limit the amount of cash flow that is available to invest in the ongoing needs of our business, which could prevent us from generating the future cash flow needed to fulfill our obligations under the notes.

We have a substantial amount of indebtedness. As of March 31, 2005, we had approximately $1.5 billion of total indebtedness and a total debt to total capitalization ratio of 0.76 to 1.0.

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 new senior secured credit facility 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; or
- places us at a competitive disadvantage compared to our competitors that have less indebtedness.

See Capitalization, Unaudited Pro Forma Condensed Consolidated Financial Information, and Description of Certain Other Indebtedness Our New Senior Secured Credit Facility.

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 new senior secured credit facility and the indenture governing the 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 March 31, 2005, we had $83.6 million of revolving loan availability under our new senior secured credit facility with $16.4 million in outstanding letters of credit, all of which are senior to the notes. To the extent new debt is added to our and our subsidiaries currently anticipated debt levels, the substantial leverage risks described above would increase. See Description of the Exchange Notes and Description of Certain Other Indebtedness Our New Senior Secured Credit Facility.

To service our indebtedness and meet our other ongoing liquidity needs, we will require a significant amount of cash. Our ability to generate cash depends on many factors beyond our control, including possible changes in government reimbursement rates or methods. If we cannot generate the required cash, we may not be able to make the required payments under the notes.

Our ability to make payments on our indebtedness, including the notes, and to fund our planned capital expenditures and our other ongoing liquidity needs will depend on our ability to generate cash in the future. Our future financial results will be subject to substantial fluctuations upon a significant change in government reimbursement rates or methods. We cannot assure you that our business will generate sufficient cash flow from operations to enable us to pay our indebtedness, including our indebtedness in respect of the notes, or to fund our other liquidity needs. Our inability to pay our debts would require us to pursue one or more alternative strategies, such as selling assets, refinancing or restructuring our indebtedness or selling equity capital. However, we cannot assure you that any alternative strategies will be feasible at the time or provide adequate funds to allow us to pay our debts as they come due and fund our other liquidity needs. Also, some alternative strategies would require the prior consent of our senior secured lenders, which we may not be able to obtain. See Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources and Description of Certain Other Indebtedness Our New Senior Secured Credit Facility.

Your right to receive payments on the notes is junior to our senior indebtedness and the senior indebtedness of the subsidiary guarantors. Further, the notes and the subsidiary guarantees are effectively subordinated to all liabilities of our non-guarantor subsidiaries.

The notes and the subsidiary guarantees are subordinated to the prior payment in full of our and the subsidiary guarantors respective current and future senior indebtedness. As of March 31, 2005, we had approximately $782.9 million of indebtedness to which the notes would have been subordinated. Because of the subordination provisions of the notes, in the event of the bankruptcy, liquidation or dissolution of our company or any subsidiary guarantor, our assets or the assets of such subsidiary guarantor would be available to pay obligations under the notes only after all payments had been made on our senior indebtedness or the senior indebtedness of such subsidiary guarantor. Sufficient assets may not remain after all these payments have been made to make any payments on the notes. In addition, all payments on the notes and the subsidiary guarantees thereof will be prohibited in the event of a payment default on our senior indebtedness (including borrowings under our new senior secured credit facility) and, for limited periods, upon the occurrence of other defaults under our new senior secured credit facility.

The notes are structurally subordinated to all of the liabilities of our subsidiaries that do not guarantee the notes. In the event of a bankruptcy, liquidation or dissolution of any of our non-guarantor subsidiaries, holders of their debt, their trade creditors and holders of their preferred equity will generally be entitled to payment on their claims from assets of those subsidiaries before any assets are made available for distribution to us. Although the indenture governing the notes contains limitations on the incurrence of additional indebtedness and the issuance of preferred stock by us and our restricted subsidiaries, such limitation is subject to a number of significant exceptions. Moreover, the indenture governing the notes does not impose any limitation in the incurrence by our restricted subsidiaries of liabilities that do not constitute indebtedness under the indenture. The aggregate net operating revenues and income from operations for the three months ended March 31, 2005 of our subsidiaries that are not guaranteeing the notes were $60.6 million and $9.5 million, respectively, and at March 31, 2005, those subsidiaries had total assets and total liabilities of $49.3 million and $10.3 million, respectively. See Description of the Exchange Notes Subordination and Description of the Exchange Notes Certain Covenants Incurrence of Indebtedness and Issuance of Disqualified Stock and Preferred Stock. See also Description of the Exchange Notes Subsidiary Guarantees and the condensed consolidating financial information included in the notes to our consolidated financial statements included herein.

The notes are not secured by our assets nor those of our subsidiaries and the lenders under our new senior secured credit facility are entitled to remedies available to a secured lender, which gives them priority over the note holders to collect amounts due to them.

In addition to being subordinated to all of our existing and future senior indebtedness, the notes and the related subsidiary guarantees are not secured by any of our or our subsidiaries assets and therefor are effectively subordinated to the claims of our secured debt holders to the extent of the value of the assets securing our secured debt. Our obligations under our new senior secured credit facility are secured by, among other things, a first priority pledge of our capital stock and the capital stock of our domestic subsidiaries, up to 65% of the capital stock of certain of our foreign subsidiaries and by substantially all of the assets of our company and each of our existing and subsequently acquired or organized domestic subsidiaries. If we become insolvent or are liquidated, or if payment under our new senior secured credit facility or in respect of any other secured senior indebtedness is accelerated, the lenders under our new senior secured credit facility or holders of other secured senior indebtedness will be entitled to exercise the remedies available to a secured lender under applicable law (in addition to any remedies that may be available under documents pertaining to our new senior secured credit facility or the other senior debt). In addition, we and or the subsidiary guarantors may incur additional secured senior indebtedness, the holders of which are also entitled to the remedies available to a secured lender. See Description of Certain Other Indebtedness Our New Senior Secured Credit Facility and Description of the Exchange Notes.

Restrictions imposed by our new senior secured credit facility and the indenture governing the notes limit our ability to engage in or enter into business, operating and financing arrangements, which could prevent us from taking advantage of potentially profitable business opportunities.

The operating and financial restrictions and covenants in our debt instruments, including our new senior secured credit facility and the indenture governing the notes, may adversely affect our ability to finance our future operations or capital needs or engage in other business activities that may be in our interest. For example, our new senior secured credit facility restricts our and our subsidiaries ability to, among other things:

- incur or guarantee additional debt and issue or sell preferred stock;
- pay dividends on, redeem or repurchase our capital stock;
- make certain acquisitions or investments;
- incur or permit to exist certain liens;
- enter into transactions with affiliates;
- merge, consolidate or amalgamate with another company;
- transfer or otherwise dispose of assets;
- redeem subordinated debt;
- incur capital expenditures;
- incur contingent obligations;
- incur obligations that restrict the ability of our subsidiaries to make dividends or other payments to us; and
- create or designate unrestricted subsidiaries.

The indenture governing the notes includes similar restrictions. See Description of the Exchange Notes. Our new senior secured credit facility also requires us to comply with certain financial covenants which become more

restrictive over time. Our ability to comply with these ratios may be affected by events beyond our control. A breach of any of these covenants or our inability to comply with the required financial ratios could result in a default under our new senior secured credit facility. In the event of any default under our new senior secured credit facility, the lenders under our new 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 due and payable, to require us to apply all of our available cash to repay these borrowings or to prevent us from making debt service payments on the notes, any of which would be an event of default under the notes. See Description of the Exchange Notes and Description of Certain Other Indebtedness Our New Senior Secured Credit Facility.

We may not have the funds to purchase the notes upon a change of control as required by the indenture governing the notes.

If we were to experience a change of control as described under Description of the Exchange Notes, we would be required to make an offer to purchase all of the notes then outstanding at 101% of their principal amount, plus accrued and unpaid interest to the date of purchase. The source of funds for any purchase of the notes would be our available cash or cash generated from other sources, including borrowings, sales of assets, sales of equity or funds provided by our existing or new stockholders. We cannot assure you that any of these sources will be available or sufficient to make the required repurchase of the notes, and restrictions in our new senior secured credit facility may not allow such repurchases. Upon the occurrence of a change of control event, we may seek to refinance the debt outstanding under our new senior secured credit facility and the notes. However, it is possible that we will not be able to complete such refinancing on commercially reasonable terms or at all. In such event, we would not have the funds necessary to finance the required change of control offer. See Description of the Exchange Notes Repurchase at the Option of Holders Change of Control.

In addition, a change of control would be an event of default under our new senior secured credit facility. Any future credit agreement or other agreements relating to our senior debt to which we become a party may contain similar provisions. Our failure to purchase the notes upon a change of control under the indenture would constitute an event of default under the indenture. This default would, in turn, constitute an event of default under our new senior secured credit facility and may constitute an event of default under future senior debt, any of which may cause the related debt to be accelerated after any applicable notice or grace periods. If debt were to be accelerated, we might not have sufficient funds to repurchase the notes and repay the debt.

Federal and state statutes could allow courts, under specific circumstances, to void the subsidiary guarantees, subordinate claims in respect of the notes and require note holders to return payments received from subsidiary guarantors.

Under U.S. bankruptcy law and comparable provisions of state fraudulent transfer laws, a court could void a subsidiary guarantee or claims related to the notes or subordinate a subsidiary guarantee to all of our other debts or to all other debts of a subsidiary guarantor if, among other things, we or a subsidiary guarantor, at the time we or such subsidiary guarantor incurred the indebtedness evidenced by its subsidiary guarantee:

- intended to hinder, delay or defraud any present or future creditor or received less than reasonably equivalent value or fair consideration for the incurrence of such indebtedness; and

- the subsidiary guarantor was insolvent or rendered insolvent by reason of such incurrence;

- the subsidiary guarantor was engaged in a business or transaction for which the subsidiary guarantor s remaining assets constituted unreasonably small capital; or

- the subsidiary guarantor intended to incur, or believed that it would incur, debts beyond the subsidiary guarantor s ability to pay such debts as they mature.

In addition, a court could void any payment by a subsidiary guarantor pursuant to the notes or a subsidiary guarantee and require that payment to be returned to such subsidiary guarantor or to a fund for the benefit of the creditors of the subsidiary guarantor.

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The measures of insolvency for purposes of fraudulent transfer laws will vary depending upon the governing law in any proceeding to determine whether a fraudulent transferred has occurred. Generally, however, a subsidiary guarantor would be considered insolvent if:

- the sum of its debts, including contingent liabilities, was greater than the fair saleable value of all of its assets;
- the present fair saleable value of its assets was less than the amount that would be required to pay its probable liability on its existing debts, including contingent liabilities, as they become absolute and mature; or
- it could not pay its debts as they become due.

On the basis of historical financial information, our operating history and other factors, we believe that, in connection with the issuance of the outstanding notes, we and each subsidiary guarantor, after giving effect to its subsidiary guarantee of the notes, were not rendered insolvent, did not have insufficient capital for the business in which we are or it is engaged and did not incur debts beyond our or its ability to pay such debts as they mature. There can be no assurance, however, as to what standard a court would apply in making such determinations or that a court would agree with our or the subsidiary guarantors conclusions in this regard.

There may be no active trading market for the exchange notes.

The exchange notes will constitute a new issue of securities for which there will be no established trading market. We do not intend to list the exchange notes on any national securities exchange or to seek the admission of the exchange notes for quotation through the National Association of Securities Dealers Automated Quotation System. Although the initial purchasers advised us that they intend to make a market in the exchange notes, they are not obligated to do so and may discontinue such market making activity at any time without notice. In addition, market making activity will be subject to the limits imposed by the Securities Act and the Securities Exchange Act of 1934, as amended, or the Exchange Act, and may be limited during the exchange offer and the pendency of any shelf registration statement. There can be no assurance as to the development or liquidity of any market for the exchange notes, the ability of the holders of the exchange notes to sell their exchange notes or the price at which the holders would be able to sell their exchange notes.

The market price for the notes may be volatile.

Historically, the market for non-investment grade debt has been subject to disruptions that have caused substantial volatility in the prices of securities similar to the notes. The market for the notes, if any, may be subject to similar disruptions. Any such disruptions may adversely affect the value of your notes.

Risk Relating to Our Structure

We depend on distributions from our operating subsidiaries to pay the interest on the notes. Contractual or legal restrictions applicable to our subsidiaries could limit distributions from them.

We are a holding company and derive all of our operating income from, and hold substantially all of our assets through, our subsidiaries. The effect of this structure is that we depend on the earnings of our subsidiaries, and the distribution, loan or other payment to us of these earnings to meet our obligations, including those under our new senior secured credit facility, the notes offered hereby and any of our other debt obligations. Our subsidiaries ability to make payments to us depends upon their operating results and is also subject to applicable law and contractual restrictions. Some of our subsidiaries may become subject to loan agreements and indentures that restrict the sale of assets and significantly restrict or prohibit the payment of dividends or the making of distributions, loans or other payments to stockholders and members. The indenture governing the notes permits our subsidiaries to incur debt with similar prohibitions and restrictions in the future. Provisions of law, like those requiring that dividends be paid only out of surplus, and provisions of our senior indebtedness can also limit the ability of our subsidiaries to make distributions, loans or other payments to us. See Description of Certain Other Indebtedness Our New Senior Secured Credit Facility.

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The interests of our principal stockholder may conflict with your interests as a holder of the notes.

An investor group led by our sponsors owns substantially all of the outstanding equity securities of our parent. Welsh Carson controls a majority of the voting power of such outstanding equity securities and therefore ultimately controls all of our affairs and policies, including the election of our board of directors, the approval of certain actions such as amending our charter, commencing bankruptcy proceedings and taking certain corporate actions (including, without limitation, incurring debt, issuing stock, selling assets and engaging in mergers and acquisitions), and appointing members of our management. Welsh Carson s interests in exercising control over our business may conflict with your interests as a holder of the notes.

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INDUSTRY AND MARKET DATA

Throughout this prospectus we rely on and refer to information and statistics regarding the healthcare industry. We obtained this information and these statistics from various third-party sources, discussions with our customers and our own internal estimates. We believe that these sources and estimates are reliable, but we have not independently verified them and cannot guarantee their accuracy or completeness.

FORWARD LOOKING STATEMENTS

This prospectus contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 regarding, among other things, our financial condition, results of operations, plans, objectives, future performance and business. All statements contained in this document other than historical information are forward-looking statements. Forward-looking statements include, but are not limited to, statements that represent our beliefs concerning future operations, strategies, financial results or other developments, and contain words and phrases such as may, expects, believes, anticipates, estimates, should, or similar expressions. Because these forward-l statements are based on estimates and assumptions that are subject to significant business, economic and competitive uncertainties, many of which are beyond our control or are subject to change, actual results could be materially different. Although we believe that our plans, intentions and expectations reflected in or suggested by these forward-looking statements are reasonable, we cannot assure you that we will achieve or realize these plans, intentions or expectations. Forward-looking statements are inherently subject to risks, uncertainties and assumptions. Important factors that could cause actual results to differ materially from the forward-looking statements include, but are not limited to:

- compliance with the Medicare hospital within a hospital regulation changes will require increased capital expenditures and may have an adverse effect on our future net operating revenues and 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;
- implementation of annual caps that limit the amounts that can be paid for outpatient therapy services rendered to any Medicare beneficiary may reduce our future net operating revenues and profitability;
- additional changes in government reimbursement for our services may have an adverse effect on our future net operating revenues and profitability;
- changes in applicable regulations or a government investigation or assertion that we have violated applicable regulations may result in increased costs or sanctions that reduce our net operating revenues and profitability;
- integration of recently acquired operations 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 our markets could reduce our net operating revenues and profitability;

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

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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; and

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

Consequently, such forward-looking statements should be regarded solely as our current plans, estimates and beliefs. You should review carefully the section captioned Risk Factors in this prospectus for a more complete discussion of the risks of an investment in the notes.

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THE EXCHANGE OFFER

General

Concurrently with the sale of the outstanding notes on February 24, 2005, we entered into an exchange and registration rights agreement with the initial purchasers of the outstanding notes, which requires us to file a registration statement under the Securities Act with respect to the exchange notes and, upon the effectiveness of the registration statement, offer to the holders of the outstanding notes the opportunity to exchange their outstanding notes for a like principal amount of exchange notes. The exchange notes will be issued without a restrictive legend and generally may be reoffered and resold without registration under the Securities Act. The exchange and registration rights agreement further provides that we must (i) file on or prior to 150 days, and use commercially reasonable efforts to cause to become effective on or prior to 240 days, from the date of the original issue of the outstanding notes, the registration statement of which this prospectus is a part with respect to the exchange of the outstanding notes for the exchange notes to be issued in the exchange offer and (ii) use commercially reasonable efforts to cause the exchange offer to be completed on or prior to 270 days from the original issue of the outstanding notes.

Except as described below, upon the completion of the exchange offer, our obligations with respect to the registration of the outstanding notes and the exchange notes will terminate. A copy of the exchange and registration rights agreement has been filed as an exhibit to the registration statement of which this prospectus is a part. Following the completion of the exchange offer, holders of outstanding notes not tendered will not have any further registration rights other than as set forth in the paragraphs below, and the outstanding notes will continue to be subject to certain restrictions on transfer.

In order to participate in the exchange offer, a holder must represent to us, among other things, that:

- the exchange notes acquired pursuant to the exchange offer are being obtained in the ordinary course of business of the holder;
- the holder does not have an arrangement or understanding with any person to participate in the distribution of the exchange notes;
- the holder is not an affiliate, as defined under Rule 405 under the Securities Act, of Select; and
- if the holder is a broker-dealer that will receive exchange notes for its own account in exchange for outstanding notes that were acquired as a result of market-making or other trading activities, then the holder will deliver a prospectus in connection with any resale of such exchange notes.

Under certain circumstances specified in the exchange and registration rights agreement, we may be required to file a shelf registration statement covering resales of the outstanding notes pursuant to Rule 415 under the Securities Act.

Based on an interpretation by the SEC s staff set forth in no-action letters issued to third parties unrelated to us, we believe that, with the exceptions set forth below, the exchange notes issued in the exchange offer may be offered for resale, resold and otherwise transferred by the holder of exchange notes without compliance with the registration and prospectus delivery requirements of the Securities Act, unless the holder:

- is an affiliate, within the meaning of Rule 405 under the Securities Act, of Select;
- is a broker-dealer who purchased outstanding notes directly from us for resale under Rule 144A or Regulation S or any other available exemption under the Securities Act;
- acquired the exchange notes other than in the ordinary course of the holder s business;
- has an arrangement with any person to engage in the distribution of the exchange notes; or
- is prohibited by any law or policy of the SEC from participating in the exchange offer.

Any holder who tenders in the exchange offer for the purpose of participating in a distribution of the exchange notes cannot rely on this interpretation by the SEC s staff and must comply with the registration and

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prospectus delivery requirements of the Securities Act in connection with a secondary resale transaction. Each broker-dealer that receives exchange notes for its own account in exchange for outstanding notes, where such outstanding notes were acquired by such broker-dealer as a result of market making activities or other trading activities, must acknowledge that it will deliver a prospectus in connection with any resale of such exchange note. See Plan of Distribution. Broker-dealers who acquired outstanding notes directly from us and not as a result of market making activities or other trading activities may not rely on the staff s interpretations discussed above or participate in the exchange offer, and must comply with the prospectus delivery requirements of the Securities Act in order to sell the outstanding notes.

Terms of the Exchange Offer

Upon the terms and subject to the conditions set forth in this prospectus and in the letter of transmittal, we will accept any and all outstanding notes validly tendered and not withdrawn prior to 5:00 p.m., New York City time, on July 26, 2005, or such date and time to which we extend the offer. We will issue $1,000 in principal amount of exchange notes in exchange for each $1,000 principal amount of outstanding notes accepted in the exchange offer. Holders may tender some or all of their outstanding notes pursuant to the exchange offer. However, outstanding notes may be tendered only in integral multiples of $1,000 in principal amount.

The exchange notes will evidence the same debt as the outstanding notes and will be issued under the terms of, and entitled to the benefits of, the indenture relating to the outstanding notes.

As of the date of this prospectus, $660.0 million in aggregate principal amount of outstanding notes were outstanding, and there was one registered holder, a nominee of The Depository Trust Company. This prospectus, together with the letter of transmittal, is being sent to the registered holder and to others believed to have beneficial interests in the outstanding notes. We intend to conduct the exchange offer in accordance with the applicable requirements of the Exchange Act and the rules and regulations of the SEC promulgated under the Exchange Act.

We will be deemed to have accepted validly tendered outstanding notes when, as and if we have given oral or written notice thereof to U.S. Bank Trust National Association, the exchange agent. The exchange agent will act as agent for the tendering holders for the purpose of receiving the exchange notes from us. If any tendered outstanding notes are not accepted for exchange because of an invalid tender, the occurrence of certain other events set forth under the heading Conditions to the Exchange Offer, certificates for any such unaccepted outstanding notes will be returned, without expense, to the tendering holder of those outstanding notes promptly after the expiration date unless the exchange offer is extended.

Holders who tender outstanding notes in the exchange offer will not be required to pay brokerage commissions or fees or, subject to the instructions in the letter of transmittal, transfer taxes with respect to the exchange of outstanding notes in the exchange offer. We will pay all charges and expenses, other than certain applicable taxes, applicable to the exchange offer. See Fees and Expenses.

Expiration Date; Extensions; Amendments

The expiration date shall be 5:00 p.m., New York City time, on July 26, 2005, unless we, in our sole discretion, extend the exchange offer, in which case the expiration date shall be the latest date and time to which the exchange offer is extended. In order to extend the exchange offer, we will notify the exchange agent and each registered holder of any extension by oral or written notice prior to 9:00 a.m., New York City time, on the next business day after the previously scheduled expiration date and will also disseminate notice of any extension by press release or other public announcement prior to 9:00 a.m., New York City time on such date. We reserve the right, in our sole discretion:

- to delay accepting any outstanding notes, to extend the exchange offer or, if any of the conditions set forth under Conditions to the Exchange Offer shall not have been satisfied, to terminate the exchange offer, by giving oral or written notice of that delay, extension or termination to the exchange agent, or

- to amend the terms of the exchange offer in any manner.

In the event that we make a fundamental change to the terms of the exchange offer, we will file a post-effective amendment to the registration statement. In the event that we make a material change in the exchange offer, including the waiver of a material condition, we will extend the expiration date of the exchange offer so that at least five business days remain in the exchange offer following notice of the material change.

Procedures for Tendering

Only a holder of outstanding notes may tender the outstanding notes in the exchange offer. Except as set forth under Book-Entry Transfer, to tender in the exchange offer a holder must complete, sign and date the letter of transmittal, or a copy of the letter of transmittal, have the signatures on the letter of transmittal guaranteed if required by the letter of transmittal and mail or otherwise deliver the letter of transmittal or copy to the exchange agent prior to the expiration date. In addition:

- certificates for the outstanding notes must be received by the exchange agent along with the letter of transmittal prior to the expiration date, or

- a timely confirmation of a book-entry transfer, or a book-entry confirmation, of the outstanding notes, if that procedure is available, into the exchange agent s account at The Depository Trust Company, which we refer to as the book-entry transfer facility, following the procedure for book-entry transfer described below, must be received by the exchange agent prior to the expiration date, or you must comply with the guaranteed delivery procedures described below.

To be tendered effectively, the letter of transmittal and the required documents must be received by the exchange agent at the address set forth under Exchange Agent prior to the expiration date.

Your tender, if not withdrawn prior to 5:00 p.m., New York City time, on the expiration date, will constitute an agreement between you and us in accordance with the terms and subject to the conditions set forth herein and in the letter of transmittal.

The method of delivery of outstanding notes and the letter of transmittal and all other required documents to the exchange agent is at your election and risk. Instead of delivery by mail, it is recommended that you use an overnight or hand delivery service. In all cases, sufficient time should be allowed to assure delivery to the exchange agent before the expiration date. No letter of transmittal or outstanding notes should be sent to us. You may request your broker, dealer, commercial bank, trust company or nominee to effect these transactions for you.

Any beneficial owner whose outstanding notes are registered in the name of a broker, dealer, commercial bank, trust company, or other nominee and who wishes to tender should contact the registered holder promptly and instruct the registered holder to tender on the beneficial owner s behalf. If the beneficial owner wishes to tender on its own behalf, the beneficial owner must, prior to completing and executing the letter of transmittal and delivering the owner s outstanding notes, either make appropriate arrangements to register ownership of the outstanding notes in the beneficial owner s name or obtain a properly completed bond power from the registered holder. The transfer of registered ownership may take considerable time.

Signatures on a letter of transmittal or a notice of withdrawal, as the case may be, must be guaranteed by an eligible guarantor institution within the meaning of Rule 17Ad-15 under the Exchange Act unless outstanding notes tendered pursuant thereto are tendered:

- by a registered holder who has not completed the box entitled Special Issuance Instruction or Special Delivery Instructions on the letter of transmittal, or

- for the account of an eligible guarantor institution.

If signatures on a letter of transmittal or a notice of withdrawal, as the case may be, are required to be guaranteed, the guarantee must be by any eligible guarantor institution that is a member of or participant in the Securities Transfer Agents Medallion Program, the New York Stock Exchange Medallion Signature Program or an eligible guarantor institution.

If the letter of transmittal is signed by a person other than the registered holder of any outstanding notes listed in the letter of transmittal, the outstanding notes must be endorsed or accompanied by a properly completed bond power, signed by the registered holder as that registered holder s name appears on the outstanding notes.

If the letter of transmittal or any outstanding notes or bond powers are signed by any trustee, executor, administrator, guardian, attorney-in-fact or officer, such person should so indicate when signing, and evidence satisfactory to us of their authority to so act must be submitted with the letter of transmittal unless waived by us.

All questions as to the validity, form, eligibility, including time of receipt, acceptance, and withdrawal of tendered outstanding notes will be determined by us in our sole discretion, which determination will be final and binding. We reserve the absolute right to reject any and all outstanding notes not properly tendered or any outstanding notes our acceptance of which would, in the opinion of our counsel, be unlawful. We also reserve the right to waive any defects, irregularities or conditions of tender as to particular outstanding notes. Our interpretation of the terms and conditions of the exchange offer, including the instructions in the letter of transmittal, will be final and binding on all parties. Unless waived, any defects or irregularities in connection with tenders of outstanding notes must be cured within such time as we shall determine. Although we intend to notify holders of defects or irregularities with respect to tenders of outstanding notes, neither we, the exchange agent, nor any other person shall incur any liability for failure to give that notification. Tenders of outstanding notes will not be deemed to have been made until such defects or irregularities have been cured or waived. Any outstanding notes received by the exchange agent that are not properly tendered and as to which the defects or irregularities have not been cured or waived will be returned by the exchange agent to the tendering holders, unless otherwise provided in the letter of transmittal, promptly following the expiration date, unless the exchange offer is extended.

In addition, we reserve the right in our sole discretion to purchase or make offers for any outstanding notes that remain outstanding after the expiration date or, as set forth under Conditions to the Exchange Offer, to terminate the exchange offer and, to the extent permitted by applicable law, purchase outstanding notes in the open market, in privately negotiated transactions, or otherwise. The terms of any such purchases or offers could differ from the terms of the exchange offer.

In all cases, issuance of exchange notes for outstanding notes that are accepted for exchange in the exchange offer will be made only after timely receipt by the exchange agent of certificates for such outstanding notes or a timely book-entry confirmation of such outstanding notes into the exchange agent s account at the book-entry transfer facility, a properly completed and duly executed letter of transmittal or, with respect to The Depository Trust Company and its participants, electronic instructions in which the tendering holder acknowledges its receipt of and agreement to be bound by the letter of transmittal, and all other required documents. If any tendered outstanding notes are not accepted for any reason set forth in the terms and conditions of the exchange offer or if outstanding notes are submitted for a greater principal amount than the holder desires to exchange, such unaccepted or non-exchanged outstanding notes will be returned without expense to the tendering holder or, in the case of outstanding notes tendered by book-entry transfer into the exchange agent s account at the book-entry transfer facility according to the book-entry transfer procedures described below, those non-exchanged outstanding notes will be credited to an account maintained with that book-entry transfer facility, in each case, promptly after the expiration or termination of the exchange offer.

Each broker-dealer that receives exchange notes for its own account in exchange for outstanding notes, where those outstanding notes were acquired by such broker-dealer as a result of market making activities or other trading activities, must acknowledge that it will deliver a prospectus in connection with any resale of those exchange notes. See Plan of Distribution.

Book-Entry Transfer

The exchange agent will make a request to establish an account with respect to the outstanding notes at the book-entry transfer facility for purposes of the exchange offer promptly after the date of this prospectus, and any financial institution that is a participant in the book-entry transfer facility s systems may make book-

entry delivery of outstanding notes being tendered by causing the book-entry transfer facility to transfer such outstanding notes into the exchange agent s account at the book-entry transfer facility in accordance with that book-entry transfer facility s procedures for transfer. However, although delivery of outstanding notes may be effected through book-entry transfer at the book-entry transfer facility, the letter of transmittal or copy of the letter of transmittal, with any required signature guarantees and any other required documents, must, in any case other than as set forth in the following paragraph, be transmitted to and received by the exchange agent at the address set forth under Exchange Agent on or prior to the expiration date or the guaranteed delivery procedures described below must be complied with.

The Depository Trust Company s Automated Tender Offer Program is the only method of processing exchange offers through The Depository Trust Company. To accept the exchange offer through the Automated Tender Offer Program, participants in The Depository Trust Company must send electronic instructions to The Depository Trust Company through The Depository Trust Company s communication system instead of sending a signed, hard copy letter of transmittal. The Depository Trust Company is obligated to communicate those electronic instructions to the exchange agent. To tender outstanding notes through the Automated Tender Offer Program, the electronic instructions sent to The Depository Trust Company and transmitted by The Depository Trust Company to the exchange agent must contain the character by which the participant acknowledges its receipt of and agrees to be bound by the letter of transmittal.

