GRSH ES, Inc.
Form 424B4
September 03, 2013

Use these links to rapidly review the document
TABLE OF CONTENTS
INDEX TO CONSOLIDATED FINANCIAL STATEMENTS SELECT MEDICAL CORPORATION
CONSOLIDATED FINANCIAL STATEMENTS WITH REPORT OF INDEPENDENT ACCOUNTANTS
CONTENTS

Table of Contents

Filed Pursuant to Rule 424(B)(4)
Registration Nos. 333-190628
through 333-190628-219

PROSPECTUS

SELECT MEDICAL CORPORATION

OFFER TO EXCHANGE

$600,000,000 principal amount of 6.375% Senior Notes due 2021 and related guarantees for all outstanding 6.375% Senior Notes due 2021

The exchange offer expires at 5:00 p.m., New York City time, on October 3, 2013, unless extended. Select Medical Corporation (the "Issuer") will exchange all old notes that are validly tendered and not validly withdrawn prior to the expiration of the exchange offer. You may withdraw tenders of old notes at any time before the exchange offer expires.

Terms of the Exchange Offer

It will expire at 5:00 p.m., New York City time, on October 3, 2013, unless we extend it.

If all the conditions to this exchange offer are satisfied, we will exchange all of our initial notes that are validly tendered and not withdrawn for the exchange notes.

You may withdraw your tender of initial notes at any time before the expiration of this exchange offer.

We will not receive any proceeds from the exchange offer.

We believe that the exchange of initial notes will not be a taxable event for U.S. Federal income tax purposes, but you should see "Certain Material U.S. Federal Income Tax Considerations" on page 210 for more information.

The exchange notes that we will issue you in exchange for your initial notes will be substantially identical to your initial notes except that, unlike your initial notes, the exchange notes will have no transfer restrictions or registration rights.

The exchange notes that we will issue you in exchange for your initial notes are new securities with no established market for trading. We do not intend to list the exchange notes on any national securities exchange or quotation system.

Broker-dealers who receive exchange notes pursuant to the exchange offer must acknowledge that they will deliver a prospectus in connection with any resale of such exchange notes.

Broker-dealers who acquired the initial notes as a result of market-making or other trading activities may use this prospectus for the exchange offer, as supplemented or amended, in connection with resales of the exchange notes.

The new notes will be senior obligations of the Issuer and initially will be guaranteed by each of the Issuer's subsidiaries that guarantees obligations under its senior secured credit facilities, subject to customary release provisions. The entities providing such guarantees are referred to collectively as the guarantors. The new notes and new note guarantees will be effectively junior in right of payment to all existing and future secured indebtedness of the Issuer and the guarantors to the extent of the value of the assets securing such indebtedness and will be junior in right of payment to all indebtedness of the Issuer's non-guarantor subsidiaries.

See "Risk Factors" beginning on page 16 for a discussion of risks that should be considered by holders prior to tendering their old notes.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

The date of this prospectus is September 3, 2013.

TABLE OF CONTENTS

Table of Contents

This prospectus incorporates important business and financial information that is not included in or delivered with this document. This information is available without charge upon written or oral request. To obtain timely delivery, note holders must request the information no later than five business days before the expiration date. The expiration date is October 3, 2013. See "Incorporation of Documents by Reference." Materials can be requested by contacting the Issuer at:

Select Medical Corporation
Attn: Corporate Secretary
4714 Gettysburg Road, P.O. Box 2034
Mechanicsburg, Pennsylvania 17055
(717) 972-1100

You should rely only on the information contained in this document and any supplement, including the periodic reports and other information we file with the Securities and Exchange Commission or to which we have referred you. See "Where You Can Find Additional Information." The Issuer has not authorized anyone to provide you with information that is different. If anyone provides you with different or inconsistent information, you should not rely on it. The Issuer is not making an offer to sell these securities in any jurisdiction where the offer or sale is not permitted, where the person making the offer is not qualified to do so, or to any person who cannot legally be offered the securities.

The distribution of this prospectus and the offer or sale of the new notes may be restricted by law in certain jurisdictions. Persons who possess this prospectus must inform themselves about, and observe, any such restrictions. See "Plan of Distribution." None of the Issuer or any of its representatives is making any representation to any offeree or purchaser under applicable legal investment or similar laws or regulations. Each prospective investor must comply with all applicable laws and regulations in force in any jurisdiction in which it purchases, offers or sells notes or possesses or distributes this prospectus and must obtain any consent, approval or permission required by it for the purchase, offer or sale by it of notes under the laws and regulations in force in any jurisdiction to which it is subject or in which it makes such purchases, offers or sales, and none of the Issuer or any of its representatives shall have any responsibility therefor.

This prospectus does not constitute an offer to sell or a solicitation of an offer to buy securities to any person in any jurisdiction where it is unlawful to make such an offer or solicitation.

MARKETS AND INDUSTRY 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.

Table of Contents

SUMMARY

The following summary should be read in connection with, and is qualified in its entirety by, the more detailed information and financial statements (including the accompanying notes) included elsewhere or incorporated by reference in this prospectus. See "Risk Factors" for a discussion of certain factors that should be considered in connection with this offering. Unless the context otherwise requires:

"we," "us," "our" and the "issuer" refers to Select Medical Corporation together with its subsidiaries;

"Holdings" refers to Select Medical Holdings Corporation, our parent holding company;

"Adjusted EBITDA" has the meaning provided in "Summary Historical Consolidated Financial and Other Data" in the Summary section of this prospectus;

"old notes" refers to the $600.0 million aggregate principal amount of 6.375% Senior Notes due 2021 issued by us in an offering on May 28, 2013;

"new notes" refers to the $600.0 million aggregate principal amount of 6.375% Senior Notes due 2021 offered by us in exchange for the old notes pursuant to this prospectus; and

"notes" refers collectively to the old notes and the new notes.

Our Business

Overview

We believe that we are one of the largest operators of both specialty hospitals and outpatient rehabilitation clinics in the United States based on number of facilities. As of June 30, 2013, we operated 109 long term acute care hospitals, or "LTCHs" and 14 inpatient rehabilitation facilities, or "IRFs" in 28 states, and 988 outpatient rehabilitation clinics in 32 states and the District of Columbia. We also provide medical rehabilitation services on a contract basis at nursing homes, hospitals, assisted living and senior care centers, schools and worksites. We began operations in 1997 under the leadership of our current management team.

We manage our company through two business segments, our specialty hospital segment and our outpatient rehabilitation segment. We had net operating revenues of $2,949.0 million for the year ended December 31, 2012. Of this total, we earned approximately 75% of our net operating revenues from our specialty hospital segment and approximately 25% from our outpatient rehabilitation segment. Our specialty hospital segment consists of hospitals designed to serve the needs of long term stay acute care patients and hospitals designed to serve patients who require intensive inpatient medical rehabilitation care. Our outpatient rehabilitation segment consists of clinics and contract therapy locations that provide physical, occupational and speech rehabilitation services.

Specialty Hospitals

The key elements of our specialty hospital strategy are to:

Focus on specialized inpatient services. We serve highly acute patients and patients with debilitating injuries and rehabilitation needs that cannot be adequately cared for in a less medically intensive environment, such as a skilled nursing facility. Generally, patients in our specialty hospitals require longer stays and can benefit from more specialized clinical care than patients treated in general acute care hospitals. Our patients' average length of stay in our specialty hospitals was 24 days for the year ended December 31, 2012.

Provide high quality care and service. We believe that our specialty hospitals serve a critical role in comprehensive healthcare delivery. Through our specialized treatment programs and staffing

Table of Contents

models, we treat patients with acute, complex and specialized medical needs who are typically referred to us by general acute care hospitals. Our specialized treatment programs focus on specific patient needs and medical conditions such as ventilator weaning programs, wound care protocols and rehabilitation programs for brain trauma and spinal cord injuries. Our responsive staffing models are designed to ensure that patients have the appropriate clinical resources over the course of their stay. We believe that we are recognized for providing quality care and service, as evidenced by accreditation by The Joint Commission, the American Osteopathic Association ("AOA"), the Commission on Accreditation of Rehabilitation Facilities ("CARF") and/or other healthcare accrediting organizations. As of June 30, 2013, all of the 123 specialty hospitals we operated were accredited by either The Joint Commission or AOA. Additionally, some of our IRFs have also applied for and received accreditation from CARF. We also believe we develop brand loyalty in the local areas we serve by demonstrating our quality of care.

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:

- centralizing administrative functions such as accounting, treasury, payroll, legal, operational support, human resources, compliance and billing and collection;
- standardizing management information systems to aid in accounting, billing, collections and data capture and analysis; and
- centralizing sourcing and contracting to receive discounted prices for pharmaceuticals, medical supplies and other commodities used in our operations.

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

Develop inpatient facilities. Since our inception in 1997, we have internally developed 64 specialty hospitals. We will continue to evaluate opportunities to develop joint venture relationships with significant health systems, and from time to time we may also develop new inpatient rehabilitation hospitals.

Pursue opportunistic acquisitions and joint ventures. In addition to our development initiatives, we may grow our network of specialty hospitals through opportunistic acquisitions or joint ventures. When we acquire a hospital or a group of hospitals or enter into a joint venture, a team of our professionals is responsible for formulating and executing an integration plan. We seek to improve financial performance at such facilities by adding clinical programs that attract commercial payors, centralizing administrative functions and implementing our standardized resource management programs.

Outpatient Rehabilitation

The key elements of our outpatient rehabilitation strategy are to:

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

Table of Contents

Increase market share. We strive to establish a leading presence within the local areas we serve. This allows us to realize economies of scale, heightened brand loyalty and workforce continuity. We are focused on increasing our workers' compensation and commercial/managed care payor mix.

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

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

Maintain strong employee relations. We seek to retain and motivate our employees whose relationships with referral sources are key to our success.

Pursue opportunistic acquisitions. We may grow our network of outpatient rehabilitation facilities through opportunistic acquisitions. We believe our size and centralized infrastructure allow us to take advantage of operational efficiencies and increase margins at acquired facilities.

Our Competitive Strengths

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

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

Proven financial performance and strong cash flow. We have established a track record of improving the financial performance of our facilities due to our disciplined approach to revenue growth, expense management and an intense focus on free cash flow generation. From 2008 through 2012, we have grown net operating revenue and cash flow provided by operating activities at compounded annual growth rates of 8.2% and 21.9%, respectively.

Significant scale. By building significant scale in each of our business segments, we have been able to leverage our operating costs by centralizing administrative functions at our corporate office. As a result, we have been able to minimize our general and administrative expense as a percentage of net operating revenues.

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

Experience in successfully completing and integrating acquisitions. From our inception in 1997 through 2012, we completed seven significant acquisitions for approximately $1,104.8 million in aggregate consideration. We believe that we have improved the operating performance of these

Table of Contents

facilities over time by applying our standard operating practices and by realizing efficiencies from our centralized operations and management.

Experienced and proven management team. Prior to co-founding our company with our current Chief Executive Officer, our Executive Chairman founded and operated three other healthcare companies focused on inpatient and outpatient rehabilitation services. In addition, our senior management team has extensive experience in the healthcare industry. In recent years, we have reorganized our operations to expand executive talent and ensure management continuity.

Industry

In the United States, spending on healthcare is expected to be 17.8% of the gross domestic product in 2013, according to the Centers for Medicare & Medicaid Services. An important factor driving healthcare spending is increased consumption of services due to the aging of the population. According to the U.S. Census Bureau, between 2000 and 2010 the population aged 65 and older in the United States grew 15.1%, while the total population grew 9.7%. The United States is projected to continue to experience rapid growth in its older population. In 2050, the number of Americans aged 65 and older is projected to be 88.5 million, more than double its population of 40.2 million in 2010. We believe that an increasing number of individuals age 65 and older will drive demand for our specialized medical services.

For individuals age 65 and older, the primary source of health insurance is the federal Medicare program. Medicare utilizes distinct payment methodologies for services provided in long term acute care hospitals, inpatient rehabilitation facilities and outpatient rehabilitation clinics. In the federal fiscal year 2010, Medicare payments for long term acute care hospital services accounted for 1.0% of overall Medicare outlays and Medicare payments for inpatient rehabilitation services accounted for 1.2%, according to the Medicare Payment Advisory Commission.

Company Information

Select Medical Corporation was formed in December 1996 by Rocco A. Ortenzio and Robert A. Ortenzio and commenced operations during February 1997 upon the completion of its first acquisition. Select Medical Holdings Corporation was formed in October 2004. On February 24, 2005, EGL Acquisition Corp., a wholly-owned subsidiary of Holdings was merged with Select Medical Corporation, with Select Medical Corporation continuing as the surviving corporation and a wholly-owned subsidiary of Holdings. Holdings was formerly known as EGL Holding Company. Holdings' primary asset is its investment in Select Medical Corporation. Holdings was originally owned by an investor group that includes Welsh, Carson, Anderson & Stowe IX, L.P., WCAS Capital Partners IV, L.P. and WCAS Management Corporation, Thoma Cressey Bravo and members of our senior management. We refer to Welsh, Carson, Anderson & Stowe IX, L.P., WCAS Capital Partners IV, L.P. and WCAS Management Corporation, collectively as "Welsh Carson" and Thoma Cressey Bravo as "Thoma Cressey." On September 30, 2009, Holdings completed its initial public offering of common stock.

Our principal executive office is located at 4714 Gettysburg Road, Mechanicsburg, Pennsylvania 17055 and our telephone number is (717) 972-1100. Our website address is www.selectmedical.com. Our website and the information contained therein or connected thereto shall not be deemed to be incorporated into this prospectus.

Table of Contents

The Exchange Offer

The summary below describes the principal terms of the exchange offer and is not intended to be complete. Certain of the terms and conditions described below are subject to important limitations and exceptions. The section of this prospectus entitled "The Exchange Offer" contains a more detailed description of the terms and conditions of the exchange offer.

On May 28, 2013, we issued and sold $600.0 million aggregate principal amount of 6.375% Senior Notes due 2021. In connection with this sale, we entered into a registration rights agreement with the initial purchasers of the old notes in which we agreed to deliver this prospectus to you and to complete an exchange offer for the old notes.

Notes Offered	$600.0 million aggregate principal amount of 6.375% Senior Notes due 2021. The issuance of the new notes will be registered under the Securities Act. The terms of the new notes and old notes are identical in all material respects, except for transfer restrictions, registration rights relating to the old notes and certain provisions relating to increased interest rates in connection with the old notes under circumstances related to the timing of the exchange offer. You are urged to read the discussions under the heading "The New Notes" in this Summary for further information regarding the new notes.
The Exchange Offer	We are offering to exchange the new notes for up to $600.0 million aggregate principal amount of the old notes. Old notes may be exchanged only in denominations of $2,000 and any integral multiple of $1,000 in excess thereof. In this prospectus, the term "exchange offer" means this offer to exchange new notes for old notes in accordance with the terms set forth in this prospectus and the accompanying letter of transmittal. You are entitled to exchange your old notes for new notes.
Expiration Date; Withdrawal of Tender	The exchange offer will expire at 5:00 p.m., New York City time, on October 3, 2013, or such later date and time to which it may be extended by us. The tender of old notes pursuant to the exchange offer may be withdrawn at any time prior to the expiration date of the exchange offer. Any old notes not accepted for exchange for any reason will be returned without expense to the tendering holder thereof promptly after the expiration or termination of the exchange offer.
Conditions to the Exchange Offer	Our obligation to accept for exchange, or to issue new notes in exchange for, any old notes is subject to customary conditions relating to compliance with any applicable law or any applicable interpretation by the staff of the Securities and Exchange Commission, the receipt of any applicable governmental approvals and the absence of any actions or proceedings of any governmental agency or court which could materially impair our ability to consummate the exchange offer. See "The Exchange Offer Conditions to the Exchange Offer."