Guaranteed Delivery Procedures

If a registered holder of the outstanding notes desires to tender outstanding notes and the outstanding notes are not immediately available, or time will not permit that holder s outstanding notes or other required documents to reach the exchange agent prior to 5:00 p.m., New York City time, on the expiration date, or the procedure for book-entry transfer cannot be completed on a timely basis, a tender may be effected if:

- the tender is made through an eligible guarantor institution;
- prior to 5:00 p.m., New York City time, on the expiration date, the exchange agent receives from that eligible guarantor institution a properly completed and duly executed letter of transmittal or a facsimile of a duly executed letter of transmittal and notice of guaranteed delivery, substantially in the form provided by us, by telegram, fax transmission, mail or hand delivery, setting forth the name and address of the holder of outstanding notes and the amount of the outstanding notes tendered and stating that the tender is being made by guaranteed delivery, the certificates for all physically tendered outstanding notes, in proper form for transfer, or a book-entry confirmation, as the case may be, will be deposited by the eligible guarantor institution with the exchange agent; and
- the certificates for all physically tendered outstanding notes, in proper form for transfer, or a book-entry confirmation, as the case may be, are received by the exchange agent within five business days after the date of execution of the notice of guaranteed delivery.

Withdrawal Rights

Tenders of outstanding notes may be withdrawn at any time prior to 5:00 p.m., New York City time, on the expiration date.

For a withdrawal of a tender of outstanding notes to be effective, a written or, for The Depository Trust Company participants, electronic Automated Tender Offer Program transmission, notice of withdrawal, must be received by the exchange agent at its address set forth under Exchange Agent prior to 5:00 p.m., New York City time, on the expiration date. Any such notice of withdrawal must:

- specify the name of the person having deposited the outstanding notes to be withdrawn, whom we refer to as the depositor;
- identify the outstanding notes to be withdrawn, including the certificate number or numbers and principal amount of such outstanding notes;

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be signed by the holder in the same manner as the original signature on the letter of transmittal by which such outstanding notes were tendered, including any required signature guarantees, or be accompanied by documents of transfer sufficient to have the trustee register the transfer of such outstanding notes into the name of the person withdrawing the tender; and

specify the name in which any such outstanding notes are to be registered, if different from that of the depositor.

All questions as to the validity, form, eligibility and time of receipt of such notices will be determined by us, whose determination shall be final and binding on all parties. Any outstanding notes so withdrawn will be deemed not to have been validly tendered for exchange for purposes of the exchange offer. Any outstanding notes which have been tendered for exchange, but which are not exchanged for any reason, will be returned to the holder of those outstanding notes without cost to that holder promptly after withdrawal, rejection of tender, or termination of the exchange offer. Properly withdrawn outstanding notes may be retendered by following one of the procedures under Procedures for Tendering at any time on or prior to the expiration date.

Conditions to the Exchange Offer

Notwithstanding any other provision of the exchange offer, we will not be required to accept for exchange, or to issue exchange notes in exchange for, any outstanding notes and may terminate or amend the exchange offer if at any time before the expiration of the exchange offer, we determine that the exchange offer violates applicable law, any applicable interpretation of the staff of the SEC or any order of any governmental agency or court of competent jurisdiction.

The foregoing conditions are for our sole benefit and may be asserted by us regardless of the circumstances giving rise to any such condition or may be waived by us in whole or in part at any time and from time to time. The failure by us at any time to exercise any of the foregoing rights shall not be deemed a waiver of any of those rights and each of those rights shall be deemed an ongoing right which may be asserted at any time and from time to time.

In addition, we will not accept for exchange any outstanding notes tendered, and no exchange notes will be issued in exchange for those outstanding notes, if at such time any stop order shall be threatened or in effect with respect to the registration statement of which this prospectus constitutes a part or the qualification of the indenture under the Trust Indenture Act of 1939. In any of those events we are required to use every reasonable effort to obtain the withdrawal of any stop order at the earliest possible time.

Effect of Not Tendering

Holders of outstanding notes who do not exchange their outstanding notes for exchange notes in the exchange offer will remain subject to the restrictions on transfer of such outstanding notes:

as set forth in the legend printed on the outstanding notes as a consequence of the issuance of the outstanding notes pursuant to the exemptions from, or in transactions not subject to, the registration requirements of the Securities Act and applicable state securities laws; and

otherwise set forth in the prospectus distributed in connection with the private offering of the outstanding notes.

Exchange Agent

All executed letters of transmittal should be directed to the exchange agent. U.S. Bank Trust National Association has been appointed as exchange agent for the exchange offer. Questions, requests for assistance

and requests for additional copies of this prospectus or of the letter of transmittal should be directed to the exchange agent addressed as follows:

By Mail, Hand Delivery or Facsimile:	U.S. Bank Trust National Association Specialized Finance Group 60 Livingston Avenue St. Paul, MN 55107 Facsimile: (651) 495-8158

Originals of all documents sent by facsimile should be sent promptly by registered or certified mail, by hand or by overnight delivery service.

Fees and Expenses

We will not make any payments to brokers, dealers or others soliciting acceptances of the exchange offer. The principal solicitation is being made by mail; however, additional solicitations may be made in person or by telephone by our officers and employees. The estimated cash expenses to be incurred in connection with the exchange offer will be paid by us and will include fees and expenses of the exchange agent, accounting, legal, printing and related fees and expenses.

Transfer Taxes

Holders who tender their outstanding notes for exchange will not be obligated to pay any transfer taxes in connection with that tender or exchange, except that holders who instruct us to register exchange notes in the name of, or request that outstanding notes not tendered or not accepted in the exchange offer be returned to, a person other than the registered tendering holder will be responsible for the payment of any applicable transfer tax on those outstanding notes.

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THE TRANSACTIONS

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

Upon the consummation of the merger, Select became a wholly owned subsidiary of Holdings and all of the capital stock of Holdings was owned by an investor group that includes our sponsors, Welsh Carson and Thoma Cressey, and certain other rollover investors that participated in the merger. We refer to those other investors as the continuing investors. Our continuing investors include Rocco A. Ortenzio, our Executive Chairman and the chairman of our board of directors, Robert A. Ortenzio, our Chief Executive Officer and a member of our board of directors, certain other investors who are members of or affiliated with the Ortenzio family, certain individuals affiliated with Welsh Carson, including Russell L. Carson, a member of our board of directors and a founding general partner of Welsh, Carson, Anderson & Stowe, Bryan C. Cressey, a member of our board of directors and a founding partner of Thoma Cressey, various investment funds affiliated with Thoma Cressey, Patricia A. Rice, our President and Chief Operating Officer, Martin F. Jackson, our Senior Vice President and Chief Financial Officer, S. Frank Fritsch, our Senior Vice President, Human Resources, Michael E. Tarvin, our Senior Vice President, General Counsel and Secretary, James J. Talalai, our Senior Vice President and Chief Information Officer, and Scott A. Romberger, our Vice President, Controller and Chief Accounting Officer. Immediately prior to the merger, shares of our common stock which were owned by our continuing investors were contributed to Holdings in exchange for equity securities of Holdings. For purposes of such exchange, these rollover shares were valued at $152.0 million in the aggregate, or $18.00 per share (the per share merger consideration). Upon consummation of the merger, these rollover shares were cancelled without payment of any merger consideration.

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

- $1,827.7 million to pay our then existing stockholders (other than rollover stockholders) and option holders all amounts due under the merger agreement;
- $152.0 million of rollover equity from our continuing investors;
- $344.2 million to repay existing indebtedness; and
- $119.2 million to pay related fees and expenses, including premiums, consent fees and interest payable in connection with the tender offers and consent solicitations for our existing senior subordinated notes.

The Transactions were financed by:

- a cash equity investment in Holdings of $570.0 million by an investor group led by our sponsors (the net proceeds of which were contributed by Holdings to us) and a rollover equity investment in Holdings of $152.0 million by our continuing investors;
- Holdings issuance and sale of senior subordinated notes, preferred stock and common stock to WCAS Capital Partners IV, L.P., an investment fund affiliated with Welsh Carson, Rocco A. Ortenzio, Robert A. Ortenzio and certain other investors who are members of or affiliated with the Ortenzio family, for an aggregate purchase price of $150.0 million (the net proceeds of which were contributed by Holdings to us);
- borrowings by us of $580.0 million in term loans and $200.0 million in revolving loans under our new senior secured credit facility;

existing cash on hand of $131.1 million; and

the issuance of $660.0 million in aggregate principal amount of the outstanding notes.

In connection with the merger, we commenced tender offers to acquire all of our 9 1/2% senior subordinated notes due 2009 and all of our 7 1/2% senior subordinated notes due 2013. In connection with each such tender offer we sought consents to eliminate substantially all of the restrictive covenants and make other amendments to the indentures governing such notes. Upon completion of the tender offers on February 24, 2005, holders of all of our 7 1/2% senior subordinated notes and holders of approximately 96.7% of our 9 1/2% senior subordinated notes had delivered consents and tendered their notes in connection with such tender offers and consent solicitations.

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

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USE OF PROCEEDS

This exchange offer is intended to satisfy certain of our obligations under the exchange and registration rights agreement, dated February 24, 2005, by and among us and the initial purchasers of the outstanding notes. We will not receive any proceeds from the issuance of the exchange notes in the exchange offer. In exchange for each of the exchange notes, we will receive outstanding notes in like principal amount. We will retire or cancel all of the outstanding notes tendered in the exchange offer. Accordingly, issuance of the exchange notes will not result in any change in our capitalization.

CAPITALIZATION

The following table sets forth our capitalization as of March 31, 2005 on an actual basis. You should read this table in conjunction with our unaudited and audited consolidated financial statements and the related notes thereto included in this prospectus.

	As of March 31, 2005 (Dollars in millions)
Cash and cash equivalents	$ 19.3
Debt:	
New revolving credit facility(1)	200.0
New term loan facility(1)	580.0
$9^{1}/2$% senior subordinated notes due 2009	5.8
Outstanding notes	660.0
Other debt and capital leases	4.3
Total debt	1,450.1
Total stockholders equity	449.6
Total capitalization	$ 1,899.7

(1) Total revolving loan availability under our new senior secured credit facility is $300.0 million. Upon consummation of the Transactions, we borrowed $200.0 million in revolving loans to provide a portion of the funds required to consummate the Transactions. In addition, approximately $16.4 million of letters of credit were outstanding under our new senior secured credit facility.

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SELECTED HISTORICAL CONSOLIDATED FINANCIAL DATA

You should read the following selected historical consolidated financial data in conjunction with our consolidated financial statements and the accompanying notes. You should also read Management s Discussion and Analysis of Financial Condition and Results of Operations. All of these materials are contained in this prospectus. The data as of December 31, 2000, 2001, 2002, 2003 and 2004 and for the years ended December 31, 2000, 2001, 2002, 2003 and 2004 have been derived from consolidated financial statements audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm. Consolidated balance sheets at December 31, 2003 and 2004 and the related statements of operations, stockholders equity and cash flows for the years ended December 31, 2002, 2003 and 2004 and the related notes appear elsewhere in this prospectus. The data for the three months ended March 31, 2004, the period from January 1, 2005 through February 24, 2005 and the period from February 25, 2005 through March 31, 2005 have been derived from unaudited consolidated financial statements also contained in this prospectus and which, in the opinion of management, include all adjustments, consisting only of normal recurring adjustments, necessary for a fair presentation of the results for the unaudited interim period. By definition, our statements of financial position and results of operations subsequent to the Transactions are not comparable to the same statements for the periods prior to the Transactions due to the resulting change in basis.

	Predecessor							Successor
	Year Ended December 31,					Three Months Ended March 31, 2004	Period from January 1, through February 24, 2005	Period from February 25 through March 31, 2005
	2000	2001	2002	2003	2004			
	(Dollars in thousands)							
Consolidated Statement of Operations Data:								
Net operating revenues	$ 805,897	$ 958,956	$ 1,126,559	$ 1,392,366	$ 1,660,791	$ 418,469	$ 287,787	$ 195,112
Operating expenses(1)	714,227	846,938	999,280	1,207,913	1,389,281	348,997	239,573	154,573
Stock compensation associated with the merger(2)							142,213	4,326
Depreciation and amortization	30,401	32,290	25,836	34,654	39,977	10,197	6,177	4,248
Income (loss) from operations	61,269	79,728	101,443	149,799	231,533	59,275	(100,176)	31,965
Loss on early retirement of	(6,247)	(14,223)					(42,736)	

debt(3)								
Merger related charges(4)							(12,025)	
Equity in earnings from joint ventures				824				
Interest expense, net	(35,187)	(29,209)	(26,614)	(25,404)	(31,051)	(9,053)	(4,211)	(9,559)
Income (loss) from continuing operations before minority interests and income taxes	19,835	36,296	74,829	125,219	200,482	50,222	(159,148)	22,406
Minority interests(5)	4,144	3,491	2,022	2,402	3,448	1,006	469	462
Income (loss) from continuing operations before income taxes	15,691	32,805	72,807	122,817	197,034	49,216	(159,617)	21,944
Income tax provision (benefit)	9,979	3,124	28,576	48,597	79,602	19,793	(59,366)	8,871
Income (loss) from continuing operations	5,712	29,681	44,231	74,220	117,432	29,423	(100,251)	13,073
Income from discontinued operations, net of tax				251	752	147		
Net income (loss)	5,712	29,681	44,231	74,471	118,184	29,570	(100,251)	13,073
Less: Preferred dividends	8,780	2,513						
Net income (loss) available to common stockholders	$ (3,068)	$ 27,168	$ 44,231	$ 74,471	$ 118,184	$ 29,570	$ (100,251)	$ 13,073

Other Financial Data:								
Capital expenditures	$ 22,430	$ 24,011	$ 43,183	$ 35,852	$ 32,626	$ 7,762	$ 2,586	$ 1,112
Ratio of earnings to fixed charges(6)	n/a	1.6x	2.3x	3.1x	3.9x	3.8x	n/a	2.7x
Cash Flow Data:								
Net cash provided by (used in) operating activities	$ 22,513	$ 95,770	$ 120,812	$ 246,248	$ 174,276	$ 76,529	$ 19,056	$ (191,971)
Net cash provided by (used in) investing activities	14,197	(61,947)	(54,048)	(261,452)	(21,928)	(11,177)	(110,865)	(3,327)
Net cash provided by (used in) financing activities	(37,616)	(26,164)	(21,423)	124,318	(70,990)	(20,042)	202	58,816
Consolidated Balance Sheet Data (at end of period):								
Cash and cash equivalents	$ 3,151	$ 10,703	$ 56,062	$ 165,507	$ 247,476	$ 210,784		$ 19,343
Working capital	105,567	126,749	130,621	188,380	313,715	210,878		157,965
Total assets	586,800	650,845	739,059	1,078,998	1,113,721	1,116,986		2,169,424
Total debt	302,788	288,423	260,217	367,503	354,590	364,744		1,450,097
Preferred stock	129,573							
Total stockholders equity	48,498	234,284	286,418	419,175	515,943	440,760		449,584

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

footnotes continued on following page

(2) Consists of stock compensation expense related to the repurchase of outstanding stock options in the Predecessor period of January 1, 2005 through February 24, 2005 and compensation expenses related to restricted stock and a warrant that were issued in the Successor period of February 25, 2005 through March 31, 2005.

(3) Reflects the write-off of deferred financing costs that resulted from the refinancing of our senior credit facilities in September 2000. Also reflects the write-off of deferred financing costs and discounts resulting from the repayment of indebtedness with the proceeds from our initial public offering in April 2001 and our 9 1/2% senior subordinated notes offering in June 2001. In connection with the merger on February 24, 2005, we tendered for all of our 9 1/2% senior subordinated notes due 2009 and all of our 7 1/2% senior subordinated notes due 2013. The loss in the Successor period of February 25, 2005 through March 31, 2005 consists of the tender premium cost of $34.8 million and the write-off of the remaining unamortized deferred financing costs of $7.9 million.

(4) As a result of the merger, we incurred costs in the Predecessor period of January 1, 2005 through February 24, 2005 directly related to the merger. This included the cost of the investment advisor hired by the Special Committee of our Board of Directors to evaluate the merger, legal and accounting fees, costs associated with the Hart-Scott-Rodino filing relating to the merger, cost associated with purchasing a six year extended reporting period under our directors and officers liability insurance policy and other associated expenses.

(5) Reflects interests held by other parties in subsidiaries, limited liability companies and limited partnerships owned and controlled by us.

(6) For purposes of computing the ratio of earnings to fixed charges, earnings consist of income (loss) from continuing operations before income taxes, fixed charges, minority interest in income of subsidiaries and income (loss) from unconsolidated joint ventures. Fixed charges include preferred dividend requirements of subsidiaries, deemed dividends on preferred stock conversion, interest expense and the portion of operating rents that is deemed representative of an interest factor. In 2000, and the period from January 1, 2005 through February 24, 2005, the ratio coverage was less than 1:1. We would have had to generate additional earnings of approximately $4.3 million in 2000, and $159.1 million in the period from January 1, 2005 through February 24, 2005 to achieve a coverage ratio of 1:1.

UNAUDITED PRO FORMA CONDENSED CONSOLIDATED FINANCIAL INFORMATION

The following unaudited pro forma condensed consolidated financial data has been derived by the application of pro forma adjustments to our historical consolidated statements of operations. The unaudited pro forma condensed consolidated statements of operations for the three months ended March 31, 2005 give effect to the Transactions as if such events occurred on January 1, 2005. The unaudited pro forma condensed consolidated statements of operations for the year ended December 31, 2004 give effect to the Transaction as if such events occurred on January 1, 2004. The unaudited pro forma condensed consolidated statements of operations is for comparative purposes only and does not purport to represent what our results of operations would actually have been had the Transactions in fact occurred on the assumed dates or to project our results of operations for any future date or future period. A pro forma balance sheet is not presented because the Transactions are fully reflected in our historical balance sheet as of March 31, 2005 that is contained herein.

The acquisition of Select by Holdings is accounted for, and is presented in the pro forma condensed consolidated statements of operations, under the purchase method of accounting prescribed in Statement of Financial Accounting Standards (SFAS) No. 141, Business Combinations, with intangible assets recorded in accordance with SFAS No. 142, Goodwill and Other Intangible Assets (FAS 142). The excess purchase price over net tangible and intangible assets acquired and liabilities assumed has been allocated to goodwill. The fair values of tangible and identifiable intangible assets acquired were determined based on preliminary valuation information. We continue to obtain additional information necessary to finalize the determination of the fair value of the assets acquired. In accordance with the provisions of SFAS 142, identifiable intangibles are amortized over their estimated life and no amortization of indefinite-lived intangible assets or goodwill will be recorded.

Assumptions underlying the pro forma adjustments are described in the accompanying notes, which should be read in conjunction with these unaudited pro forma condensed consolidated statements of operations. The actual purchase accounting adjustments described in the accompanying notes were made as of the closing date of the Transactions. Revisions to the preliminary purchase price allocation of the Transactions may have an impact on the unaudited pro forma condensed consolidated statements of operations contained herein.

You should read our unaudited pro forma condensed consolidated statements of operations and the related note thereto in conjunction with our historical consolidated financial statements and related notes thereto and other information in Select Consolidated Financial Information, and Management s Discussion and Analysis of Financial Condition and Results of Operations.

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UNAUDITED PRO FORMA CONDENSED CONSOLIDATED STATEMENT OF OPERATIONS FOR THE TWELVE MONTHS ENDED DECEMBER 31, 2004

	Historical	Adjustments	Pro Forma
		(In thousands)	
Net operating revenues	$ 1,660,791	$	$ 1,660,791
Costs and expenses:			
Cost of services	1,294,903		1,294,903
General and administrative	45,856		45,856
Bad debt expense	48,522		48,522
Depreciation and amortization	39,977	6,414(1)	46,391
Total costs and expenses	1,429,258	6,414	1,435,672
Income from operations	231,533	(6,414)	225,119
Other income and expense:			
Interest expense, net	(31,051)	(64,946)(2)	(95,997)
Income from continuing operations before minority interests and income taxes	200,482	(71,360)	129,122
Minority interest in consolidated subsidiary companies	3,448		3,448
Income from continuing operations before income taxes	197,034	(71,360)	125,674
Income tax expense	79,602	(28,830)(3)	50,772
Income from continuing operations	$ 117,432	$ (42,530)	$ 74,902

UNAUDITED PRO FORMA CONDENSED CONSOLIDATED STATEMENT OF OPERATIONS FOR THE THREE MONTHS ENDED MARCH 31, 2005

	Predecessor	Successor			
	For the Period January 1 through February 24, 2005	For the Period February 25 through March 31, 2005	Combined Three Months Ended March 31, 2005	Adjustments	Pro Forma
			(In thousands)		
Net operating revenues	$ 287,787	$ 195,112	$ 482,899	$	$ 482,899
Costs and expenses:					
Cost of services	225,428	145,608	371,036		371,036
Stock compensation associated with merger	142,213	4,326	146,539		146,539
General and administrative	7,484	4,356	11,840		11,840
Bad debt expense	6,661	4,609	11,270		11,270
Depreciation and amortization	6,177	4,248	10,425	1,069(1)	11,494
Total costs and expenses	387,963	163,147	551,110	1,069	552,179
Income (loss) from operations	(100,176)	31,965	(68,211)	(1,069)	(69,280)
Other income and expense:					
Loss on early retirement of debt	(42,736)		(42,736)		(42,736)
Merger related charges	(12,025)		(12,025)		(12,025)
Interest expense, net	(4,211)	(9,559)	(13,770)	(10,280)(2)	(24,050)
Income (loss) before minority interests and income taxes	(159,148)	22,406	(136,742)	(11,349)	(148,091)
Minority interest in consolidated subsidiary companies	469	462	931		931
Income (loss) before income taxes	(159,617)	21,944	(137,673)	(11,349)	(149,022)
Income tax expense (benefit)	(59,366)	8,871	(50,495)	(4,163)(3)	(54,658)
Net income (loss)	$ (100,251)	$ 13,073	$ (87,178)	(7,186)	$ (94,364)

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NOTES TO UNAUDITED PRO FORMA CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

(1) Represents amortization on an incremental increase in identifiable intangible assets of which $32.1 million would be amortized over a five year life.

(2) The adjustment to interest expense represents the elimination of historical interest expense related to the 9 1/2% and 7 1/2% senior subordinated notes that were tendered. In addition, the adjustment includes the recording of interest expense for the Transactions, as if the Transactions had occurred as of the beginning of the respective periods presented. The following presents the interest expense for the senior subordinated notes being offered hereby calculated based upon the interest rate and principal amount outstanding and the interest expense for the new term loans and revolving credit facility are calculated based on the principal amount outstanding and interest rates:

	Outstanding Principal	Interest Rate
	(In thousands)	
New revolving credit facility	$ 200,000	5.4145%
New term loans	580,000	4.6300%
Senior subordinated notes	660,000	7.6250%

The following table summarizes the Transactions pro forma interest expense adjustment (in thousands):

	Year Ended December 31, 2004	Three Months Ended March 31, 2005(a)
Eliminate interest expense on 9 1/2% senior subordinated notes	$ (16,079)	$ (2,457)
Eliminate interest expense on 7 1/2% senior subordinated notes	(13,125)	(2,005)
Eliminate amortization of deferred financing fees from the tendered 9 1/2% and 7 1/2% senior subordinated notes and existing credit facility	(2,169)	(361)
Eliminate commitment fees related to former credit facility	(1,054)	(147)
Interest on new revolving credit facility	10,829	1,654
Commitment fee on unused portion of credit facility	424	70
Interest on new term loan facility	26,854	4,103
Interest on senior subordinated notes	50,325	7,689
Amortization of deferred financing fees from senior subordinated notes and new credit facility	7,302	1,217
Reduction of interest income related to use of existing cash to fund transaction(b)	1,639	517
Transaction pro forma interest adjustment	$ 64,946	$ 10,280

(a) Transaction pro forma interest adjustment for the three months ended March 31, 2005 represents elimination of historical amounts from January 1, 2005 through February 24, 2005 and inclusion of pro forma amounts for that

same period.

(b) The reduction in interest income is related to the use of $131.1 million of Select s existing cash to fund the transaction. The interest rates used were 1.250% and 2.369% for the year ended December 31, 2004 and the three months ended March 31, 2005, respectively, and represent the average interest rate earned by us during the period presented.

An increase or decrease in 12.5 basis points would result in an increase or decrease of annual interest expense associated with the new revolving credit facility and the new term loan facility of approximately $1.0 million.

(3) Represents the incremental tax effect of the adjustments based upon our effective statutory tax rate as follows:

Time Period	Tax Rate
Year Ended December 31, 2004	40.4%
Three Months Ended March 31, 2005	36.7%

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

You should read this discussion together with our consolidated financial statements and the accompanying notes and Selected Historical Consolidated Financial Data included elsewhere in this prospectus.

Overview

We are a leading operator of specialty hospitals in the United States. We are also a leading operator of outpatient rehabilitation clinics in the United States and Canada. As of March 31, 2005, we operated 99 long-term acute care hospitals in 26 states, four acute medical rehabilitation hospitals, which are certified by Medicare as inpatient rehabilitation facilities, in New Jersey and 753 outpatient rehabilitation clinics in 25 states, the District of Columbia and seven Canadian provinces. We also provide medical rehabilitation services on a contract basis at 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, we consummated a merger with a wholly owned subsidiary of Select Medical Holdings Corporation (Holdings) pursuant to which we became a wholly owned subsidiary of Holdings. Holdings is owned by an investor group that includes affiliates of Welsh Carson and Thoma Cressey and members of our senior management. This merger is discussed in more detail herein. As a result of the merger, a majority of our 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 financing transactions associated with the merger. Accordingly, our amortization expense and interest expense is 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 $1.3 billion has been allocated to goodwill, which will be the subject of 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 to be recorded at the stockholder s predecessor basis and a corresponding portion of the acquired assets to be recorded likewise.

Although the Predecessor and Successor results are not comparable by definition due to the merger and the resulting change in basis, for ease of comparison in the following discussion, the financial data for the period after the merger, February 25, 2005 through March 31, 2005 (Successor period), has been added to the financial data for the period from January 1, 2005 through February 24, 2005 (Predecessor period), to arrive at the combined three months ended March 31, 2005. The combined data is referred to herein as the combined three months ended March 31, 2005. As a result of the merger, interest expense, loss on early retirement of debt, merger related charges, depreciation and amortization have been impacted. No other statement of operations data has been affected as a result of the merger. Accordingly, 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 $1,660.8 million and $482.9 million for the year ended December 31, 2004 and the combined three months ended March 31, 2005, respectively. Of this total, we earned approximately 66% and 71% of our net operating revenues from our specialty hospitals and approximately 34% and 29% from our outpatient rehabilitation business for the year ended December 31, 2004 and the combined three months ended March 31, 2005, 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 that 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

First Quarter Ended March 31, 2005

For the combined three months ended March 31, 2005, our net operating revenues increased 15.4% to $482.9 million compared to the three months ended March 31, 2004. This increase in net operating revenues was principally attributable to our acquisition of SemperCare, Inc. on January 1, 2005 and the growth in net operating revenues at our same store hospitals. This growth in net operating revenue was offset by a decline in our outpatient rehabilitation net operating revenues that resulted from a decline in the number of clinics we operate and in the volume of visits occurring at the operating clinics. We incurred a loss from operations for the combined three months ended March 31, 2005 of $68.2 million that was attributable to the stock compensation costs associated with the merger. Excluding the stock compensation costs associated with the merger of $146.5 million, income from operations would have been $78.3 million compared to $59.3 million for the three months ended March 31, 2004. This increase is also principally attributable to the growth in income at our same store hospitals and the income generated from the recently acquired SemperCare hospitals. For the combined three months ended March 31, 2005, we also incurred a loss of early retirement of debt of $42.7 million related to the tender of our 7 1/2% and 9 1/2% senior subordinated notes and other expenses related to our merger of $12.0 million.

Our cash flow from operations used $172.9 million of cash for the combined three months ended March 31, 2005, which includes $186.0 million in cash expenses related to the merger. Excluding the merger related expenses, operating activities would have provided $13.1 million of cash flow.

SemperCare Acquisition

On January 1, 2005, we acquired SemperCare, Inc., or SemperCare, for approximately $100 million in cash. The purchase price for the SemperCare acquisition is subject to an upward or downward adjustment based on the level of SemperCare s net working capital on the closing date of the acquisition. SemperCare operated 17 long-term acute care hospitals in 11 states. Six of the SemperCare facilities are in markets that overlap with other of our hospital markets. All of the SemperCare facilities are HIHs, and we expect to transition these facilities to adapt to the new HIH regulations within a similar time frame and using strategies similar to those that we will use to transition our other HIHs.

Year Ended December 31, 2004

In 2004 our net operating revenues increased 19.3%, income from operations increased 54.6%, net income increased 58.7% and diluted earnings per share increased 54.2% over 2003. Our specialty hospital segment was the primary source of this growth. In our specialty hospital segment we experienced growth resulting from the addition of four inpatient rehabilitation facilities acquired through our September 2003 acquisition of Kessler Rehabilitation Corporation, growth from our hospitals opened in 2003 and 2004, and an increase in our revenue per patient day in our same store hospitals. Our outpatient segment experienced growth related primarily to the full year effect of the Kessler clinics in 2004. We also continued to experience significant cash flow from operations resulting from our growth in net income and a continued reduction in accounts receivable days outstanding.

Regulatory Changes

On August 11, 2004, the Centers for Medicare & Medicaid Services, also known as CMS, published final regulations applicable to long-term acute care hospitals that are operated as hospitals within hospitals or as satellites (collectively referred to as HIHs). HIHs are separate hospitals located in space leased from, and located in, general acute care hospitals, known 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 hosts 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%. For HIHs that meet specified criteria and were in existence as of October 1, 2004, including all of our existing HIHs, the Medicare admissions thresholds will be phased-in over a four-year period starting with hospital cost reporting periods beginning on or after October 1, 2004, as follows: (i) for discharges during the cost reporting period beginning on or after October 1, 2004 and before October 1, 2005, the Medicare admissions threshold is the Fiscal 2004 Percentage (as defined below) of Medicare discharges admitted from the host hospital; (ii) for discharges during the cost reporting period beginning on or after October 1, 2005 and before October 1, 2006, the Medicare admissions threshold is the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 75%; (iii) for discharges during the cost reporting period beginning on or after October 1, 2006 and before October 1, 2007, the Medicare admissions threshold is the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 50%; and (iv) for discharges during cost reporting periods beginning on or after October 1, 2007, the Medicare admissions threshold is 25%. As used above, Fiscal 2004 Percentage means, with respect to any HIH, the percentage of all Medicare patients discharged by such HIH during its cost reporting period beginning on or after October 1, 2003 and before October 1, 2004 who were admitted to such HIH from its host hospital.

At December 31, 2004, we operated 82 long-term acute care hospitals. Of this total, 78 operated as HIHs. At March 31, 2005 we operated 99 long-term acute care hospitals, 95 of which operated as HIHs. For the year ended December 31, 2004, approximately 60% of the Medicare admissions to our HIHs were from host hospitals. For the year ended December 31, 2004, approximately 9% of our HIHs admitted 25% or fewer of their Medicare patients from their host hospitals, approximately 31% of our HIHs admitted 50% or fewer of their Medicare patients from their host hospitals, and approximately 78% of our HIHs admitted 75% or fewer of their Medicare patients from their host hospitals. There are several factors that should be taken into account in evaluating this admissions data. First, the admissions data for the year ended December 31, 2004 is not necessarily indicative of the admissions mix these hospitals will experience in the future. Second, admissions data for the year ended December 31, 2004 includes four hospitals that were open for less than one year, and the data from these hospitals may not be indicative of the admissions mix these hospitals will experience over a longer period of time. Third, admissions data for the year ended December 31, 2004 does not include admissions data for the hospitals recently acquired in the SemperCare acquisition.

Our existing HIHs will be substantially unaffected by the new HIH regulations until cost reporting periods beginning on or after October 1, 2005, when the 75% limitation on Medicare host admissions is implemented. Thus, the HIH regulations had no effect on our 2004 financial results. Our HIHs have cost reporting periods that commence on various dates throughout the calendar year. Consequently, any effect of the new admissions thresholds on our HIHs may be delayed depending on when a particular HIH s cost reporting period begins. For example, although approximately 22% of our HIHs open at December 31, 2004 admitted more than 75% of their Medicare patients from their host hospitals during the year ended December 31, 2004, only three of such HIHs have cost reporting periods that will begin after October 1, 2005 and before December 31, 2005. As a result, the HIH regulations should have only a minimal impact on our 2005 financial results.

In order to minimize the more significant impact of the HIH regulations in 2006 and future years, we have developed a business plan and strategy in each of our markets to adapt to the HIH regulations and maintain our company s current business. Our transition plan includes managing admissions at existing HIHs, relocating certain HIHs to leased spaces in smaller host hospitals in the same markets, consolidating HIHs in certain of our markets, relocating certain of our facilities to alternative settings, building or buying free-standing facilities and closing a small number of facilities. We currently anticipate that approximately 50% of our hospitals will not require a move.

The new HIH regulations established exceptions to the Medicare admissions thresholds with respect to patients who reach outlier status at the host hospital, HIHs located in MSA-dominant hospitals or HIHs located in rural areas.

Development of New Specialty Hospitals and Clinics

Historically our goal had been to open approximately eight to ten new long-term acute care hospitals each year, utilizing primarily our hospital within a hospital model. As a result of the regulatory changes published by CMS on August 11, 2004, we opened four long-term acute care hospitals in 2004. We expect to open four new long-term acute care hospitals in 2005, primarily in settings where the new HIH regulations would have little or no impact, for example, in free-standing buildings. Additionally, we are evaluating opportunities to develop free-standing inpatient rehabilitation facilities similar to the four inpatient rehabilitation facilities acquired through our September 2003 Kessler acquisition. We also intend to open new outpatient rehabilitation clinics in our current markets 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%, 46% and 40% of net operating revenues for the years ended December 31, 2004, 2003 and 2002, respectively, and approximately 55% and 48% of net operating revenues for the combined three months ended March 31, 2005 and the three months ended March 31, 2004, respectively. The increase in the percentage of our revenues generated from the Medicare program is due to the growth in the number of specialty hospitals and their higher respective share of Medicare revenues generated in this segment of our business compared to our outpatient rehabilitation segment.

Approximately 68%, 69% and 63% of our specialty hospital revenues for the years ended December 31, 2004, 2003 and 2002, respectively, and approximately 74% and 69% of our specialty hospital revenues for the combined three months ended March 31, 2005 and the three months ended March 31, 2004, respectively, were received in respect of services provided to Medicare patients. For the year ended December 31, 2004 and the combined three months ended March 31, 2005, all of our Medicare payments are being paid under a prospective payment system. For the years ended December 31, 2003 and 2002, approximately 23% and 92%, respectively, were paid by Medicare under a full cost-based reimbursement methodology. Payments made under a cost-based reimbursement methodology are subject to final cost report settlements based on administrative review and audit by third parties. An annual cost report was filed for each provider to report the cost of providing services and to settle the difference between the interim payments we receive and final costs. We record adjustments to the original estimates in the periods that such adjustments become known. Historically these adjustments have not been significant. Substantially all of our Medicare cost reports are settled through 2002. Because our routine payments from Medicare are different than the final reimbursement due to us under the cost based reimbursement system, we record a receivable or payable for the difference.

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.

While the implementation of LTCH-PPS is intended to be revenue neutral to the industry, our long-term acute care hospitals experienced enhanced financial performance in 2003 due to our low cost operating model and the high acuity of our patient population.

Most of our specialty hospitals receive bi-weekly periodic interim payments (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.

For 2003 and 2004, other revenue primarily represents amounts we have received for other services, which include sales of home medical equipment, orthotics, prosthetics, infusion/intravenous services and computer software. In 2002, other revenue primarily represented amounts the Medicare program reimbursed us for a portion of our corporate expenses that are related to our long-term acute care hospital operations. Under the LTCH-PPS, we no longer are specifically reimbursed for the portion of our corporate costs related to the provision of Medicare services in our long-term acute care hospitals. Instead, we receive from Medicare a pre-determined fixed amount assigned to the applicable LTC-DRG, which is intended to reflect the average cost of treating such a patient, including corporate costs. As a result of this change in our revenue stream, in 2003 we began allocating corporate departmental costs that are directly related to our long-term acute care hospital operations to our specialty hospital segment to better match the cost with the revenues for this segment. This allocation has not had any adverse impact on the profitability or margins of this segment, due to the expected increase in net revenue this segment has experienced under LTCH-PPS. In addition to the Medicare revenue we recorded in 2003, we also reported as other revenue amounts we received for other services, which include sales of home medical equipment, orthotics, prosthetics and infusion/intravenous services. These other services were acquired as part of our acquisition of Kessler.

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 the 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 payors 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. Deductible, co-payments and self-insured amounts are an immaterial portion of our net accounts receivable balance. At December 31, 2004, deductible, co-payments and self-insured amounts owed by the patient accounted for approximately 1.7% 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 which includes 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 receivables. 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,			
	2004		**2003**	
	0-90 Days	**Over 90 Days**	**0-90 Days**	**Over 90 Days**
Medicare and Medicaid	$ 88,174	$ 20,182	$ 87,089	$ 28,490
Commercial insurance, and other	127,691	75,426	114,392	111,717
Total net accounts receivable	$ 215,865	$ 95,608	$ 201,481	$ 140,207

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,	
	2004	**2003**
0 to 90 days	69.3%	59.0%
91 to 180 days	11.2%	11.6%
180 to 365 days	9.9%	10.0%
Over 365 days	9.6%	19.4%
Total	100.0%	100.0%

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

As of December 31,

	2004	2003
Insured receivables	98.3%	97.9%
Self-pay receivables (including deductible and copayments)	1.7%	2.1%
Total	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 principal 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 March 31, 2005 and December 31, 2004, we have recorded a liability of $48.4 million and $44.4 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 $0.4 million and $1.9 million for the combined three months ended March 31, 2005 and the year ended December 31, 2004, respectively. Our future commitments are related to commercial office space we lease for our corporate headquarters in Mechanicsburg, Pennsylvania. These future commitments amount to $18.0 million through 2014. 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.

Operating Statistics

The following table sets 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 and consolidations. The operating statistics reflect data for the period of time these operations were managed by us.

	Fiscal Year Ended December 31,			Three Months Ended March 31,	
	2002	**2003**	**2004**	**2004**	**2005**
Specialty hospital data(1):					
Number of hospitals start of period	64	72	83	83	86
Number of hospital start-ups	8	8	4		
Number of hospitals acquired		4			17
Number of hospitals closed		(1)	(1)		
Number of hospitals end of period	72	83	86	83	103
Available licensed beds	2,594	3,204	3,403	3,256	3,907
Admissions	21,065	27,620	33,523	8,738	10,336
Patient days	619,322	722,231	816,898	212,727	250,839
Average length of stay (days)	30	26	24	25	25
Net revenue per patient day(2)	$ 1,009	$ 1,173	$ 1,306	$ 1,243	$ 1,330
Occupancy rate	71%	70%	67%	72%	71%
Percent patient days Medicare	76%	76%	74%	75%	77%
Outpatient rehabilitation data:					
Number of clinics owned start of	664	679	758	758	705

period					
Number of clinics acquired	14	125	5	2	7
Number of clinic start-ups	49	30	20	4	9
Number of clinics closed/sold	(48)	(76)	(78)	(23)	(6)
Number of clinics owned end of period	679	758	705	741	715
Number of clinics managed end of period	58	32	36	36	38
Total number of clinics (all) end of period	737	790	741	777	753
Number of visits (U.S.)	3,841,841	4,027,768	3,810,284	1,004,106	915,822
Net revenue per visit (U.S.)(3)	$ 86	$ 87	$ 90	$ 91	$ 91

(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) Net revenue per visit (U.S.) 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 our Canadian subsidiary and contract services revenue.

Results of Operations

The following table presents the combined consolidated statement of operations for the three months ended March 31, 2005. The financial data for the period after the merger, February 25, 2005 through March 31, 2005 (Successor period), has been added to the financial data for the period from January 1, 2005 through February 24, 2005 (Predecessor period), to arrive at the combined three months ended March 31, 2005.

			Three Months Ended March 31, 2005
	Predecessor	Successor	Combined
		(Dollars in thousands)	
Net operating revenues	$ 287,787	$ 195,112	$ 482,899
Costs and expenses:			
Cost of services	225,428	145,608	371,036
Stock compensation associated with merger	142,213	4,326	146,539
General and administrative	7,484	4,356	11,840
Bad debt expense	6,661	4,609	11,270
Depreciation and amortization	6,177	4,248	10,425
Total costs and expenses	387,963	163,147	551,110
Income (loss) from operations	(100,176)	31,965	(68,211)
Other income and expense:			
Loss on early retirement of debt	42,736		42,736
Merger related charges	12,025		12,025
Interest income	(523)	(77)	(600)
Interest expense	4,734	9,636	14,370
Income (loss) before minority interests and income taxes	(159,148)	22,406	(136,742)
Minority interest in consolidated subsidiary companies	469	462	931
Income (loss) before income taxes	(159,617)	21,944	(137,673)
Income tax expense (benefit)	(59,366)	8,871	(50,495)
Net income (loss)	$ (100,251)	$ 13,073	$ (87,178)

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

	Fiscal Year Ended December 31,			Three Months Ended March 31,	
	2002	2003	2004	2004	2005(1)
Net operating revenues	100.0%	100.0%	100.0%	100.0%	100.0%
Cost of services(2)	81.9	79.8	78.0	77.8	76.9
Stock compensation associated with merger					30.3
General and administrative	3.5	3.2	2.8	2.8	2.4
Bad debt expense	3.3	3.7	2.9	2.8	2.3
Depreciation and amortization	2.3	2.5	2.4	2.4	2.2
Income (loss) from operations	9.0	10.8	13.9	14.2	(14.1)
Loss on early retirement of debt					8.9
Equity in earnings from joint ventures		(0.1)			
Merger related charges					2.4
Interest expense, net	2.4	1.8	1.8	2.2	2.9
Income (loss) from continuing operations before minority interests and income taxes	6.6	9.1	12.1	12.0	(28.3)
Minority interests	0.2	0.2	0.2	0.3	0.2
Income (loss) from continuing operations before income taxes	6.4	8.9	11.9	11.7	(28.5)
Income tax (benefit)	2.5	3.6	4.8	4.7	(10.5)
Income (loss) from continuing operations	3.9	5.3	7.1	7.0	(18.0)
Income from discontinued operations, net of tax		N/M	N/M	N/M	
Net income (loss)	3.9%	5.3%	7.1%	7.0%	(18.0)%

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

	Fiscal Year Ended December 31,			% Change	% Change	Three Months Ended March 31,		
	2002	2003	2004	2002-2003	2003-2004	2004	2005(1)	% Change
	(Dollars in thousands)					(Dollars in thousands)		
Net operating revenues:								
Specialty hospitals	$ 625,238	$ 849,261	$ 1,089,538	35.8%	28.3%	$ 269,379	$ 341,511	26.8%

Outpatient rehabilitation	485,101	529,262	558,097	9.1	5.4	145,664	138,232	(5.1)
Other	16,220	13,843	13,156	(14.7)	(5.0)	3,426	3,156	(7.9)
Total company	$ 1,126,559	$ 1,392,366	$ 1,660,791	23.6%	19.3%	$ 418,469	$ 482,899	15.4%
Income (loss) from operations:								
Specialty hospitals	$ 57,975	$ 129,861	$ 216,803	124.0%	66.9%	$ 53,070	$ 72,762	37.1%
Outpatient rehabilitation	70,342	60,778	66,805	(13.6)	9.9	19,339	19,174	(0.9)
Other	(26,874)	(40,840)	(52,075)	(52.0)	(27.5)	(13,134)	(160,147)	N/M
Total company	$ 101,443	$ 149,799	$ 231,533	47.7%	54.6%	$ 59,275	$ (68,211)	N/M
Adjusted EBITDA(3):								
Specialty hospitals	$ 70,891	$ 145,649	$ 236,181	105.5%	62.2%	$ 57,907	$ 79,055	36.5%
Outpatient rehabilitation	81,136	74,988	81,616	(7.6)	8.8	22,908	21,823	(4.7)
Other	(24,748)	(36,184)	(46,287)	(46.2)	(27.9)	(11,343)	(12,125)	(6.9)

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	Fiscal Year Ended December 31,					Three Months Ended March 31,		
	2002	2003	2004	% Change 2002-2003	% Change 2003-2004	2004	2005(1)	% Change
	(Dollars in thousands)					(Dollars in thousands)		
Adjusted EBITDA margins(3):								
Specialty hospitals	11.3%	17.2%	21.7%	52.2%	26.2%	21.5%	23.1%	7.4%
Outpatient rehabilitation	16.7	14.2	14.6	(15.0)	2.8	15.7	15.8	0.6
Other	N/M	N/M	N/M	N/M	N/M	N/M	N/M	N/M
Total assets:								
Specialty hospitals	$ 332,737	$ 512,956	$ 520,572			$ 479,559	$ 1,552,031	
Outpatient rehabilitation	326,763	365,534	318,180			390,823	530,855	
Other	79,559	200,508	274,969			246,604	86,538	
Total company	$ 739,059	$ 1,078,998	$ 1,113,721			$ 1,116,986	$ 2,169,424	
Purchases of property and equipment, net:								
Specialty hospitals	$ 28,791	$ 22,559	$ 23,320			$ 3,878	$ 1,943	
Outpatient rehabilitation	12,637	8,514	5,885			1,746	682	
Other	1,755	4,779	3,421			2,138	1,073	
Total company	$ 43,183	$ 35,852	$ 32,626			$ 7,762	$ 3,698	

The following tables reconcile same hospitals information:

	Fiscal Year Ended December 31,	
	2002	2003
	(Dollars in thousands)	
Net operating revenue		
Specialty hospitals net operating revenue	$ 625,238	$ 849,261
Less: Specialty hospitals opened and acquired after 1/1/02	6,480	120,925

Closed specialty hospital		4,636		1,537
Specialty hospitals same store net operating revenue	$	614,122	$	726,799
Adjusted EBITDA(3)				
Specialty hospitals Adjusted EBITDA(3)	$	70,891	$	145,649
Less: Specialty hospitals opened and acquired after 1/1/02		(5,829)		21,416
Closed specialty hospital		143		206
Specialty hospitals same store Adjusted EBITDA(3)	$	76,577	$	124,027
All specialty hospitals Adjusted EBITDA margin(3)		11.3%		17.2%
Specialty hospitals same store Adjusted EBITDA margin(3)		12.5%		17.1%

	Fiscal Year Ended December 31,	
	2003	2004
	(Dollars in thousands)	
Net operating revenue		
Specialty hospitals net operating revenue	$ 849,261	$ 1,089,538
Less: Specialty hospitals opened and acquired after 1/1/03	56,320	216,356
Closed specialty hospital	9,695	5,693
Specialty hospitals same store net operating revenue	$ 783,246	$ 867,489
Adjusted EBITDA(3)		
Specialty hospitals Adjusted EBITDA(3)	$ 145,649	$ 236,181
Less: Specialty hospitals opened and acquired after 1/1/03	2,868	48,896
Closed specialty hospital	28	(2,083)
Specialty hospitals same store Adjusted EBITDA(3)	$ 142,753	$ 189,368
All specialty hospitals Adjusted EBITDA margin(3)	17.2%	21.7%
Specialty hospitals same store Adjusted EBITDA margin(3)	18.2%	21.8%

	Three Months Ended March 31,	
	2004	2005(1)
	(Dollars in thousands)	
Net operating revenue		
Specialty hospitals net operating revenue	$ 269,379	$ 341,511
Less: Specialty hospitals opened, acquired or closed after 1/1/04	1,985	48,674
Specialty hospitals same store net operating revenue	$ 267,394	$ 292,837
Adjusted EBITDA(3)		
Specialty hospitals Adjusted EBITDA(3)	$ 57,907	$ 79,055
Less: Specialty hospitals opened, acquired or closed after 1/1/04	(663)	7,314
Specialty hospitals same store Adjusted EBITDA(3)	$ 58,570	$ 71,741
All specialty hospitals Adjusted EBITDA margin(3)	21.5%	23.1%
Specialty hospitals same store Adjusted EBITDA margin(3)	21.9%	24.5%

N/ M Not Meaningful.

(1) The financial data for the period after the merger, February 25, 2005 through March 31, 2005 (Successor period), has been added to the financial data for the period from January 1, 2005 through February 24, 2005 (Predecessor period), to arrive at the combined three months ended March 31, 2005.

(2) Cost of services include salaries, wages and benefits, operating supplies, lease and rent expense and other operating costs.

(3) We define Adjusted EBITDA as net income before interest, income taxes, depreciation and amortization, income from discontinued operations, loss on early retirement of debt, equity in income from joint ventures, merger related charges, stock compensation associated with merger, and minority interest. We believe that the presentation of Adjusted EBITDA is important to investors because 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 for the year ended December 31, 2004 and footnote 10 to our interim consolidated financial statements for the period ended March 31, 2005 for a reconciliation of net income to Adjusted EBITDA as utilized by us in reporting our segment performance in accordance with SFAS No. 131.

Combined Three Months Ended March 31, 2005 Compared to Three Months Ended March 31, 2004

Net Operating Revenues

Our net operating revenues increased by 15.4% to $482.9 million for the combined three months ended March 31, 2005 compared to $418.5 million for the three months ended March 31, 2004.

Specialty Hospitals. Our specialty hospital net operating revenues increased 26.8% to $341.5 million for the combined three months ended March 31, 2005 compared to $269.4 million for the three months ended March 31, 2004. Net operating revenues for the specialty hospitals opened before January 1, 2004 and operated by us throughout both periods increased 9.5% to $292.8 million for the combined three months ended March 31, 2005 from $267.4 million for the three months ended March 31, 2004. This increase resulted primarily from higher net revenue per patient day. Our patient days for these hospitals increased 2.0%. Additionally, our occupancy percentage increased to 74% for the combined three months ended March 31, 2005 compared to 72% for the three months ended March 31, 2004. The remaining increase of $46.7 million resulted primarily from the acquisition of the SemperCare facilities, which contributed $42.1 million of net revenue growth.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues declined 5.1% to $138.2 million for the combined three months ended March 31, 2005 compared to $145.7 million for the three months ended March 31, 2004. The number of patient visits in our U.S. based outpatient rehabilitation clinics declined 8.8% for the combined three months ended March 31, 2005 to 915,822 visits compared to 1,004,106 visits for the three months ended March 31, 2004. The decrease in net operating revenues and patient visits was principally related to a 3.5% decline in the number of clinics we own and operate and a 3.8% decline in the volume of visits per clinic at our U.S. locations. Net revenue per visit in these clinics was $91 in both 2005 and 2004.

Other. Our other revenues were $3.2 million for the combined three months ended March 31, 2005 compared to $3.4 million for the three months ended March 31, 2004.

Operating Expenses

Our operating expenses increased by 12.9% to $394.1 million for the combined three months ended March 31, 2005 compared to $349.0 million for the three months ended March 31, 2004. Our operating expenses include our cost of services, general and administrative expense and bad debt expense. The increase in operating expenses was principally related to the acquisition of SemperCare facilities on January 1, 2005. As a percentage of our net operating revenues, our operating expenses were 81.6% for the combined three months ended March 31, 2005 compared to 83.4% for the three months ended March 31, 2004. Cost of services as a percentage of operating revenues decreased to 76.9% for the combined three months ended March 31, 2005 from 77.8% for the three months ended March 31, 2004. These costs primarily reflect our labor expenses. This decrease resulted because we experienced a larger rate of growth in our specialty hospital revenues compared to the growth in our specialty hospital cost of services. Another component of cost of services is facility rent expense, which was $21.7 million for the combined three months ended March 31, 2005 compared to $19.7 million for the three months ended March 31, 2004. This increase is principally related to the SemperCare hospitals we acquired on January 1, 2005. During the same time period, general and administrative expense as a percentage of net operating revenues declined to 2.4% for the combined three months ended March 31, 2005 from 2.8% for the three months ended March 31, 2004. This decrease in

general and administrative expenses as a percentage of net operating revenue is the result of a growth in net operating revenues of 15.4% that exceeded the growth in our general and administrative costs which were 1.9%. Our bad debt expense as a percentage of net operating revenues was 2.3% for the combined three months ended March 31, 2005 compared to 2.8% for the three months ended March 31, 2004. This decrease in bad debt expense resulted from an improvement in the composition and aging of our accounts receivable.

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA increased by 36.5% to $79.1 million for the combined three months ended March 31, 2005 compared to $57.9 million for the three months ended March 31, 2004. Our Adjusted EBITDA margins increased to 23.1% for the combined three months ended March 31, 2005 from 21.5% for the three months ended March 31, 2004. The hospitals opened before January 1, 2004 and operated throughout both periods had Adjusted EBITDA of $71.7 million, an increase of 22.5% over the Adjusted EBITDA of these hospitals in 2004. This increase in same hospital Adjusted EBITDA resulted from an increase in revenue per patient day that exceeded our increase in cost per patient day and an increase in our patient days. Our Adjusted EBITDA margin in these same store hospitals increased to 24.5% for the combined three months ended March 31, 2005 from 21.9% for the three months ended March 31, 2004.

Outpatient Rehabilitation. Adjusted EBITDA decreased by 4.7% to $21.8 million for the combined three months ended March 31, 2005 compared to $22.9 million for the three months ended March 31, 2004. Our Adjusted EBITDA margins increased to 15.8% for the combined three months ended March 31, 2005 from 15.7% for the three months ended March 31, 2004. The decline in Adjusted EBITDA was the result of the decline in number of clinics we operate and the decline in clinic visit volumes described under Net Operating Revenue Outpatient Rehabilitation above.

Other. The Adjusted EBITDA loss was $12.1 million for the combined three months ended March 31, 2005 compared to a loss of $11.3 million for the three months ended March 31, 2004. This small increase in the Adjusted EBITDA loss was primarily the result of the decline in the profitability at one of our ancillary businesses.

Income (Loss) from Operations

For the combined three months ended March 31, 2005 we experienced a loss from operations of $68.2 million compared to income from operations of $59.3 million for the three months ended March 31, 2004. The loss from operations experienced for the combined three months ended March 31, 2005 resulted from the significant stock compensation costs recorded related to the merger of $146.5 million offset by the Adjusted EBITDA increases described above. The stock compensation expense was comprised of $142.2 million related to the repurchase of all vested and unvested outstanding stock options in accordance with the terms of the merger agreement in the Predecessor period of January 1, 2005 through February 24, 2005 and an additional $4.3 million of stock compensation expense related to restricted stock and a warrant that were issued in the Successor period of February 25, 2005 through March 31, 2005.

Loss on early retirement of debt

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

Merger related charges

As a result of the merger, we incurred costs in the Predecessor period of January 1, 2005 through February 24, 2005 directly related to the merger. This included the cost of the investment advisor hired by the Special Committee of our Board of Directors to evaluate the merger, legal and accounting fees, costs associated with the Hart-Scott-Rodino filing relating to the merger, cost associated with purchasing a six year

extended reporting period under our directors and officers liability insurance policy and other associated expenses.

Interest Expense

Interest expense increased by $5.0 million to $14.4 million for the combined three months ended March 31, 2005 from $9.4 million for the three months ended March 31, 2004. The increase in interest expense is due to the higher debt levels outstanding in the Successor period of February 25, 2005 through March 31, 2005. During this Successor period we had approximately $1.1 billion in additional debt.

Minority Interests

Minority interests in consolidated earnings was $0.9 million for the combined three months ended March 31, 2005 compared to $1.0 million for the three months ended March 31, 2004.

Income Taxes

We recorded income tax benefit of $59.4 million for the Predecessor period of January 1, 2005 through February 24, 2005. The tax benefit represented an effective tax benefit rate of 37.2%. This effective tax benefit rate consisted of the statutory Federal rate of 35% and a state rate of 2.2%. The Federal tax benefit will be carried forward and used to offset our Federal tax throughout the remainder of 2005. Because of the differing state tax rules related to net operating losses, a portion of these state net operating losses received valuation allowances. We recorded income tax expense of $8.9 million for the Successor period of February 25, 2005 through March 31, 2005. The expense represented an effective tax rate of 40.4%. For the three months ended March 31, 2004 we recorded income tax expense of $19.8 million. This expense represented an effective tax rate of 40.2%.

Income from discontinued operation, net of tax

On September 27, 2004 we sold the land, building and certain other assets and liabilities associated with our only skilled nursing facility that we acquired as part of the Kessler acquisition in September 2003. The operating results of the skilled nursing facility have been reclassified and reported as discontinued operations.

Year Ended December 31, 2004 Compared to Year Ended December 31, 2003

Net Operating Revenues

Our net operating revenues increased by 19.3% to $1,660.8 million for the year ended December 31, 2004 compared to $1,392.4 million for the year ended December 31, 2003.

Specialty Hospitals. Our specialty hospital net operating revenues increased 28.3% to $1,089.5 million for the year ended December 31, 2004 compared to $849.3 million for the year ended December 31, 2003. Net operating revenues for the specialty hospitals opened before January 1, 2003 and operated by us throughout both periods increased 10.8% to $867.5 million for the year ended December 31, 2004 from $783.2 million for the year ended December 31, 2003. This increase resulted primarily from higher net revenue per patient day, offset by a decline in our patient days and occupancy rates. Our patient days and occupancy rates declined primarily as a result of additional admissions criteria implemented in our long-term acute care hospitals. The remaining increase of $155.9 million resulted from the acquisition of the Kessler facilities, which contributed $96.3 million of net revenue growth, and the internal development of new specialty hospitals that commenced operations in 2003 and 2004.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues increased 5.4% to $558.1 million for the year ended December 31, 2004 compared to $529.3 million for the year ended December 31, 2003. The increase in net operating revenues was principally related to the acquisition of the Kessler operations. The number of patient visits in our U.S. based outpatient rehabilitation clinics declined 5.4% for the year ended December 31, 2004 to 3,810,284 visits compared to 4,027,768 visits for the year ended December 31, 2003. Net revenue per visit in these clinics was $90 in 2004 compared to $87 in 2003. Excluding

the effects of the Kessler operations in both periods, visits declined 11.0%. The majority of this decline is related to clinic closures. In addition, during the first and second quarters of 2004 various market factors such as elimination of unprofitable contracts and competition from referring physicians who are now developing their own rehabilitation therapy practices contributed to the decline.

Other. Our other revenues declined to $13.2 million for the year ended December 31, 2004 compared to $13.8 million for the year ended December 31, 2003. The principal reason for the decline is the conversion of our long-term acute care hospitals to LTCH-PPS and the associated changes in how we get reimbursed for the services which was $8.7 million in 2003. The decline was offset by revenues related to the Kessler other businesses that are now being reported under this category. These businesses generated approximately $7.9 million of incremental net operating revenues in 2004. See Critical Accounting Matters Sources of Revenue for a further discussion of this change.