Table of Contents

Procedures for Tendering Old Notes	If you wish to accept the exchange offer and tender your old notes, you must either: complete, sign and date the Letter of Transmittal, or a facsimile of the Letter of Transmittal, in accordance with its instructions and the instructions in this prospectus, and mail or otherwise deliver such Letter of Transmittal, or the facsimile, together with the old notes and any other required documentation, to the exchange agent at the address set forth herein; or if old notes are tendered pursuant to book-entry procedures, the tendering holder must arrange with the Depository Trust Company, or DTC, to cause an agent's message to be transmitted through DTC's Automated Tender Offer Program System with the required information (including a book-entry confirmation) to the exchange agent. 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."
Broker-Dealers	Each broker-dealer that receives new notes for its own account in exchange for old notes, where such old 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 new notes. See "Plan of Distribution."
Use of Proceeds	We will not receive any proceeds from the exchange offer. See "Use of Proceeds."
Exchange Agent	U.S. Bank National Association is serving as the exchange agent in connection with the exchange offer.
Fees and Expenses	We will pay all expenses related to this exchange offer. See "Exchange Offer Fees and Expenses."
U.S. Federal Income Tax Consequences	The exchange of old notes for new notes pursuant to the exchange offer should not be a taxable event for federal income tax purposes. See "Certain Material U.S. Federal Income Tax Considerations."

Table of Contents

Consequences of Exchanging Old Notes Pursuant to the Exchange Offer

Based on certain interpretive letters issued by the staff of the Securities and Exchange Commission to third parties in unrelated transactions, the Issuer is of the view that holders of old notes (other than any holder who is an "affiliate" of the Issuer within the meaning of Rule 405 under the Securities Act) who exchange their old notes for new notes pursuant to the exchange offer generally may offer the new notes for resale, resell such new notes and otherwise transfer the new notes without compliance with the registration and prospectus delivery provisions of the Securities Act, provided that:

- the new notes are acquired in the ordinary course of the holders' business;
- the holders have no arrangement or understanding with any person to participate in a distribution of the new notes; and
- neither the holder nor any other person is engaging in or intends to engage in a distribution of the new notes.

Each broker-dealer that receives new notes for its own account in exchange for old 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 new notes. See "Plan of Distribution." If a holder of old notes does not exchange the old notes for new notes according to the terms of the exchange offer, the old notes will continue to be subject to the restrictions on transfer contained in the legend printed on the old notes. In general, the old notes may not be offered or sold, unless registered under the Securities Act, except under an exemption from, or in a transaction not subject to, the Securities Act and applicable state securities laws. Holders of old notes do not have any appraisal or dissenters' rights in connection with the exchange offer. See "The Exchange Offer Resales of New Notes."

Additionally, if you do not participate in the exchange offer, you will not be able to require us to register the resale of your old notes under the Securities Act except in limited circumstances. These circumstances are:

- the exchange offer is not permitted by applicable law or SEC policy,
- the exchange offer is not completed before the later of (i) 60 days after the effectiveness of this registration statement and (ii) 270 days after date of issuance of the old notes, or
- prior to the 30th day following consummation of the exchange offer:
  - any initial purchaser of the old notes requests that we register old notes that were not eligible to be exchanged for new notes in the exchange offer and that are held by it following consummation of the exchange offer; or
  - any holder of old notes notifies us that it is not eligible to participate in the exchange offer or a broker-dealer notifies us that it holds securities acquired directly from us or our affiliates; or
  - any initial purchaser of the old notes notifies us that it will not receive freely tradable new notes in exchange for old notes constituting any portion of an unsold allotment.

In these cases, the registration rights agreement requires us to file a registration statement for a continuous offering in accordance with Rule 415 under the Securities Act for the benefit of the holders of the old notes. We do not currently anticipate that we will register under the Securities Act any old notes that remain outstanding after completion of the exchange offer.

Table of Contents

The New Notes

The summary below describes the principal terms of the new notes and is not intended to be complete. Many of the terms and conditions described below are subject to important limitations and exceptions. The "Description of the Notes" section of this prospectus contains a more detailed description of the terms and conditions of the new notes.

Issuer	Select Medical Corporation, a Delaware corporation.
Notes Offered	$600.0 million aggregate principal amount of 6.375% Senior Notes due 2021.
Maturity Date	June 1, 2021.
Interest Payment Dates	Interest on the notes is payable on June 1 and December 1 of each year, commencing on December 1, 2013. Interest will accrue from May 28, 2013.
Ranking	The notes will be our senior unsecured obligations and will:
	be effectively subordinated to all of our existing and future secured indebtedness, including our senior secured credit facilities, to the extent of the value of the assets securing such indebtedness;
	rank equal in right of payment to all of our existing and future unsecured indebtedness that are not, by their terms, expressly subordinated in right of payment to the notes;
	rank senior in right of payment to all of our existing and future indebtedness that are, by their terms, expressly subordinated in right of payment to the notes; and
	be structurally subordinated to any existing and future indebtedness of any of our subsidiaries that are not subsidiary guarantors.
	The subsidiary guarantees will be the senior unsecured obligations of the subsidiary guarantors and will:
	be effectively subordinated to all of the existing and future secured indebtedness, including their guarantees under our senior secured credit facilities, of the subsidiary guarantors to the extent of the value of the assets securing such obligations;
	rank equal in right of payment to all existing and future unsecured indebtedness of the subsidiary guarantors that are not, by their terms, expressly subordinated in right of payment to the subsidiary guarantees; and
	rank senior in right of payment to all existing and future indebtedness of the subsidiary guarantors that are, by their terms, expressly subordinated in right of payment to the subsidiary guarantees.

Table of Contents

Optional Redemption

At any time on or after June 1, 2016, we may redeem all or any portion of the notes at the redemption prices set forth under "Description of the Notes Optional Redemption."

Prior to June 1, 2016, we may redeem all or any portion of the notes at 100% of their principal amount, plus a "make whole" premium, plus accrued interest.

In addition, at any time and from time to time on or prior to June 1, 2016, we may redeem up to 35% of the aggregate principal amount of the notes using the net cash proceeds of certain public equity offerings, so long as:

we pay 35% of the principal amount of the notes to be redeemed, plus accrued and unpaid interest, if any, to the date of redemption;

at least 65% of the aggregate principal amount of all notes issued under the indenture remain outstanding afterwards; and

the redemption occurs within 90 days of the date of the closing of such public equity offering.

Change of Control; Asset Sales

If a change of control occurs, we must offer to purchase the notes from holders at a price equal to 101% of the principal amount thereof, plus accrued and unpaid interest, if any, to the date of repurchase. See "Description of the Notes Repurchase at the Option of Holders Change of Control."

If we sell certain assets and do not apply the net proceeds in compliance with the indenture, we will be required to make an offer to repurchase the notes at a price equal to 100% of the principal amount thereof, plus accrued and unpaid interest, if any, to the date of repurchase. See "Description of the Notes Repurchase at the Option of Holders Asset Sales."

Certain covenants

The notes will be issued under an indenture among us, each of the subsidiary guarantors named therein and U.S. Bank National Association, as trustee. The terms of the notes and indenture will restrict our ability and the ability of our restricted subsidiaries to:

incur additional indebtedness;

pay dividends or make distributions or redeem or repurchase stock;

make certain investments;

create liens;

merge or consolidate with another company or transfer or sell assets;

enter into restrictions affecting the ability of our restricted subsidiaries to make distributions, loans or advances to us or other restricted subsidiaries;

Table of Contents

	engage in transactions with affiliates; and
	enter into sale and leaseback transactions.
	These covenants are subject to a number of important limitations and exceptions, which are described under "Description of the Notes Certain Covenants."
No prior market	The notes are a new issue of securities and there is currently no established trading market for the notes. An active or liquid market may not develop for the notes. See "Plan of distribution."
Tax consequences	For a discussion of certain material U.S. Federal income tax consequences of an investment in the notes, see "Certain Material U.S. Federal Income Tax Considerations." You should consult your own tax advisor to determine the U.S. Federal, state, local and other tax consequences of an investment in the notes specific to your particular circumstances.
Use of proceeds	We will not receive any proceeds from the exchange offer. See "Use of Proceeds."
Risk factors	You should carefully consider all information in this prospectus. In particular, you should evaluate the specific risks described in the section entitled "Risk Factors" in this prospectus and in the documents incorporated by reference herein for a discussion of risks relating to an investment in the notes. Please read that section carefully before you decide whether to invest in the notes.

Table of Contents

Summary Historical Consolidated Financial and Other Data

The following table sets forth summary historical consolidated financial data for the Issuer. You should read the summary consolidated financial and other data below in conjunction with our consolidated financial statements and the accompanying notes which are included in this prospectus. We derived the historical financial data for the years ended December 31, 2010, 2011 and 2012, and as of December 31, 2010, 2011 and 2012 from consolidated financial statements audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm. We derived the historical financial data for the six months ended June 30, 2012 and 2013 and as of June 30, 2012 and 2013, from our unaudited interim consolidated financial statements. You should also read "Selected Historical Consolidated Financial Data," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and "Consolidated Financial Statements" in this prospectus.

	For the Year Ended December 31,			Six Months Ended June 30,	
Consolidated Statement of Operations Data (in thousands):	**2010**	**2011**	**2012**	**2012**	**2013**
Net operating revenues	$ 2,390,290	$ 2,804,507	$ 2,948,969	$ 1,494,214	$ 1,506,628
Costs and expenses:					
Cost of services	1,982,179	2,308,570	2,443,550	1,224,288	1,250,634
General and administrative	62,121	62,354	66,194	32,778	35,325
Bad debt expense	41,147	51,347	39,055	20,404	18,167
Depreciation and amortization	68,706	71,517	63,311	31,627	31,709
Total costs and expenses	2,154,153	2,493,788	2,612,110	1,309,097	1,335,835
Income from operations	236,137	310,719	336,859	185,117	170,793
Other income and expense:					
Loss on early retirement of debt(1)		(20,385)	(6,064)		(17,788)
Equity in earnings (losses) of unconsolidated subsidiaries	(440)	2,923	7,705	5,217	1,626
Other income	632				
Interest income		322			
Interest expense	(84,472)	(81,232)	(83,759)	(42,207)	(42,952)
Income before income taxes	151,857	212,347	254,741	148,127	111,679
Income tax expense	51,380	80,984	93,574	57,156	42,809
Net income	100,477	131,363	161,167	90,971	68,870
Less: Net income attributable to non-controlling interests	4,720	4,916	5,663	2,674	4,482
Net income attributable to Select Medical Corporation	$ 95,757	$ 126,447	$ 155,504	$ 88,297	$ 64,388
Other comprehensive income (loss):					
Unrealized gain (loss) on interest rate swap, net of tax	8,914				
Comprehensive income attributable to Select Medical Corporation	$ 104,671	$ 126,447	$ 155,504	$ 88,297	$ 64,388

Table of Contents

Segment Data:	For the Year Ended December 31, 2010	2011	2012	Six Months Ended June 30, 2012	2013
Specialty hospitals					
Number of hospitals end of period					
Long term acute care hospitals	111	110	110	111	109
Acute medical rehabilitation hospitals	7	9	12	12	14
Total specialty hospitals	118	119	122	123	123
Net operating revenues (,000)	$ 1,702,165	$ 2,095,519	$ 2,197,529	$ 1,110,168	$ 1,117,137
Patient days	1,119,566	1,330,890	1,345,430	679,037	681,037
Admissions	45,990	54,734	55,147	27,927	27,962
Net revenue per patient day(2)	$ 1,474	$ 1,497	$ 1,534	$ 1,539	$ 1,538
Adjusted segment EBITDA (,000)(3)	$ 284,558	$ 362,334	$ 381,354	$ 202,120	$ 189,740
Outpatient rehabilitation					
Number of clinics end of period	944	954	979	956	988
Net operating revenues (,000)	$ 688,017	$ 708,867	$ 751,317	$ 383,949	$ 389,181
Number of visits	4,567,153	4,470,061	4,568,821	2,318,759	2,380,221
Net revenue per visit(4)	$ 101	$ 103	$ 103	$ 103	$ 104
Adjusted segment EBITDA (,000)(3)	$ 83,772	$ 83,864	$ 87,024	$ 48,315	$ 48,887
Balance Sheet Data (in thousands):					
Cash and cash equivalents	$ 4,365	$ 12,043	$ 40,144	$ 21,520	$ 8,768
Working capital (deficit)(5)	$ (73,481)	$ 97,348	$ 63,217	$ 105,300	$ 135,428
Total assets	$ 2,719,572	$ 2,770,738	$ 2,760,313	$ 2,778,414	$ 2,845,055
Total debt	$ 1,124,292	$ 1,229,498	$ 1,302,943	$ 1,186,619	$ 1,530,958
Total Select Medical Corporation stockholders' equity	$ 1,081,661	$ 983,446	$ 881,317	$ 1,027,547	$ 758,299

Consolidated Statement of Operations Data (in thousands):	For the Year Ended December 31, 2010	2011	2012	Six Months Ended June 30, 2012	2013
Other Financial Data (in thousands):					
Capital expenditures	$ 51,761	$ 46,016	$ 68,185	$ 27,934	$ 27,962
Adjusted EBITDA(3)	$ 307,079	$ 385,961	$ 405,847	$ 219,343	$ 206,039
Statement of Cash Flows Data (in thousands):					
Net cash provided by operating activities	$ 170,064	$ 240,053	$ 309,371	$ 124,049	$ 27,602
Net cash used in investing activities	$ (216,998)	$ (54,735)	$ (72,406)	$ (21,643)	$ (56,849)
Net cash used in financing activities	$ (32,381)	$ (177,640)	$ (208,864)	$ (92,929)	$ (2,129)
Ratio of earnings to fixed charges	2.11	2.54	2.77	3.03	2.56

(1) The gain (loss) on early retirement of debt relates to the following:

On June 1, 2011, we refinanced our senior secured credit facility which consisted of an $850.0 million term loan facility and a $300.0 million revolving loan facility. A portion of the proceeds from this transaction were used to repurchase and retire $266.5 million of our 7⅝% senior subordinated notes. A loss on early retirement of debt of $20.4 million was recognized for the year ended December 31, 2011, which included the write-off of unamortized deferred financing costs, tender premiums and original issue discount.

On August 13, 2012, we entered into an additional credit extension amendment to our secured credit facility. Pursuant to the terms and conditions of the additional credit extension amendment, the lenders extended an aggregate principal amount of $275.0 million in additional

Table of Contents

term loans to us at the same interest rate and with the same term as applies to the existing term loan amounts borrowed by us under our senior secured credit facility. On September 12, 2012, we used the proceeds of the additional term loans (other than amounts used for fees and expenses) and cash on hand to redeem an aggregate of $275.0 million principal amount of our outstanding 7⅝% senior subordinated notes due 2015 at a redemption price of 101.271% of the principal amount. We recognized a loss on early retirement of debt of $6.1 million for the year ended December 31, 2012 in connection with the redemption of the senior subordinated notes, which included the write-off of unamortized deferred financing costs and call premiums.

On March 22, 2013, we redeemed all of our outstanding 7⅝% senior subordinated notes due 2015. We recognized a loss on early retirement of debt of $0.5 million during the first quarter 2013, for the unamortized debt issuance costs associated with the redeemed debt. On May 28, 2013, we repaid a portion of our original term loan and series A term loan of our senior secured credit facility and on June 3, 2013, we amended our existing senior secured credit facility. We recognized a loss on early retirement of debt of $17.3 million in the second quarter 2013, which included unamortized debt issuance costs, unamortized original issue discount, and certain debt issuance costs associated with refinancing activities.

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

(3) We define Adjusted EBITDA as net income before interest, income taxes, depreciation and amortization, gain (loss) on early retirement of debt, stock compensation expense, equity in earnings (losses) of unconsolidated subsidiaries and other income (expense). We believe that the presentation of Adjusted EBITDA is important to investors because Adjusted EBITDA is commonly used as an analytical indicator of performance by investors within the healthcare industry. Adjusted EBITDA is used by management to evaluate financial performance and determine resource allocation for each of our operating units. Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles. Items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to, or substitute for, net income, cash flows generated by operations, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because Adjusted EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies. Adjusted EBITDA has limitations as an analytical tool and should not be considered in isolation or as a substitute for analyzing our results as reported under U.S. GAAP. Some of these limitations are:

Adjusted EBITDA does not reflect changes in, or cash requirements for, our working capital needs;

Adjusted EBITDA does not reflect our interest expense, or the requirements necessary to service interest or principal payments on our debt;

Adjusted EBITDA does not reflect our income tax expenses or the cash requirements to pay our taxes; and

Adjusted EBITDA does not reflect our cash expenditures or future requirements for capital expenditures or contractual commitments.