Operating Expenses

Our operating expenses increased by 15.0% to $1,389.3 million for the year ended December 31, 2004 compared to $1,207.9 million for the year ended December 31, 2003. Our operating expenses include our cost of services, general and administrative expense and bad debt expense. The increase in operating expenses was principally related to the acquisition of Kessler and the internal development of new specialty hospitals that commenced operations in 2003 and 2004. As a percentage of our net operating revenues, our operating expenses were 83.7% for the year ended December 31, 2004 compared to 86.7% for the year ended December 31, 2003. Cost of services as a percentage of operating revenues decreased to 78.0% for the year ended December 31, 2004 from 79.8% for the year ended December 31, 2003. These costs primarily reflect our labor expenses. This decrease resulted because we experienced a larger rate of growth in our specialty hospital revenues compared to the growth in our specialty hospital cost of services. Another component of cost of services is facility rent expense, which was $80.4 million for the year ended December 31, 2004 compared to $74.3 million for the year ended December 31, 2003. This increase is principally related to our new hospitals that opened during 2003 and 2004 and the rent expense for the acquired Kessler clinics. During the same time period, general and administrative expense as a percentage of net operating revenues declined to 2.8% for the year ended December 31, 2004 from 3.2% for the year ended December 31, 2003. This decrease in general and administrative expenses as a percentage of net operating revenue is the result of a growth in net operating revenues that exceeded the growth in our general and administrative costs. Our bad debt expense as a percentage of net operating revenues was 2.9% for the year ended December 31, 2004 compared to 3.7% for the year ended December 31, 2003. This decrease in bad debt expense resulted from an improvement in the composition and aging of our accounts receivable.

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA increased by 62.2% to $236.2 million for the year ended December 31, 2004 compared to $145.6 million for the year ended December 31, 2003. Our Adjusted EBITDA margins increased to 21.7% for the year ended December 31, 2004 from 17.2% for the year ended December 31, 2003. The hospitals opened before January 1, 2003 and operated throughout both periods had Adjusted EBITDA of $189.4 million, an increase of 32.7% over the Adjusted EBITDA of these hospitals in 2003. This increase in same hospital Adjusted EBITDA resulted from an increase in revenue per patient day that exceeded our increase in cost per patient day. Our Adjusted EBITDA margin in these same store hospitals increased to 21.8% for the year ended December 31, 2004 from 18.2% for the year ended December 31, 2003.

Outpatient Rehabilitation. Adjusted EBITDA increased by 8.8% to $81.6 million for the year ended December 31, 2004 compared to $75.0 million for the year ended December 31, 2003. Our Adjusted EBITDA margins increased to 14.6% for the year ended December 31, 2004 from 14.2% for the year ended December 31, 2003. This Adjusted EBITDA margin increase was primarily the result of three factors. First, the acquired Kessler outpatient operations experienced negative margins in 2003, which had the effect of lowering the overall margins for the segment in 2003. We consolidated or closed many of the underperforming

clinics in 2004. Second, we experienced lower bad debt expense in 2004. Third, the increases previously described were offset by an increase in labor costs due to increased competition for hiring therapists.

Other. The Adjusted EBITDA loss was $46.3 million for the year ended December 31, 2004 compared to a loss of $36.2 million for the year ended December 31, 2003. This increase in the Adjusted EBITDA loss was primarily the result of the decline in hospital reimbursements for corporate support costs of $8.7 million (See Critical Accounting Matters Sources of Revenue) and an increase in our general and administrative expenses of $1.4 million.

Income from Operations

Income from operations increased 54.6% to $231.5 million for the year ended December 31, 2004 compared to $149.8 million for the year ended December 31, 2003. The increase in income from operations resulted from the Adjusted EBITDA increases described above, and was offset by an increase in depreciation and amortization expense of $5.3 million. The increase in depreciation and amortization expense resulted primarily from the additional depreciation associated with acquired Kessler assets, the amortization of the Kessler non-compete agreement, and increases in depreciation on fixed asset additions that are principally related to new hospital and clinic development.

Interest Expense

Interest expense increased by $7.3 million to $33.6 million for the year ended December 31, 2004 from $26.3 million for the year ended December 31, 2003. The increase in interest expense is due to the higher debt levels outstanding in 2004 compared to 2003 resulting from the issuance of $175.0 million of $7^1/2$% senior subordinated notes due 2013 on August 12, 2003, offset by a reduction in borrowings under our senior credit facility. The lower debt levels on our senior credit facility resulted from scheduled term amortization payments and principal pre-payments. All repayments have been made with cash flows generated through operations.

Minority Interests

Minority interests in consolidated earnings increased to $3.4 million for the year ended December 31, 2004 compared to $2.4 million for the year ended December 31, 2003. This increase is the result of the improved profitability of these jointly owned entities.

Income Taxes

We recorded income tax expense of $79.6 million for the year ended December 31, 2004. The expense represented an effective tax rate of 40.4%. We recorded income tax expense of $48.6 million for the year ended December 31, 2003. This expense represented an effective tax rate of 39.6%. The increase in the tax rate is the result of a larger portion of our net income in states with higher tax rates and the non-deductibility of certain expenses.

Year Ended December 31, 2003 Compared to Year Ended December 31, 2002

Net Operating Revenues

Our net operating revenues increased by 23.6% to $1,392.4 million for the year ended December 31, 2003 compared to $1,126.6 million for the year ended December 31, 2002.

Specialty Hospitals. Our specialty hospital net operating revenues increased 35.8% to $849.3 million for the year ended December 31, 2003 compared to $625.2 million for the year ended December 31, 2002. Net operating revenues for the specialty hospitals opened before January 1, 2002 and operated throughout both periods increased 18.3% to $726.8 million for the year ended December 31, 2003 from $614.1 million for the year ended December 31, 2002. This increase resulted primarily from higher net revenue per patient day, which is primarily attributable to the improved reimbursement we are receiving from Medicare under the LTCH-PPS. Our patient days and occupancy rates for these hospitals were consistent in both periods. The remaining increase of $111.4 million resulted from the acquisition of the Kessler facilities, which contributed

$43.9 million of net revenue, and the internal development of new specialty hospitals that commenced operations in 2002 and 2003.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues increased 9.1% to $529.3 million for the year ended December 31, 2003 compared to $485.1 million for the year ended December 31, 2002. The number of patient visits in our U.S. based outpatient rehabilitation clinics increased 4.8% for the year ended December 31, 2003 to 4,027,768 visits compared to 3,841,841 visits for the year ended December 31, 2002. Net revenue per visit in these clinics was $87 in 2003 compared to $86 in 2002. The increase in net operating revenues was related to the acquisition of the Kessler operations, which contributed $23.0 million of net operating revenue, the consolidation of clinics that we previously managed and clinics that we acquired during 2002 and 2003, and changes in the economic environment that are reducing the number of therapy visits. These macro-economic trends affecting therapy visit volumes include increasing patient co-pays and a decline in the number of approved visits for a patient. Excluding the effects of the previously managed clinics and the recently acquired clinics (including the Kessler clinics), net operating revenues for the year ended December 31, 2003 would have been $493.2 million, and the number of U.S. based visits would have been 3,741,717.

Other. Our other revenues declined to $13.8 million for the year ended December 31, 2003 compared to $16.2 million for the year ended December 31, 2002. The principal reason for the decline is the conversion of our long-term acute care hospitals to LTCH-PPS and the associated changes in how we get reimbursed for the services we provide. The decline was offset by revenues related to the other businesses we acquired as part of our Kessler acquisition that are now being reported under this category. These businesses generated approximately $3.6 million of revenues in 2003. We expect this revenue item to continue declining throughout 2004. See Critical Accounting Matters Sources of Revenue for a further discussion of this change.

Operating Expenses

Our operating expenses increased by 20.9% to $1,207.9 million for the year ended December 31, 2003 compared to $999.3 million for the year ended December 31, 2002. Our operating expenses include our cost of services, general and administrative expense and bad debt expense. The increase in operating expenses was principally related to the acquisition of Kessler, the internal development of new specialty hospitals that commenced operations in 2002 and 2003, costs associated with increased patient volumes and the consolidation of previously managed clinics. As a percentage of our net operating revenues, our operating expenses were 86.7% for the year ended December 31, 2003 compared to 88.7% for the year ended December 31, 2002. Cost of services as a percentage of operating revenues decreased to 79.8% for the year ended December 31, 2003 from 81.9% for the year ended December 31, 2002. These costs primarily reflect our labor expenses. This decrease resulted because we experienced a larger rate of growth in our specialty hospital revenues compared to the growth in our specialty hospital cost of services. Another component of cost of services is facility rent expense, which was $74.3 million for the year ended December 31, 2003 compared to $66.4 million for the year ended December 31, 2002. This increase is principally related to our new hospitals that opened during 2002 and 2003 and the rent expense for the acquired Kessler clinics. During the same time period, general and administrative expense as a percentage of net operating revenues declined to 3.2% for the year ended December 31, 2003 from 3.5% for the year ended December 31, 2002. This decrease in general and administrative expenses as a percentage of net operating revenue is the result of a growth in net operating revenues that exceeded the growth in our general and administrative costs. Our bad debt expense as a percentage of net operating revenues was 3.7% for the year ended December 31, 2003 compared to 3.3% for the year ended December 31, 2002. This increase in bad debt expense resulted primarily from two factors. First, we experienced a migration of some of our accounts receivable to older aging categories where we significantly reduce our estimates of net realizable value. Second, the transition to the new LTCH-PPS payment mechanism in our long-term acute care hospitals has caused uncertainty associated with collections from payors that insure patient s co-payments and Medicare supplemental coverage.

Adjusted EBITDA

Specialty Hospitals. Specialty hospital Adjusted EBITDA increased by 105.5% to $145.6 million for the year ended December 31, 2003 compared to $70.9 million for the year ended December 31, 2002. Our specialty hospital Adjusted EBITDA margins increased to 17.2% for the year ended December 31, 2003 from 11.3% for the year ended December 31, 2002. The hospitals opened before January 1, 2002 and operated throughout both periods had Adjusted EBITDA of $124.0 million, an increase of 62.0% over the Adjusted EBITDA of these hospitals in 2002. This increase in same hospital Adjusted EBITDA resulted from an increase in revenue per patient day, which is primarily attributable to the improved reimbursement we are receiving from Medicare under LTCH-PPS. Our Adjusted EBITDA margin in these same store hospitals increased to 17.1% for the year ended December 31, 2003 from 12.5% for the year ended December 31, 2002.

Outpatient Rehabilitation. Outpatient rehabilitation Adjusted EBITDA decreased by 7.6% to $75.0 million for the year ended December 31, 2003 compared to $81.1 million for the year ended December 31, 2002. Our outpatient rehabilitation Adjusted EBITDA margins decreased to 14.2% for the year ended December 31, 2003 from 16.7% for the year ended December 31, 2002. This Adjusted EBITDA margin decline was primarily the result of two factors. First, the acquired Kessler outpatient operations, which have historically had lower income from operations than our outpatient rehabilitation clinics, experienced negative margins for the year. The negative margins were primarily due to severance expense from staff reductions related to our consolidation and integration plan. Second, in January 2003 we began consolidating a group of clinics that we previously managed, which had the effect of further compressing margins.

Other. The Adjusted EBITDA loss was $36.2 million for the year ended December 31, 2003 compared to a loss of $24.7 million for the year ended December 31, 2002. This decrease in Adjusted EBITDA was primarily the result of the decline in Medicare reimbursements for corporate support costs of $6.2 million resulting from the implementation of LTCH-PPS (See Critical Accounting Matters Sources of Revenue) and an increase in our general and administrative expenses of $5.0 million.

Income from Operations

Income from operations increased 47.7% to $149.8 million for the year ended December 31, 2003 compared to $101.4 million for the year ended December 31, 2002. The increase in income from operations resulted from the Adjusted EBITDA increases described above, and was offset by an increase in depreciation and amortization expense of $8.8 million. The increase in depreciation and amortization expense resulted primarily from the additional depreciation associated with the acquired Kessler assets, the amortization of the value of the seven year non-compete agreement that we received from Kessler s selling stockholder, and increases in depreciation on fixed asset additions that are principally related to new hospital and clinic development.

Interest Expense

Interest expense decreased by $0.9 million to $26.3 million for the year ended December 31, 2003 from $27.2 million for the year ended December 31, 2002. The decline in interest expense is due to the lower debt levels outstanding in 2003 compared to 2002 on our credit facility and a lower effective interest rate in 2003. The lower debt levels resulted from scheduled term amortization payments and principal pre-payments that we have made under our credit facility. All repayments have been made with cash flows generated through operations. These reductions were offset by the incremental interest that resulted from the issuance of $175 million of $7^1/2$% senior subordinated notes in August 2003.

Minority Interests

Minority interests in consolidated earnings increased to $2.4 million for the year ended December 31, 2003 compared to $2.0 million for the year ended December 31, 2002. This increase resulted from the improved profitability of our outpatient rehabilitation subsidiaries with minority interests. See Liquidity and Capital Resources.

Income Taxes

We recorded income tax expense of $48.6 million for the year ended December 31, 2003. The expense represented an effective tax rate of 39.6%. We recorded income tax expense of $28.6 million for the year ended December 31, 2002, representing an effective tax rate of 39.3%. The effective tax rates in both 2003 and 2002 approximate the federal and state statutory tax rates. The increase in the tax rate is the result of a larger portion of our net income being earned in states with higher tax rates.

Liquidity and Capital Resources

Three Months Ended March 31, 2005 and 2004

Operating activities used $172.9 million for the combined three months ended March 31, 2005 which includes $186.0 million in cash expenses related to the merger. Excluding the merger related expenses, operating activities would have provided $13.1 million of cash flow. This adjusted operating cash flow of $13.1 million is below our recent historical trends due to a significant increase in our accounts receivable balance. Our days sales outstanding increased to 58 days at March 31, 2005, up from 48 days at December 31, 2004. The increase in days sales outstanding is primarily the result of a change in the way Medicare calculates our Periodic Interim Payments in our Specialty Hospitals. Medicare changed from a per day based calculation to a discharge based calculation to better align the Periodic Interim Payment methodology with the current discharged based reimbursement system. As a result, we are no longer receiving a periodic payment for those patients still in the hospital through our periodic interim payments. For the three months ended March 31, 2004, operating activities provided $76.5 million of cash flow. Our cash flow from operations in this period benefited from strong collections of our accounts receivable, the timing of our payments from Medicare and our deferral of estimated tax payments. Our accounts receivable days outstanding were 49 days at March 31, 2004.

Investing activities used $114.2 million of cash flow for the combined three months ended March 31, 2005. The primary use of cash related to the acquisition of SemperCare, which used $105.1 million in cash. The remaining use of cash was primarily related to purchases of property and equipment of $3.7 million and other acquisition related payments of $5.4 million. For the three months ended March 31, 2004, investing activities used $11.2 million of cash flow. This usage resulted from purchases of property and equipment of $7.8 million, $3.0 million in earn out payments and $0.4 million in acquisition costs.

Financing activities provided $59.0 million of cash for the combined three months ended March 31, 2005. The merger financing discussed below was the primary contributor of this cash flow. These excess proceeds from the merger financing were used to pay merger related costs, which includes the cancellation and cash-out of outstanding stock options. For the three months ended March 31, 2004, financing activities utilized $20.0 million of cash. This principally related to the repurchase of our common stock during the quarter in accordance with the stock repurchase program we announced on February 23, 2004.

Years Ended December 31, 2004, 2003, and 2002

Operating activities generated $174.3 million, $246.2 million, and $120.8 million in cash during the years ended December 31, 2004, 2003 and 2002, respectively. The significant increase in cash flow experienced in 2004 and 2003 compared to 2002 is attributable to improved operating income and significant reductions in our accounts receivable days outstanding. Our accounts receivable days outstanding were 48 days at December 31, 2004 compared to 52 days at December 31, 2003 and 73 days at December 31, 2002. This reduction has resulted from improvements we implemented in our business office operations which includes a focused effort to resolve problematic accounts in a timely manner and improved pre-admission policies to validate insurance coverage. In 2004, a one day change in our accounts receivable days outstanding had a $4.6 million effect on operating cash flows.

Investing activities used $21.9 million, $261.5 million and $54.0 million of cash flow for the years ended December 31, 2004, 2003 and 2002, respectively. Of this amount, we incurred earnout and acquisition related payments of $4.9 million, $228.2 million and $10.9 million, respectively in 2004, 2003 and 2002. The Kessler acquisition costs, net of cash acquired, of $223.9 million comprise most of the 2003 expenditures. The earnout

payments related principally to obligations we assumed as part of our 1999 NovaCare acquisition. Acquisition payments related to amounts we paid for new business acquisitions. This usage also resulted from purchases of property and equipment of $32.6 million, $35.9 million and $43.2 million in 2004, 2003 and 2002, respectively, which was related principally to new hospital development.

Financing activities used $71.0 million and $21.4 million of cash for the years ended December 31, 2004 and 2002, respectively. In 2004, this was principally due to the repurchase of our common stock during in accordance with the stock repurchase program we announced on February 23, 2004. During 2004, we repurchased a total of 3,399,400 shares at a cost, including fees and commissions, of $48.1 million. Additionally, during 2004, we repaid all outstanding balances under our credit facility of $8.5 million and repaid $3.9 million of seller and other debt. Cash dividend payments in 2004 were $9.2 million. Additionally, during 2004 we had $18.6 million of cash flow from the issuance of common stock under our stock option plans. In 2002, the use of cash was due principally to the repayment of our credit facility and seller debt.

Financing activities provided $124.3 million of cash for the year ended December 31, 2003. During 2003, we sold $175.0 million of 7 1/2% senior subordinated notes due 2013. The net proceeds from the sale were approximately $169.4 million after deducting discounts, commissions and expenses of the offering, and were used to finance a portion of the Kessler acquisition. Deferred financing costs associated with the offering were $5.9 million. During 2003, we repaid $65.6 million of credit facility debt and $3.7 million of seller and other debt. In December 2003, we declared and paid our company s first ever common stock cash dividend of $0.03 per share, which resulted in an aggregate payment to our stockholders of $3.1 million. In 2003 we received $28.6 million of proceeds from the issuance of stock related to the exercise of employee stock options and stock warrants.

Capital Resources

Net working capital was $158.0 million at March 31, 2005 compared to $313.7 million at December 31, 2004. This decrease in working capital was principally related to the use of cash to fund merger costs, offset by an increase in accounts receivable.

Net working capital increased to $313.7 million at December 31, 2004 compared to $188.4 million at December 31, 2003. This increase in working capital was principally related to an increase in cash and a reduction in amounts due to third party payors. The reduction in amounts due to third-party payors was a result of filing and settling cost reports and refinements in the bi-weekly payments we receive from our Medicare fiscal intermediary related to our Medicare patients.

In connection with the Transactions, on February 24, 2005 we borrowed $780.0 million under a new $880.0 million senior secured credit facility and issued $660.0 million principal amount of our outstanding notes. See The Transactions. At March 31, 2005 we had outstanding $1.45 billion in aggregate indebtedness, excluding $16.4 million of letters of credit, with approximately $83.6 million of additional borrowing capacity under our new senior secured credit facility. As a result, our liquidity requirements will be significantly higher in future periods due to our increased debt service obligations then they were in prior years. For the year ended December 31, 2004, on a pro forma basis after giving effect to the Transactions, our interest expense would have been $96.9 million.

On February 24, 2005, we entered into a new senior secured credit facility with a syndicate of financial institutions and institutional lenders. Our new senior secured credit facility provides for senior secured financing of up to $880.0 million, consisting of:

- a $300.0 million revolving loan facility with a maturity of six years, including both a letter of credit sub-facility and a swingline loan sub-facility, and

- a $580.0 million term loan facility with a maturity of seven years.

Proceeds of the term loans and $200.0 million of revolving loans, together with other sources of funds described under The Transactions, were used to finance the Transactions. Proceeds of the revolving loans borrowed after the closing date of the Transactions, swingline loans and letters of credit will be used for working capital and general corporate purposes.

The interest rates per annum applicable to loans, other than swingline loans, under our new senior secured credit facility are, at our option, equal to either an alternate base rate or an adjusted LIBOR rate for a one, two, three or six month interest period, or a nine or twelve month period if available, in each case, plus an applicable margin percentage. The alternate base rate is the greater of (1) JPMorgan Chase Bank, N.A. s prime rate and (2) one-half of 1% over the weighted average of rates on overnight Federal funds as published by the Federal Reserve Bank of New York. The adjusted LIBOR rate will be determined by reference to settlement rates established for deposits in dollars in the London interbank market for a period equal to the interest period of the loan and the maximum reserve percentages established by the Board of Governors of the United States Federal Reserve to which our lenders are subject. The applicable margin percentage is (1) 1.50% for alternate base rate revolving loans and (2) 2.50% for adjusted LIBOR rate revolving loans, subject to reduction beginning approximately six months after the closing based upon the ratio of our total indebtedness to our consolidated EBITDA (as defined in the credit agreement governing our new senior secured credit facility). The applicable margin percentages for the term loans are (1) 0.75% for alternate base rate loans and (2) 1.75% for adjusted LIBOR loans. See Interest Rate Risks.

For a summary of the terms of our new senior secured credit facility, see Description of Certain Other Indebtedness Our New Senior Secured Credit Facility.

On February 24, 2005, we issued and sold $660.0 million in aggregate principal amount of our outstanding 7^{5}/8% senior subordinated notes due 2015. The net proceeds of the offering were used to finance a portion of the funds needed to consummate the merger with EGL Acquisition Corp. The notes were issued under an indenture between us and U.S. Bank Trust National Association, as trustee. Interest on the notes is payable semiannually in arrears on February 1 and August 1 of each year, commencing August 1, 2005. The notes are guaranteed by all of our wholly-owned domestic subsidiaries, subject to certain exceptions. On or after February 1, 2010, the notes may be redeemed at our option, in whole or in part, at redemption prices that decline annually to 100% on and after February 1, 2013, plus accrued and unpaid interest. Prior to February 1, 2008, we may at our option on one or more occasions with the net cash proceeds from certain equity offerings redeem the outstanding notes in an aggregate principal amount not to exceed 35% of the aggregate principal amount originally issued at a redemption price of 107.625%, plus accrued and unpaid interest to the redemption date.

Upon a change of control of our company (as defined in the indenture governing the notes), each holder of notes may require us to repurchase all or any portion of the holder s notes at a purchase price equal to 101% of the principal amount plus accrued and unpaid interest to the date of purchase.

Our 9^{1}/2% senior subordinated notes due 2009 were issued in June 2001 in an original aggregate principal amount of $175.0 million. We commenced a debt tender offer and redeemed $169.3 million in aggregate principal amount of these notes in connection with the Transactions. See The Transactions. On June 15, 2005, we redeemed the remaining $5.7 million outstanding principal amount of our 9^{1}/2% senior subordinated notes due 2009 for a redemption price of 104.750% of the principal amount plus accrued and unpaid interest.

We believe internally generated cash flows and borrowings of revolving loans under our new senior secured credit facility will be sufficient to finance operations for at least the next twelve months.

As a result of the recently enacted HIH regulations, we currently anticipate that we will need to relocate approximately 50% of our long-term acute care hospitals over the next five years, including certain of our hospitals acquired in the SemperCare acquisition. This process will include relocating certain HIHs to leased spaces in smaller host hospitals in the same markets, consolidating HIHs in certain of our markets, relocating certain of our HIHs to alternative settings, building or buying free-standing facilities. These relocation efforts will require us to spend additional capital above historic levels. We currently expect to spend approximately $500 million on capital expenditures over the next five years, including both our ongoing maintenance capital expenditures and the capital required for hospital relocations.

In the year ended December 31, 2004, we opened four long-term acute care hospitals and closed one existing hospital. We expect to open four new long-term acute care hospitals in 2005, primarily in settings

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where the HIH regulations would have little or no impact, such as in free-standing buildings. Additionally, we are evaluating opportunities to develop free-standing inpatient rehabilitation facilities similar to the four inpatient rehabilitation facilities acquired through our September 2003 Kessler acquisition. We also intend to open new outpatient rehabilitation clinics in our current markets where we can benefit from existing referral relationships and brand awareness to produce incremental growth. From time to time, we also intend to evaluate specialty hospital acquisition opportunities that may enhance the scale of our business and expand our geographic reach.

Commitments and Contingencies

The following table summarizes our contractual obligations at December 31, 2004, and the effect such obligations are expected to have on our liquidity and cash flow in future periods.

		Payments Due by Year			
Contractual Obligations	**Total**	**2005**	**2006-2008**	**2009-2010**	**After 2010**
			(Dollars in thousands)		
9 1/2% Senior Subordinated Notes	$ 175,000	$	$	$ 175,000	$
7 1/2% Senior Subordinated Notes	175,000				175,000
Seller Notes	3,406	2,782	624		
Capital Lease Obligations	252	119	133		
Other Debt Obligations	932	656	276		
Total Debt	354,590	3,557	1,033	175,000	175,000
Letters of Credit Outstanding	15,125	15,125			
Purchase Obligations	7,470	3,131	4,013	326	
Patient Care Obligation(1)	3,234	246	739	494	1,755
Naming, Promotional and Sponsorship Agreement	35,219	1,498	4,494	3,100	26,127
Operating Leases	225,886	73,039	123,239	16,070	13,538
Related Party Operating Leases	18,018	1,731	5,401	3,369	7,517
Total Contractual Cash Obligations	$ 659,542	$ 98,327	$ 138,919	$ 198,359	$ 223,937

(1) For a description of this obligation, see Note 16 to our consolidated audited financial statements for the year ended December 31, 2004.

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The following table summarizes our contractual obligations pro forma for the Transactions at December 31, 2004, and the effect such obligations are expected to have on our liquidity and cash flow in future periods.

		Payments Due by Year			
Contractual Obligations	**Total**	**2005**	**2006-2008**	**2009-2010**	**After 2010**
		(Dollars in thousands)			
$7^{5}/8$% Senior Subordinated Notes	$ 660,000	$	$	$	$ 660,000
Term loans	580,000	4,350	17,400	11,600	546,650
Borrowing on revolver	200,000				200,000
$9^{1}/2$% Senior Subordinated Notes	5,750			5,750	
Seller Notes	3,406	2,782	624		
Capital Lease Obligations	252	119	133		
Other Debt Obligations	932	656	276		
Total Debt	1,450,340	7,907	18,433	17,350	1,406,650
Letters of Credit Outstanding	15,125	15,025	100		
Purchase Obligations	7,470	3,131	4,013	326	
Patient Care Obligation(1)	3,234	246	739	494	1,755
Naming, Promotional and Sponsorship Agreement	35,219	1,498	4,494	3,100	26,127
Operating Leases	225,886	73,039	123,239	16,070	13,538
Related Party Operating Leases	18,018	1,731	5,401	3,369	7,517
Total Contractual Cash Obligations	$ 1,755,292	$ 102,577	$ 156,419	$ 40,709	$ 1,455,587

(1) For a description of this obligation, see Note 16 to our consolidated audited financial statements for the year ended December 31, 2004.

Medical and Professional Malpractice Insurance

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large claims and significant defense costs. To protect ourselves from the cost of these claims, we maintain professional malpractice liability insurance and general liability insurance in amounts and with deductibles that we believe to be sufficient for our operations. Unfavorable pricing and availability trends have emerged in the professional liability insurance market and the insurance market in general that have caused the cost of professional liability coverage to increase dramatically. 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 and the significant failures of some nationally known insurance underwriters. In some instances, insurance underwriters will no longer issue new policies in certain states that have a history of high medical malpractice awards. Physicians who refer patients to our facilities are facing similar difficulties obtaining malpractice insurance at a reasonable cost, which could adversely impact the number of our referrals. As a result, we experienced substantial changes in our medical and professional malpractice insurance

program beginning in 2003. Specifically, we have been required to assume substantial self-insured retentions for our professional liability claims. A self-insured retention is a minimum amount of damages and expenses (including legal fees) that we must pay for each claim. We use actuarial methods to estimate the value of the losses that may occur within this self-insured retention level and we are required under our insurance agreements to post a letter of credit or set aside cash in trust funds to securitize the estimated losses that we will assume. Because of the high retention levels, we cannot predict with absolute certainty the actual amount of the losses we will assume and pay. To the extent that subsequent claims information varies from loss estimates, the liabilities will be adjusted to reflect current loss data. There can be no assurance that in the

future malpractice insurance will be available at a reasonable price or that we will not have to further increase our levels of self-insurance.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, suppliers pass along rising costs to us in the form of higher prices. We have implemented cost control measures, including our case and resource management program, to curtail increases in operating costs and expenses. We have, to date, offset increases in operating costs by increasing reimbursement for services and expanding services. However, we cannot predict our ability to cover or offset future cost increases.

Interest Rate Risks

We are subject to interest rate risk in connection with our long-term indebtedness. Our principal interest rate exposure relates to the loans outstanding under our new senior secured credit facility. As of March 31, 2005, we had $580.0 million in term loans outstanding and $200.0 million of revolving loans outstanding under our new senior secured credit facility, each bearing interest at variable rates. Each eighth point change in interest rates would result in a $1.0 million change in interest expense on our new term loans. Our new revolving loan facility provides for borrowings of up to $300.0 million. Assuming an outstanding balance of $200.0 million is drawn on our revolver, each eighth point change in interest rates would result in a $0.3 million change in interest expense on our new revolving loan facility. In the future, we may enter into interest rate swaps, involving exchange of floating for fixed rate interest payments, to reduce interest rate volatility.

Recent Accounting Pronouncements

In March 2005, the Financial Accounting Standards Board issued interpretation (FIN) No. 47, Accounting for Conditional Asset Retirement Obligations an interpretation of FASB Statement No. 143. The statement clarifies that the term conditional asset retirement obligation, as used in SFAS No. 143, Accounting for Asset Retirement Obligations, refers to a legal obligation to perform an asset retirement activity in which the timing and (or) method of settlement are conditional on a future event that may or may not be within the control of the entity. This interpretation also clarifies when an entity would have sufficient information to reasonably estimate the fair value of an asset retirement obligation. The effective date of this interpretation is no later than the end of the fiscal year ending after December 15, 2005. The adoption of FIN No. 47 is not expected to have a material impact on our financial position and results of operations.

In December 2004, the Financial Accounting Standards Board issued SFAS No. 123R (revised 2004), Share-Based Payment. This Statement is a revision of SFAS No. 123, Accounting for Stock-Based Compensation, and supersedes APB Opinion No. 25, Accounting for Stock Issued to Employees, and its related implementation guidance. SFAS No. 123R requires that compensation cost relating to share-based payment transactions be recognized in financial statements. That cost will be measured based on the fair value of the equity or liability instruments issued. The provisions of this statement are effective for us beginning at our next annual reporting period beginning January 1, 2006, however, we have adopted SFAS No. 123R in the Successor period beginning on February 25, 2005. The adoption of SFAS No. 123R had an immaterial impact on our financial position and results of operations.

In December 2004, the Financial Accounting Standards Board issued SFAS No. 153, Exchanges of Nonmonetary Assets, an amendment of APB Opinion No. 29. The guidance in APB Opinion No. 29, Accounting for Nonmonetary Transactions, is based on the principle that exchanges of nonmonetary assets should be measured based on the fair value of assets exchanged. The guidance in that Opinion, however, included certain exceptions to that principle. This Statement amends Opinion 29 to eliminate the exception for nonmonetary exchanges of similar productive assets that do not have commercial substance. A nonmonetary exchange has commercial substance if the future cash flows of the entity are expected to change significantly as a result of the exchange. SFAS No. 153 is effective for nonmonetary exchanges occurring in fiscal periods beginning after June 15, 2005. The adoption of SFAS No. 153 is not expected to have a material impact on our financial position and results of operations.

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OUR BUSINESS

Company Overview

We are a leading operator of specialty hospitals in the United States. We are also a leading operator of outpatient rehabilitation clinics in the United States and Canada. As of March 31, 2005, we operated 99 long-term acute care hospitals in 26 states, four acute medical rehabilitation hospitals, which are certified by Medicare as inpatient rehabilitation facilities, in New Jersey and 753 outpatient rehabilitation clinics in 25 states, the District of Columbia and seven Canadian provinces. 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, both of whom have significant experience in the healthcare industry. Under this leadership, we have grown our business through internal development initiatives and strategic acquisitions. For the three months ended March 31, 2005, we had net operating revenues of $482.9 million.

We manage our company through two business segments, our specialty hospital segment and our outpatient rehabilitation segment. For the three months ended March 31, 2005, approximately 71% of our net operating revenues were from our specialty hospitals and approximately 29% were from our outpatient rehabilitation business.

Specialty Hospitals

As of March 31, 2005, we operated 103 specialty hospitals. Of this total, 99 operated as long-term acute care hospitals, 97 of which were certified by the federal Medicare program as long-term acute care hospitals, and two of which were in the process of becoming certified as long-term acute care hospitals. The remaining four specialty hospitals are certified by the federal Medicare program as inpatient rehabilitation facilities. For the three months ended March 31, 2005, approximately 74% of the net operating revenues of our specialty hospital segment came from Medicare reimbursement. As of March 31, 2005, we operated a total of 3,907 available licensed beds and employed approximately 11,800 people in our specialty hospital segment, with the majority being registered or licensed nurses, respiratory therapists, physical therapists, occupational therapists and speech therapists.

Patients are admitted to our specialty hospitals from general acute care hospitals. These patients have specialized needs, and serious and often complex medical conditions such as respiratory failure, neuromuscular disorders, traumatic brain and spinal cord injuries, stroke, cardiac disorders, non-healing wounds, renal disorders and cancer. These patients generally require a longer length of stay than patients in a general acute care hospital and benefit from being treated in a specialty hospital that is designed to meet their unique medical needs. Below is a table that shows the distribution by medical condition (based on primary diagnosis) of patients in our hospitals for the year ended December 31, 2004:

Medical Condition	Distribution of Patients
Neuromuscular disorder	34%
Respiratory disorder	30
Cardiac disorder	12
Wound care	8
Other	16
Total	100%

We believe that we provide our services on a more cost-effective basis than a typical general acute care hospital because we provide a much narrower range of services. We believe that our services are therefore attractive to healthcare payors who are seeking to provide the most cost-effective level of care to their enrollees. Additionally, we continually seek to increase our admissions by expanding and improving our relationships with the physicians and general acute care hospitals that refer patients to our facilities.

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

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

Each of our specialty hospitals has an onsite management team consisting of a chief executive officer, a director of clinical services and a director of provider relations. These teams manage local strategy and day-to-day operations, including oversight of clinical care and treatment. They also assume primary responsibility for developing relationships with the general acute care providers and clinicians in our markets that refer patients to our specialty hospitals. We provide our hospitals with centralized accounting, payroll, legal, reimbursement, human resources, compliance, management information systems, billing and collecting services. The centralization of these services improves efficiency and permits hospital staff to spend more time on patient care.

We operate most of our long-term acute care hospitals using a hospital within a hospital model. A long-term acute care hospital that operates as a hospital within a hospital leases space from a general acute care host hospital and operates as a separately-licensed hospital within the host hospital in contrast to a long-term acute care hospital that owns or operates a free-standing facility. Of the 99 long-term acute care hospitals we operated as of March 31, 2005, 95 were operated as hospitals within hospitals and four were operated as free-standing facilities.

Recent HIH Regulatory Changes

On August 11, 2004, the Centers for Medicare & Medicaid Services, also known as CMS, published final regulations applicable to long-term acute care hospitals that are operated as hospitals within hospitals or as satellites (collectively referred to as HIHs). These HIH regulations became effective for hospital cost reporting periods beginning on or after October 1, 2004. Subject to certain exceptions, under these HIH regulations, HIHs will receive lower rates of reimbursement for Medicare patients admitted from their hosts that are in excess of specified percentages. For new HIHs, the Medicare admissions threshold has been established at 25%. For HIHs that meet specified criteria and were in existence as of October 1, 2004, including all of our existing HIHs, the Medicare admissions thresholds will be phased-in over a four-year period starting with hospital cost reporting periods beginning on or after October 1, 2004, according to the following schedule:

Cost Reporting Period Beginning on or After:	**Threshold of Medicare Discharges Admitted from Host Hospital**
October 1, 2004	Fiscal 2004 Percentage (as defined below)
October 1, 2005	Lesser of Fiscal 2004 Percentage or 75%
October 1, 2006	Lesser of Fiscal 2004 Percentage or 50%
October 1, 2007	25%

As used in this prospectus, Fiscal 2004 Percentage means, with respect to any HIH, the percentage of all Medicare patients discharged by such HIH during its cost reporting period beginning on or after October 1, 2003 and before October 1, 2004 who were admitted to such HIH from its host hospital. In no event will the Fiscal 2004 Percentage be less than 25% when evaluating any cost reporting period beginning on or after October 1, 2004.

For the year ended December 31, 2004 approximately 60% of all Medicare admissions to our HIHs were from host hospitals. For the same time period, the percentages of our HIHs that admitted less than or equal to 25%, 50% and 75% of their Medicare admissions from their host hospitals were as follows:

Percentage of Medicare Admissions from Host Hospital	Percentage of Our HIHs Meeting Such Criteria for the Year Ended December 31, 2004
25% or less	9%
50% or less	31%
75% or less	78%

Our existing HIHs will be substantially unaffected by these new HIH regulations until cost reporting periods beginning on or after October 1, 2005. In addition, because our HIHs have cost reporting periods that commence on various dates throughout the calendar year, the effect of the new admissions thresholds on any particular HIH may be delayed depending on when the particular HIH s cost reporting period begins. For example, although approximately 22% of our HIHs that were open as of December 31, 2004 admitted more than 75% of their Medicare patients from their host hospitals during the year ended December 31, 2004, only three of such HIHs have cost reporting periods that will begin after October 1, 2005 and before December 31, 2005.

As a result of the phase-in described above, the HIH regulations will have only a minimal impact on our 2005 financial results. The effect of these HIH regulations on our business and financial results will become more significant in 2006 and have an even greater impact in 2007 and in subsequent years. In order to minimize the more significant impact of the HIH regulations in 2006 and future years, we have developed a business plan and strategy in each of our markets to adapt to the HIH regulations and maintain our company s current business. Our transition plan includes managing admissions at existing HIHs, relocating certain HIHs to leased spaces in smaller host hospitals in the same markets, consolidating HIHs in certain of our markets, relocating certain of our facilities to alternative settings, building or buying free-standing facilities and closing a small number of facilities. We currently anticipate that approximately 50% of our long-term acute care hospitals will not require a move. We believe that we will be able to accomplish our strategy to adapt to the HIH regulations with minimal disruption to our business. Our team has experience relocating long-term acute care hospitals having successfully relocated eight hospitals since 2000 with minimal disruption to our business. In addition, our team has a proven development track record having developed 48 new long-term acute care hospitals since our inception.

See Our Business Government Regulations and Management s Discussion and Analysis of Financial Condition and Results of Operations Regulatory Changes.

Outpatient Rehabilitation

As of March 31, 2005, we operated 753 clinics throughout 25 states, the District of Columbia and seven Canadian provinces. As of March 31, 2005, our outpatient rehabilitation segment employed approximately 8,500 people. Typically, each of our clinics is located in a medical complex or retail location.

In our clinics and through our contractual relationships, we provide physical, occupational and speech rehabilitation programs and services. We also provide certain specialized programs such as hand therapy or sports performance enhancement that treat sports and work related injuries, musculoskeletal disorders, chronic or acute pain and orthopedic conditions. The typical patient in one of our clinics suffers from musculoskeletal impairments that restrict his or her ability to perform normal activities of daily living. These impairments are often associated with accidents, sports injuries, strokes, heart attacks and other medical conditions. Our rehabilitation programs and services are designed to help these patients minimize physical and cognitive impairments and maximize functional ability. We also design services to prevent short-term disabilities from becoming chronic conditions. Our rehabilitation services are provided by our professionals including licensed physical therapists, occupational therapists, speech-language pathologists and respiratory therapists.

Outpatient rehabilitation patients are generally referred or directed to our clinics by a physician, employer or health insurer who believes that a patient, employee or member can benefit from the level of therapy we

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

Other Services

Other services (which accounted for less than 1% of our net operating revenues in the three months ended March 31, 2005) include home medical equipment, orthotics, prosthetics, oxygen and ventilator systems, infusion/intravenous and certain non-healthcare services.

Our Competitive Strengths

Leading market position. Since beginning our operations in 1997, we believe that we have developed a reputation as a high quality, cost-effective healthcare provider in the markets we serve. We are a leading operator of specialty hospitals for long-term stay patients in the United States and a leading operator of outpatient rehabilitation clinics in the United States and Canada. As of March 31, 2005, we operated 99 long-term acute care hospitals with 3,585 available licensed beds in 26 states, four inpatient rehabilitation facilities with 322 beds in New Jersey, and 753 outpatient rehabilitation clinics in 25 states, the District of Columbia and seven Canadian provinces. Our leadership position allows us to attract patients, aids us in our marketing efforts to payors and referral sources and helps us negotiate favorable payor contracts.

Experienced and proven management team with a significant equity investment. Prior to co-founding Select, our Executive Chairman founded and operated three other healthcare companies focused on rehabilitation services. Our five senior operations executives have an average of 27 years of experience in the healthcare industry. In addition, 12 of our 17 corporate officers worked together at Continental Medical Systems, Inc., a developer and operator of inpatient rehabilitation facilities that was managed under the leadership of Rocco A. Ortenzio and Robert A. Ortenzio from its inception in 1986 until it was sold in 1995. Their extensive experience in this industry and their proven ability to adapt to regulatory and reimbursement changes will be of great value as we reposition many of our long-term acute care hospitals to respond to the new HIH regulations. In addition, our senior management team has a significant investment in Select through the aggregate equity and debt investments of approximately $74.2 million made by them in connection with the merger. Furthermore, members of our senior management team are entitled to participate in our parent s equity and long-term cash incentive plans. See The Transactions and Certain Relationships and Related Transactions.

Proven financial performance and strong cash flow. We have established a track record of improving the performance of the facilities we operate. A significant reason for our strong operating performance over the past several years has been our disciplined approach to growth and intense focus on cash flow generation and debt reduction:

- net operating revenues and income from operations have grown from $456.0 million and $20.3 million, respectively, for the fiscal year ended December 31, 1999 to $1,660.8 million and $231.5 million, respectively, for the fiscal year ended December 31, 2004; and

- accounts receivable days outstanding have decreased from 119 as of December 31, 1999 to 58 as of March 31, 2005;

We intend to pursue a strategy of reducing leverage and believe that our future operating cash flow will provide the opportunity to do so.

Significant scale and diversity. By building significant scale in our specialty hospital and outpatient rehabilitation clinic businesses, we have been able to leverage our operating costs by centralizing administra-

tive functions at our corporate office. We believe that our size improves our ability to negotiate favorable outpatient contracts with commercial insurers. Additionally, we believe our strength in two attractive segments of the healthcare industry allows us to diversify business risk and reduce our exposure to any single governmental or commercial reimbursement source. Furthermore, our broad geographic reach helps diversify our business and reduce our exposure to risk associated with any single state or other geographic region.

Demonstrated facility development expertise. From our inception through March 31, 2005, we have developed 48 new long-term acute care hospitals and 206 outpatient rehabilitation clinics. These initiatives have demonstrated our ability to effectively identify new opportunities and implement start-up plans.

Successful history of long-term acute care relocations. We have successfully completed the relocation of eight long-term acute care hospitals since 2000 with minimal disruption to our business. In each case these relocations have been successful from a financial and operational standpoint. We believe our experience and success with these moves will benefit us as we adapt to the new HIH regulations.

Experience in successfully completing and integrating acquisitions. From our inception in 1997 through March 31, 2005, we completed five significant acquisitions for approximately $697 million in aggregate consideration. We believe that we have significantly improved the operating performance of the facilities we have acquired by applying our standard operating practices to the acquired businesses.

Specialty Hospital Strategy

Provide high quality care and service. We believe that our patients benefit from our experience in addressing complex medical and rehabilitation needs. To effectively address the nature of our patients medical conditions, we have developed specialized treatment programs focused solely on their needs. We have also implemented specific staffing models that are designed to ensure that patients have access to the necessary level of clinical attention. We believe that by focusing on quality care and service we develop brand loyalty in our markets allowing us to retain patients and strengthen our relationships with physicians, employers, and health insurers.

Our treatment and staffing programs benefit patients because they give our clinicians access to the regimens that we have found to be most effective in treating various conditions such as respiratory failure, non-healing wounds, brain and spinal cord injuries, strokes and neuromuscular disorders. In addition, we combine or modify these programs to provide a treatment plan tailored to meet a patient s unique needs.

The quality of the patient care we provide is continually monitored using several measures, including patient, payor and physician satisfaction, as well as clinical outcomes. Quality measures are collected monthly and reported quarterly and annually. In order to benchmark ourselves against other healthcare organizations, we have contracted with outside vendors to collect our clinical and patient satisfaction information and compare it to other healthcare organizations. The information collected is reported back to each hospital, to the corporate office, and directly to the Joint Commission on Accreditation of Healthcare Organizations, commonly known as JCAHO. As of March 31, 2005, JCAHO had accredited all but two of our hospitals. These two hospitals have not yet undergone a JCAHO survey. Each of our four inpatient rehabilitation facilities have also received accreditation from the Commission on Accreditation of Rehabilitation Facilities. See Government Regulations Licensure Accreditation.

Maintain operational and financial results under the revised Medicare HIH regulations. As a result of the regulatory changes published by CMS on August 11, 2004, much of our effort in the near-term will be focused on implementing strategic initiatives at our existing hospitals. These initiatives will include managing admissions at existing HIHs, relocating certain HIHs to leased spaces in smaller host hospitals in the same markets, relocating certain of our facilities to alternative settings and building or buying free-standing facilities. We believe that there is sufficient time during the phase-in period to meet the requirements of the new HIH regulations while maintaining our existing business.

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

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

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

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

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

Increase higher margin commercial volume. We typically receive higher reimbursement rates from commercial insurers than we do from the federal Medicare program. As a result, we work to expand relationships with insurers to increase commercial patient volume. We believe that commercial payors seek to contract with our hospitals because we offer patients high quality and cost-effective care. 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. As a result of our lower relative costs, we offer more attractive rates to commercial payors. We also offer commercial enrollees customized treatment programs not typically offered in general acute care hospitals.

Develop new specialty hospitals. We expect to open four long-term acute care hospitals in 2005, primarily in settings where the new HIH regulations would have little or no impact, for example, in free-standing buildings. Additionally, we are evaluating opportunities to develop free-standing inpatient rehabilitation facilities similar to the four inpatient rehabilitation facilities acquired through our September 2003 Kessler acquisition.

We have a dedicated development team with significant market experience. When we target a new market, the development team conducts an extensive review of local market referral patterns and commercial insurance to determine the general reimbursement trends and payor mix. Ultimately, when we determine a location or sign a lease for our planned space, the project is transitioned to our start-up team, which is experienced in preparing a specialty hospital for opening. The start-up team oversees facility improvements, equipment purchases, licensure procedures, and the recruitment of a full-time management team. After the facility is opened, responsibility for its management is transitioned to this new management team and our corporate operations group.

During the period from January 1, 2001 to March 31, 2005, we completed the development and opening of the following 30 long-term acute care hospitals:

Hospital Name	City	State	Opening Date	Licensed Beds (as of March 31, 2005)
SSH-Birmingham	Birmingham	AL	February 2001	38
SSH-Jefferson Parish	New Orleans	LA	February 2001	41
SSH-Pontiac	Pontiac	MI	June 2001	30
SSH-Camp Hill	Camp Hill	PA	June 2001	31
SSH-Wyandotte	Wyandotte	MI	September 2001	35
SSH-Charleston	Charleston	WV	December 2001	32
SSH-Northwest Detroit	Detroit	MI	December 2001	36
SSH-Scottsdale	Scottsdale	AZ	December 2001	29
SSH-Bloomington	Bloomington	IN	December 2001	30

SSH-Phoenix-Downtown	Phoenix	AZ	December 2001	33
SSH-Central Pennsylvania	York	PA	June 2002	23
SSH-Saginaw	Saginaw	MI	June 2002	32

Hospital Name	City	State	Opening Date	Licensed Beds (as of March 31, 2005)
SSH-South Dallas	DeSoto	TX	July 2002	100
SSH-Jackson	Jackson	MS	July 2002	40
SSH-Milwaukee (St. Luke s Campus)	Milwaukee	WI	October 2002	29
SSH-Lexington	Lexington	KY	October 2002	41
SSH-Denver (South Campus)	Denver	CO	November 2002	28
SSH-Miami	Miami	FL	December 2002	40
SSH-Augusta (Central Campus)	Augusta	GA	May 2003	35
SSH-Conroe	Conroe	TX	June 2003	46
SSH-Durham	Durham	NC	June 2003	30
SSH-Knoxville (U.T. Campus)	Knoxville	TN	June 2003	25
SSH-Zanesville	Zanesville	OH	July 2003	35
SSH-Omaha (North Campus)	Omaha	NE	August 2003	36
SSH-Northeast Ohio (Canton Campus)	Canton	OH	November 2003	30
SSH-Wichita (Central Campus)	Wichita	KS	December 2003	30
SSH-Honolulu(1)	Honolulu	HI	June 2004	30
SSH-Danville	Danville	PA	June 2004	30
SSH-Columbus/ Grant (Mt. Carmel Campus)	Columbus	OH	June 2004	24
SSH-Western Missouri(1)	Kansas City	MO	July 2004	34
Total				1,053

(1) As of March 31, 2005, certification as a long-term acute care hospital was pending, subject to successful completion of a start-up period and/or surveys by the applicable licensure or certifying agencies. See Government Regulations Licensure Certification.

Pursue opportunistic acquisitions. In addition to our development initiatives, we may grow our network of specialty hospitals through opportunistic acquisitions, such as our recently completed SemperCare acquisition. We adhere to selective criteria in our acquisition analysis and have historically been able to obtain assets for what we believe are attractive valuations. When we acquire a hospital or a group of hospitals, a team of our professionals is responsible for formulating and executing an integration plan. We have generally been able to increase margins at acquired facilities by adding clinical programs that attract commercial payors, centralizing administrative functions and implementing our standardized staffing models and resource management programs. From our inception in 1997 through March 31, 2005, we have acquired and integrated 58 hospitals. All of these hospitals now share our centralized billing and standardized management information systems. All of our acquired hospitals participate in our centralized purchasing program.

Outpatient Rehabilitation Strategy

Provide high quality care and service. We are focused on providing a high level of service to our patients throughout their entire course of treatment. To measure satisfaction with our service we have developed surveys for both patients and physicians. Our clinics utilize the feedback from these surveys to continuously refine and improve service levels. We believe that by focusing on quality care and offering a high level of customer service we develop brand loyalty in our markets. This loyalty allows us to retain patients and strengthen our relationships with the physicians, employers, and health insurers in our markets who refer or direct additional patients to us.

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Increase market share. Our goal is to be a leading provider of outpatient rehabilitation services in our local markets. Having a strong market share in our local markets allows us to benefit from heightened brand awareness, economies of scale and increased leverage when negotiating payor contracts. To increase our market share, we seek to expand our services and programs and to continue to provide high quality care and strong customer service in order to generate loyalty with patients and referral sources.

Expand rehabilitation programs and services. We assess the healthcare needs of our markets and implement programs and services targeted to meet the demands of the local community. In designing these programs we benefit from the knowledge we gain through our national network of clinics. This knowledge is used to design programs that optimize treatment methods and measure changes in health status, clinical outcomes and patient satisfaction.

Optimize the profitability of our payor contracts. Before we enter into a new contract with a commercial payor, we evaluate it with the aid of our contract management system. We assess potential profitability by evaluating past and projected patient volume, clinic capacity, and expense trends. Each contract we enter into is continually re-evaluated to determine how it is affecting our profitability. We create a retention strategy for each of the top performing contracts and a renegotiation strategy for contracts that do not meet our defined criteria.

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

Sources of Net Operating Revenues

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

	Fiscal Year Ended December 31,			Three Months Ended March 31,	
Net Operating Revenues by Payor Source	**2002**	**2003**	**2004**	**2004**	**2005(1)**
Medicare	40.3%	46.0%	48.0%	47.5%	54.7%
Commercial insurance(2)	49.1	43.2	40.8	42.4	35.3
Private and other(3)	9.5	9.2	9.1	8.1	8.1
Medicaid	1.1	1.6	2.1	2.0	1.9
Total	100.0%	100.0%	100.0%	100.0%	100.0%

(1) The net operating revenues for the period after the merger, February 25, 2005 through March 31, 2005 (Successor period), has been added to the net operating revenues for the period from January 1, 2005 through February 24, 2005 (Predecessor period), to arrive at the combined three months ended March 31, 2005.

(2) Includes commercial healthcare insurance carriers, health maintenance organizations, preferred provider organizations, workers compensation and managed care programs.

(3) Includes self payors, Canadian revenues, contract management services and non-patient related payments. Self pay revenues represent less than 1% of total net operating revenues.

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Non-Government Sources

Although in recent years an increasing percentage of our net operating revenues were generated from the Medicare program, a majority of our net operating revenues continue to come from private payor sources. These sources include insurance companies, workers compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies, and employers, as well as by patients directly. Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs, insurance companies, workers compensation companies, health maintenance organizations, preferred provider organizations, and other managed care companies, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. To further reduce their healthcare costs, most insurance companies, health maintenance organizations, preferred provider organizations, and other managed care companies have negotiated discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. Our results of operations may be negatively affected if these organizations are successful in negotiating further discounts.

Government Sources

Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to individuals who are unable to afford healthcare. All of our hospitals are currently certified as Medicare providers. Our outpatient rehabilitation clinics regularly receive Medicare payments for their services. Additionally, our specialty hospitals participate in thirteen state Medicaid programs. Amounts received under the Medicare and Medicaid programs are generally less than the customary charges for the services provided. In recent years, there have been significant changes made to the Medicare and Medicaid programs. Since nearly half of our revenues come from patients under the Medicare program, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in the Medicare program. See Government Regulations Overview of U.S. and State Government Reimbursements.

Employees

As of March 31, 2005, we employed approximately 20,900 people throughout the United States and Canada. A total of approximately 13,700 of our employees are full time and the remaining approximately 7,200 are part time employees. Outpatient, contract therapy and physical rehabilitation and occupational health employees totaled approximately 8,500 and inpatient employees totaled approximately 11,800. The remaining approximately 600 employees were in corporate management, administration and other services.

Competition

We compete on the basis of pricing, the quality of the patient services we provide and the results that we achieve for our patients. The primary competitive factors in the long-term acute care and inpatient rehabilitation businesses include quality of services, charges for services and responsiveness to the needs of patients, families, payors and physicians. Other companies operate long-term acute care hospitals and inpatient rehabilitation facilities that compete with our hospitals, including large operators of similar facilities, such as Kindred Healthcare Inc. and HealthSouth Corporation. The competitive position of any hospital is also affected by the ability of its management to negotiate contracts with purchasers of group healthcare services, including private employers, managed care companies, preferred provider organizations and health maintenance organizations. Such organizations attempt to obtain discounts from established hospital charges. The importance of obtaining contracts with preferred provider organizations, health maintenance organizations and other organizations which finance healthcare, and its effect on a hospital s competitive position, vary from market to market, depending on the number and market strength of such organizations.

Our outpatient rehabilitation clinics face competition principally from locally owned and managed outpatient rehabilitation clinics in the communities they serve. Many of these clinics have longer operating histories and greater name recognition in these communities than our clinics, and they may have stronger relations with physicians in these communities on whom we rely for patient referrals. In addition, HealthSouth Corporation, which operates more outpatient rehabilitation clinics in the United States than we do, competes with us in a number of our markets.

Government Regulations

General

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

Licensure

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

Some states still require us to get approval under certificate of need regulations when we create, acquire or expand our facilities or services. If we fail to show public need and obtain approval in these states for our facilities, we may be subject to civil or even criminal penalties, lose our facility license or become ineligible for reimbursement if we proceed with our development or acquisition of the new facility or service.

Professional licensure and corporate practice. Healthcare professionals at our hospitals and outpatient rehabilitation clinics are required to be individually licensed or certified under applicable state law. We take steps to ensure that our employees and agents possess all necessary licenses and certifications. In some states, business corporations such as ours are restricted from practicing therapy through the direct employment of therapists. In those states, in order to comply with the restrictions imposed, we either contract to obtain therapy services from an entity permitted to employ therapists, or we manage the physical therapy practice owned by licensed therapists through which the therapy services are provided.

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

Accreditation. Our hospitals receive accreditation from the Joint Commission on Accreditation of Healthcare Organizations, a nationwide commission which establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. As of March 31, 2005, JCAHO had accredited all but two of our hospitals. These two hospitals have not yet undergone a JCAHO survey. Generally, our hospitals must be in operation for at least six months before they are eligible for accreditation. Each of our four inpatient rehabilitation facilities has also received accreditation from the Commission on Accreditation of Rehabilitation Facilities, an independent, not-for-profit organization which

reviews and grants accreditation for rehabilitation facilities that meet established standards for service and quality.

Overview of U.S. and State Government Reimbursements

Medicare. The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services. For the year ended December 31, 2004 and the three months ended March 31, 2005, we received approximately 48% and 55%, respectively, of our revenue from Medicare.

The Medicare program reimburses various types of providers, including long-term acute care hospitals, inpatient rehabilitation facilities and outpatient rehabilitation providers, using different payment methodologies. The Medicare reimbursement systems for long-term acute care hospitals, inpatient rehabilitation facilities and outpatient rehabilitation providers, as described below, are different than the system applicable to general acute care hospitals. For general acute care hospitals, Medicare inpatient costs are reimbursed under a prospective payment system under which a hospital receives a fixed payment amount per discharge (adjusted for area wage differences) using diagnosis related groups, commonly referred to as DRGs. The general acute care hospital DRG payment rate is based upon the national average cost of treating a Medicare patient s condition in that type of facility. Although the average length of stay varies for each DRG, the average stay of all Medicare patients in a general acute care hospital is approximately six days. Thus, the prospective payment system for general acute care hospitals creates an economic incentive for those hospitals to discharge medically complex Medicare patients as soon as clinically possible. CMS has recently proposed to expand its post-acute care transfer policy under which general acute care hospitals are paid on a per diem basis rather than the full DRG rate if a hospital is discharged early to certain post-acute care settings, including long-term acute care hospitals. The expansion of this policy to patients in a greater number of DRGs could cause general acute care hospitals to delay discharging those patients to our long-term acute care hospitals.

Long-term acute care hospital Medicare reimbursement. The Medicare payment system for long-term acute care hospitals has been changed to a new prospective payment system specifically applicable to long-term acute care hospitals, which is referred to as LTCH-PPS. LTCH-PPS was established by final regulations published on August 30, 2002 by CMS, and applies to long-term care hospitals for their cost reporting periods beginning on or after October 1, 2002. Ultimately, when LTCH-PPS is fully implemented, each patient discharged from a long-term acute care hospital will be assigned to a distinct long-term care diagnosis-related group, which is referred to as an LTC-DRG, and a long-term acute care hospital will generally be paid a predetermined fixed amount applicable to the assigned LTC-DRG (adjusted for area wage differences). The payment amount for each LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that LTC-DRG in a long-term acute care hospital. LTCH-PPS also includes special payment policies that adjust the payments for some patients based on the patient s length of stay, the facility s costs, whether the patient was discharged and readmitted and other factors. As required by Congress, LTC-DRG payment rates have been set to maintain budget neutrality with total expenditures that would have been made under the previous reasonable cost-based payment system.