Table of Contents

Following is a reconciliation of net income to Adjusted EBITDA as utilized by us in reporting our segment performance.

	Six Months Ended June 30, 2013			
(in thousands)	**Total**	**Specialty Hospitals**	**Outpatient Rehabilitation**	**All Other**
Net income	$ 68,870			
Income tax expense	42,809			
Interest expense	42,952			
Equity in earnings of unconsolidated subsidiaries	(1,626)			
Loss on early retirement of debt	17,788			
Income (loss) from operations	$ 170,793	$ 165,946	$ 42,917	$ (38,070)
Stock compensation expense	3,537			3,537
Depreciation and amortization	31,709	23,794	5,970	1,945
Adjusted EBITDA	$ 206,039	$ 189,740	$ 48,887	$ (32,588)

	Six Months Ended June 30, 2012			
(in thousands)	**Total**	**Specialty Hospitals**	**Outpatient Rehabilitation**	**All Other**
Net income	$ 90,971			
Income tax expense	57,156			
Interest expense	42,207			
Equity in earnings of unconsolidated subsidiaries	(5,217)			
Income (loss) from operations	$ 185,117	$ 178,798	$ 41,433	$ (35,114)
Stock compensation expense	2,599			2,599
Depreciation and amortization	31,627	23,322	6,882	1,423
Adjusted EBITDA	$ 219,343	$ 202,120	$ 48,315	$ (31,092)

	Year Ended December 31, 2012			
(in thousands)	**Total**	**Specialty Hospitals**	**Outpatient Rehabilitation**	**All Other**
Net income	$ 161,167			
Income tax expense	93,574			
Interest expense	83,759			
Equity in earnings of unconsolidated subsidiaries	(7,705)			
Loss on early retirement of debt	6,064			
Income (loss) from operations	$ 336,859	$ 334,518	$ 73,816	$ (71,475)
Stock compensation expense	5,677			5,677
Depreciation and amortization	63,311	46,836	13,208	3,267
Adjusted EBITDA	$ 405,847	$ 381,354	$ 87,024	$ (62,531)

Table of Contents

(in thousands)	Year Ended December 31, 2011 Total	Specialty Hospitals	Outpatient Rehabilitation	All Other
Net income	$ 131,363			
Income tax expense	80,984			
Interest expense, net of interest income	80,910			
Equity in earnings of unconsolidated subsidiaries	(2,923)			
Loss on early retirement of debt	20,385			
Income (loss) from operations	$ 310,719	$ 311,705	$ 67,377	$ (68,363)
Stock compensation expense	3,725			3,725
Depreciation and amortization	71,517	50,629	16,487	4,401
Adjusted EBITDA	$ 385,961	$ 362,334	$ 83,864	$ (60,237)

(in thousands)	Year Ended December 31, 2010 Total	Specialty Hospitals	Outpatient Rehabilitation	All Other
Net income	$ 100,477			
Income tax expense	51,380			
Interest expense	84,472			
Other income	(632)			
Equity in losses of unconsolidated subsidiaries	440			
Income (loss) from operations	$ 236,137	$ 239,442	$ 63,328	$ (66,633)
Stock compensation expense	2,236			2,236
Depreciation and amortization	68,706	45,116	20,444	3,146
Adjusted EBITDA	$ 307,079	$ 284,558	$ 83,772	$ (61,251)

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

(5) Current assets less current liabilities.

Table of Contents

RISK FACTORS

You should carefully consider the risks described below, as well as the other information contained in this prospectus, before deciding whether to participate in the exchange offer. The risks described below are not the only ones that we face. Additional risks not presently known to us may also impair our business operations. The actual occurrence of any of these risks could materially adversely affect our business, financial condition and results of operations. In that case, the value of the new notes could decline substantially, and you may lose part or all of your investment.

Risks Related to the Exchange Offer

If you fail to exchange your old notes for new notes your old notes will continue to be subject to restrictions on transfer and may become less liquid.

We did not register the resale of the old notes under the Securities Act or any state securities laws, nor do we intend to after the exchange offer. In general, you may only offer or sell the old notes if the resale is registered under the Securities Act and applicable state securities laws, or offered and sold under an exemption from these requirements. If you do not exchange your old notes in the exchange offer, you will remain subject to such restrictions on transfer and you may be unable to sell the old notes.

Because we anticipate that most holders of old notes will elect to exchange their old notes, we expect that the liquidity of the market for any old notes remaining after the completion of the exchange offer will be substantially limited. Any old notes tendered and exchanged in the exchange offer will reduce the aggregate principal amount of the old notes outstanding. Following the exchange offer, if you do not tender your old notes you generally will not have any further registration rights, and your old notes will continue to be subject to certain transfer restrictions. Accordingly, the liquidity of the market for the old notes will be adversely affected.

If an active trading market for the new notes does not develop, the liquidity and value of the new notes could be harmed.

There is no existing market for the new notes. An active public market for the new notes may not develop or, if developed, may not continue. If an active public market does not develop or is not maintained, you may not be able to sell your new notes at their fair market value or at all.

Even if a public market for the new notes develops, trading prices will depend on many factors, including prevailing interest rates, our operating results and the market for similar securities. 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 new notes. Declines in the market for debt securities generally may also materially and adversely affect the liquidity of the new notes, independent of our financial performance.

You must comply with the exchange offer procedures in order to receive new notes.

The new notes will be issued in exchange for the old notes only after timely receipt by the exchange agent of the old notes or a book-entry confirmation related thereto, a properly completed and executed letter of transmittal or an agent's message and all other required documentation. If you want to tender your old notes in exchange for new notes, you should allow sufficient time to ensure timely delivery. None of us, Holdings, nor the exchange agent are under any duty to give you notification of defects or irregularities with respect to tenders of old notes for exchange. Old notes that are not tendered or are tendered but not accepted will, following the exchange offer, continue to be subject to the existing transfer restrictions. In addition, if you tender the old notes in the exchange offer to participate in a distribution of the new notes, you will be required to comply with the

Table of Contents

registration and prospectus delivery requirements of the Securities Act in connection with any resale transaction. For additional information, please refer to the sections entitled "The Exchange Offer" and "Plan of Distribution" later in this prospectus.

Some persons who participate in the exchange offer must deliver a prospectus in connection with resales of the new notes.

Based on interpretations of the staff of the SEC contained in Exxon Capital Holdings Corp., SEC no-action letter (April 13, 1988), Morgan Stanley & Co. Inc., SEC no-action letter (June 5, 1991) and Shearman & Sterling, SEC no-action letter (July 2, 1983), we believe that you may offer for resale, resell or otherwise transfer the new notes without compliance with the registration and prospectus delivery requirements of the Securities Act. However, in some instances described in this prospectus under "Plan of Distribution," you will remain obligated to comply with the registration and prospectus delivery requirements of the Securities Act to transfer your new notes. In these cases, if you transfer any new note without delivering a prospectus meeting the requirements of the Securities Act or without an exemption from registration of your exchange under the Securities Act, you may incur liability under the Securities Act. We do not and will not assume, or indemnify you against, this liability.

Risks Related to the New Notes

Our substantial indebtedness may limit the amount of cash flow 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.

As of June 30, 2013, we had approximately $1,531.0 million of total indebtedness on a consolidated basis. Our indebtedness could have important consequences to you. For example, it:

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

See "Capitalization" and "Description of Other Indebtedness."

Restrictions imposed by our senior secured credit facilities 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 senior secured credit facilities 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

Table of Contents

interest. For example, our senior secured credit facilities restrict 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.

Our senior secured credit facilities also require us to comply with certain financial covenants. 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 senior secured credit facilities. In the event of any default under our senior secured credit facilities, the lenders under our senior secured credit facilities 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 Notes" and "Description of Other Indebtedness."

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

We and our subsidiaries may be able to incur additional indebtedness in the future. Although our senior secured credit facilities and the indenture governing the new notes contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. Also, these restrictions do not prevent us or our subsidiaries from incurring obligations that do not constitute indebtedness. As of June 30, 2013, we had $153.1 million of revolving loan availability under our senior secured credit facilities (after giving effect to $41.9 million of outstanding letters of credit). In addition, to the extent new debt is added to our and our subsidiaries' current debt levels, the substantial leverage risks described above would increase.

18

Table of Contents

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 new 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 Other Indebtedness."

The notes and the subsidiary guarantees will be effectively subordinated to all liabilities of our non-guarantor subsidiaries.

The notes will be 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 twelve months ended December 31, 2012 of our subsidiaries that are not guaranteeing the notes were $399.0 million and $42.5 million, respectively, and at June 30, 2013, those subsidiaries had total assets and indebtedness and other liabilities (excluding intercompany indebtedness and liabilities) of $240.1 million and $47.6 million, respectively. See "Description of the Notes Certain Covenants Incurrence of Indebtedness and Issuance of Disqualified Stock and Preferred Stock." See also "Description of the Notes Subsidiary Guarantees" and the condensed consolidating financial information included in the notes to our consolidated financial statements included herein.

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

The new notes and the related subsidiary guarantees will not be secured by any of our or our subsidiaries' assets and therefore will be 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 senior secured credit facilities are secured by, among other things, a first priority pledge of Holdings' capital stock and the capital stock of Holdings' subsidiaries and by substantially all of our assets and each of our existing and subsequently acquired or organized domestic subsidiaries that is a guarantor. If we become insolvent or are liquidated, or if payment under our senior secured credit facilities or in respect of any other secured senior indebtedness is accelerated, the lenders under our senior secured

Table of Contents

credit facilities 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 senior secured credit facilities or other secured debt). In addition, we and or the subsidiary guarantors may incur additional secured senior indebtedness, the holders of which will also be entitled to the remedies available to a secured lender. See "Description of Other Indebtedness Senior Secured Credit Facilities" and "Description of the Notes."

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 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 senior secured credit facilities may not allow such repurchases. Upon the occurrence of a change of control event, we may seek to refinance the debt outstanding under our senior secured credit facilities 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 Notes Repurchase at the Option of Holders Change of Control."

In addition, a change of control would be an event of default under our senior secured credit facilities. 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 senior secured credit facilities 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, at the time we or a subsidiary guarantor incurred the indebtedness evidenced by its subsidiary guarantee:

- we or the subsidiary guarantor 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;
- 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.

Table of Contents

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 transfer 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, recent operating history and other factors, we believe that we and each subsidiary guarantor are not insolvent, do not have insufficient capital for the business in which we are or it is engaged and have not incurred 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 is no public market for the notes, and we cannot be sure that a market for the notes will develop.

The notes are a new issue of securities for which there is currently no active trading market. As a result, we cannot assure you that the initial prices at which the notes will sell in the market after this offering will not be lower than the initial offering price or that an active trading market for the notes will develop and continue after completion of this offering. The initial purchasers have advised us that they currently intend to make a market for the notes. However, the initial purchasers are not obligated to do so, and may discontinue any market-making activities with respect to the notes at any time without notice. In addition, market-making activities will be subject to the limits imposed by the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and may be limited. Accordingly, we cannot assure you as to the liquidity of, or trading market for, the notes.

Risks Related to Our Business and Our Industry

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

Approximately 47% of our net operating revenues for the year ended December 31, 2010, 48% of our net operating revenues for the year ended December 31, 2011 and 47% of our net operating revenues for the year ended December 31, 2012 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. President Obama signed into law comprehensive reforms to the healthcare system, including changes to the methods for, and amounts of, Medicare reimbursement. Additional reforms or other changes to these payment systems, including modifications to the conditions on qualification for payment, bundling payments to cover both acute and post-acute care or the imposition of enrollment limitations on new providers, may be proposed or could be adopted, either by the U.S. Congress or by the Centers for Medicare & Medicaid Services, or CMS. If revised regulations are adopted, the availability, methods and rates of Medicare reimbursements for services of the type furnished at our facilities could change. Some of these changes and proposed changes could adversely affect our business strategy, operations and financial results. In addition, there can be no assurance that any increases in Medicare reimbursement rates established by CMS will fully reflect increases in our operating costs.

Table of Contents

The Budget Control Act of 2011, enacted on August 2, 2011, increased the federal debt ceiling in connection with deficit reductions over the next ten years. The Budget Control Act of 2011 requires automatic reductions in federal spending by approximately $1.2 trillion split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap, which are expected to reduce Medicare payments by more than $11 billion in fiscal year 2013 and $123 billion over the period of fiscal years 2013 to 2021. On April 1, 2013 a 2% reduction to Medicare payments was implemented. For the three months ended June 30, 2013, this reduction has reduced our net operating revenues and income from operations by approximately $9.5 million. We have estimated that this reduction will reduce our net operating revenues and income from operations by approximately $16.0 million to $17.0 million for the remainder of 2013.

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

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to (1) facility and professional licensure, including certificates of need, (2) conduct of operations, including financial relationships among healthcare providers, Medicare fraud and abuse and physician self-referral, (3) addition of facilities and services and enrollment of newly developed facilities in the Medicare program, (4) payment for services and (5) safeguarding protected health information.

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

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

Full implementation of Medicare admission thresholds applicable to LTCHs operated as HIHs or as "satellites" will have an adverse effect on our future net operating revenues and profitability.

Effective for hospital cost reporting periods beginning on or after October 1, 2004, LTCHs that are operated as "hospitals within hospitals" ("HIHs"), or as HIH "satellites," are subject to a payment reduction for those Medicare patients admitted from their host hospitals that are in excess of a specified percentage threshold. These HIHs and their HIH satellites are separate hospitals located in space leased from, or located on the same campus of, another hospital, which we refer to as "host hospitals." For HIHs opened after October 1, 2004, the Medicare admissions threshold has been established at 25% except for HIHs located in rural areas or co-located with an MSA dominant

Table of Contents

hospital or single urban hospital (as defined by the current regulations) in which cases the percentage is no more than 50%, nor less than 25%. Certain grandfathered HIHs were initially excluded from the Medicare admission threshold regulations. Grandfathered HIHs refer to certain HIHs that were in existence on or before September 30, 1995, and grandfathered satellite facilities refer to satellites of grandfathered HIHs that were in existence on or before September 30, 1999.

The Medicare and Medicaid SCHIP Extension Act of 2007, (the "SCHIP Extension Act"), as amended by the American Recovery and Reinvestment Act (the "ARRA") and the Patient Protection and Affordable Care Act (the "PPACA"), limited the application of the Medicare admission threshold on HIHs in existence on October 1, 2004. For these HIHs, the admission threshold was no lower than 50% for a five year period to commence on an LTCH's first cost reporting period to begin on or after October 1, 2007. Under the SCHIP Extension Act, for HIHs located in rural areas the percentage threshold was no more than 75% for the same five year period. For HIHs that are co-located with MSA dominant hospitals or single urban hospitals, the percentage threshold was no more than 75% during the same five year period. The SCHIP Extension Act, as amended, limited the full application of the Medicare percentage threshold and, in some cases, postponed application of the percentage threshold until cost reporting periods beginning on or after July 1, 2012 or October 1, 2012. Through regulations published on August 1, 2012, CMS adopted a one-year extension of relief granted by the SCHIP Extension Act from the full application of Medicare admission thresholds. As a result, full implementation of the Medicare admission thresholds go into effect during cost reporting periods beginning on or after October 1, 2013.

As of June 30, 2013, we owned 76 LTCH HIHs; five of these HIHs were subject to a maximum 25% Medicare admission threshold, two HIHs are co-located with an MSA dominant hospital and were subject to a Medicare admission threshold of no more than 50%, nor less than 25%, 18 of these HIHs were co-located with a MSA dominant hospital or single urban hospital and were subject to a Medicare admission threshold of no more than 75%, 46 of these HIHs were subject to a maximum 50% Medicare admissions threshold, three of these HIHs were located in a rural area and were subject to a maximum 75% Medicare admission threshold, and two of these HIHs were grandfathered HIHs and not subject to a Medicare admission threshold.

Because these rules are complex and are based on the volume of Medicare admissions from our host hospitals as a percent of our overall Medicare admissions, we cannot predict with any certainty the impact on our future net operating revenues, income from operations and Adjusted EBITDA of compliance with these regulations. We expect many of our HIHs will experience an adverse financial impact when full implementation of the Medicare admission thresholds goes into effect for LTCHs with cost reporting periods beginning on or after October 1, 2013. As a result, we expect these rules will adversely affect our future net operating revenues and profitability.

Full implementation of Medicare admission thresholds applicable to LTCHs operated as free-standing or grandfathered HIHs or grandfathered "satellites" will have an adverse effect on our future net operating revenues and profitability.

For cost reporting periods beginning on or after July 1, 2007, CMS expanded the current Medicare HIH admissions threshold to apply to Medicare patients admitted from any individual hospital. Previously, the admissions threshold was applicable only to Medicare HIH admissions from hospitals co-located with an LTCH or satellite of an LTCH. Under the expanded rule, free-standing LTCHs and grandfathered LTCH HIHs are subject to the Medicare admission thresholds, as well as HIHs that admit Medicare patients from non-co-located hospitals. To the extent that any LTCH's or LTCH satellite facility's discharges that are admitted from an individual hospital (regardless of whether the referring hospital is co-located with the LTCH or LTCH satellite) exceed the applicable percentage threshold during a particular cost reporting period, the payment rate for those discharges is subject to a downward payment adjustment. Cases admitted in excess of the applicable threshold are reimbursed at

Table of Contents

a rate comparable to that under the general acute care inpatient prospective payment system ("IPPS"). IPPS rates are generally lower than the long-term care hospital prospective payment system ("LTCH-PPS") rates. Cases that reach outlier status in the discharging hospital do not count toward the limit and are paid under LTCH-PPS.

The SCHIP Extension Act, as amended, postponed the application of the percentage threshold to free-standing LTCHs and grandfathered HIHs for a five-year period commencing on an LTCH's first cost reporting period on or after July 1, 2007. However, the SCHIP Extension Act did not postpone the application of the percentage threshold to Medicare patients discharged from an LTCH HIH or HIH satellite that were admitted from a non-co-located hospital. In addition, the SCHIP Extension Act, as interpreted by CMS, did not provide relief from the application of the threshold for patients admitted from a co-located hospital to certain non-grandfathered HIHs. The ARRA limits application of the admission threshold to no more than 50% of Medicare admissions to grandfathered satellites from a co-located hospital for a five year period commencing on the first cost reporting period beginning on or after July 1, 2007. Through regulations published on August 1, 2012, CMS adopted a one-year extension of relief granted by the SCHIP Extension Act from the full application of Medicare admission thresholds. As a result, full implementation of the Medicare admission thresholds will not go into effect until cost reporting periods beginning on or after October 1, 2013, except for certain LTCHs with cost reporting periods that begin between July 1, 2012 and September 30, 2012. Those freestanding facilities, grandfathered HIHs and grandfathered satellites with cost reporting periods beginning on or after July 1, 2012 and before October 1, 2012 are subject to a modified admission threshold for discharges occurring in a three month period between July 1, 2012 and September 30, 2012. Full application of Medicare admission thresholds will go into effect in cost reporting periods beginning on or after October 1, 2013, including the Medicare admission thresholds applicable to freestanding facilities, grandfathered HIHs and grandfathered satellites. Of the 108 LTCHs we owned as of June 30, 2013, 32 were operated as free-standing hospitals and two qualified as grandfathered LTCH HIHs.

Because these rules are complex and are based on the volume of Medicare admissions from other referring hospitals as a percent of our overall Medicare admissions, we cannot predict with any certainty the impact on our future net operating revenues, income from operations and Adjusted EBITDA of compliance with these regulations. Our LTCHs have cost reporting periods that commence on various dates throughout the calendar year. Therefore, the application of the lower admission thresholds will be staggered and we would not realize the full impact of lower admission thresholds until 2015. We have performed an initial review of the potential impact of lower admission thresholds to our LTCHs. Without initiating any mitigation, we estimate the net impact to income from operations and Adjusted EBITDA for the year ending December 31, 2013 to be less than $1.0 million. With the execution of successful mitigation strategies and operating cost reductions, we believe the net impact to income from operations and Adjusted EBITDA for the years ending December 31, 2014 and 2015 to be between $5.0 to $10.0 million and $5.0 to $15.0 million, respectively.

Expiration of the moratorium imposed on the payment adjustment for very short-stay cases in our LTCHs has reduced and will continue to reduce our future net operating revenues and profitability.

On May 1, 2007, CMS published a new provision that changed the payment methodology for Medicare patients with a length of stay that is less than the IPPS comparable threshold. Beginning with discharges on or after July 1, 2007, for these very short-stay cases, the rule lowered the LTCH payment to a rate based on the general acute care hospital IPPS per diem. Short stay outlier ("SSO") cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the existing SSO payment policy. The SCHIP Extension Act and PPACA prevented CMS from applying this change to SSO policy for a period of five years through December 28, 2012. The implementation

Table of Contents

of the payment methodology for very short-stay outliers discharged after December 29, 2012 has reduced and will continue to reduce our future net operating revenues and profitability.

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

As of June 30, 2013, we operated 109 LTCHs, all of which are currently certified by Medicare as LTCHs. LTCHs must meet certain conditions of participation to enroll in, and seek payment from, the Medicare program as an LTCH, including, among other things, maintaining an average length of stay for Medicare patients in excess of 25 days. An LTCH that fails to maintain this average length of stay for Medicare patients in excess of 25 days during a single cost reporting period is generally allowed an opportunity to show that it meets the length of stay criteria during the subsequent cost reporting period. If the LTCH can show that it meets the length of stay criteria during this cure period, it will continue to be paid under the LTCH prospective payment system ("LTCH-PPS"). If the LTCH again fails to meet the average length of stay criteria during the cure period, it will be paid under the general acute care inpatient prospective payment system at rates generally lower than the rates under the LTCH-PPS.

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

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

CMS and industry stakeholders have, for a number of years, explored the development of facility and patient certification criteria for LTCHs, potentially as an alternative to the current specific payment adjustment features of LTCH-PPS. In its June 2004 report to Congress, MedPAC recommended the adoption by CMS of new facility staffing and services criteria and patient clinical characteristics and treatment requirements for LTCHs in order to ensure that only appropriate patients are admitted to these facilities. MedPAC is an independent federal body that advises Congress on issues affecting the Medicare program. After MedPAC's recommendation, CMS awarded a contract to Research Triangle Institute International to examine such recommendation. However, while acknowledging that Research Triangle Institute International's findings are expected to have a substantial impact on future Medicare policy for LTCHs, CMS stated in its payment update published in May 2006, that many of the specific payment adjustment features of LTCH-PPS then in place may still be necessary and appropriate even with the development of patient- and facility-level criteria for LTCHs. In early 2008, CMS indicated that Research Triangle Institute International continues to work with the clinical community to make recommendations to CMS regarding payment and treatment of critically ill patients in LTCHs. The SCHIP Extension Act requires the Secretary of the Department of Health and Human Services to conduct a study and submit a report to Congress on the establishment of national LTCH facility and patient criteria and to consider the recommendations contained in MedPAC's June 2004 report to Congress.

In the preamble to the proposed update to the Medicare policies and payment rates for fiscal year 2014, CMS described the preliminary findings of the ongoing research being conducted by Kennell and Associates and its subcontractor, Research Triangle Institute International, under the guidance of the

Table of Contents

Center for Medicare and Medicaid Innovation. According to CMS, the preliminary findings suggest that chronically critically ill and medically complex patients can be identified by specific clinical factors as appropriate for treatment in an LTCH. CMS indicated that it is seeking public comment on a proposed change to the payment system that would limit full LTCH-PPS payment to cases that qualify as chronically critically ill/medically complex ("CCI/MC") during the patient's initial stay in an IPPS hospital inpatient setting and subsequently directly admitted to a LTCH. Payment for non-CCI/MC patients would be made at an "IPPS comparable amount," that is, an amount comparable to what would have been paid under the IPPS calculated as a per diem rate with total payments capped at the full IPPS MS-DRG payment rate. CMS also noted that it intends to study the alternative policy options for payment of chronically critically ill cases presented at MedPAC's April 5, 2013 meeting where the MedPAC staff discussed the options of: (1) paying for CCI/MC patients under the IPPS, no matter the site of care, but with an expanded outlier policy; (2) paying for CCI/MC patients under the IPPS, but creating new CCI/MC payment groups with a larger outlier pool; and (3) bundling post-acute costs into new CCI/MC payment groups.

We cannot predict whether CMS will adopt additional patient criteria in the future or, if adopted, how such criteria would affect our LTCHs. Legislation was introduced in the United States Senate on August 2, 2011. The proposed legislation would have implemented new patient-level and facility-level criteria for LTCHs, including a standardized preadmission screening process, specific criteria for admission and continued stay in an LTCH, and a list of core services that an LTCH must offer. In addition, the legislation would have required LTCHs to meet additional classification criteria to continue to be paid under LTCH-PPS. After a phase-in period, a threshold percentage of an LTCH's Medicare fee-for-service discharges would have been required to meet specified criteria. The proposed legislation would have repealed, and prohibited CMS from applying, the 25 Percent Rule that applies to Medicare patients discharged from LTCHs who were admitted from a co-located hospital or a non-co-located hospital and caused the LTCH to exceed the applicable percentage thresholds for discharged Medicare patients. Though no action was taken by Congress with respect to the proposed legislation, hospital industry groups continue to press for similar legislation. Implementation of these or other criteria that may limit the population of patients eligible for our LTCHs' services or change the basis on which we are paid could adversely affect our net operating revenues and profitability. See "Business Government Regulations Overview of U.S. and State Government Reimbursements Long Term Acute Care Hospital Medicare Reimbursement" in our annual report on Form 10-K incorporated by reference into this prospectus.

Decreases in Medicare reimbursement rates received by our outpatient rehabilitation clinics, implementation of annual caps, and payment reductions applied to the second and subsequent therapy services may reduce our future net operating revenues and profitability.

Our outpatient rehabilitation clinics receive payments from the Medicare program under a fee schedule. The Medicare physician fee schedule rates are automatically updated annually based on the sustainable growth rate formula ("SGR formula"), contained in legislation. The American Taxpayer Relief Act of 2012 froze the Medicare physician fee schedule rates at 2012 levels through December 31, 2013, averting a scheduled 26.5% cut as a result of the SGR formula that would have taken effect on January 1, 2013. If no further legislation is passed by Congress and signed by the President, the SGR formula will likely reduce our Medicare outpatient rehabilitation payment rates beginning January 1, 2014.

Congress has established annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for outpatient therapy services rendered to any Medicare beneficiary. As directed by Congress in the Deficit Reduction Act of 2005, CMS implemented an exception process for therapy expenses incurred in 2006. Under this process, a Medicare enrollee (or person acting on behalf of the Medicare enrollee) was able to request an exception from the therapy caps if the provision of

Table of Contents

therapy services was deemed to be medically necessary. Therapy cap exceptions were available automatically for certain conditions and on a case-by-case basis upon submission of documentation of medical necessity. The exception process has been extended by Congress several times. Most recently, the Middle Class Tax Relief and Job Creation Act of 2012 extended the exceptions process through December 31, 2013. The exception process will expire on January 1, 2014 unless further extended by Congress. There can be no assurance that Congress will extend it further. To date, the implementation of the therapy caps has not had a material adverse effect on our business. However, if the exception process is not renewed, our future net operating revenues and profitability may decline.

CMS adopted a multiple procedure payment reduction for therapy services in the final update to the Medicare physician fee schedule for calendar year 2011. The policy became effective January 1, 2011 and applies to all outpatient therapy services paid under Medicare Part B occupational therapy, physical therapy and speech-language pathology. Under the policy, the Medicare program pays 100% of the practice expense component of the therapy procedure or unit of service with the highest Relative Value Unit, and then reduces the payment for the practice expense component for the second and subsequent therapy procedures or units of service furnished during the same day for the same patient, regardless of whether those therapy services are furnished in separate sessions. In 2011 and 2012 the second and subsequent therapy service furnished during the same day for the same patient was reduced by 20% in office and other non-institutional settings and by 25% in institutional settings. The American Taxpayer Relief Act of 2012 increased the payment reduction to 50% effective April 1, 2013. Our outpatient rehabilitation therapy services are primarily offered in institutional settings and, as such, were subject to the applicable 25% payment reduction in the practice expense component for the second and subsequent therapy services furnished by us to the same patient on the same day until April 1, 2013 when the payment reduction increased to 50%. See "Business Government Regulations."

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

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") required the United States Department of Health and Human Services to adopt standards to protect the privacy and security of individually identifiable health-related information. The department released final regulations containing privacy standards in December 2000 and published revisions to the final regulations in August 2002. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. The regulations also provide patients with significant new rights related to understanding and controlling how their health information is used or disclosed. The security regulations require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically. The Health Information Technology for Economic and Clinical Health Act ("HITECH"), which was signed into law in February of 2009, enhanced the privacy, security and enforcement provisions of HIPAA by, among other things establishing security breach notification requirements, allowing enforcement of HIPAA by state attorneys general, and increasing penalties for HIPAA violations. Violations of HIPAA or HITECH could result in civil or criminal penalties.

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

We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy laws. Our compliance officer, privacy officer and information security officer are responsible for implementing and monitoring compliance with our privacy and security policies and

Table of Contents

procedures at our facilities. We believe that the cost of our compliance with HIPAA and other federal and state privacy laws will not have a material adverse effect on our business, financial condition, results of operations or cash flows. However, there can be no assurance that a breach of privacy or security will not occur. If there is a breach, we may be subject to various penalties and damages and may be required to incur costs to mitigate the impact of the breach on affected individuals.

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

The federal self referral law ("Stark Law") prohibits a physician who has a financial relationship with an entity from referring his or her Medicare or Medicaid patients to that entity for certain designated health services, including inpatient and outpatient hospital services. Under the transparency and program integrity provisions of the PPACA, the exception to the Stark Law that previously permitted physicians to refer patients to hospitals in which they have an ownership or investment interest has been dramatically curtailed. Only hospitals, including LTCHs, with physician ownership and a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the percentage of physician ownership or investment interests held in the hospital after March 23, 2010. In addition, physician-owned hospitals are prohibited from increasing the number of licensed beds after March 23, 2010, unless meeting specific exceptions related to the hospital's location and patient population. In order to retain their exemption from the general ban on self-referrals, our physician-owned hospitals are required to adopt specific measures relating to conflicts of interest, bona fide investments and patient safety. Furthermore, initiatives are underway in some states to restrict physician referrals to physician-owned hospitals. Currently, ten of our consolidating hospitals have physicians as minority owners. The aggregate net operating revenue of these ten hospitals was $200.3 million for the year ended December 31, 2012, or approximately 6.8% of our consolidated net operating revenues for the year ended December 31, 2012. The range of physician minority ownership of these ten hospitals was 2.1% to 49.0% as of the year ended December 31, 2012. There can be no assurance that new legislation or regulation prohibiting or limiting physician referrals to physician-owned hospitals will not be successfully enacted in the future. If such federal or state laws are adopted, among other outcomes, physicians who have invested in our hospitals could be precluded from referring to, investing in or continuing to be physician owners of a hospital. In addition, expansion of our physician-owned hospitals may be limited, and the revenues, profitability and overall financial performance of our hospitals may be negatively affected.

Table of Contents

We could experience significant increases to our operating costs due to shortages of healthcare professionals or union activity.

Our specialty hospitals are highly dependent on nurses, and our outpatient rehabilitation division is highly dependent on therapists, for patient care. The market for qualified healthcare professionals is highly competitive. We have sometimes experienced difficulties in attracting and retaining qualified healthcare personnel. We cannot assure you we will be able to attract and retain qualified healthcare professionals in the future. Additionally, the cost of attracting and retaining qualified healthcare personnel may be higher than we anticipate, and as a result, our profitability could decline.

In addition, U.S. healthcare providers are continuing to see an increase in the amount of union activity. Though we cannot predict the degree to which we will be affected by future union activity, there are continuing legislative proposals that could result in increased union activity. We could experience an increase in labor and other costs from such union activity.

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

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

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

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

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

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

Significant legal actions could subject us to substantial uninsured liabilities.

Physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions

Table of Contents

involve large claims and significant defense costs. We are also subject to lawsuits under federal and state whistleblower statutes designed to combat fraud and abuse in the healthcare industry. These whistleblower lawsuits are not covered by insurance and can involve significant monetary damages and award bounties to private plaintiffs who successfully bring the suits. See "Legal Proceedings."