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.

Prior to becoming subject to LTCH-PPS, a long-term acute care hospital is paid on the basis of Medicare reasonable costs per case, subject to limits. Under this cost-based reimbursement system, costs accepted for reimbursement depend on a number of factors, including necessity, reasonableness, related party principles and relatedness to patient care. Qualifying costs under Medicare s cost reimbursement system typically include all operating costs and also capital costs that include interest expense, depreciation, amortization, and

rental expense. Non-qualifying costs include marketing costs. Under the cost-based reimbursement system, a long-term acute care hospital is subject to per discharge payment limits. During a long-term acute care hospital s initial operations, Medicare payment is capped at the average national target rate established by the Tax Equity and Fiscal Responsibility Act of 1982, commonly known as TEFRA. After the second year of operations, payment is subject to a target amount based on the lesser of the hospital s cost-per-discharge or the national ceiling in the applicable base year. Legislation enacted in December 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, increased the target amount by 25% and the national ceiling by 2% for cost reporting periods beginning after October 1, 2000.

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

LTCH-PPS is being phased-in over a five-year transition period, during which a long-term care hospital s payment for each Medicare patient will be a blended amount consisting of set percentages of the LTC-DRG payment rate and the hospital s reasonable cost-based reimbursement. The LTC-DRG payment rate is 20% for a hospital s cost reporting period beginning on or after October 1, 2002, and will increase by 20% for each cost reporting period thereafter until the hospital s cost reporting period beginning on or after October 1, 2006, when the hospital will be paid solely on the basis of LTC-DRG payment rates. A long-term acute care hospital may elect to be paid solely on the basis of LTC-DRG payment rates (and not be subject to the transition period) at the start of any of its cost reporting periods during the transition period.

As of March 31, 2005, all 97 of our eligible long-term acute care hospitals have implemented LTCH-PPS. We have elected to be paid solely on the basis of LTC-DRG payments for all 97 of these hospitals. The remaining two hospitals will be paid under LTCH-PPS upon obtaining their long-term acute care hospital certification.

While the implementation of LTCH-PPS is intended to be revenue neutral to the industry, our hospitals experienced enhanced financial performance in 2003 and 2004 due to our low cost operating model and the high acuity of our patient population.

Regulatory changes. On August 11, 2004, the Centers for Medicare & Medicaid Services, also known as CMS, published final regulations applicable to long-term acute care hospitals that are operated as hospitals within hospitals or as satellites (collectively referred to as HIHs). HIHs are separate hospitals located in space leased from, and located in, general acute care hospitals, known 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 hosts 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%. For HIHs that meet specified criteria and were in existence as of October 1, 2004, including all of our existing HIHs, the Medicare admissions thresholds will be phased-in over a four-year period starting with hospital cost reporting periods beginning on or after October 1, 2004, as follows: (i) for discharges during the cost reporting period beginning on or after October 1, 2004 and before October 1, 2005, the Medicare admissions threshold is the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital; (ii) for discharges during the cost reporting period beginning on or after October 1, 2005 and before October 1, 2006, the Medicare admissions threshold is the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 75%; (iii) for discharges during the cost reporting period beginning on or after October 1, 2006 and before October 1, 2007, the Medicare admissions threshold is the lesser of the Fiscal 2004 Percentage of Medicare discharges admitted from the host hospital or 50%; and (iv) for discharges during cost reporting periods beginning on or after October 1, 2007, the Medicare admissions threshold is 25%.

At December 31, 2004, we operated 82 long-term acute care hospitals. Of this total, 78 operated as HIHs. For the year ended December 31, 2004, approximately 60% of the Medicare admissions to our HIHs were from host hospitals. For the year ended December 31, 2004, approximately 9% of our HIHs admitted

25% or fewer of their Medicare patients from their host hospitals, approximately 31% of our HIHs admitted 50% or fewer of their Medicare patients from their host hospitals, and approximately 78% of our HIHs admitted 75% or fewer of their Medicare patients from their host hospitals. There are several factors that should be taken into account in evaluating this admissions data. First, the admissions data for the year ended December 31, 2004 is not necessarily indicative of the admissions mix these hospitals will experience in the future. Second, admissions data for the year ended December 31, 2004 includes four hospitals that were open for less than one year, and the data from these hospitals may not be indicative of the admissions mix these hospitals will experience over a longer period of time. Third, admissions data for the year ended December 31, 2004 does not include admissions data for the hospitals recently acquired in the SemperCare acquisition. See Management s Discussion and Analysis of Financial Condition and Results of Operations Recent Trends and Events SemperCare Acquisition.

The new Medicare host admission thresholds are phased in over a four-year period. Our existing HIHs will be substantially unaffected by the new HIH regulations until cost reporting periods beginning on or after October 1, 2005, when the threshold on Medicare host admissions drops to 75%. Thus, the HIH regulations had no effect on our 2004 financial results. Our HIHs have cost reporting periods that commence on various dates throughout the calendar year. Consequently, any effect of the new admissions thresholds on our HIHs may be delayed depending on when a particular HIH s cost reporting period begins. For example, although approximately 22% of our HIHs open at December 31, 2004 admitted more than 75% of their Medicare patients from their host hospitals during the year ended December 31, 2004, only three of such HIHs have cost reporting periods that will begin after October 1, 2005 and before December 31, 2005. As a result, the HIH regulations should have only a minimal impact on our 2005 financial results. In order to minimize the more significant impact of the HIH regulations in 2006 and for the subsequent years, we have developed a business plan and strategy in each of our markets to adapt to the HIH regulations and maintain our company s current business. Our transition plan includes managing admissions at existing HIHs, relocating certain HIHs to leased spaces in smaller host hospitals in the same markets, consolidating HIHs in certain of our markets, relocating certain of our facilities to alternative settings, building or buying free-standing facilities and closing a small number of facilities.

The new HIH regulations established exceptions to the Medicare admissions thresholds with respect to patients who reach outlier status at the host hospital, HIHs located in MSA-dominant hospitals and HIHs located in rural areas. In its preamble to the May 6, 2005 final rule updating the LTCH-PPS, CMS also confirmed that it had awarded a contract to Research Triangle Institute (RTI) to examine recent recommendations concerning how long-term acute care hospitals are defined and differentiated from other types of Medicare providers made by the Medicare Payment Advisory Commission, or MedPAC. MedPAC is an independent federal body that advises Congress on issues affecting the Medicare program. In its June 2004 Report to Congress, MedPAC recommended the adoption by CMS of new facility staffing and services criteria and patient clinical characteristics and treatment requirements for long-term acute care hospitals in order to ensure that only appropriate patients are admitted to these facilities. CMS anticipates making RTI s findings available in the proposed LTCH-PPS update to be published in early 2006. Although CMS as so far declined to impose the MedPAC recommended criteria, the agency has stated that if RTI s analysis suggests that changes should be made affecting LTCH payments, discharges or certification criteria, statutory or regulatory modifications to implement those changes may be required.

Inpatient rehabilitation facility Medicare reimbursement. Our acute medical rehabilitation hospitals are certified as inpatient rehabilitation facilities by the Medicare program, and are subject to a prospective payment system for services provided to each discharged Medicare beneficiary. Prior to January 1, 2002, inpatient rehabilitation facilities were paid on the basis of Medicare reasonable costs per case, subject to limits under TEFRA. For cost reporting periods beginning on or after January 1, 2002, inpatient rehabilitation facilities are paid under a new prospective payment system specifically applicable to this provider type, which is referred to as IRF-PPS. Under the IRF-PPS, each patient discharged from an inpatient rehabilitation facility is assigned to a case-mix group or IRF-CMG containing patients with similar clinical problems that are expected to require similar amounts of resources. An inpatient rehabilitation facility is generally paid a predetermined fixed amount applicable to the assigned IRF-CMG (subject to applicable case adjustments

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related to length of stay and facility level adjustments for location and low income patients). The payment amount for each IRF-CMG is intended to reflect the average cost of treating a Medicare patient s condition in an inpatient rehabilitation facility relative to patients with conditions described by other IRF-CMGs. The IRF-PPS also includes special payment policies that adjust the payments for some patients based on the patient s length of stay, the facility s costs, whether the patient was discharged and readmitted and other factors. As required by Congress, IRF-CMG payments rates have been set to maintain budget neutrality with total expenditures that would have been made under the previous reasonable cost based system. The IRF-PPS was phased-in over a transition period in 2002. For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility s payment for each Medicare patient was a blended amount consisting of $66^{2}/3\%$ of the IRF-PPS payment rate and $33^{1}/3\%$ of the hospital s reasonable cost based reimbursement. For cost reporting periods beginning on or after October 1, 2002, inpatient rehabilitation facilities are paid solely on the basis of the IRF-PPS payment rate.

Although the IRF-PPS regulations did not change the criteria that must be met in order for a hospital to be certified as an inpatient rehabilitation facility, CMS adopted a separate final rule on May 7, 2004 that made significant changes to those criteria. The new inpatient rehabilitation facility certification criteria became effective for cost reporting periods beginning on or after July 1, 2004.

Under the historic IRF certification criteria that had been in effect since 1983, in order to qualify as an IRF, a hospital was required to satisfy certain operational criteria as well as demonstrate that, during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75% required intensive rehabilitation services for one or more of ten conditions specified in regulation (referred to as the 75% test). In 2002, CMS became aware that its various contractors were using inconsistent methods to assess compliance with the 75% test and that the percentage of inpatient rehabilitation facilities in compliance with the 75% test might be low. In response, in June 2002, CMS suspended enforcement of the 75% test and, on September 9, 2003, proposed modifications to the regulatory standards for certification as an inpatient rehabilitation facility. In addition, during 2003, several CMS contractors, including the contractor overseeing our inpatient rehabilitation facilities, promulgated draft local medical review policies that would change the guidelines used to determine the medical necessity for inpatient rehabilitation care.

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 or changes to the 75% test for additional study of clinically appropriate certification criteria, CMS adopted four major changes to the 75% test in its May 7, 2004 final rule. First, CMS temporarily lowered the 75% compliance threshold, as follows: (i) 50% for cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005; (ii) 60% for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006; (iii) 65% for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007; and (iv) 75% for cost reporting periods beginning on or after July 1, 2007. Second, CMS modified and expanded from 10 to 13 the medical conditions used to determine whether a hospital qualifies as an inpatient rehabilitation facility. Third, the agency finalized the conditions under which comorbidities can be used to verify compliance with the 75% test. Fourth, CMS changed the timeframe used to determine compliance with the 75% test from the most recent 12-month cost reporting period to the most recent, consecutive, and appropriate 12-month period, with the result that a determination of non-compliance with the applicable compliance threshold will affect the facility s certification for its cost reporting period that begins immediately after the 12-month review period.

Congress temporarily suspended CMS enforcement of the 75% test under the Consolidated Appropriations Act, 2005, enacted on December 8, 2004. The Act requires the Secretary of Health and Human Services to respond within 60 days to a study by the Government Accountability Office, or GAO, on the standards for defining inpatient rehabilitation services before the Secretary may use funds appropriated under the Act to redesignate as a general acute care hospital any hospital that was certified as an inpatient rehabilitation facility on or before June 30, 2004 as a result of the hospital s failure to meet the 75% test. The GAO issued its study on April 22, 2005, and recommended that CMS, based on further research, refine the 75% test to describe more thoroughly the subgroups of patients within the qualifying conditions that are appropriate for care in an

inpatient rehabilitation facility. The Secretary has not yet issued a formal response to the GAO study. If the revised 75% test is ultimately enforced without further modifications, during the years while the new standard is being phased-in, it will be necessary for us to reassess and change our inpatient admissions standards. Such changes may include more restrictive admissions policies. Stricter admissions standards may result in reduced patient volumes at our inpatient rehabilitation facilities, which, in turn, may result in lower net operating revenue and net income for these operations.

Outpatient rehabilitation services Medicare reimbursement. We provide the majority of our outpatient rehabilitation services in our rehabilitation clinics. Through our contract services agreements, we also provide outpatient rehabilitation services in the following settings:

- schools;
- physician-directed clinics;
- worksites;
- assisted living centers;
- hospitals; and
- skilled nursing facilities.

Most of our outpatient rehabilitation services are provided in rehabilitation agencies and through our inpatient rehabilitation facilities.

Prior to January 1, 1999, outpatient therapy services, including physical therapy, occupational therapy, and speech-language pathology, were reimbursed on the basis of the lower of 90% of reasonable costs or actual charges. Beginning on January 1, 1999, the Balanced Budget Act of 1997 (the BBA) required that outpatient therapy services be reimbursed on a fee schedule, subject to annual limits. Outpatient therapy providers receive a fixed fee for each procedure performed, which is adjusted by the geographical area in which the facility is located.

The BBA also imposed annual per Medicare beneficiary caps beginning January 1, 1999 that limited Medicare coverage to $1,500 for outpatient rehabilitation services (including both physical therapy and speech-language pathology services) and $1,500 for outpatient occupational health services, including deductible and coinsurance amounts. The caps were to be increased beginning in 2002 by application of an inflation index. Subsequent legislation imposed a moratorium on the application of these limits for the years 2000, 2001 and 2002. With the expiration of the moratorium, CMS implemented the caps beginning on September 1, 2003. The Medicare Prescription Drug, Improvement and Modernization Act, signed by President Bush on December 8, 2003 (MMA), re-imposed the moratorium on the application of the therapy caps from the date of MMA s enactment through December 31, 2005.

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

Payment for rehabilitation services furnished to patients of skilled nursing facilities has been affected by the establishment of a Medicare prospective payment system and consolidated billing requirement for skilled nursing facilities. The resulting pressure on skilled nursing facilities to reduce their costs by negotiating lower payments to therapy providers, such as our contract therapy services, and the inability of the therapy providers to bill the Medicare program directly for their services have tended to reduce the amounts that rehabilitation providers can receive for services furnished to many skilled nursing facility residents.

Long-term acute care hospital Medicaid reimbursement. The Medicaid program is designed to provide medical assistance to individuals unable to afford care. The program is governed by the Social Security Act of 1965 and administered and funded jointly by each individual state government and CMS. Medicaid payments are made under a number of different systems, which include cost based reimbursement, prospective payment systems or programs that negotiate payment levels with individual hospitals. In addition, Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may increase or decrease the level of program payments to our hospitals. Medicaid payments accounted for approximately 2% of our long-term acute care net operating revenues for the year ended December 31, 2004.

Workers compensation. Workers compensation programs accounted for approximately 19% of our revenue from outpatient rehabilitation services for the year ended December 31, 2004. Workers compensation is a state mandated, comprehensive insurance program that requires employers to fund or insure medical expenses, lost wages and other costs resulting from work related injuries and illnesses. Workers compensation benefits and arrangements vary on a state-by-state basis and are often highly complex. In some states, payment for services covered by workers compensation programs are subject to cost containment features, such as requirements that all workers compensation injuries be treated through a managed care program, or the imposition of payment caps. In addition, these workers compensation programs may impose requirements that affect the operations of our outpatient rehabilitation services.

Canadian Reimbursement

The Canada Health Act governs the publicly funded Canadian healthcare system, and provides for federal funding to be transferred to provincial health systems. Our Canadian outpatient rehabilitation clinics receive approximately 44% of their funding through workers compensation benefits, which are administered by provincial workers compensation boards. The workers compensation boards assess employers fees based on their industry and past claims history. These fees are then distributed independently by each provincial workers compensation board as payments for healthcare services. Therefore, the payments each of our rehabilitation clinics receive for similar services can vary substantially because of the different reimbursement guidelines in each province. Additional funding sources for our Canadian clinics are commercial insurance programs, direct payment contribution and publicly funded healthcare sources. For the year ended December 31, 2004, we derived approximately 3.5% of our total net operating revenues from our operations in Canada.

Other Healthcare Regulations

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

From time to time, various federal and state agencies, such as the Office of the Inspector General of the Department of Health and Human Services, issue a variety of pronouncements, including fraud alerts, the Office of Inspector General s Annual Work Plan and other reports, identifying practices that may be subject to heightened scrutiny. These pronouncements can identify issues relating to long-term acute care hospitals, inpatient rehabilitation facilities or outpatient rehabilitation services or providers. For example, the Office of Inspector General s 2004 Work Plan describes the government s intention to study providers use of the hospital within a hospital model for furnishing long-term acute care hospital services and whether they

comply with the 5% limitation on discharges to the host hospital that are subsequently readmitted to the hospital within a hospital. The 2005 Work Plan describes plans to study the accuracy of Medicare payments for inpatient rehabilitation stays when patient assessments are entered later than the required deadlines and to study whether patients in long-term acute care hospitals are receiving acute-level services or could be cared for in skilled nursing facilities. We monitor government publications applicable to us and focus a portion of our compliance efforts towards these areas targeted for enforcement.

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

Remuneration and fraud measures. The federal anti-kickback statute prohibits some business practices and relationships under Medicare, Medicaid and other federal healthcare programs. These practices include the payment, receipt, offer or solicitation of remuneration in connection with, to induce, or to arrange for, the referral of patients covered by a federal or state healthcare program. Violations of the anti-kickback law may be punished by a criminal fine of up to $50,000 or imprisonment for each violation, or both, civil monetary penalties of $50,000 and damages of up to three times the total amount of remuneration, and exclusion from participation in federal or state healthcare programs.

Section 1877 of the Social Security Act, commonly known as the Stark Law, prohibits referrals for designated health services by physicians under the Medicare and Medicaid programs to other healthcare providers in which the physicians have an ownership or compensation arrangement unless an exception applies. Sanctions for violating the Stark Law include civil monetary penalties of up to $15,000 per prohibited service provided, assessments equal to three times the dollar value of each such service provided and exclusion from the Medicare and Medicaid programs and other federal and state healthcare programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. In addition, many states have adopted or may adopt similar anti-kickback or anti-self-referral statutes. Some of these statutes prohibit the payment or receipt of remuneration for the referral of patients, regardless of the source of the payment for the care.

Provider-based status. The designation provider-based refers to circumstances in which a subordinate facility (e.g., a separately certified Medicare provider, a department of a provider or a satellite facility) is treated as part of a provider for Medicare payment purposes. In these cases, the services of the subordinate facility are included on the main provider s cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that they are shared. We operate 19 specialty hospitals that are treated as provider-based satellites of certain of our other facilities, certain of our outpatient rehabilitation services are operated as departments of our inpatient rehabilitation facilities, and we provide rehabilitation management and staffing services to hospital rehabilitation departments that may be treated as provider-based. These facilities are required to satisfy certain operational standards in order to retain their provider-based status.

Health information practices. In addition to broadening the scope of the fraud and abuse laws, the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, also mandates, among other things, the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the healthcare industry. If we fail to comply with the standards, we could be subject to criminal penalties and civil sanctions. Among the standards that the Department of Health and Human Services has adopted or will adopt pursuant to HIPAA are standards for the following:

- electronic transactions and code sets;
- unique identifiers for providers, employers, health plans and individuals;
- security and electronic signatures;
- privacy; and

enforcement.

Although HIPAA was intended ultimately to reduce administrative expenses and burdens faced within the healthcare industry, the law has brought about significant and, in some cases, costly changes.

The Department of Health and Human Services has adopted standards in three areas that most affect our operations. First, standards relating to electronic transactions and code sets require the use of uniform standards for common healthcare transactions, including healthcare claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits. We were required to comply with these requirements by October 16, 2003.

Second, standards relating to the privacy of individually identifiably health information govern our use and disclosure of protected health information, and require us to impose those rules, by contract, on any business associate to whom such information is disclosed. We were required to comply with these standards by April 21, 2003.

Third, standards for the security of electronic health information which were issued on February 20, 2003 require us to implement various administrative, physical and technical safeguards to ensure the integrity and confidentiality of health information. We were required to comply with the security standards by April 20, 2005.

We maintain a HIPAA implementation committee that is charged with evaluating and implementing HIPAA. The implementation committee monitors HIPAA s regulations as they have been adopted to date and as additional standards and modifications are adopted. At this time, we anticipate that we will be able to fully comply with those HIPAA requirements that have been adopted. However, we cannot at this time estimate the cost of such compliance, nor can we estimate the cost of compliance with standards that have not yet been issued or finalized by the Department of Health and Human Services. Although the new health information standards are likely to have a significant effect on the manner in which we handle health data and communicate with payors, based on our current knowledge, we believe that the cost of our compliance will not have a material adverse effect on our business, financial condition or results of operations.

Compliance Program

Our Compliance Program

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

Operating Our Compliance Program

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

Compliance Committee

Our compliance committee is made up of members of our senior management and in-house counsel. The compliance committee meets on a quarterly basis and reviews the activities, reports and operation of our

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compliance program. In addition, the HIPAA committee meets on a regular basis to review compliance with HIPAA regulations.

Compliance Issue Reporting

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

Compliance Monitoring and Auditing/ Comprehensive Training and Education

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

Policies and Procedures Reflecting Compliance Focus Areas

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

Internal Audit

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

Facilities

We currently lease most of our facilities, including clinics, offices, specialty hospitals and our corporate headquarters. We own each of our inpatient rehabilitation facilities and our 176,000 square foot long-term acute care hospital located in Houston, Texas.

We lease all of our clinics and related offices, which, as of March 31, 2005, included 753 outpatient rehabilitation clinics throughout the United States and Canada. The outpatient rehabilitation clinics generally have a five-year lease term and include options to renew. We also lease all of our long-term acute care hospital facilities except for the facility located in Houston, Texas that is described above. As of March 31, 2005, we had 95 hospital within a hospital leases and three free-standing building leases.

We generally seek a five-year lease for our long-term acute care hospitals, with an additional five-year renewal at our option. We lease our corporate headquarters from companies owned by a related party affiliated with us through common ownership or management. Our corporate headquarters is approximately 83,530 square feet and is located in Mechanicsburg, Pennsylvania. We lease several other administrative spaces related to administrative and operational support functions. As of March 31, 2005, this comprised 19 locations throughout the United States with approximately 126,739 square feet in total.

Legal Proceedings

Purported Class Action Lawsuits

On August 24, 2004, Clifford C. Marsden and Ming Xu filed a purported class action complaint in the United States District Court for the Eastern District of Pennsylvania on behalf of the public stockholders of

our company against Martin Jackson, Robert A. Ortenzio, Rocco A. Ortenzio, Patricia Rice and us. In February 2005, James Shaver, Frank C. Bagatta and Capital Invest, die Kapitalanlagegesellschaft der Bank Austria Creditanstalt Gruppe GmbH were appointed as lead plaintiffs (Lead Plaintiffs).

On April 19, 2005, Lead Plaintiffs filed an amended complaint, purportedly on behalf of a class of shareholders of Select, against Martin Jackson, Robert A. Ortenzio, Rocco A. Ortenzio, Patricia Rice, and us as defendants. The amended complaint continues to allege, among other things, failure to disclose adverse information regarding a potential regulatory change affecting reimbursement for our services applicable to long-term acute care hospitals operated as hospitals within hospitals, and the issuance of false and misleading statements about our financial outlook. The amended complaint continues to seek, among other things, damages in an unspecified amount, interest and attorneys fees. We believe that the allegations in the amended complaint are without merit and intend to vigorously defend against this action.

On October 18, 2004, Garco Investments, LLP filed a purported class action complaint in the Court of Chancery of the State of Delaware, New Castle County, which is herein referred to as the Court, on behalf of our unaffiliated stockholders against Russell L. Carson, David S. Chernow, Bryan C. Cressey, James E. Dalton, Jr., Meyer Feldberg, Robert A. Ortenzio, Rocco A. Ortenzio, Thomas A. Scully, Leopold Swergold and LeRoy S. Zimmerman, who are all of our directors, us and Welsh, Carson, Anderson & Stowe. On November 3, 2004, Terrence C. Davey filed a purported class action complaint in the Court, on behalf of our unaffiliated stockholders against all of our directors, us and Welsh, Carson, Anderson & Stowe. On November 18, 2004, the Court entered an Order of Consolidation which, among other things, consolidated the above-mentioned actions under the caption In re: Select Medical Corporation Shareholders Litigation, Consolidated C.A. No. 755-N and appointed co-lead plaintiffs counsel.

On December 20, 2004, plaintiffs Garco Investments LLP and Terence C. Davey filed an Amended Consolidated Complaint in the Court, purportedly on behalf of our unaffiliated stockholders against all of our directors, us and Welsh Carson Anderson & Stowe. The amended complaint alleges, among other things, that the defendants have breached their fiduciary duties owed to the plaintiffs and our stockholders in connection with the proposed going private transaction, that the proposed merger consideration is not fair or adequate, and that the defendants failed to disclose and/or misrepresented material information in the proxy statement relating to the merger and/or disseminated a stale fairness opinion by Banc of America Securities LLC. The complaint seeks, among other things, to enjoin the defendants from completing the merger or, alternatively, to rescind the merger (if complete) or award rescissory damages in an unspecified amount, and to require issuance of corrective and/or supplemental disclosures and an update of the stale fairness opinion.

As a result of arm s-length settlement negotiations among counsel in the Delaware consolidated lawsuit, on January 21, 2005 the parties executed a stipulation of settlement which recognizes, among other things, that the allegations of the amended complaint were a material factor in causing us to make certain additional disclosures in the proxy statement, and that those disclosures, and the other terms set forth in the stipulation of settlement (which is on file with the Court) are a fair and reasonable means by which to resolve the action. On June 1, 2005, the Court, following a hearing, granted final approval of the settlement.

We carry director and officer insurance covering these purported class action lawsuits, and while we do not believe these claims will have a material adverse effect on our financial position or results of operations, due to the uncertain nature of such litigation, we cannot predict the outcome of these matters.

Other Legal Proceedings

We are subject to legal proceedings and claims that arise in the ordinary course of our business, which include malpractice claims covered under our insurance policies. In our opinion, the outcome of these actions will not have a material adverse effect on the financial position or results of operations of our company.

To cover claims arising out of the operations of our hospitals and outpatient rehabilitation facilities, we maintain professional malpractice liability insurance and general liability insurance. We also maintain umbrella liability insurance covering claims which, due to their nature or amount, are not covered by or not fully covered by our other insurance policies. These insurance policies also do not generally cover punitive

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

Health care providers are often subject to lawsuits under the *qui tam*provisions of the federal False Claims Act. *Qui tam* lawsuits typically remain under seal (hence, unknown to the defendant) for some time while the government decides whether or not to intervene on behalf of a private *qui tam* plaintiff (known as a relator) and take the lead in the litigation. A *qui tam* lawsuit against our company has been filed in the United States District Court for the District of Nevada, but because the action is still under seal, we do not know the details of the allegations or the relief sought. As is required by law, the federal government is conducting an investigation of this complaint to determine if it will intervene in the case. We have received subpoenas for patient records and other documents apparently related to the federal government s investigation of matters alleged in this *qui tam* complaint. We believe that that this investigation involves the billing practices of certain of our subsidiaries that provide outpatient services to beneficiaries of Medicare and other federal health care programs. The three relators in this *qui tam* lawsuit are two former employees of our Las Vegas, Nevada subsidiary who were terminated by us in 2001 and a former employee of our Florida subsidiary who we asked to resign. We sued the former Las Vegas employees in state court in Nevada in 2001 for, among other things, return of misappropriated funds, and our lawsuit has recently been transferred to the federal court in Las Vegas. While the government has investigated but chosen not to intervene in two previous *qui tam* lawsuits filed against our company, we cannot assure you that the government will not intervene in this case. However, we believe, based on our prior experiences with *qui tam* cases and the information currently available to us, that this *qui tam* action will not have a material adverse effect on our company.

MANAGEMENT

Executive Officers and Directors

Holdings and our company have identical boards of directors. The following table sets forth information about our directors and executive officers as of the date of this prospectus:

Name	Age	Position(s)
Rocco A. Ortenzio	72	Director and Executive Chairman
Robert A. Ortenzio	48	Director and Chief Executive Officer
Russell L. Carson	61	Director
Bryan C. Cressey	55	Director
Thomas A. Scully	47	Director
Sean M. Traynor	36	Director
Patricia A. Rice	58	President and Chief Operating Officer
David W. Cross	58	Senior Vice President and Chief Development Officer
S. Frank Fritsch	53	Senior Vice President, Human Resources
Martin F. Jackson	51	Senior Vice President and Chief Financial Officer
James J. Talalai	43	Senior Vice President and Chief Information Officer
Michael E. Tarvin	45	Senior Vice President, General Counsel and Secretary
Scott A. Romberger	45	Vice President, Controller and Chief Accounting Officer

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

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

Robert A. Ortenzio co-founded our company and has served as a director since February 1997. He became a director of Holdings upon consummation of the Transactions. Mr. Ortenzio has served as our Chief Executive Officer since January 1, 2005 and as our President and Chief Executive Officer from September 2001 to January 1, 2005. Mr. Ortenzio also served as our President and Chief Operating Officer from February 1997 to September 2001. He was an Executive Vice President and a director of Horizon/ CMS Healthcare Corporation from July 1995 until July 1996. In 1986, Mr. Ortenzio co-founded Continental Medical Systems, Inc., and served in a number of different capacities, including as a Senior Vice President from February 1986 until April 1988, as Chief Operating Officer from April 1988 until July 1995, as President from May 1989 until August 1996 and as Chief Executive Officer from July 1995 until August 1996. Before co-founding Continental Medical Systems, Inc., he was a Vice President of Rehab Hospital Services Corporation. Mr. Ortenzio is the son of Rocco A. Ortenzio, our Executive Chairman.