We currently maintain professional malpractice liability insurance and general liability insurance coverages under a combination of policies with a total annual aggregate limit of $30.0 million. Our insurance for the professional liability coverage is written on a "claims-made" basis and our commercial general liability coverage is maintained on an "occurrence" basis. These coverages apply after a self-insured retention of $2.0 million per medical incident for professional liability claims and $2.0 million per occurrence for general liability claims. We review our insurance program annually and may make adjustments to the amount of insurance coverage and self-insured retentions in future years. In addition, our insurance coverage does not generally cover punitive damages and may not cover all claims against us. See "Business Government Regulations Other Healthcare Regulations."

Concentration of ownership among our existing executives, directors and principal stockholders may conflict with your interests as a holder of the notes.

Welsh Carson and Thoma Cressey beneficially own approximately 33.9% and 2.3%, respectively, of Holdings' outstanding common stock as of July 31, 2013. Holdings' executives, directors and principal stockholders, including Welsh Carson and Thoma Cressey, beneficially own, in the aggregate, approximately 54.4% of Holdings' outstanding common stock as of July 31, 2013. As a result, these stockholders have significant control over our management and policies and are able to exercise influence over all matters requiring stockholder approval, including the election of directors, amendment of Holdings' certificate of incorporation and approval of significant corporate transactions. The directors elected by these stockholders are able to make decisions affecting Holdings' capital structure, including decisions to issue additional capital stock, implement stock repurchase programs and incur indebtedness. This influence may have the effect of deterring hostile takeovers, delaying or preventing changes in control or changes in management, or limiting the ability of our other stockholders to approve transactions that they may deem to be in their best interest.

Table of Contents

FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements within the meaning of the federal securities laws. Statements that are not historical facts, including statements about our beliefs and expectations, are forward-looking statements. Forward-looking statements include statements preceded by, followed by or that include the words "may," "could," "would," "should," "believe," "expect," "anticipate," "plan," "target," "estimate," "project," "intend" and similar expressions. These statements include, among others, statements regarding our expected business outlook, anticipated financial and operating results, our business strategy and means to implement our strategy, our objectives, the amount and timing of capital expenditures, the likelihood of our success in expanding our business, financing plans, budgets, working capital needs and sources of liquidity.

Forward-looking statements are only predictions and are not guarantees of performance. These statements are based on our management's beliefs and assumptions, which in turn are based on currently available information. Important assumptions relating to the forward-looking statements include, among others, assumptions regarding our services, the expansion of our services, competitive conditions and general economic conditions. These assumptions could prove inaccurate. Forward-looking statements also involve known and unknown risks and uncertainties, which could cause actual results to differ materially from those contained in any forward-looking statement. Many of these factors are beyond our ability to control or predict. Such factors include, but are not limited to, the following:

- changes in government reimbursement for our services due to the implementation of healthcare reform legislation, deficit reduction measures, and/or new payment policies (including, for example, the expiration of the moratorium on the 25-percent payment adjustment threshold that would reduce our Medicare payments for those patients admitted to a long-term acute care hospital from a referring hospital in excess of the percentage threshold) may result in a reduction in net operating revenues, an increase in costs and a reduction in profitability;

- the impact of the Budget Control Act of 2011 which, as amended by the American Taxpayer Relief Act of 2012, has resulted in a 2% reduction to Medicare payments for services furnished on or after April 1, 2013 and will continue unless further legislation is enacted;

- the failure of our specialty hospitals to maintain their Medicare certifications 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;

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

- acquisitions or joint ventures may prove difficult or unsuccessful, use significant resources or expose us to unforeseen liabilities;

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

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

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

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

Table of Contents

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

the effect of claims asserted against us could subject us to substantial uninsured liabilities; and

other factors discussed from time to time in our filings with the SEC, including factors discussed under the heading "Risk Factors" in this prospectus.

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

USE OF PROCEEDS

We will not receive any proceeds from this exchange offer. Because we are exchanging the new notes for the old notes, which have substantially identical terms, the issuance of the new notes will not result in any increase in our indebtedness. The exchange offer is intended to satisfy our obligations under the registration rights agreements.

Net proceeds from the offering of the old notes were approximately $587.0 million and were used to prepay a portion of the term loans outstanding due 2018 under our senior secured credit facilities.

See "Description of Other Indebtedness."

Table of Contents

RATIO OF EARNINGS TO FIXED CHARGES
(IN THOUSANDS)
(UNAUDITED)

	Year Ended December 31,					Six Months Ended June 30,	
	2008	2009	2010	2011	2012	2012	2013
Pre-tax income from operations before adjustments for non-controlling interests in consolidated subsidiaries or earnings (loss) from equity investees	$ 84,100	$ 152,037	$ 152,297	$ 209,424	$ 247,036	$ 142,910	$ 110,053
Fixed Charges:							
Interest expense and amortization of debt discount and premium on all indebtedness	110,889	99,543	84,472	81,232	83,759	42,207	42,952
Capitalized interest	474	427	767	304	153	29	43
Rentals:							
Buildings 33%(A)	36,380	38,644	39,033	39,070	40,973	20,349	20,230
Office and other equipment 33%(A)	9,580	9,309	12,038	15,010	14,577	7,698	7,105
Total fixed charges	$ 157,323	$ 147,922	$ 136,310	$ 135,616	$ 139,462	$ 70,283	$ 70,330
Pre-tax income from operations before adjustment for non-controlling interests in consolidated subsidiaries or earnings (loss) from equity investees plus fixed charges, less preferred stock dividend requirements of consolidated subsidiaries less capitalized interest	$ 240,949	$ 299,532	$ 287,840	$ 344,736	$ 386,345	$ 213,164	$ 180,340
Ratio of earnings to fixed charges	1.53	2.02	2.11	2.54	2.77	3.03	2.56

(A) The Company uses 33% to estimate the interest on its rentals. This percentage is a reasonable approximation of the interest factor.

Table of Contents

CAPITALIZATION

The following table sets forth our consolidated cash and cash equivalents and capitalization as of June 30, 2013. You should read this table in conjunction with "Summary Summary Historical Consolidated Financial and Other Data" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and the related notes thereto included in this prospectus.

	As of June 30, 2013 (in thousands)	
Cash and cash equivalents	$	8,768
Debt:		
Senior secured term loans(1)	$	811,060
Senior secured revolving loan(2)		105,000
Notes offered to be exchanged hereby(3)		600,000
Other(4)		14,898
Total debt	$	1,530,958
Total stockholders' equity	$	758,299
Total capitalization	$	2,289,257

(1) Reflects the balance sheet liability of the term loans under our senior secured credit facilities in accordance with GAAP. The balance sheet liability so reflected is less than the $818.3 million aggregate principal amount of such loans because such loans were issued with original issue discount. The remaining unamortized original issue discount is $7.2 million at June 30, 2013. Interest on the term loans under our senior secured credit facilities accrues on the full payment thereof, and we will be obligated to repay the full principal amount thereof at maturity or upon any mandatory or voluntary prepayment thereof.

(2) The revolving loan under our senior secured credit facilities provides for borrowings of up to $300.0 million of which $153.1 million was available as of June 30, 2013 for working capital and general corporate purposes (after giving effect to $41.9 million of outstanding letters of credit at June 30, 2013).

(3) Represents the aggregate principal amount of the new notes.

(4) Other debt consists primarily of borrowings to finance insurance programs, indebtedness to sellers of acquired businesses and other miscellaneous borrowings.

Table of Contents

SELECTED HISTORICAL CONSOLIDATED FINANCIAL DATA

The following table sets forth selected historical consolidated condensed financial data for the Issuer. The summary of operations data, balance sheet data and other financial data for each of the years in the five-year period ended December 31, 2012 have been derived from consolidated financial statements audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm. The summary of operations data, balance sheet data and other financial data for each of the six-month periods ended June 30, 2012 and 2013 have been derived from our unaudited interim consolidated financial statements. You should read the following financial information in conjunction with, and it is qualified by reference to, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our audited consolidated financial statements, the related notes and the other financial information included therein.

	For the Year Ended December 31,					Six Months Ended June 30,	
Consolidated Statement of Operations Data (in thousands):	**2008(1)**	**2009**	**2010**	**2011**	**2012**	**2012**	**2013**
Net operating revenues	$ 2,153,362	$ 2,239,871	$ 2,390,290	$ 2,804,507	$ 2,948,969	$ 1,494,214	$ 1,506,628
Operating expenses(2)(3)	1,885,168	1,933,052	2,085,447	2,422,271	2,548,799	1,277,470	1,304,126
Depreciation and amortization	71,786	70,981	68,706	71,517	63,311	31,627	31,709
Income from operations	196,408	235,838	236,137	310,719	336,859	185,117	170,793
Other income and expense:							
Gain (loss) on early retirement of debt(4)	912	12,446		(20,385)	(6,064)		(17,788)
Equity in earnings (losses) of unconsolidated subsidiaries			(440)	2,923	7,705	5,217	1,626
Other income (expense)	(2,802)	3,204	632				
Interest expense, net(5)	(110,418)	(99,451)	(84,472)	(80,910)	(83,759)	(42,207)	(42,952)
Income before income taxes	84,100	152,037	151,857	212,347	254,741	148,127	111,679
Income tax expense	37,334	49,987	51,380	80,984	93,574	57,156	42,809
Net income	46,766	102,050	100,477	131,363	161,167	90,971	68,870
Less: Net income attributable to non-controlling interests(6)	3,393	3,606	4,720	4,916	5,663	2,674	4,482
Net income attributable to Select Medical Corporation	43,373	98,444	95,757	126,447	155,504	88,297	64,388
Other comprehensive income (loss):							
Unrealized gain (loss) on interest rate swap, net of tax	(6,493)	2,522	8,914				
Comprehensive income attributable to Select Medical Corporation	$ 36,880	$ 100,966	$ 104,671	$ 126,447	$ 155,504	$ 88,297	$ 64,388
Balance Sheet Data (at end of period):							
Cash and cash equivalents	$ 64,260	$ 83,680	$ 4,365	$ 12,043	$ 40,144	$ 21,520	$ 8,768
Working capital (deficit)	100,127	153,231	(73,481)	97,348	63,217	105,300	135,428
Total assets	2,562,425	2,585,092	2,719,572	2,770,738	2,760,313	2,778,414	2,845,055
Total debt	1,469,322	1,100,987	1,124,292	1,229,498	1,302,943	1,186,619	1,530,958
Total Select Medical Corporation stockholders' equity	630,315	1,034,006	1,081,661	983,446	881,317	1,027,547	758,299

(1) Adjusted for the adoption of an amendment issued by the FASB in December 2007 to ASC Topic 810, "Consolidation." See Note 1, Organization and Significant Accounting Policies Non-controlling Interests, in our audited consolidated financial statements.

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

(3) Includes stock compensation expense related to restricted stock, stock options and long term incentive compensation.

(4)

The gain (loss) on early retirement of debt relates to the following:

In the year ended December 31, 2008, we paid approximately $1.0 million to repurchase and retire a portion of our 7⅝% senior subordinated notes. These notes had a carrying value of $2.0 million. The gain on early retirement of debt recognized was net of the write-off of unamortized deferred financing costs related to the debt.

Table of Contents

During the year ended December 31, 2009, we paid approximately $30.1 million to repurchase and retire a portion of our 7⅝% senior subordinated notes. These notes had a carrying value of $46.5 million. The gain on early retirement of debt recognized was net of the write-off of unamortized deferred financing costs related to the debt. These gains were offset by the write-off of deferred financing costs of $2.9 million that occurred due to our early prepayment on the term loan portion of its senior secured credit facility.

On June 1, 2011, we refinanced our senior secured credit facility which consisted of an $850.0 million term loan facility and a $300.0 million revolving loan facility. A portion of the proceeds from this transaction were used to repurchase and retire $266.5 million of our 7⅝% senior subordinated notes. A loss on early retirement of debt of $20.4 million was recognized for the year ended December 31, 2011, which included the write-off of unamortized deferred financing costs, tender premiums and original issue discount.

On August 13, 2012, we entered into an additional credit extension amendment to our senior secured credit facility. Pursuant to the terms and conditions of the additional credit extension amendment, the lenders extended an aggregate principal amount of $275.0 million in additional term loans to us at the same interest rate and with the same term as applies to the existing term loan amounts borrowed by us under our senior secured credit facility. On September 12, 2012, we used the proceeds of the additional term loans (other than amounts used for fees and expenses) and cash on hand to redeem an aggregate of $275.0 million principal amount of our outstanding 7⅝% senior subordinated notes due 2015 at a redemption price of 101.271% of the principal amount. We recognized a loss on early retirement of debt of $6.1 million for the year ended December 31, 2012 in connection with the redemption of the senior subordinated notes, which included the write-off of unamortized deferred financing costs and call premiums.

On March 22, 2013, we redeemed all of its outstanding 7⅝% senior subordinated notes due 2015. We recognized a loss on early retirement of debt of $0.5 million during the first quarter 2013, for the unamortized debt issuance costs associated with the redeemed debt. On May 28, 2013, we repaid a portion of our original term loan and series A term loan of our senior secured credit facility and on June 3, 2013, we amended our existing senior secured credit facility. We recognized a loss on early retirement of debt of $17.3 million in the second quarter 2013, which included unamortized debt issuance costs, unamortized original issue discount, and certain debt issuance costs associated with refinancing activities.

(5) Interest expense, net equals interest expense minus interest income.

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

Table of Contents

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

The following is a discussion and analysis of the financial positions of Select as of June 30, 2013 and December 31, 2012 and the results of operations for the six months ended June 30, 2013 and 2012 and years ended December 31, 2012, 2011, and 2010. This commentary should be read in conjunction with the condensed consolidated financial statements and accompanying notes for the six months ended June 30, 2013 and the year ended December 31, 2012 appearing in "Financial Statements and Supplementary Data."

Select is a wholly owned subsidiary of Select Medical Holdings Corporation. Holdings' primary asset is its investment in Select. Holdings conducts all of its business through Select and its subsidiaries.

Overview

We believe that we are one of the largest operators of both specialty hospitals and outpatient rehabilitation clinics in the United States based on number of facilities. As of June 30, 2013, we operated 109 long term acute care hospitals and 14 acute medical rehabilitation hospitals in 28 states, and 988 outpatient rehabilitation clinics in 32 states and the District of Columbia. We also provide medical rehabilitation services on a contracted basis to nursing homes, hospitals, assisted living and senior care centers, schools and work sites. We began operations in 1997 under the leadership of our current management team. As of June 30, 2013 we had operations in 44 states and the District of Columbia.

We manage our Company through two business segments, our specialty hospital segment and our outpatient rehabilitation segment. We had net operating revenues of $2,949.0 million for the year ended December 31, 2012 and $1,506.6 million for the six months ended June 30, 2013. Of this total, we earned approximately 75% and 74% of our net operating revenues from our specialty hospitals and approximately 25% and 26% from our outpatient rehabilitation business for the year ended December 31, 2012 and the six months ended June 30, 2013, 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 are typically admitted to our specialty hospitals from general acute care hospitals. These patients have specialized needs, and serious and often complex medical conditions such as respiratory failure, neuromuscular disorders, traumatic brain and spinal cord injuries, strokes, non-healing wounds, cardiac disorders, renal disorders and cancer. Our outpatient rehabilitation segment 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.

Significant 2013 Events

Refinancing Activities

On February 20, 2013, we entered into an additional credit extension amendment to our senior secured credit facilities providing for a $300.0 million additional term loan tranche, (the "series B term loan"). We used the borrowings under the series B term loan to redeem all of our outstanding 7$^{5}/_{8}$% senior subordinated notes due 2015 on March 22, 2013, to finance Holdings' redemption of all of its senior floating rate notes due 2015 on March 22, 2013 and to repay a portion of the balance outstanding under our revolving credit facility. We recognized a loss on early retirement of debt of $0.5 million in the three months ended March 31, 2013 related to the redemption of our senior subordinated notes.

On May 28, 2013, we issued and sold $600.0 million aggregate principal amount of 6.375% senior notes due 2021. The senior notes are senior unsecured obligations and are fully and unconditionally

Table of Contents

guaranteed by all of our wholly owned subsidiaries. On May 28, 2013, we used the proceeds of the senior notes to pay a portion of the amounts outstanding on the original term loan and the series A term loan and to pay related fees and expenses. We recognized a loss on early retirement of debt of $17.3 million in the three months ended June 30, 2013 in connection with the repayment of a portion of our term loans and amendment of the existing senior secured credit facility, which included the write-off of unamortized debt issuance costs.

On June 3, 2013, we amended our existing senior secured credit facilities in order to:

- extend the maturity date on $293.3 million of our $300.0 million revolving credit facility from June 1, 2016 to March 1, 2018;

- convert the remaining original term loan and series A term loan to a series C term loan and lower the interest rate payable on the series C term loan from Adjusted LIBO plus 3.75%, or Alternate Base Rate plus 2.75%, to Adjusted LIBO plus 3.00%, or Alternate Base Rate plus 2.00%, and amend the provision of the series C term loan from providing that Adjusted LIBO will at no time be less than 1.75% to providing that Adjusted LIBO will at no time be less than 1.00%; and

- amend the restrictive covenants governing the senior secured credit facilities in order to allow for unlimited restricted payments so long as there is no event of default under the senior secured credit facilities and the total pro forma ratio of total indebtedness to Consolidated EBITDA (as defined in our senior secured credit facilities) is less than or equal to 2.75 to 1.00.

Budget Control Act of 2011

On April 1, 2013 a federally mandated 2% reduction to Medicare payments was implemented resulting in reductions to our net operating revenues and income from operations of approximately $9.5 million, of which approximately $9.1 million was related to our specialty hospitals and $0.4 million was related to outpatient rehabilitation, in the three months ended June 30, 2013. See the section titled "Regulatory Changes" "Budget Control Act of 2011" for a discussion of this regulatory change.

American Taxpayer Relief Act of 2012

On April 1, 2013 the multiple procedure payment reduction ("MPPR Reduction") for therapy services was increased to 50% resulting in reductions to our net operating revenues and income from operations of approximately $1.7 million in the three months ended June 30, 2013. See the section titled "Regulatory Changes" "Medicare Reimbursement of Outpatient Rehabilitation Services" "Multiple Procedure Payment Reduction" for a discussion of this regulatory change.

Significant 2012 Events

Refinancing Activities

On August 13, 2012, we entered into an additional credit extension amendment to our senior secured credit facility. Pursuant to the terms and conditions of the additional credit extension amendment, the lenders extended an aggregate principal amount of $275.0 million in additional term loans to us at the same interest rate and with the same term as applies to the existing term loan amounts borrowed by us under our senior secured credit facility. On September 12, 2012, we used the proceeds of the additional term loans (other than amounts used for fees and expenses) and cash on hand to redeem an aggregate of $275.0 million principal amount of our outstanding $7^{5}/_{8}$% senior subordinated notes due 2015 at a redemption price of 101.271% of the principal amount. We recognized a loss on early retirement of debt of $6.1 million for the year ended December 31, 2012 in connection with the redemption of the senior subordinated notes, which included the write-off of unamortized deferred financing costs and call premiums.

Table of Contents

Special Cash Dividend

On October 30, 2012, Holdings' board of directors declared a special cash dividend of $1.50 per share, or $210.9 million, paid on December 12, 2012 to all common stockholders of record (including holders of shares of restricted stock) on December 5, 2012. Cash for the dividend came from our cash on hand and borrowings under our senior secured revolving credit facility.

Stock Repurchase Program

Holdings' board of directors had authorized a common stock repurchase program of up to $350.0 million through March 31, 2014, unless extended by the board of directors. Stock repurchases under this program may be made in the open market or through privately negotiated transactions, and at times and in such amounts as Holdings deems appropriate. The timing of purchases of stock will be based upon market conditions and other factors. Holdings is funding this program with our cash on hand or borrowings under our revolving credit facility. Holdings repurchased 5,725,782 shares at a cost of $46.8 million, an average cost per share of $8.17, which includes transaction costs, during the year ended December 31, 2012 and an additional 1,115,691 shares at a cost of approximately $10.0 million, an average cost per share of $8.95, which includes transaction costs, during the six months ended June 30, 2013. Since the inception of the program through June 30, 2013, Holdings has repurchased 23,606,080 shares at a cost of approximately $173.6 million, or $7.36 per share, which includes transaction costs.

Summary Financial Results

Six Months Ended June 30, 2013

For the six months ended June 30, 2013, our net operating revenues increased 0.8% to $1,506.6 million compared to $1,494.2 million for the six months ended June 30, 2012. We experienced increases in net operating revenues in both our specialty hospital and outpatient rehabilitation segments. We had income from operations for the six months ended June 30, 2013 of $170.8 million compared to $185.1 million for the six months ended June 30, 2012. Our Adjusted EBITDA for the six months ended June 30, 2013 was $206.0 million, compared to $219.3 million for the six months ended June 30, 2012 and our Adjusted EBITDA margin was 13.7% for the six months ended June 30, 2013 compared to 14.7% for the six months ended June 30, 2012. See the section entitled "Results of Operations" for a reconciliation of net income to Adjusted EBITDA. The decrease in our income from operations, Adjusted EBITDA and Adjusted EBITDA margin is principally due to the 2% reduction in Medicare payments implemented April 1, 2013 as part of the automatic reductions in federal spending mandated under the Budget Control Act of 2011 and the MPPR Reduction, and increases in our operating expenses.

Net income attributable to Select was $64.4 million for the six months ended June 30, 2013 compared to $88.3 million for the six months ended June 30, 2012. The decrease in net income resulted from a decrease in our income from operations described above, a loss on early retirement of debt, and a decrease in our equity in earnings of unconsolidated subsidiaries, offset in part by a reduction in our effective income tax rate. Cash flow from operations provided $27.6 million of cash for the six months ended June 30, 2013.

Year Ended December 31, 2012

For the year ended December 31, 2012, our net operating revenues increased 5.2% to $2,949.0 million compared to $2,804.5 million for the year ended December 31, 2011. For the year ended December 31, 2012, our specialty hospital revenues increased $102.0 million or 4.9% from the prior year and our outpatient rehabilitation revenues increased $42.5 million or 6.0% from the prior year. We had income from operations for the year ended December 31, 2012 of $336.9 million compared to $310.7 million for the year ended December 31, 2011. We had net income attributable to

Table of Contents

Select for the year ended December 31, 2012 of $155.5 million compared to $126.4 million for the year ended December 31, 2011. Our Adjusted EBITDA for the year ended December 31, 2012 was $405.8 million compared to $386.0 million for the year ended December 31, 2011. See the section entitled "Results of Operations" for a reconciliation of net income to Adjusted EBITDA. The increases in our income from operations and Adjusted EBITDA for the year ended December 31, 2012 are principally due to increases in the operating performance of our specialty hospital segment. We were able to increase our specialty hospital income from operations $22.8 million or 7.3% and our specialty hospital Adjusted EBITDA $19.0 million or 5.2% for the year ended December 31, 2012 as compared to the year ended December 31, 2011.

Net income attributable to Select increased $29.1 million to $155.5 million for the year ended December 31, 2012 compared to $126.4 million for the year ended December 31, 2011. The increase resulted primarily from an increase in our income from operations described above, increases in our equity in earnings of unconsolidated subsidiaries principally related to our joint venture with the Baylor Health Care System, or the "Baylor JV," and a reduction of interest expense. We also incurred a smaller loss on early retirement of debt related to the refinancing transactions completed in 2012 compared to the refinancing transactions completed in 2011. Cash flow from operations provided $309.4 million of cash for the year ended December 31, 2012.

Year Ended December 31, 2011

For the year ended December 31, 2011, our net operating revenues increased 17.3% to $2,804.5 million compared to $2,390.3 million for the year ended December 31, 2010. This increase in net operating revenues resulted principally from a 23.1% increase in our specialty hospital net operating revenue. The increase in our specialty hospital revenue is primarily due to the Regency hospitals we acquired on September 1, 2010. We had income from operations for the year ended December 31, 2011 of $310.7 million compared to $236.1 million for the year ended December 31, 2010. We had net income attributable to Select for the year ended December 31, 2011 of $126.4 million compared to $104.7 million for the year ended December 31, 2010. Our Adjusted EBITDA for the year ended December 31, 2011 was $386.0 million compared to $307.1 million for the year ended December 31, 2010. See the section entitled "Results of Operations" for a reconciliation of net income to Adjusted EBITDA.

The increase in income from operations, net income and Adjusted EBITDA for the year ended December 31, 2011 from the prior year resulted from the addition of the Regency hospitals acquired on September 1, 2010 and improved operating performance at our other specialty hospitals. Interest expense for the year ended December 31, 2011 was $81.2 million compared to $84.5 million for the year ended December 31, 2010. The decrease in interest expense is attributable to a reduction in our average interest rate that resulted from the expiration of interest rate swaps during 2010 that carried higher fixed interest rates and lower interest rates on portions of the debt we refinanced on June 1, 2011. Cash flow from operations provided $240.1 million of cash for the year ended December 31, 2011.

Regulatory Changes

The Medicare program reimburses us 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. Net operating revenues generated directly from the Medicare program represented approximately 47%, 48% and 47% of our consolidated net operating revenues for the years ended December 31, 2010, 2011 and 2012, respectively.

The Medicare program reimburses our long term acute care hospitals, inpatient rehabilitation facilities and outpatient rehabilitation providers, using different payment methodologies. Those payment methodologies are complex and are described elsewhere in this report under "Business Government

Table of Contents

Regulations." The following is a summary of some of the more significant healthcare regulatory changes that have affected our financial performance in the periods covered by this report or are likely to affect our financial performance and financial condition in the future.

Budget Control Act of 2011

The Budget Control Act of 2011, enacted on August 2, 2011, increased the federal debt ceiling in connection with deficit reductions over the next ten years. The Budget Control Act of 2011 requires automatic reductions in federal spending by approximately $1.2 trillion split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap, which are expected to reduce Medicare payments by more than $9.5 billion in fiscal year 2013 and $123 billion over the period of fiscal years 2013 to 2021. On April 1, 2013, a 2% reduction to Medicare payments was implemented. For the three months ended June 30, 2013, this reduction has reduced our net operating revenues and income from operation by approximately $9.5 million. We have estimated that this reduction will reduce our net operating revenues and income from operations by approximately $16.0 million to $17.0 million for the remainder of 2013.

Medicare Reimbursement of LTCH Services

In the last few years, there have been significant regulatory changes affecting long term acute care hospitals that have affected our net operating revenues and, in some cases, caused us to change our operating models and strategies. We have been subject to regulatory changes that occur through the rulemaking procedures of the Centers for Medicare & Medicaid Services, or "CMS." All Medicare payments to our long term acute care hospitals are made in accordance with a prospective payment system specifically applicable to long term acute care hospitals, referred to as "LTCH-PPS." Proposed rules specifically related to LTCHs are generally published in May, finalized in August and effective on October 1st of each year, coinciding with the start of the federal fiscal year.

The following is a summary of significant changes to the Medicare prospective payment system for long term acute care hospitals which have affected our results of operations, as well as the policies and payment rates for fiscal year 2014 that affect our patient discharges and cost reporting periods beginning on or after October 1, 2013.

Fiscal Year 2011. On August 16, 2010, CMS published the policies and payment rates for LTCH-PPS for fiscal year 2011 (affecting discharges and cost reporting periods beginning on or after October 1, 2010 through September 30, 2011). The standard federal rate for fiscal year 2011 was $39,600, which was a decrease from the fiscal year 2010 standard federal rate of $39,897 in effect from October 1, 2009 to March 31, 2010 and the fiscal year 2010 standard federal rate of $39,795 that went into effect on April 1, 2010. This update to the standard federal rate for fiscal year 2011 was based on a market basket increase of 2.5% less a reduction of 2.5% to account for what CMS attributed as an increase in case-mix in prior periods that resulted from changes in documentation and coding practices less an additional market basket reduction of 0.5% as mandated by the PPACA. The final rule established a fixed-loss amount for high cost outlier cases for fiscal year 2011 of $18,785, which was an increase from the fiscal year 2010 fixed-loss amount of $18,425 in effect from October 1, 2009 to March 31, 2010 and the $18,615 that went into effect on April 1, 2010.

Fiscal Year 2012. On August 18, 2011, CMS published the policies and payment rates for LTCH-PPS for fiscal year 2012 (affecting discharges and cost reporting periods beginning on or after October 1, 2011 through September 30, 2012). The standard federal rate for fiscal year 2012 was $40,222, which was an increase from the fiscal year 2011 standard federal rate of $39,600. The update to the standard federal rate for fiscal year 2012 included a market basket increase of 2.9%, less a productivity adjustment of 1.0%, and less an additional market basket reduction of 0.1% as mandated

Table of Contents

by the PPACA. The final rule established a fixed-loss amount for high cost outlier cases for fiscal year 2012 of $17,931, which was a decrease from the fixed loss amount in the 2011 fiscal year of $18,785.

Fiscal Year 2013. On August 1, 2012, CMS published the final rule updating the policies and payment rates for LTCH-PPS for fiscal year 2013 (affecting discharges and cost reporting periods beginning on or after October 1, 2012 through September 30, 2013). Two different standard federal rates apply during fiscal year 2013. The standard federal rate for discharges on or after October 1, 2012 and through December 28, 2012 was set at $40,916 and the standard federal rate for discharges on or after December 29, 2012 for the remainder of fiscal year 2013 is $40,398 both of which are an increase from the fiscal year 2012 standard federal rate of $40,222. The update to the standard federal rate for fiscal year 2013 through December 28, 2012 included a market basket increase of 2.6%, less a productivity adjustment of 0.7% and less an additional reduction of 0.1% mandated by the Patient Protection and Affordable Care Act ("PPACA"). The standard federal rate for the period of December 29, 2012 through the remainder of fiscal 2013 is further reduced by a portion of the one-time budget neutrality adjustment of 1.266%, as discussed below. The final rule established a fixed-loss amount for high cost outlier cases for fiscal year 2013 of $15,408, which is a decrease from the fixed-loss amount in the 2012 fiscal year of $17,931.

Fiscal Year 2014. On August 1, 2013, CMS released an advanced copy of the final rule updating the policies and payment rates for LTCH-PPS for fiscal year 2014 (affecting discharges and cost reporting periods beginning on or after October 1, 2013 through September 30, 2014). The standard federal rate was set at $40,607, an increase from the standard federal rate applicable during the period from December 29, 2012 through September 30, 2013 of $40,398. The update to the standard federal rate for fiscal year 2014 includes a market basket increase of 2.5%, less a productivity adjustment of 0.5%, less a reduction of 0.3% mandated by the PPACA, and less a budget neutrality adjustment of 1.266%, as discussed below. The fixed-loss amount for high cost outlier cases was set at $13,314, which is a decrease from the fixed-loss amount in the 2013 fiscal year of $15,408.

Medicare Market Basket Adjustments

The PPACA instituted a market basket payment adjustment to LTCHs. In fiscal year 2014, the market basket update will be reduced by 0.3%. Fiscal years 2015 and 2016 the market basket update will be reduced by 0.2%. Finally, in fiscal years 2017-2019, the market basket update will be reduced by 0.75%. The PPACA specifically allows these market basket reductions to result in less than a 0% payment update and payment rates that are less than the prior year.

25 Percent Rule

The 25 Percent Rule is a downward payment adjustment that applies to Medicare patients discharged from LTCHs who were admitted from a co-located hospital or a non-co-located hospital and caused the LTCH to exceed the applicable percentage thresholds for discharged Medicare patients. The SCHIP Extension Act of 2007 as amended by the American Recovery and Reinvestment Act and the PPACA has limited the application of the 25 Percent Rule. CMS adopted through regulations an additional one-year extension of relief from the full application of Medicare admission thresholds. As a result, full implementation of the Medicare admission thresholds will not go into effect until cost reporting periods beginning on or after October 1, 2013. After the expiration of the extension, our LTCHs will be subject to a downward payment adjustment for any Medicare patients who were admitted from a co-located or a non-co-located hospital and that exceed the applicable percentage threshold of all Medicare patients discharged from the LTCH during the cost reporting period.