Russell L. Carson has been a director of our company since February 1997 and became a director of Holdings upon consummation of the Transactions. He co-founded Welsh, Carson, Anderson & Stowe in 1978 and has focused on healthcare investments. Mr. Carson has been a general partner of Welsh, Carson, Anderson & Stowe since 1979. Welsh, Carson, Anderson & Stowe has created 14 institutionally funded limited partnerships with total capital of more than $13 billion and has invested in more than 200 companies. Before co-founding Welsh, Carson, Anderson & Stowe, Mr. Carson was employed by Citicorp Venture

Capital Ltd., a subsidiary of Citigroup, Inc., and served as its Chairman and Chief Executive Officer from 1974 to 1978.

Bryan C. Cressey has been a director of our company since February 1997 and became a director of Holdings upon consummation of the Transactions. He has been a partner at Thoma Cressey Equity Partners since its founding in June 1998 and prior to that time was a principal, partner and co-founder of Golder, Thoma, Cressey and Rauner, the predecessor of GTCR Golder Rauner, LLC, since 1980. He also serves as a director and chairman of Belden CDT Inc. and several private companies.

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

Sean M. Traynor joined our board of directors following the consummation of the Transactions and has been a director of Holdings since October 2004. Mr. Traynor is a general partner of Welsh, Carson, Anderson & Stowe where he focuses on investments in healthcare as well as the information and business services industries. Prior to joining Welsh Carson in April 1999, Mr. Traynor worked in the healthcare and insurance investment banking groups at BT Alex.Brown after spending three years with Coopers & Lybrand. Mr. Traynor earned his bachelor s degree from Villanova University in 1991 and his MBA from the Wharton School of Business in 1996.

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

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

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

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

James J. Talalai has served as our Senior Vice President and Chief Information Officer since August 2001. He served as our Vice President and Chief Information Officer from November 1999 to August 2001. Prior to that time, he served as Vice President of Information Services from October 1998 to November 1999, and served as Director of Information Services since May 1997. He was Director, Information Technology for Horizon/ CMS Healthcare Corporation from 1995 to 1997. He also served as Data Center Manager at Continental Medical Systems, Inc. from 1994 to 1995.

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

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

Board Committees

Our board directs the management of our business and affairs as provided by Delaware law and conducts its business through meetings of the full board of directors and two standing committees: the audit committee and the compensation committee. In addition, from time to time, other committees may be established under the direction of the board of directors when necessary to address specific issues.

The compensation committee reviews and makes recommendations to the board regarding the compensation to be provided to our Executive Chairman, Chief Executive Officer and our directors. In addition, the compensation committee reviews compensation arrangements for our other executive officers. The compensation committee also administers our equity compensation plans.

The audit committee reviews and monitors our corporate financial reporting, external audits, internal control functions and compliance with laws and regulations that could have a significant effect on our financial condition or results of operations. In addition, the audit committee has the responsibility to consider and appoint, and to review fee arrangements with, our independent auditors.

Director Compensation

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

Executive Compensation

The following table sets forth the remuneration paid by us for the three fiscal years ended December 31, 2004 to the Chief Executive Officer and our four most highly compensated executive officers other than our Chief Executive Officer (*Named Executive Officers*):

		Annual Compensation			Long-Term Compensation Awards	
					Securities	
Name and Principal Position	**Year**	**Salary**	**Bonus**	**Other Annual Compensation(1)**	**Underlying Options**	**All Other Compensation**
Rocco A. Ortenzio	2004	$ 824,000	$ 1,711,385	$	1,550,000	$
Executive Chairman	2003	824,000	1,648,000		3,550,000	
	2002	800,000	640,000		3,120,000	
Robert A. Ortenzio(2)	2004	824,000	1,711,385		1,250,000	5,948
Chief Executive Officer	2003	824,000	1,648,000		2,060,000	4,531
	2002	800,000	640,000		2,270,000	5,500
Patricia A. Rice(2)	2004	592,250	768,786		215,000	5,948
President and Chief	2003	592,250	740,000		440,000	4,531
Operating Officer	2002	575,000	345,000		600,000	5,500
Martin F. Jackson(3)	2004	371,315	481,476		30,000	5,948
Senior Vice President	2003	360,500	451,300		340,000	4,531
and Chief Financial	2002	350,000	175,000		400,000	25,500
Officer						
S. Frank Fritsch(2)	2004	275,834	286,134		59,000	5,948
Senior Vice President,	2003	267,800	268,000		123,500	4,531
Human Resources	2002	242,000	117,000		185,200	5,500

(1) The value of certain perquisites and other personal benefits is not included because it did not exceed for any officer in the table above the lesser of either $50,000 or 10% of the total annual salary and bonus reported for such officer.

(2) All other compensation represents employer matching contributions to the 401(k) plan.

(3) All other compensation for Martin F. Jackson includes employer matching contributions to the 401(k) plan in the amounts of $5,948, $4,531 and $5,500 in fiscal 2004, fiscal 2003 and fiscal 2002, respectively. All other compensation also includes the forgiveness of principal in the amounts of $20,000 in fiscal 2002 in connection with a loan we made to Mr. Jackson in 1999 for the purpose of purchasing shares of our common stock.

Option Grants In Last Fiscal Year(1)

Name	Number of Securities Underlying Options Granted(2)	Percent of Total Options Granted to Employees in 2004	Exercise Price per Share	Expiration Date	Grant Date Present Value(3)
Rocco A. Ortenzio	950,000	24.9%	$ 15.50	2/09/2014	$ 5,315,060
	600,000	15.7	14.00	8/09/2014	3,181,740
Robert A. Ortenzio	750,000	19.7	15.50	2/09/2014	5,269,600
	500,000	13.1	14.00	8/09/2014	3,287,899
Patricia A. Rice	65,000	1.7	15.50	2/09/2014	491,157
	150,000	3.9	13.86	5/10/2014	1,105,236
Martin F. Jackson	30,000	0.8	14.00	8/09/2014	211,677
S. Frank Fritsch	50,000	1.3	15.50	2/09/2014	377,813
	9,000	0.2	13.86	5/10/2014	66,314

(1) All options listed herein were accelerated and canceled in connection with the Transactions in exchange for the right to receive $18.00 in cash less the exercise price of the option. Upon consummation of the Transactions certain of our Named Executive Officers and certain other executive officers received options to purchase Holdings common stock pursuant to our parent s new equity incentive plan. See New Restricted Stock and Option Plan and Security Ownership of Certain Beneficial Owners and Management.

(2) All options were granted under our Second Amended and Restated 1997 Stock Option Plan. We granted options at an exercise price equal to or greater than the fair market value of our common stock on the date of grant, as determined by our Board of Directors. The plan was terminated upon consummation of the Transactions.

(3) Based on the Black-Scholes option pricing model adapted for use in valuing executive stock options. The actual value, if any, an executive may realize will depend upon the excess of the stock price over the exercise price on the day the option is exercised, so there is no assurance that the value realized by an executive will be at or near the value estimated by the Black-Scholes model.

Option Exercises in Last Year and Year-End Option Value Table(1)

			Number of Securities Underlying Unexercised Options Held at 2004 Year End		Value of Unexercised In-the-Money Options at 2004 Year End(2)	
Name	**Number of Options Exercised**	**Amount Realized**	**Exercisable**	**Unexercisable**	**Exercisable**	**Unexercisable**
Rocco A. Ortenzio	1,342,000	$ 13,708,340	7,778,000		$ 39,348,060	$
Robert A. Ortenzio	800,000	8,369,850	2,400,003	3,779,997	20,239,820	18,669,880
Patricia A. Rice	237,120	2,645,424	88,003	1,080,599	266,260	7,359,738
Martin F. Jackson			259,424	651,954	2,500,318	4,748,633
S. Frank Fritsch	97,056	1,092,868	24,701	344,025	74,464	2,559,933

(1) All shares of common stock issued upon exercise of the options listed herein were converted in the Transactions into the right to receive $18.00 in cash or were contributed to Holdings in exchange for equity securities of Holdings. See The Transactions. Upon consummation of the Transactions certain of the named executive officers and certain other officers received options to purchase common stock pursuant to our parent s new stock option plan. See New Restricted Stock and Option Plan and Security Ownership of Certain Beneficial Owners and Management.

(2) Based on our stock s closing price on the New York Stock Exchange on December 31, 2004, less the exercise price, multiplied by the number of shares underlying the option. Such amounts may not be realized. Actual values which may be realized, if any, upon any exercise of such options will be based on the market price of the common stock at the time of any such exercise and thus are dependent upon future performance of the stock.

Employment Agreements

Set forth below is a brief description of the employment agreements and other compensation arrangements that we have with our Named Executive Officers.

In March 2000, we entered into three-year employment agreements with three of our executive officers, Rocco A. Ortenzio, Robert A. Ortenzio and Patricia A. Rice. These agreements were amended on August 8, 2000, February 23, 2001, and, with respect to Rocco Ortenzio, April 24, 2001, and, with respect to Messrs. Rocco and Robert Ortenzio, September 17, 2001. Additionally, we further amended the employment agreements for Patricia A. Rice and Robert A. Ortenzio effective as of January 1, 2005 to change Ms. Rice s title to President and Chief Operating Officer and change Mr. Ortenzio s title to Chief Executive Officer. Under these agreements, Messrs. Rocco and Robert Ortenzio are to be paid an annual salary of $800,000 and Ms. Rice is to be paid a salary of $500,000, subject to adjustment by our Board of Directors. In addition, these

executives are eligible for bonus compensation. The compensation committee has increased each of such executive s salary on several occasions subsequent to entering their employment agreements. The employment agreements also provide that the executive officers will receive long-term disability insurance. In the event Rocco A. Ortenzio s employment is terminated due to his disability, we must make salary continuation payments to him equal to 100% of his annual base salary for ten years after his date of termination or until he is physically able to become gainfully employed in an occupation consistent with his education, training and experience. We are also obligated to make disability payments to Robert A. Ortenzio and Patricia A. Rice for the same period; however, payments to them must equal 50% of their annual base salary. In addition, Rocco A. Ortenzio and Robert A. Ortenzio are each entitled to six weeks paid vacation. Patricia A. Rice is entitled to four weeks paid vacation.

Under the terms of each of these executive officers employment agreements, their employment term began on March 1, 2000 and expired on March 1, 2003. At the end of each 12-month period beginning March 1, 2000, however, the term of each employment agreement automatically extends for an additional year unless one of the executives or we give written notice to the other not less than three months prior to the end of that 12-month period that we or they do not want the term of the employment agreement to continue. Each of these agreements was extended for an additional year on March 1 of 2001, 2002, 2003, 2004 and 2005. Thus, in the absence of written notice given by one of the executives or us, the remaining term of each employment agreement will be three years from each anniversary of March 1, 2000. In each employment agreement, for the term of the agreement and for two years after the termination of employment, the executive may not participate in any business that competes with us within a twenty-five mile radius of any of our hospitals or outpatient rehabilitation clinics. The executive also may not solicit any of our employees for one year after the termination of the executive s employment.

Each of these three employment agreements also contains a change of control provision. If, within the one-year period immediately following a change of control of Select, we terminate Rocco A. Ortenzio or Robert A. Ortenzio without cause or Rocco A. Ortenzio or Robert A. Ortenzio terminates his employment agreement for any reason, we are obligated to pay them a lump sum cash payment equal to their base salary plus bonus for the previous three completed calendar years. If, within the one-year period immediately following a change of control of Select, Patricia A. Rice terminates her employment for certain specified reasons or, within the five-year period immediately following a change of control, is terminated without cause, has her compensation reduced from that in effect prior to the change of control or is relocated to a location more than 25 miles from Mechanicsburg, Pennsylvania, we are obligated to pay her a lump sum cash payment equal to her base salary plus bonus for the previous three completed calendar years. In addition, if any of these executives are terminated within one year of a change of control, all of their unvested and unexercised stock options will vest as of the date of termination. A change in control is generally defined to include: (i) the acquisition by a person or group, other than our current stockholders who own 12% or more of the common stock, of more than 50% of our total voting shares; (ii) a business combination following which there is an increase in share ownership by any person or group, other than the executive or any group of which the executive is a part, by an amount equal to or greater than 33% of our total voting shares; (iii) our current directors, or any director elected after the date of the respective employment agreement whose election was approved by a majority of the then current directors, cease to constitute at least a majority of our board; (iv) a business combination following which our stockholders cease to own shares representing more than 50% of the voting power of the surviving corporation; or (v) a sale of substantially all of our assets other than to an entity controlled by our shareholders prior to the sale. Notwithstanding the foregoing, no change in control will be deemed to have occurred unless the transaction provides our stockholders with a specified level of consideration. Otherwise, if any of the executives services are terminated by us other than for cause or they terminate their employment for good reason, we are obligated to pay them a pro-rated bonus for the year of termination equal to the product of the target bonus established for that year, or if no target bonus is established the bonus paid or payable to them for the year prior to their termination, in either case multiplied by the fraction of the year of termination they were employed. In addition, we would also be obligated to pay these executives their base salary as of the date of termination for the balance of the term of the agreement and all vested and unexercised stock options will vest immediately. Upon completion of the Transactions, these executive officers entered into amendments to their employment agreements which contained acknowl-

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edgements that the merger would not trigger any change of control payments under their employments agreements.

In June 1997, we entered into a senior management agreement with S. Frank Fritsch, which remains in effect until terminated by either us or Mr. Fritsch. Under this agreement, Mr. Fritsch is entitled to an annual salary of $130,000, subject to adjustment from time to time by the compensation committee of our board of directors. The compensation committee has increased Mr. Fritsch s salary on several occasions subsequent to entering that agreement. The compensation committee may also in its discretion award incentive compensation to Mr. Fritsch. Further, Mr. Fritsch is entitled to any employment and fringe benefits under our policies as they exist from time to time and which are made available to our senior executive employees. During the employment term and for two years after the termination of his employment, Mr. Fritsch may not solicit any of our customers or employees or participate in any business that competes with us in the United States.

In March 2000, we entered into change of control agreements with Mr. Fritsch and Martin F. Jackson, which were each amended on February 23, 2001. These agreements provide that if within a five-year period immediately following a change of control of our company, we terminate Mr. Fritsch or Mr. Jackson without cause, reduce either of their compensation from that in effect prior to the change of control or relocate Mr. Fritsch or Mr. Jackson to a location more than 25 miles from Mechanicsburg, Pennsylvania, we are obligated to pay the affected individual a lump sum cash payment equal to his base salary plus bonus for the previous three completed calendar years. If at the time we terminate Mr. Fritsch or Mr. Jackson without cause or Mr. Fritsch or Mr. Jackson terminates his employment for good reason in connection with a change in control, Mr. Fritsch or Mr. Jackson has been employed by us for less than three years, we must pay the terminated individual three times his average total annual cash compensation (base salary and bonus) for his years of service. In addition, the agreements provide that all unvested stock options will vest upon termination. A change in control has the same definition as in the employment agreements of Rocco A. Ortenzio, Robert A. Ortenzio and Patricia A. Rice, as described above. Upon completion of the Transactions, Mr. Fritsch and Mr. Jackson entered into amendments to their change of control agreements which contained acknowledgements that the merger would not trigger any change of control payments under their change of control agreements.

Restricted Stock and Option Plan

Holdings adopted a 2005 Equity Incentive Plan which became effective contemporaneously with the consummation of the Transactions, which we refer to as the equity plan. The total number of shares of common stock for which options or awards may be granted under the equity plan for the grant of stock options is 33,067,575 shares in the aggregate plus an additional amount, calculated from time to time, equal to 15% of Holdings total issued and outstanding shares of common stock in excess of 218,245,979; *provided* that not more than 25,000,000 shares may be delivered upon incentive stock options granted under the equity plan. The number of shares of stock available under the equity plan for issuance of restricted stock is 43,589,075 shares in the aggregate.

Shares of common stock relating to expired or terminated options may again be subject to an option or award under the equity plan, subject to limited restrictions, including any limitation required by the United States Internal Revenue Code of 1986, as amended (referred to below as the Code). In addition, upon the exercise of a stock option, the number of shares underlying the option will be added to the total number of shares with respect to which stock options may be granted; *provided* that all the applicable securities law requirements and listing requirements, if any, have been satisfied. The equity plan provides for the grants of incentive stock options, within the meaning of Section 422 of the Code, to selected employees, and for grants of non-qualified stock options and awards and restricted stock awards to selected employees, directors or consultants. The purposes of the equity plan are to attract and retain the best available personnel, provide additional incentives to our employees, directors and consultants and to promote the success of our business.

The compensation committee of the board of directors of Holdings administers the equity plan which, from and after the date Holdings registers any class of its equity securities under the Securities Exchange Act of 1934, as amended, will be comprised of at least two members of the board of directors who are non-

employee directors and outside directors within the meaning of the Code. If there is no compensation committee, the board of directors, within the meaning of applicable securities laws, will administer the equity plan. The administrator of the equity plan has the authority to select participants to receive awards of stock options or restricted stock pursuant to the equity plan. The administrator also has the authority to determine the time of receipt, the types of awards and number of shares covered by awards, and to establish the terms, conditions and other provisions of the awards under the equity plan.

In general, the exercise price of any stock option granted is set by the administrator, but in no event will be less than 100% of the fair market value of the underlying shares at the time of grant. Stock options may be subject to terms and conditions, including vesting provisions, set forth by the administrator. The exercise price of any incentive stock option granted to an employee who possess more than 10% of the total combined voting power of all classes of our shares within the meaning of Section 422(b)(6) of the Code must be at least 110% of the fair market value of the underlying share at the time the option is granted. Furthermore, the aggregate fair market value of shares of common stock that may be exercisable for the first time under an incentive stock option by an employee during any calendar year may not exceed $100,000. The term of any incentive stock option cannot exceed ten years from the date of grant.

Shares of restricted stock granted under the equity plan may not be sold, assigned, transferred, pledged or otherwise encumbered by the participant until the satisfaction of conditions set by the administrator and may be subject to forfeiture or repurchase by our company prior to the satisfaction of conditions set by the administrator.

The equity plan will terminate ten years following its effective date but the board of directors of Holdings may terminate the equity plan at any time in its sole discretion. The board of directors of Holdings may amend the equity plan subject to restrictions requiring the approval of Welsh Carson.

Long-Term Cash Incentive Plan

On June 2, 2005, Holdings adopted a Long-Term Cash Incentive Plan, which we refer to as the cash plan. The total number of units available under the cash plan for awards may not exceed 100,000. If any awards are terminated, forfeited or cancelled, units granted under such awards are available for award again under the cash plan. The purposes of the cash plan are to attract and retain key employees, motivate participating key employees to achieve the long-range goals of our company, provide competitive incentive compensation opportunities and further align the interests of participating key employees with Holdings stockholders.

The compensation committee of the board of directors of Holdings administers the cash plan. If there is no compensation committee, the board of directors will administer the cash plan. The administrator of the cash plan has the authority, in its sole discretion, to select participants to receive awards of units. The administrator also has the authority to determine the time of receipt, the types of awards and number of units conveyed by awards, and to establish the terms, conditions and other provisions of the awards under the cash plan. Except as otherwise provided in a participant s unit award agreement, a participant will forfeit all such units granted upon termination of employment for any reason other than for death or disability.

Payment of cash benefits is based upon (i) the value of our company upon a change of control of Holdings or upon qualified initial public offering of Holdings or (ii) a redemption of Holdings preferred stock or special dividends paid on Holdings preferred stock. Until the occurrence of an event that would trigger the payment of cash on any outstanding units is deemed probable by us, no expense for any award is reflected in our financial statements.

Employee Stock Purchase Plan

On April 1, 2005, Holdings adopted an Employee Stock Purchase Plan, which we refer to as the stock plan, pursuant to which specified employees of our company (other than members of our senior management team) have been given the opportunity to purchase shares of Holdings preferred stock and common stock. The maximum number of shares of participating preferred stock available under the stock plan is 89,216 and the

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maximum number of shares of common stock available under the plan is 599,975. As of June 1, 2005, 66,676.59 shares of Holdings participating preferred stock and 448,400 shares of Holdings common stock were issued to employees under the stock plan. The purposes of the stock plan are to attract and retain the best available personnel, provide additional incentives to our employees and to promote the success of our business.

The board of directors of Holdings administers the stock plan. The administrator of the stock plan has the authority to sell to any employee shares of stock in such quantity, at such price and on such terms, subject to the terms and conditions set forth in the stock plan, as the administrator may determine in its sole discretion.

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SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The following table sets forth information as of June 2, 2005, with respect to the beneficial ownership of our parent s capital stock by (i) our chief executive officer and each of the other named executive officers set forth below, (ii) each of our directors, (iii) all of our directors and executive officers as a group and (iv) each holder of five percent (5%) or more of any class of our parent s outstanding capital stock.

Name of Beneficial Owner(1)	Common Shares Beneficially Owned	Percent of Outstanding Common Shares	Participating Preferred Shares Beneficially Owned	Percent of Outstanding Participating Preferred Shares
Welsh, Carson, Anderson & Stowe(2)	114,938,181	58.7%	16,877,179.59	77.1%
Thoma Cressey Equity Partners(3)	17,962,732	9.2%	2,671,038.22	12.2%
Rocco A. Ortenzio(4)	17,838,968	9.1%	978,853.33	4.5%
Robert A. Ortenzio(5)	16,401,873	8.4%	913,858.31	4.2%
Russell L. Carson(6)	2,910,387	1.5%	432,771.36	2.0%
Bryan C. Cressey(7)	17,962,732	9.2%	2,671,038.22	12.2%
Thomas A. Scully(8)	130,256	*	4,460.97	*
Sean M. Traynor(9)	5,000	*	743.49	*
Patricia A. Rice(10)	4,283,361	2.2%	53,531.60	*
S. Frank Fritsch(11)	1,448,482	*	46,864.77	*
Martin F. Jackson(12)	3,632,781	1.9%	54,066.93	*
All directors and named executive officers as a group(13)	83,818,143	33.0%	4,009,907.10	23.6%

* Less than one percent

(1) Unless otherwise indicated, the address of each of the beneficial owners identified is 4716 Old Gettysburg Road, P.O. Box 2034, Mechanicsburg, Pennsylvania 17055.

(2) Represents (A) 80,857,283 common shares and 12,023,373.01 participating preferred shares held by WCAS IX over which WCAS IX has sole voting and investment power, (B) 15,000 common shares and 2,230.48 participating preferred shares held by WCAS Management Corporation, over which WCAS Management Corporation has sole voting and investment power, (C) 3,623,302 common shares and 538,780.97 participating preferred shares held by WCAS Capital Partners IV, L.P., over which WCAS Capital Partners IV, L.P. has sole voting and investment power, (D) an aggregate 8,246,203 common shares and 1,226,213.10 participating preferred shares held by individuals who are general partners of WCAS IX Associates LLC, the sole general partner of WCAS IX and/or otherwise employed by an affiliate of Welsh, Carson, Anderson & Stowe, and (E) an aggregate 22,196,394 common shares and 3,086,582.03 participating preferred shares held by other co-investors, over which WCAS IX has sole voting power. WCAS IX Associates LLC, the sole general partner of WCAS IX and the individuals who serve as general partners of WCAS IX Associates LLC, including Russell L. Carson, and Sean M. Traynor, may be deemed to beneficially own the shares beneficially owned by WCAS IX. Such persons disclaim beneficial ownership of such shares. The principal executive offices of Welsh,

Carson, Anderson & Stowe are located at 320 Park Avenue, Suite 2500, New York, New York 10022.

(3) Represents (A) 7,480,145 common shares and 1,112,289.19 participating preferred shares held by Thoma Cressey Fund VI, L.P. over which Thoma Cressey Fund VI, L.P. has shared voting and investment power, (B) 74,801 common shares and 11,122.80 participating preferred shares held by Thoma Cressey Friends Fund VI, L.P., over which Thoma Cressey Friends Fund VI, L.P. has shared

voting and investment power, (C) 9,846,200 common shares and 1,464,118.96 participating preferred shares held by Thoma Cressey Fund VII, L.P., over which Thoma Cressey Fund VII, L.P. has shared voting and investment power, (D) 153,800 common shares and 22,869.89 participating preferred shares held by Thoma Cressey Friends Fund VII, L.P., over which Thoma Cressey Friends Fund VII, L.P. has shared voting and investment power and (E) 407,786 common shares and 60,637.38 participating preferred shares held by Mr. Cressey. Mr. Cressey is a principal of Thoma Cressey Equity Partners Inc. The principal address of Thoma Cressey Equity Partners Inc. is 9200 Sears Tower, 233 South Wacker Drive, Chicago, IL 60606.

(4) Includes 385,697 common shares held by the Ortenzio Family Foundation of which Mr. Ortenzio is a trustee. Does not include 5,000,000 common shares held by The Robert A. Ortenzio Descendants Trust of which Mr. Ortenzio is a trustee. Does not include 2,615,000 common shares held by The 2005 Rice Family Trust of which Mr. Ortenzio is a trustee.

(5) Includes 10,256,176 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the Transactions. Does not include 5,000,000 common shares held by The Robert A. Ortenzio Descendants Trust of which Mr. Ortenzio is a trustee. Does not include 2,615,000 common shares held by The 2005 Rice Family Trust of which Mr. Ortenzio is a trustee. Does not include 4,000,000 common shares held by The Rocco A. Ortenzio Descendants Trust of which Mr. Ortenzio is a trustee.

(6) Does not include 80,857,283 common shares and 12,023,373.01 participating preferred shares owned by WCAS IX, 15,000 common shares and 2,230.48 participating preferred shares owned by WCAS Management Corporation or 3,623,302 common shares and 538,780.97 participating preferred shares owned by WCAS Capital Partners IV, L.P. Mr. Carson, as a general partner of WCAS IX and WCAS Capital Partners IV, L.P. and as an officer of WCAS Management Corporation, may be deemed to beneficially own the shares beneficially owned by WCAS IX, WCAS Management Corporation and WCAS Capital Partners IV, L.P. Mr. Carson disclaims beneficial ownership of such shares.

(7) Includes (A) 7,480,145 common shares and 1,112,289.19 participating preferred shares held by Thoma Cressey Fund VI, L.P., (B) 74,801 common shares and 11,122.80 participating preferred shares held by Thoma Cressey Friends Fund VI, L.P., (C) 9,846,200 common shares and 1,464,118.96 participating preferred shares held by Thoma Cressey Fund VII, L.P., and (D) 153,800 common shares and 22,869.89 participating preferred shares held by Thoma Cressey Friends Fund VII, L.P. Mr. Cressey is a principal of Thoma Cressey Equity Partners Inc. Mr. Cressey may be deemed to beneficially own the shares beneficially owned by Thoma Cressey Fund VI, L.P., Thoma Cressey Friends Fund VI, L.P., Thoma Cressey Fund VII, L.P. and Thoma Cressey Friends Fund VII, L.P. Mr. Cressey disclaims beneficial ownership of such shares. The principal address of Mr. Cressey is 9200 Sears Tower, 233 South Wacker Drive, Chicago, IL 60606.

(8) Includes 100,256 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the Transactions.

(9) Does not include 80,857,283 common shares and 12,023,373.01 participating preferred shares owned by WCAS IX, 15,000 common shares and 2,230.48 participating preferred shares owned by WCAS Management Corporation or 3,623,302 common shares and 538,780.97 participating preferred shares owned by WCAS Capital Partners IV, L.P. Mr. Traynor, as a general partner of WCAS IX and WCAS Capital Partners IV, L.P. and as an officer of WCAS Management Corporation, may be deemed to beneficially own the shares beneficially owned by WCAS IX, WCAS Management Corporation and WCAS Capital Partners IV, L.P. Mr. Traynor disclaims beneficial ownership of such shares.

(10)

Includes 3,923,361 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the Transactions and 360,000 common shares and 53,531.60 participating preferred shares owned by The Patricia Ann Rice Living Trust for which Ms. Rice acts as a trustee.

(11) Includes 1,133,316 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the Transactions.

(12) Includes 3,269,181 common shares which are subject to restrictions on transfer set forth in a restricted stock award agreement entered into at the time of the consummation of the Transactions. Includes 14,400 common shares owned by Mr. Jackson s children who live in his household and over which Mr. Jackson acts as custodian.

(13) Does not include 80,857,283 common shares and 12,023,373.01 participating preferred shares owned by WCAS IX, 15,000 common shares and 2,230.48 participating preferred shares owned by WCAS Management Corporation or 3,623,302 common shares and 538,780.97 participating preferred shares owned by WCAS Capital Partners IV, L.P. Includes an aggregate 18,722,290 common shares which are subject to restrictions on transfer set forth in restricted stock award agreements entered into at the time of the consummation of the Transactions.

CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

Arrangements with Our Investors

In connection with the consummation of the Transactions, our sponsors and their co-investors and our continuing investors, including Rocco A. Ortenzio, Robert A. Ortenzio, Russell L. Carson and other individuals affiliated with Welsh Carson, Bryan C. Cressey, various investment funds affiliated with Thoma Cressey, Patricia A. Rice, Martin F. Jackson, S. Frank Fritsch, Michael E. Tarvin, James J. Talalai and Scott A. Romberger, entered into agreements with Holdings as described below.

Stock Subscription and Exchange Agreement

Pursuant to a stock subscription and exchange agreement, in connection with the Transactions the investors purchased shares of Holdings preferred stock and common stock for an aggregate purchase price of $570.0 million in cash plus rollover shares of Select common stock (with such rollover shares being valued at $152.0 million in the aggregate, or $18.00 per share, for such purposes). Our continuing investors purchased shares of Holdings stock at the same price and on the same terms as our sponsors and their co-investors. Upon consummation of the merger, all rollover shares were cancelled without payment of any merger consideration.