In the preamble to the proposed update to the Medicare policies and payment rates for fiscal year 2014, CMS seeks public comments on adoption of a payment adjustment based on whether a particular case qualifies as chronically critically ill/medically complex ("CCI/MC"). CMS is considering a change to the LTCH-PPS payment policies that would limit full LTCH-PPS payment to those patients meeting

Table of Contents

the definition of CCI/MC while they were in an IPPS hospital inpatient setting and subsequently directly admitted to an LTCH. Payment for non-CCI/MC patients would be made at an "IPPS comparable amount," that is, an amount comparable to what would have been paid under the IPPS calculated as a per diem rate with total payments capped at the full IPPS MS-DRG payment rate. We cannot predict whether CMS will adopt the CCI/MC patient-level criteria in the future or, if adopted, how such criteria would affect the application of the 25 Percent Rule to our LTCHs.

One-Time Budget Neutrality Adjustment

The regulations governing LTCH-PPS authorizes CMS to make a one-time adjustment to the standard federal rate to correct any "significant difference between actual payments and estimated payments for the first year" of LTCH-PPS. In the update to the Medicare policies and payment rates for fiscal year 2013, CMS adopted a one-time budget neutrality adjustment that results in a permanent negative adjustment of 3.75% to the LTCH base rate. CMS is implementing the adjustment over a three-year period by applying a factor of 0.98734 to the standard federal rate in fiscal years 2013, 2014 and 2015, except that the adjustment did not apply to payments for discharges occurring on or after October 1, 2012 through December 28, 2012.

Short Stay Outlier Policy

CMS established a different payment methodology for Medicare patients with a length of stay less than or equal to five-sixths of the geometric average length of stay for that particular MS-LTC-DRG, referred to as a short stay outlier, or "SSO." The SSO rule was further revised adding a category referred to as a "very short stay outlier" for discharges occurring on or after December 29, 2012. For cases with a length of stay that is equal to or less than one standard deviation from the geometric average length of stay for the same MS-DRG under IPPS, referred to as the so-called "IPPS comparable threshold," the rule lowers the LTCH payment to a rate based on the general acute care hospital IPPS per diem. SSO cases with covered lengths of stay that exceed the IPPS comparable threshold continue to be paid under the SSO payment policy.

Moratorium on New LTCHs and New LTCH Beds

The SCHIP Extension Act imposed a moratorium on the establishment and classification of new LTCHs, LTCH satellite facilities and LTCH beds in existing LTCHs or satellite facilities subject to certain exceptions. PPACA extended this moratorium by two years. The moratorium expired on December 28, 2012. Unless Congress or CMS take further action, new LTCHs, LTCH satellite facilities and LTCH beds may be established and enrolled in the Medicare program.

Medicare Reimbursement of Inpatient Rehabilitation Facility Services

The following is a summary of significant changes to the Medicare prospective payment system for inpatient rehabilitation facilities which have affected our results of operations during the periods presented in this report, as well as the policies and payment rates for fiscal year 2013 that affect our patient discharges and cost reporting periods beginning on or after October 1, 2012.

Fiscal Year 2011. On July 22, 2010, CMS published an update to the payment rates for IRF-PPS for fiscal year 2011 (affecting discharges and cost reporting periods beginning on or after October 1, 2010 through September 30, 2011). The standard payment conversion factor for discharges during fiscal year 2011 was $13,860, which was an increase from the standard payment conversion factor from fiscal year 2010 of $13,627. The update to the standard payment conversion factor for fiscal year 2011 included the market basket reduction of 0.25% required by PPACA. CMS also increased the outlier threshold amount for fiscal year 2011 to $11,410 from $10,721.

Table of Contents

Fiscal Year 2012. On August 5, 2011, CMS published the policies and payment rates for IRF-PPS for fiscal year 2012 (affecting discharges and cost reporting periods beginning on or after October 1, 2011 and through September 30, 2012). The standard payment conversion factor for discharges during fiscal year 2012 was $14,076 which was an increase from the fiscal year 2011 standard payment conversion factor of $13,860. The update to the standard payment conversion factor for fiscal year 2012 included a market basket increase of 2.9%, less a productivity adjustment of 1.0%, and less an additional market basket reduction of 0.1% as mandated by the PPACA. CMS decreased the outlier threshold amount for fiscal year 2012 to $10,660 from $11,410 established in the final rule for fiscal year 2011. In a notice published September 26, 2011, CMS corrected its calculation of the outlier threshold amount for fiscal year 2012 to $10,713.

Fiscal Year 2013. On July 30, 2012, CMS published the policies and payment rates for IRF-PPS for fiscal year 2013 (affecting discharges and cost reporting periods beginning on or after October 1, 2012 through September 30, 2013). The standard payment conversion factor for discharges for fiscal year 2013 is $14,343, which is an increase from the fiscal year 2012 standard payment conversion factor of $14,076. The update to the standard payment conversion factor for fiscal year 2013 includes a market basket increase of 2.7%, less a productivity adjustment of 0.7%, less an additional reduction of 0.1% as mandated by the PPACA. CMS decreased the outlier threshold amount for fiscal year 2013 to $10,466 from $10,713 established in the final rule for fiscal year 2012.

Fiscal Year 2014. On July 31, 2013, CMS released an advanced copy of the final rule updating policies and payment rates for IRF-PPS for fiscal year 2014 (affecting discharges and cost reporting periods beginning on or after October 1, 2013 through September 30, 2014). The standard payment conversion factor for discharges for fiscal year 2014 is $14,846, which is an increase from the fiscal year 2013 standard payment conversion factor of $14,343. The update to the standard payment conversion factor for fiscal year 2014 includes a market basket increase of 2.6%, less a productivity adjustment of 0.5%, less an additional reduction of 0.3% as mandated by the PPACA. CMS decreased the outlier threshold amount for fiscal year 2014 to $9,272 from $10,466 established in the final rule for fiscal year 2013.

Classification Criteria for Inpatient Rehabilitation Facilities

In order to be excluded from the hospital inpatient PPS and be paid at the higher IRF-PPS rates, an inpatient hospital must demonstrate that at least 60 percent of its patients meet the criteria specified in the regulations, including the need for intensive inpatient rehabilitation services for one or more of the 13 listed conditions, representing a presumptive need for intensive inpatient rehabilitation. Compliance is demonstrated through either medical review or the "presumptive" method, in which a patient's diagnosis codes are compared to a "presumptive compliance" list.

CMS has announced that it will remove a number of diagnosis codes from the presumptive compliance list. According to CMS, these conditions do not demonstrate the need for intensive inpatient rehabilitation services in the absence of additional facts that would have to be pulled from a patient's medical record. As a result, beginning on or after October 1, 2014, a number of diagnosis codes previously on the presumptive compliance list will be removed, including diagnosis codes in the following categories: non specific diagnosis codes, arthritis diagnosis codes, unilateral upper extremity amputations diagnosis, some congenital anomalies diagnosis codes, other miscellaneous diagnosis codes.

Medicare Market Basket Adjustments

The PPACA instituted a market basket payment adjustment for IRFs. For fiscal year 2014, the reduction is 0.3%. For fiscal years 2015 and 2016, the reduction is 0.2%. For fiscal years 2017 - 2019, the reduction is 0.75%. The PPACA specifically allows these market basket reductions to result in less than a 0% payment update and payment rates that are less than the prior year.

Table of Contents

Medicare Reimbursement of Outpatient Rehabilitation Services

Medicare Physician Fee Schedule and Sustainable Growth Rate Update

The Medicare program reimburses outpatient rehabilitation providers based on the Medicare physician fee schedule. The Medicare physician fee schedule rates are automatically updated annually based on a formula, called the sustainable growth rate ("SGR") formula, contained in legislation. The SGR formula has resulted in automatic reductions in rates in every year since 2002; however, for each year through 2013 CMS or Congress has taken action to prevent the SGR formula reductions. The American Taxpayer Relief Act of 2012 froze Medicare physician fee schedule rates at 2012 levels through December 31, 2013, averting a scheduled 26.5% cut as a result of the SGR formula that would have taken effect on January 1, 2013. On March 5, 2013, CMS estimated a 24.4% reduction in the Medicare physician fee schedule payment rates for calendar year 2014, unless Congress again takes legislative action to prevent the SGR formula reductions from going into effect. If Congress takes such legislative action, the projected impact of the proposed 2014 Medicare physician fee schedule rule on outpatient physical therapy services would be a positive 1% in aggregate for calendar year 2014. However, the amount of payment for each service would vary depending on CPT codes billed and the geographic practice cost indices adjustments among localities.

Therapy Caps

Beginning on January 1, 1999, the Balanced Budget Act of 1997 subjected certain outpatient therapy providers reimbursed under the Medicare physician fee schedule to annual limits for therapy expenses. Effective January 1, 2013, the annual limit on outpatient therapy services is $1,900 for combined physical and speech language pathology services and $1,900 for occupational therapy services. The per beneficiary caps were $1,880 for calendar year 2012. It is anticipated that in calendar year 2014 the therapy cap will be the 2013 rate increased by the percentage increase in the Medicare Economic Index. The Middle Class Tax Relief and Job Creation Act of 2012 extended the annual limits on therapy expenses to hospital outpatient departments for dates of service on or after October 1, 2012. The application of annual limits to hospital outpatient department settings will sunset at the end of 2013 unless Congress takes further action to extend it.

In the Deficit Reduction Act of 2005, Congress implemented an exceptions process to the annual limit for therapy expenses. Under this process, a Medicare enrollee (or person acting on behalf of the Medicare enrollee) is able to request an exception from the therapy caps if the provision of therapy services was deemed to be medically necessary. Therapy cap exceptions have been available automatically for certain conditions and on a case-by-case basis upon submission of documentation of medical necessity. The American Taxpayer Relief Act of 2012 extends the exceptions process for outpatient therapy caps through December 31, 2013. Unless Congress extends the exceptions process, the therapy caps will apply to all outpatient therapy services beginning January 1, 2014, except those services furnished and billed by outpatient hospital departments, as noted above.

The Middle Class Tax Relief and Job Creation Act of 2012 made several changes to the exceptions process to the annual limit for therapy expenses. For any claim above the annual limit, the claim must contain a modifier indicating that the services are medically necessary and justified by appropriate documentation in the medical record. Effective October 1, 2012, all claims exceeding $3,700 are subject to a manual medical review process. The $3,700 threshold is applied separately to the combined physical therapy/speech therapy cap and the occupational therapy cap. The American Taxpayer Relief Act of 2012 extends through December 31, 2013 the requirement that Medicare perform manual medical review of therapy services when an exception is requested for cases in which the beneficiary has reached a specified dollar aggregate threshold, including therapy services furnished in hospital outpatient departments. Effective October 1, 2012, all therapy claims, whether above or below the annual limit, must include the national provider identifier (NPI) of the physician responsible for

Table of Contents

certifying and periodically reviewing the plan of care. As of January 1, 2013, CMS implemented a claims based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy. Effective January 1, 2013, all therapy claims must include additional codes and modifiers providing information about the beneficiary's functional status at the outset of the therapy episode of care, specified points during treatment, and at the time of discharge. After July 1, 2013, claims submitted without the appropriate codes and modifiers will be returned unpaid.

Multiple Procedure Payment Reduction

CMS adopted a multiple procedure payment reduction for therapy services in the final update to the Medicare physician fee schedule for calendar year 2011. This multiple procedure payment reduction policy became effective January 1, 2011 and applies to all outpatient therapy services paid under Medicare Part B. Furthermore, the multiple procedure payment reduction policy applies across all therapy disciplines occupational therapy, physical therapy and speech-language pathology. Under the policy, the Medicare program pays 100% of the practice expense component of the therapy procedure or unit of service with the highest Relative Value Unit, and then reduces the payment for the practice expense component for the second and subsequent therapy procedures or units of service furnished during the same day for the same patient, regardless of whether those therapy services are furnished in separate sessions. In 2011 and 2012, the second and subsequent therapy service furnished during the same day for the same patient was reduced by 20% in office and other non-institutional settings and by 25% in institutional settings. The American Taxpayer Relief Act of 2012 increases the payment reduction in either setting to 50% effective April 1, 2013 for all outpatient therapy services. Our outpatient rehabilitation therapy services are primarily offered in institutional settings and, as such, are subject to the applicable 25% payment reduction in the practice expense component for the second and subsequent therapy services furnished by us to the same patient on the same day until April 1, 2013 when the payment reduction was increased to 50%.

Critical Accounting Matters

Merger Transactions

On February 24, 2005, EGL Acquisition Corp. was merged with and into Select, with Select continuing as the surviving corporation and a wholly owned subsidiary of Holdings. The merger was completed pursuant to an agreement and plan of merger, dated as of October 17, 2004, among EGL Acquisition Corp., Holdings and Select. We refer to the merger and the related transactions collectively as the "Merger."

As a result of the Merger transactions, the majority of Select's assets and liabilities were adjusted to their fair value as of February 25, 2005. The excess of the total purchase price over the fair value of Select's tangible and identifiable intangible assets was allocated to goodwill. Additionally, 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.

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 47%, 48% and 47% of net operating revenues for the years ended

Table of Contents

December 31, 2012, 2011 and 2010, respectively. Net operating revenues generated directly from the Medicare program from all segments represented approximately 46% and 47% of net operating revenues for the six months ended June 30, 2013 and 2012. Approximately 60%, 61% and 61% of our specialty hospital revenues for the years ended December 31, 2012, 2011 and 2010, respectively, were received for services provided to Medicare patients. Approximately 59% and 60% of our specialty hospital revenues for the six months ended June 30, 2013 and 2012 were received for services provided to Medicare patients.

Most of our specialty hospitals receive bi-weekly periodic interim payments from Medicare instead of being paid on an individual claim basis. Under a periodic interim payment methodology, Medicare estimates a hospital's claim volume based on historical trends and makes bi-weekly interim payments to us based on these estimates. Twice a year per hospital, Medicare reconciles the differences between the actual claim data and the estimated payments. To the extent our actual hospital's experience is different from the historical trends used by Medicare to develop the estimate, the periodic interim payment will result in our being either temporarily over-paid or under-paid for our Medicare claims. At each balance sheet date, we record any aggregate under-payment as an account receivable or any aggregate over-payment as a payable to third-party payors on our balance sheet. The timing of when we receive our bi-weekly periodic interim payments, in relation to our balance sheet date, can have an impact on our accounts receivable balance and our days sales outstanding as of the end of any reporting period.

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. In our specialty hospital segment our billing system automatically calculates estimated Medicare reimbursement and associated contractual allowances. For non-governmental payors in our specialty hospital segment, we either manually calculate the contractual allowance for each patient based upon the contractual provisions associated with the specific payor or where we have a relatively homogeneous patient population, we monitor individual payors' historical closed paid claims data and apply those payment rates to the existing patient population. The net payments are converted into per diem rates. The per diem rates are applied to unpaid patient days to determine the expected payment and a contractual adjustment is recorded to adjust the recorded amount to agree with the expected payment. Quarterly, we update our analysis of historical closed paid claims. 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 to gross revenues to arrive at net operating revenues in the period that the difference is determined. We believe the processes described above and used in recording our contractual adjustments have resulted in reasonable estimates determined on a consistent basis.