Stockholders Agreement and Equity Registration Rights Agreement

The stockholders agreement entered into by Holdings investors in connection with the Transactions contains certain restrictions on the transfer of equity securities of Holdings and provides certain stockholders with certain preemptive and information rights. Pursuant to the registration rights agreement, Holdings granted certain of our investors rights to require Holdings to register shares of common stock under the Securities Act.

Securities Purchase Agreement and Debt Registration Rights Agreement

In connection with the Transactions, Holdings, WCAS Capital Partners IV, L.P., Rocco A. Ortenzio, Robert A. Ortenzio and certain other investors who are members of or affiliated with the Ortenzio family entered into a securities purchase agreement pursuant to which they purchased senior subordinated notes and shares of preferred and common stock from Holdings for an aggregate $150.0 million purchase price. In connection with such investment, these investors entered into the stockholders and registration rights agreements referred to under Stockholders Agreement and Equity Registration Rights Agreement with respect to the Holdings equity securities acquired by them and a separate registration rights agreement with Holdings that granted these investors rights to require Holdings to register the senior subordinated notes acquired by them under the Securities Act under certain circumstances.

Transaction Fee

In connection with the Transactions, an aggregate $24.6 million in financing fees was paid to our sponsors (or affiliates thereof) and to certain of our other continuing investors in connection with the Transactions and we reimbursed Welsh Carson and its affiliates for their out-of-pocket expenses in connection with the Transactions.

Restricted Stock Award Agreement

On June 2, 2005, Holdings and Rocco A. Ortenzio entered into a Restricted Stock Award Agreement, pursuant to which a warrant previously granted to Mr. Ortenzio was cancelled and Mr. Ortenzio was awarded shares of Holdings common stock.

Other Arrangements with Directors and Executive Officers

Lease of Office Space

We lease our corporate office space at 4716, 4718 and 4720 Old Gettysburg Road, Mechanicsburg, Pennsylvania, from Old Gettysburg Associates, Old Gettysburg Associates II and Old Gettysburg Associates III. Old Gettysburg Associates and Old Gettysburg Associates III are general partnerships that are owned by Rocco A. Ortenzio, Robert A. Ortenzio and John M. Ortenzio. Old Gettysburg Associates II is a general partnership owned by Rocco A. Ortenzio, Robert A. Ortenzio, John M. Ortenzio and Select Capital Corporation, a Pennsylvania corporation whose principal offices are located in Mechanicsburg, Pennsylvania. Rocco A. Ortenzio, Robert A. Ortenzio, Martin J. Ortenzio and John M. Ortenzio each own 25% of Select Capital Corporation. We obtained independent appraisals at the time we executed leases with these partnerships which support the amount of rent we pay for this space. In the year ended December 31, 2004, we paid to these partnerships an aggregate amount of $1,901,285, for office rent, for various improvements to our office space and miscellaneous expenses. Our current lease for 43,919 square feet of office space at 4716 Old Gettysburg Road and our lease for 12,225 square feet of office space at 4718 Old Gettysburg Road expire on December 31, 2014. On May 15, 2001 we entered into a lease for 7,214 square feet of additional office space at 4720 Old Gettysburg Road in Mechanicsburg, Pennsylvania which expires on December 31, 2014. We amended this lease on February 26, 2002 to add a net of 4,200 square feet of office space. On October 29, 2003, we entered into leases for an additional 3,008 square feet of office space at 4718 Old Gettysburg Road for a five year initial term at $17.40 per square foot, and an additional 8,644 square feet of office space at 4720 Old Gettysburg Road for a five year initial term at $18.01 per square foot. We currently pay approximately $1,713,277 per year in rent for the office space leased from these three partnerships. We amended our lease for office space at 4718 Old Gettysburg Road on February 19, 2004 to relinquish a net of 695 square feet of office space. On March 19, 2004, we entered into leases for an additional 2,436 square feet of office space at 4718 Old Gettysburg Road from Old Gettysburg Associates for a three year initial term at $19.31 per square foot, and an additional 2,579 square feet of office space at 4720 Old Gettysburg Road from Old Gettysburg Associates II for a five year initial term at $18.85 per square foot.

Equity Incentive Plan

Holdings has adopted a restricted stock and option plan. Members of our management, including some of those who participated in the Transactions as continuing investors, received awards under this plan. Rocco A. Ortenzio received 25% of the restricted stock issuable pursuant to this plan and Robert A. Ortenzio received 35% of the restricted stock issuable pursuant to this plan. See Management Restricted Stock and Option Plan.

Long-Term Cash Incentive Plan

Holdings has adopted a long-term cash incentive plan. Participants under this plan will receive cash payments in respect of awards issued under the plan to the extent Holdings exceeds targeted returns on invested equity as of a liquidity event, such as a sale of our company or an initial public offering by Holdings, within a specified number of years or upon the redemption of Holdings preferred stock or special dividends on Holdings preferred stock. See Management Long-Term Cash Incentive Plan.

Employee Stock Purchase Plan

Holdings has also adopted an employee stock purchase plan pursuant to which specified employees of our company (other than members of our senior management team) were given the opportunity to purchase shares of Holdings preferred stock and common stock. See Management Employee Stock Purchase Plan.

Consulting Agreement with Director

On January 1, 2004, we entered into a consulting agreement with Thomas A. Scully, a member of our board of directors. Pursuant to the terms of the consulting agreement, Mr. Scully agreed to provide regulatory

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advice and government relations services to our company as directed by our Chief Executive Officer. In exchange for his services, Mr. Scully is entitled to annual compensation of $75,000. The consulting agreement can be terminated by either party without cause upon 30 days prior written notice to the other party. We may also terminate the consulting agreement for cause upon the occurrence of certain specified events. On April 18, 2005, we entered into an amendment to Mr. Scully s consulting agreement which extended the term of the agreement to December 31, 2005.

DESCRIPTION OF CERTAIN OTHER INDEBTEDNESS

We summarize below the principal terms of the agreements that govern our new senior secured credit facility, any of our senior subordinated notes that were not acquired in the tender offers described under The Transactions and Holdings senior subordinated notes. This summary is not a complete description of all the terms of such agreements.

Our New Senior Secured Credit Facility

General

On February 24, 2005, we entered into a new senior secured credit facility with a syndicate of financial institutions and institutional lenders. Set forth below is a summary of the terms of our new senior secured credit facility.

Our new senior secured credit facility provides for senior secured financing of up to $880.0 million, consisting of:

- a $300.0 million revolving credit facility with a maturity of six years, including both a letter of credit sub-facility and a swingline loan sub-facility, and

- a $580.0 million term loan facility with a maturity of seven years.

In addition, we may request additional tranches of term loans or increases to the revolving credit facility in an aggregate amount not exceeding $100.0 million, subject to certain conditions and receipt of commitments by existing or additional financial institutions or institutional lenders.

All borrowings under our new senior secured credit facility are subject to the satisfaction of customary conditions, including the absence of a default and the accuracy of representations and warranties.

Interest and Fees

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

The applicable margin is initially (1) 1.50% for alternate base rate revolving loans and (2) 2.50% for adjusted LIBOR revolving loans, subject to reduction beginning approximately six months after the closing of the Transactions based upon the ratio of our total indebtedness to our consolidated EBITDA (such term being used herein as defined in the credit agreement governing our new senior secured credit facility). The applicable margins for the term loans are (1) 0.75% for alternative base rate loans and (2) 1.75% for adjusted LIBOR loans.

Swingline loans will bear interest at the interest rate applicable to alternate base rate revolving loans.

On the last day of each calendar quarter we are required to pay each lender a commitment fee in respect of any unused commitments under the revolving credit facility, which is initially 0.50% per annum for the first six months and thereafter is subject to adjustment based upon the ratio of our total indebtedness to our consolidated EBITDA.

Prepayments

Subject to exceptions, our new senior secured credit facility requires mandatory prepayments of term loans in amounts equal to:

- 50% (as may be reduced based on our ratio of total indebtedness to consolidated EBITDA) of our annual excess cash flow (as defined in the credit agreement governing our new senior secured credit facility);

- 100% of the net cash proceeds from asset sales and casualty and condemnation events, subject to reinvestment rights and certain other exceptions;

- 50% (as may be reduced based on our ratio of total indebtedness to consolidated EBITDA) of the net cash proceeds from specified issuances of equity securities; and

- 100% of the net cash proceeds from certain incurrences of debt.

Voluntary prepayments and commitment reductions are permitted, in whole or in part, in minimum amounts without premium or penalty, other than customary breakage costs with respect to adjusted LIBOR rate loans.

Amortization of Principal

Our new senior secured credit facility requires scheduled quarterly payments on the term loans each equal to 0.25% of the original principal amount of the term loans for the first six years, with the balance paid in four equal quarterly installments thereafter.

Collateral and Guarantors

Our new senior secured credit facility is guaranteed by our parent and substantially all of our current domestic subsidiaries, and will be guaranteed by substantially all of our future domestic subsidiaries and secured by substantially all of our existing and future property and assets and by a pledge of our capital stock, the capital stock of our domestic subsidiaries and up to 65% of the capital stock of certain of our foreign subsidiaries.

Restrictive Covenants and Other Matters

Our new senior secured credit facility requires that we comply on a quarterly basis with certain financial covenants, including a minimum interest coverage ratio test and a maximum leverage ratio test, which financial covenants become more restrictive over time. In addition, our new senior secured credit facility includes negative covenants, subject to significant exceptions, restricting or limiting our ability and the ability of our parent and restricted subsidiaries, to, among other things:

- incur, assume or permit to exist additional indebtedness or guarantees;

- incur liens and engage in sale and leaseback transactions;

- make capital expenditures;

- make loans and investments;

- declare dividends, make payments or redeem or repurchase capital stock;

- engage in mergers, acquisitions and other business combinations;

- prepay, redeem or purchase certain indebtedness including the notes;

- amend or otherwise alter terms of our indebtedness including the notes;

- enter into agreements limiting subsidiary distributions;

- sell assets;

transact with affiliates; and

alter the business that we conduct.

Our new senior secured credit facility contains certain customary representations and warranties, affirmative covenants and events of default, including payment defaults, breach of representations and warranties, covenant defaults, cross-defaults to certain indebtedness, certain events of bankruptcy, certain events under ERISA, material judgments, actual or asserted failure of any guaranty or security document supporting our new senior secured credit facility to be in full force and effect and change of control. If such an event of default occurs, the lenders under our new senior secured credit facility will be entitled to take various actions, including the acceleration of amounts due under our new senior secured credit facility and all actions permitted to be taken by a secured creditor.

Non-Tendered Senior Subordinated Notes

Our 9 1/2% senior subordinated notes due 2009 were issued pursuant to an indenture on June 11, 2001 in an original aggregate principal amount of $175.0 million, of which $5.7 million remained outstanding as of March 31, 2005. Interest on these notes accrues at 9 1/2% per annum, payable semi-annually in arrears on each June 15 and December 15 to the holders of record of such notes as of each June 1 and December 1 immediately preceding each such respective payment date.

In connection with the Transactions, we commenced a debt tender offer to acquire all of these existing senior subordinated notes and obtain consents to eliminate substantially all of the restrictive covenants and make other amendments to the indenture governing such notes. Pursuant to a debt tender offer, we purchased approximately 96.7% of our 9 1/2% senior subordinated notes at a price of $1,066.56 per $1,000 principal amount plus accrued and unpaid interest. On June 15, 2005, we redeemed the remaining $5.7 million outstanding principal amount of our 9 1/2% senior subordinated notes for a redemption price of 104.750% of the principal amount plus accrued and unpaid interest.

Holding Company Notes

Concurrently with the consummation of the Transactions, Holdings issued to WCAS Capital Partners IV, L.P., an investment fund affiliated with Welsh Carson, and Rocco A. Ortenzio, Robert A. Ortenzio and certain other investors who are members of or affiliated with the Ortenzio family, $150.0 million in aggregate principal amount of Holdings senior subordinated notes and 573,171.23 shares of its participating preferred stock and 3,854,577 shares of its common stock, for an aggregate purchase price of $150.0 million. The proceeds from this issuance of holding company notes, preferred stock and common stock was contributed by Holdings to Select as equity. The holding company notes will mature on the tenth anniversary of their issuance.

Our new senior secured credit facility and the indenture governing the notes offered hereby contain certain restrictions on our ability to pay dividends to Holdings for the purpose of paying cash interest on the holding company notes. See Our New Senior Secured Credit Facility and Description of the Exchange Notes Certain Covenants Restricted Payments. The holding company notes bear interest at a rate of 10% per annum, except that if any interest payment is not paid in cash, such unpaid amount will be multiplied by 1.2 and added to the outstanding principal amount of the holding company notes (with the result that such unpaid interest will have accrued at an effective rate of 12% instead of 10%). Interest on the holding company notes will be payable semi-annually in arrears.

The holding company notes may be prepaid, in whole or in part, without premium or penalty. In addition, the holding company notes are subject to mandatory prepayment in the event of any change of control, initial public offering or sale of all or substantially all the assets of Holdings. Our new senior secured credit facility and the indenture governing the notes contain certain restrictions on our ability to pay dividends to Holdings for the purpose of making principal payments on the holding company notes. The holding company notes are subordinate in right of payment to Holdings guaranty of our new senior secured credit facility on the terms set forth in the holding company notes.

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DESCRIPTION OF THE EXCHANGE NOTES

You can find the definitions of certain terms used in this description under the subheading Certain Definitions. In this description, (1) the term Issuer refers only to Select Medical Corporation and not to any of its subsidiaries and (2) the term notes refers to the $660.0 million in aggregate principal amount of the Issuer 5/8% senior subordinated notes due 2015 and the exchange notes.

The Issuer issued the outstanding notes, and will issue the exchange notes, under an indenture, dated as of February 24, 2005, among the Issuer, the Guarantors and U.S. Bank Trust National Association, as trustee. The terms of the notes include those stated in the indenture and those made part of the indenture by reference to the Trust Indenture Act of 1939, as amended (the *Trust Indenture Act*).

The terms of the exchange notes are identical in all material respects to the outstanding notes except that upon completion of the exchange offer, the exchange notes will be registered under the Securities Act and free of any covenants regarding exchange registration rights.

The following description is a summary of the material provisions of the indenture. It does not restate the indenture in its entirety. We urge you to read the indenture because the indenture, and not this description, defines your rights as holders of the notes. Copies of the indenture are available as set forth below under Available Information. Certain defined terms used in this description but not defined below under Certain Definitions have the meanings assigned to them in the indenture.

The registered holder of a note will be treated as the owner of it for all purposes. Only registered holders will have rights under the indenture.

Brief Description of the Notes and the Subsidiary Guarantees of the Notes

The Notes

The notes:

- are general unsecured obligations of the Issuer;
- are subordinated in right of payment to all existing and future Senior Debt of the Issuer, including Indebtedness under the Credit Agreement;
- are *pari passu* in right of payment to any senior subordinated Indebtedness of the Issuer;
- are senior in right of payment to any future subordinated Indebtedness of the Issuer; and
- are unconditionally guaranteed by each of the Guarantors on a senior subordinated basis.

The Subsidiary Guarantees of the Notes

The notes are guaranteed by all of the Issuer s current Domestic Subsidiaries other than those that are Non-Guarantor Subsidiaries. Future Restricted Subsidiaries (other than Non-Guarantor Subsidiaries) that are guarantors under the Credit Agreement will also become guarantors of the notes.

The guarantee of each Guarantor of the notes:

- is a general unsecured obligation of that Guarantor;
- is subordinated in right of payment to all existing and future Senior Debt of that Guarantor, including guarantees of Indebtedness under the Credit Agreement;
- is *pari passu* in right of payment with any senior subordinated Indebtedness of that Guarantor; and
- is senior in right of payment to any future subordinated Indebtedness of that Guarantor.

As of March 31, 2005, the Issuer and the Guarantors had total Senior Debt of $782.9 million, including $780.0 million of borrowings under the Credit Agreement. As indicated above and as discussed in detail below

under the caption Subordination, payments on the notes and under the guarantees are subordinated to the payment of Senior Debt. The indenture permits us and the Guarantors to incur additional Senior Debt.

The Non-Guarantor Subsidiaries do not guarantee the notes. In the event of a bankruptcy, liquidation or reorganization of any of the Non-Guarantor Subsidiaries, the Non-Guarantor Subsidiaries will pay the holders of their debt and their trade creditors before they will be able to distribute any of their assets to us. As a result, the notes are effectively subordinated in right of payment to all Indebtedness and other liabilities and commitments (including trade payables and lease obligations) of the Non-Guarantor Subsidiaries. The Non-Guarantor Subsidiaries held $49.3 million of our consolidated assets as of March 31, 2005. As of March 31, 2005, the Non-Guarantor Subsidiaries had approximately $10.3 million of total liabilities (excluding debt owing to the Issuer and its Subsidiaries). See Risk Factors Risks Related to the Notes Your right to receive payments on the notes is junior to our senior indebtedness and the senior indebtedness of the subsidiary guarantors. Further, the notes and the subsidiary guarantees are effectively subordinated to all liabilities of our non-guarantor subsidiaries. For more detail about the revenues and assets of certain of our Non-Guarantor Subsidiaries, see the condensed consolidating financial information included in the notes to our consolidated financial statements included elsewhere in this prospectus.

The Subsidiaries described in clause (w) of the definition of Non-Guarantor Subsidiaries below under Certain Definitions are Non-Guarantor Subsidiaries. In addition, other Subsidiaries of the Issuer may become Non-Guarantor Subsidiaries. See the definition of Non-Guarantor Subsidiaries under Certain Definitions below.

Certain of our Non-Guarantor Subsidiaries may guarantee, and may pledge their assets to secure, the Issuer s obligations under the Credit Agreement. As of March 31, 2005, all of our Subsidiaries were Restricted Subsidiaries. However, under the circumstances described below under the caption Certain Covenants Designation of Restricted and Unrestricted Subsidiaries, we are permitted to designate certain of our Subsidiaries as Unrestricted Subsidiaries. Our Unrestricted Subsidiaries will not be subject to many of the restrictive covenants in the indenture and will not guarantee the notes.

Principal, Maturity and Interest

On the Issue Date, we issued $660.0 million in aggregate principal amount of notes. We may issue additional notes other than the notes under the indenture from time to time. Any issuance of additional notes other than the notes is subject to all of the covenants in the indenture, including the covenant described below under the caption Certain Covenants Incurrence of Indebtedness and Issuance of Disqualified Stock and Preferred Stock. The notes issued on the Issue Date are, and any additional notes subsequently issued under the indenture will be, treated as a single class for all purposes under the indenture, including, without limitation, waivers, amendments, redemptions and offers to purchase. We issued notes in denominations of $1,000 and integral multiples of $1,000. The notes mature on February 1, 2015.

Interest on the notes accrues at the rate of $7^5/8$% per annum and is payable semiannually in arrears on February 1 and August 1, commencing on August 1, 2005. Interest on overdue principal, interest and Additional Interest, if any, accrues at a rate that is 1% higher than the then applicable interest rate on the notes. The Issuer will make each interest payment to the holders of record on the immediately preceding January 15 or July 15.

Interest on the notes accrues from the date of original issuance or, if interest has already been paid, from the date it was most recently paid. Interest is computed on the basis of a 360-day year comprised of twelve 30-day months.

Methods of Receiving Payments on the Notes

Principal of, premium, if any, and interest and Additional Interest on the notes will be payable, and the notes may be exchanged or transferred, at the office or agency of the Issuer in the Borough of Manhattan, The City of New York (which initially will be an office of an affiliate of the trustee in New York, New York); at the option of the Issuer, however, payment of interest and Additional Interest may be made by check mailed

to the address of the holders as such address appears in the register of holders, and in addition, if a holder of at least $1.0 million in aggregate principal amount of notes has given wire transfer instructions to us prior to the record date for a payment, the Issuer will make such payment of principal of, premium, if any, and interest and Additional Interest on such holder s notes in accordance with those instructions. Payment of principal of, premium, if any, and interest and Additional Interest on, notes in global form registered in the name of or held by DTC or any successor depositary or its nominee will be made by wire transfer of immediately available funds to such depositary or its nominee, as the case may be, as the registered holder of such global note.

Paying Agent and Registrar for the Notes

The trustee currently acts as paying agent and registrar. The Issuer may change the paying agent or registrar without prior notice to the holders of the notes, and the Issuer or any of its Subsidiaries may act as paying agent or registrar.

Transfer and Exchange

A holder may transfer or exchange notes in accordance with the provisions of the indenture. The registrar and the trustee may require a holder, among other things, to furnish appropriate endorsements and transfer documents in connection with a transfer of notes. No service charge will be made for any registration of transfer or exchange of notes, but the Issuer may require payment of a sum sufficient to cover any transfer tax or other similar governmental charge payable in connection therewith. The Issuer is not required to transfer or exchange any note selected for redemption. Also, the Issuer is not required to transfer or exchange any note for a period of 15 days before a selection of notes to be redeemed.

Subsidiary Guarantees

The notes are guaranteed by each of the Issuer s current Domestic Subsidiaries, other than those that are Non-Guarantor Subsidiaries, as long as they remain Restricted Subsidiaries. Future Restricted Subsidiaries (other than Non-Guarantor Subsidiaries) that are guarantors under the Credit Agreement will also become guarantors of the notes. The Subsidiary Guarantees are joint and several obligations of the Guarantors. Each Subsidiary Guarantee is subordinated to the prior payment in full of all Senior Debt of that Guarantor. The obligations of each Guarantor under its Subsidiary Guarantee are limited as necessary to prevent that Subsidiary Guarantee from constituting a fraudulent conveyance under applicable law. See Risk Factors Risks Related to the Notes Federal and state statutes could allow courts, under certain circumstances, to void the subsidiary guarantees, subordinate claims in respect of the notes and require note holders to return payments received from subsidiary guarantors. A Guarantor may not sell or otherwise dispose of all or substantially all of its assets to, or consolidate with or merge with or into (whether or not such Guarantor is the surviving Person) another Person, other than the Issuer or another Guarantor, unless:

(1) immediately after giving effect to that transaction, no Default or Event of Default exists; and

(2) either:

(a) the Person (if other than the Issuer or a Guarantor) acquiring the property in any such sale or disposition or the Person (if other than the Issuer or a Guarantor) formed by or surviving any such consolidation or merger assumes all the obligations of that Guarantor under the indenture, its Subsidiary Guarantee and the exchange and registration rights agreement pursuant to a supplemental indenture satisfactory to the trustee; or

(b) such transaction does not violate the Asset Sale provisions of the indenture and the Net Proceeds of such sale or other disposition are applied in accordance with the applicable provisions of the indenture.

The Subsidiary Guarantee of a Guarantor will be released:

(1) in connection with any sale or other disposition of all or substantially all of the assets of that Guarantor (including by way of merger or consolidation) to a Person that is not (either before or after

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giving effect to such transaction) the Issuer or a Restricted Subsidiary of the Issuer (other than a Non-Guarantor Subsidiary), if the sale or other disposition does not violate the Asset Sale provisions of the indenture;

(2) in connection with any sale or other disposition of all of the Capital Stock of that Guarantor to a Person that is not (either before or after giving effect to such transaction) the Issuer or a Restricted Subsidiary of the Issuer (other than a Non-Guarantor Subsidiary), if the sale or other disposition does not violate the Asset Sale provisions of the indenture;

(3) if the Issuer designates any Restricted Subsidiary that is a Guarantor to be an Unrestricted Subsidiary or a Non-Guarantor Subsidiary in accordance with the applicable provisions of the indenture;

(4) if that Guarantor is released from its guarantee under the Credit Agreement; or

(5) upon legal defeasance, covenant defeasance or satisfaction and discharge of the indenture as provided below under the captions Legal Defeasance and Covenant Defeasance and Satisfaction and Discharge.

If any Guarantor is released from its Subsidiary Guarantee, any of its Subsidiaries that are Guarantors will be released from their Subsidiary Guarantees, if any.

See Repurchase at the Option of Holders Asset Sales.

Subordination

The payment of all Obligations in respect of the notes will be subordinated to the prior payment in full in cash of all Senior Debt of the Issuer, including Senior Debt of the Issuer incurred after the Issue Date.

The holders of Senior Debt of the Issuer are entitled to receive payment in full in cash of all Obligations due in respect of such Senior Debt (including interest after the commencement of any bankruptcy proceeding at the rate specified in the applicable Senior Debt, whether or not such interest is an allowable claim) before the holders of notes are entitled to receive any payment (by setoff or otherwise) with respect to the notes (except that holders of notes may receive and retain Permitted Junior Securities and payments made from either of the trusts described under Legal Defeasance and Covenant Defeasance and Satisfaction and Discharge), in the event of any distribution to creditors of the Issuer:

(1) in a liquidation or dissolution of the Issuer;

(2) in a bankruptcy, reorganization, insolvency, receivership or similar proceeding relating to the Issuer or its property;

(3) in an assignment for the benefit of the Issuer s creditors; or

(4) in any marshaling of the Issuer s assets and liabilities.

The Issuer also may not make any payment (by setoff or otherwise) in respect of the notes or acquire or redeem the notes for cash or property or otherwise (except in Permitted Junior Securities or from the trusts described under Legal Defeasance and Covenant Defeasance and Satisfaction and Discharge) if:

(1) a payment default on Designated Senior Debt occurs and is continuing beyond any applicable grace period; or

(2) any other default occurs and is continuing on any Designated Senior Debt that permits holders of that Designated Senior Debt to accelerate its maturity and the trustee receives a notice of such default (a Payment Blockage Notice) from a representative of the holders of any Designated Senior Debt.

Payments on the notes may and will be resumed:

(a) in the case of a payment default, upon the date on which such default is cured or waived; and

(b) in the case of a nonpayment default, upon the earlier of the date on which such nonpayment default is cured or waived or 179 days after the date on which the applicable Payment Blockage Notice is

received, unless the maturity of any Designated Senior Debt has been accelerated or a payment default exists on any Designated Senior Debt.

No new Payment Blockage Notice may be delivered unless and until:

(1) 360 days have elapsed since the delivery of the immediately prior Payment Blockage Notice; and

(2) all scheduled payments of principal, interest and premium and Additional Interest, if any, on the notes that have come due have been paid in full in cash.

No nonpayment default that existed or was continuing on the date of delivery of any Payment Blockage Notice to the trustee will be, or be made, the basis for a subsequent Payment Blockage Notice unless such default has been cured or waived for a period of not less than 90 days.

If the trustee or any holder of the notes receives a payment (including a payment by a Guarantor under its Subsidiary Guarantee) in respect of the notes (except in Permitted Junior Securities or from the trusts described under Legal Defeasance and Covenant Defeasance and Satisfaction and Discharge) when:

(1) the payment is prohibited by these subordination provisions; and

(2) the trustee or the holder has actual knowledge that the payment is prohibited, the trustee or the holder, as the case may be, will hold the payment in trust for the benefit of the holders of Senior Debt. Upon the proper written request of the holders of Senior Debt, the trustee or the holder, as the case may be, will deliver the amounts in trust to the holders of Senior Debt or their proper representative.

The Issuer must promptly notify holders of Senior Debt of the Issuer if payment on the notes is accelerated because of an Event of Default.

The obligations of each Guarantor under its Subsidiary Guarantee will be subordinated to the Senior Debt of that Guarantor on the same basis as the notes are subordinated to the Senior Debt of the Issuer.

As a result of the subordination provisions described above, in the event of a bankruptcy, liquidation or reorganization of the Issuer or a Guarantor, holders of notes may recover less ratably than creditors of the Issuer or that Guarantor, as applicable, who are holders of Senior Debt. As a result of the obligation to deliver amounts received in trust to holders of Senior Debt, holders of notes may recover less ratably than trade creditors of the Issuer or a Guarantor. See Risk Factors Risks Related to the Notes Your right to receive payments on the notes is junior to our senior indebtedness and the senior indebtedness of the subsidiary guarantors. Further, the notes and the subsidiary guarantees are effectively subordinated to all liabilities of our non-guarantor subsidiaries.

Optional Redemption

At any time prior to February 1, 2008, the Issuer may, on any one or more occasions, redeem up to 35% of the aggregate principal amount of notes issued under the indenture at a redemption price of 107.625% of the principal amount, plus accrued and unpaid interest and Additional Interest, if any, to the redemption date, with the net cash proceeds of one or more Equity Offerings by the Issuer or a contribution to the equity capital of the Issuer (other than Disqualified Stock) from the net proceeds of one or more Equity Offerings by Holdings or any other direct or indirect parent of the Issuer (in each case, other than Excluded Contributions); provided that:

(1) at least 65% of the aggregate principal amount of notes originally issued under the indenture (excluding notes held by the Issuer and its Subsidiaries) remains outstanding immediately after the occurrence of such redemption; and

(2) the redemption occurs within 90 days of the date of the closing of such Equity Offering or equity contribution.

Except pursuant to the preceding paragraph and the second succeeding paragraph, the notes will not be redeemable at the Issuer s option prior to February 1, 2010.

On or after February 1, 2010, the Issuer may redeem all or a part of the notes upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as percentages of principal amount) set forth below plus accrued and unpaid interest and Additional Interest, if any, on the notes redeemed, to the applicable redemption date, if redeemed during the twelve-month period beginning on February 1 of the years indicated below, subject to the rights of holders of notes on the relevant record date to receive interest on the relevant interest payment date:

Year	**Percentage**
2010	103.813%
2011	102.542%
2012	101.271%
2013 and thereafter	100.000%

Before February 1, 2010, the Issuer may also redeem all or any portion of the notes upon not less than 30 nor more than 60 days prior notice, at a redemption price equal to 100% of the principal amount thereof plus the Applicable Premium as of, and accrued and unpaid interest thereon, if any, to the date of redemption (a *Make-Whole Redemption Date*).