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 financial performance. Our primary collection risks relate to non-governmental payors who insure these patients,

Table of Contents

and deductibles, co-payments and self-insured amounts owed by the patient. Deductibles, co-payments and self-insured amounts are an immaterial portion of our net accounts receivable balance. At June 30, 2013, deductibles, co-payments and self-insured amounts owed by the patient accounted for approximately 0.3% of our net accounts receivable balance before doubtful accounts. Our general policy is to verify insurance coverage prior to the date of admission for a patient admitted to our hospitals, or in the case of our outpatient rehabilitation clinics, we verify insurance coverage prior to their first therapy visit. Our estimate for the allowance for doubtful accounts is calculated by providing a reserve allowance based upon the age of an account balance. Generally we reserve as uncollectible all governmental accounts over 365 days from discharge 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 have historically collected substantially all of our third-party insured receivables (net of contractual allowances) which include receivables from governmental agencies. Historically, there has not been a material difference between our bad debt allowances and the ultimate historical collection rates on accounts receivable. We review our overall reserve adequacy by monitoring historical cash collections as a percentage of net revenue less the provision for bad debts. Uncollected accounts are charged against the reserve 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 as of the dates indicated (in thousands):

	Balance as of December 31,				Balance as of June 30,	
	2011		2012		2013	
	0-180 Days	Over 180 Days	0-180 Days	Over 180 Days	0-180 Days	Over 180 Days
Commercial insurance and other	$ 237,171	$ 35,801	$ 230,878	$ 31,441	$ 247,571	$ 29,744
Medicare and Medicaid	176,616	11,624	133,318	6,146	186,203	6,739
Total net accounts receivable	$ 413,787	$ 47,425	$ 364,196	$ 37,587	$ 433,774	$ 36,483

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

	As of December 31,		As of June 30,
	2011	2012	2013
0 to 90 days	82.9%	83.0%	84.8%
91 to 180 days	6.9%	7.6%	7.5%
181 to 365 days	4.5%	4.8%	4.0%
Over 365 days	5.7%	4.6%	3.7%
Total	100.0%	100.0%	100.0%

Table of Contents

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

	As of December 31,		As of June 30,
	2011	2012	2013
Commercial insurance and other	59.0%	65.1%	58.6%
Medicare and Medicaid	40.8%	34.7%	41.1%
Self-pay receivables (including deductibles and co-payments)	0.2%	0.2%	0.3%
Total	100.0%	100.0%	100.0%

Insurance

Under a number of our insurance programs, which include our employee health insurance program and certain components under our property and casualty insurance program, we are liable for a portion of our losses. In these cases we accrue for our losses under an occurrence based principle whereby we estimate the losses that will be incurred by us in a given accounting period and accrue that estimated liability. Where we have substantial exposure, we utilize actuarial methods in estimating the losses. In cases where we have minimal exposure, we will estimate our losses by analyzing historical trends. We monitor these programs quarterly and revise our estimates as necessary to take into account additional information. At June, 30, 2013, December 31, 2012 and December 31, 2011, we have recorded a liability of $88.8 million, $92.5 million and $85.7 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 $4.0 million for both the years ended December 31, 2012 and 2011. Our payments to these related parties amounted to $2.1 million for the six months ended June 30 2013 and $2.0 million for the six months ended June 30, 2012. Our future commitments are related to commercial office space we lease for our corporate headquarters in Mechanicsburg, Pennsylvania. These future commitments as of December 31, 2012 amount to $36.4 million through 2023. These transactions and commitments are described more fully in the notes to our consolidated financial statements included herein. The Company's practice is that any such transaction must receive the prior approval of both the audit and compliance committee of the board of directors and a majority of non-interested members of the board of directors. It is the Company's practice that an independent third-party appraisal supporting the amount of rent for such leased space is obtained prior to approving the related party lease of office space.

Goodwill and Other Intangible Assets

Goodwill and certain other indefinite-lived intangible assets are subject to periodic impairment evaluations. Our most recent impairment assessment was completed during the fourth quarter of 2012, which indicated that there was no impairment with respect to goodwill or other recorded intangible assets. The majority of our goodwill resides in our specialty hospital reporting unit. In performing periodic impairment tests, the fair value of the reporting unit is compared to the carrying value, including goodwill and other intangible assets. If the carrying value exceeds the fair value, an impairment condition exists, which results in an impairment loss equal to the excess carrying value. Impairment tests are required to be conducted at least annually, or when events or conditions occur that might suggest a possible impairment. These events or conditions include, but are not limited to, a significant adverse change in the business environment, regulatory environment or legal factors; a

Table of Contents

current period operating or cash flow loss combined with a history of such losses or a projection of continuing losses; or a sale or disposition of a significant portion of a reporting unit. The occurrence of one of these events or conditions could significantly impact an impairment assessment, necessitating an impairment charge and adversely affecting our results of operations. For purposes of goodwill impairment assessment, we have defined our reporting units as specialty hospitals, outpatient rehabilitation clinics and contract therapy, with goodwill having been allocated among reporting units based on the relative fair value of those divisions when the Merger occurred in 2005 and based on subsequent acquisitions.

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

Realization of Deferred Tax Assets

Deferred tax assets and liabilities are required to be recognized using enacted tax rates for the effect of temporary differences between the book and tax bases of recorded assets and liabilities. Deferred tax assets are also required to be reduced by a valuation allowance if it is more likely than not that some portion or all of the deferred tax asset will not be realized. As part of the process of preparing our consolidated financial statements, we estimate our income taxes based on our actual current tax exposure together with assessing temporary differences resulting from differing treatment of items for tax and accounting purposes. We also recognize as deferred tax assets the future tax benefits from net operating loss carry forwards. We evaluate the realizability of these deferred tax assets by assessing their valuation allowances and by adjusting the amount of such allowances, if necessary. Among the factors used to assess the likelihood of realization are our projections of future taxable income streams, the expected timing of the reversals of existing temporary differences, and the impact of tax planning strategies that could be implemented to avoid the potential loss of future tax benefits. However, changes in tax codes, statutory tax rates or future taxable income levels could materially impact our valuation of tax accruals and assets and could cause our provision for income taxes to vary significantly from period to period.

At December 31, 2012 and June 30, 2013, we had deferred tax liabilities in excess of deferred tax assets of approximately $71.6 million and $74.8 million, respectively, principally due to depreciation deductions that have been accelerated for tax purposes. This amount includes approximately $13.3 million and $11.1 million of valuation reserves at December 31, 2012 and June 30, 2013, respectively, related primarily to state net operating losses.

Uncertain Tax Positions

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

Table of Contents

Stock Based Compensation

We measure the compensation costs of share-based compensation arrangements based on the grant-date fair value and recognize the costs in the financial statements over the period during which employees are required to provide services. Our share-based compensation arrangements comprise both stock options and restricted share plans. We value employee stock options using the Black-Scholes option valuation method that uses assumptions that relate to the expected volatility of our common stock, the expected dividend yield of our stock, the expected life of the options and the risk free interest rate. Such compensation amounts, if any, are amortized over the respective vesting periods or period of service of the option grant. We value restricted stock grants by using the public market price of our stock on the date of grant.

Operating Statistics

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

	Year Ended December 31, 2010	Year Ended December 31, 2011	Year Ended December 31, 2012
Specialty hospital data(1):			
Number of hospitals owned start of period	94	116	115
Number of hospital start-ups	1		1
Number of hospitals acquired	23	1	1
Number of hospitals closed/sold	(2)	(2)	(1)
Number of hospitals owned end of period	116	115	116
Number of hospitals managed end of period	2	4	6
Total number of hospitals (all) end of period	118	119	122
Long term acute care hospitals	111	110	110
Rehabilitation hospitals	7	9	12
Available licensed beds(2)	5,163	5,135	5,138
Admissions(2)	45,990	54,734	55,147
Patient days(2)	1,119,566	1,330,890	1,345,430
Average length of stay (days)(2)	24	24	24
Net revenue per patient day(2)(3)	$ 1,474	$ 1,497	$ 1,534
Occupancy rate(2)	67%	71%	71%
Percent patient days Medicare(2)	64%	65%	64%
Outpatient rehabilitation data:			
Number of clinics owned start of period	883	875	850
Number of clinics acquired	1	15	12
Number of clinic start-ups	23	26	30
Number of clinics closed/sold	(32)	(66)	(25)
Number of clinics owned end of period	875	850	867
Number of clinics managed end of period	69	104	112
Total number of clinics (all) end of period	944	954	979
Number of visits(2)	4,567,153	4,470,061	4,568,821
Net revenue per visit(2)(4)	$ 101	$ 103	$ 103

Table of Contents

	Six Months Ended June 30,	
	2012	2013
Specialty hospital data(1):		
Number of hospitals owned start of period	115	116
Number of hospitals acquired	1	1
Number of hospital start-ups	1	
Number of hospitals closed/sold		(1)
Number of hospitals owned end of period	117	116
Number of hospitals managed end of period	6	7
Total number of hospitals (all) end of period	123	123
Long term acute care hospitals	111	109
Rehabilitation hospitals	12	14
Available licensed beds(2)	5,205	5,181
Admissions(2)	27,927	27,962
Patient days(2)	679,037	681,037
Average length of stay (days)(2)	24	25
Net revenue per patient day(2)(3)	$ 1,539	$ 1,538
Occupancy rate(2)	72%	73%
Percent patient days Medicare(2)	65%	64%
Outpatient rehabilitation data:		
Number of clinics owned start of period	850	867
Number of clinic start-ups	18	11
Number of clinics closed/sold	(16)	(6)
Number of clinics owned end of period	852	872
Number of clinics managed end of period	104	116
Total number of clinics (all) end of period	956	988
Number of visits(2)	2,318,759	2,380,221
Net revenue per visit(2)(4)	$ 103	$ 104

(1) Specialty hospitals consist of long term acute care hospitals and inpatient rehabilitation facilities.

(2) Data excludes specialty hospitals and outpatient clinics managed by the Company.

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

(4) Net revenue per visit is calculated by dividing outpatient rehabilitation clinic direct patient service revenue by the total number of visits. For purposes of this computation, outpatient rehabilitation clinic direct patient service revenue does not include managed clinics or contract services revenue.

Table of Contents

Results of Operations

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

	Year Ended December 31,		
	2010	2011	2012
Net operating revenues	100.0%	100.0%	100.0%
Cost of services(1)	82.9	82.3	82.9
General and administrative	2.6	2.2	2.2
Bad debt expense	1.7	1.8	1.3
Depreciation and amortization	2.9	2.6	2.2
Income from operations	9.9	11.1	11.4
Loss on early retirement of debt		(0.7)	(0.2)
Equity in earnings (losses) of unconsolidated subsidiaries	(0.0)	0.1	0.3
Other income	0.0		
Interest expense, net	(3.5)	(2.9)	(2.9)
Income before income taxes	6.4	7.6	8.6
Income tax expense	2.2	2.9	3.1
Net income	4.2	4.7	5.5
Net income attributable to non-controlling interests	0.2	0.2	0.2
Net income attributable to Select	4.0%	4.5%	5.3%

	Six Months Ended June 30,	
	2012	2013
Net operating revenues	100.0%	100.0%
Cost of services(1)	81.9	83.0
General and administrative	2.2	2.4
Bad debt expense	1.4	1.2
Depreciation and amortization	2.1	2.1
Income from operations	12.4	11.3
Loss on early retirement of debt		(1.2)
Equity in earnings of unconsolidated subsidiaries	0.3	0.1
Interest expense	(2.8)	(2.8)
Income before income taxes	9.9	7.4
Income tax expense	3.8	2.8
Net income	6.1	4.6
Net income attributable to non-controlling interests	0.2	0.3
Net income attributable to Select	5.9%	4.3%

Table of Contents

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

	Year Ended December 31,			% Change	
	2010	2011	2012	2010-2011	2011-2012
	(in thousands)				
Net Operating revenues:					
Specialty hospitals	$ 1,702,165	$ 2,095,519	$ 2,197,529	23.1%	4.9%
Outpatient rehabilitation	688,017	708,867	751,317	3.0	6.0
Other(2)	108	121	123	12.0	1.7
Total Company	$ 2,390,290	$ 2,804,507	$ 2,948,969	17.3%	5.2%
Income (loss) from operations:					
Specialty hospitals	$ 239,442	$ 311,705	$ 334,518	30.2%	7.3%
Outpatient rehabilitation	63,328	67,377	73,816	6.4	9.6
Other(2)	(66,633)	(68,363)	(71,475)	(2.6)	(4.6)
Total Company	$ 236,137	$ 310,719	$ 336,859	31.6%	8.4%
Adjusted EBTIDA:(3)					
Specialty hospitals	$ 284,558	$ 362,334	$ 381,354	27.3%	5.2%
Outpatient rehabilitation	83,772	83,864	87,024	0.1	3.8
Other(2)	(61,251)	(60,237)	(62,531)	1.7	(3.8)
Total Company	$ 307,079	$ 385,961	$ 405,847	25.7%	5.2%
Adjusted EBTIDA margins:(3)					
Specialty hospitals	16.7%	17.3%	17.4%		
Outpatient rehabilitation	12.2	11.8	11.6		
Other(2)	N/M	N/M	N/M		
Total Company	12.8%	13.8%	13.8%		
Total assets:					
Specialty hospitals	$ 2,162,726	$ 2,187,767	$ 2,143,906		
Outpatient rehabilitation	481,828	429,503	434,834		
Other(2)	75,018	153,468	181,573		
Total Company	$ 2,719,572	$ 2,770,738	$ 2,760,313		
Purchases of property and equipment, net					
Specialty hospitals	$ 39,237	$ 30,464	$ 50,005		
Outpatient rehabilitation	9,449	12,135	13,209		
Other(2)	3,075	3,417	4,971		
Total Company	$ 51,761	$ 46,016	$ 68,185		

Table of Contents

	Six Months Ended June 30,		
	2012	2013	% Change
	(in thousands)		
Net operating revenues:			
Specialty hospitals	$ 1,110,168	$ 1,117,137	0.6%
Outpatient rehabilitation	383,949	389,181	1.4
Other(2)	97	310	N/M
Total company	$ 1,494,214	$ 1,506,628	0.8%
Income (loss) from operations:			
Specialty hospitals	$ 178,798	$ 165,946	(7.2)%
Outpatient rehabilitation	41,433	42,917	3.6
Other(2)	(35,114)	(38,070)	(8.4)
Total company	$ 185,117	$ 170,793	(7.7)%
Adjusted EBITDA:(3)			
Specialty hospitals	$ 202,120	$ 189,740	(6.1)%
Outpatient rehabilitation	48,315	48,887	1.2
Other(2)	(31,092)	(32,588)	(4.8)
Total company	$ 219,343	$ 206,039	(6.1)%
Adjusted EBITDA margins:(3)			
Specialty hospitals	18.2%	17.0%	
Outpatient rehabilitation	12.6	12.6	
Other(2)	N/M	N/M	
Total company	14.7%	13.7%	
Total assets:			
Specialty hospitals	$ 2,184,743	$ 2,229,458	
Outpatient rehabilitation	437,591	445,411	
Other(2)	156,080	170,186	
Total company	$ 2,778,414	$ 2,845,055	
Purchases of property and equipment:			
Specialty hospitals	$ 19,682	$ 21,100	
Outpatient rehabilitation	6,713	5,844	
Other(2)	1,539	1,018	
Total company	$ 27,934	$ 27,962	

N/M Not Meaningful.

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

(2) Other includes our general and administrative services and non-healthcare services.

(3)

We define Adjusted EBITDA as net income before interest, income taxes, depreciation and amortization, gain (loss) on early retirement of debt, stock compensation expense, equity in earnings (losses) of unconsolidated subsidiaries, and other income (expense). We believe that the presentation of Adjusted EBITDA is important to investors because Adjusted EBITDA is commonly used as an analytical indicator of performance by investors within the healthcare industry. Adjusted EBITDA is used by management to evaluate financial performance and determine resource allocation for each of our

Table of Contents

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.

	Year Ended December 31,		
	2010	2011	2012
	(in thousands)		
Net income	$ 100,477	$ 131,363	$ 161,167
Income tax expense	51,380	80,984	93,574
Other income	(632)		
Loss on early retirement of debt		20,385	6,064
Interest expense, net of interest income	84,472	80,910	83,759
Equity in (earnings) losses of unconsolidated subsidiaries	440	(2,923)	(7,705)
Stock compensation expense:			
Included in general and administrative	763	1,996	3,538
Included in cost of services	1,473	1,729	2,139
Depreciation and amortization	68,706	71,517	63,311
Adjusted EBITDA	$ 307,079	$ 385,961	$ 405,847

	Six Months Ended June 30,	
	2012	2013
	(in thousands)	
Net income	$ 90,971	$ 68,870
Income tax expense	57,156	42,809
Interest expense	42,207	42,952
Loss on early retirement of debt		17,788
Equity in earnings of unconsolidated subsidiaries	(5,217)	(1,626)
Stock compensation expense:		
Included in general and administrative	1,589	2,427
Included in cost of services	1,010	1,110
Depreciation and amortization	31,627	31,709
Adjusted EBITDA	$ 219,343	$ 206,039

Six Months Ended June 30, 2013 Compared to Six Months Ended June 30, 2012

Net Operating Revenues

Our net operating revenues increased by 0.8% to $1,506.6 million for the six months ended June 30, 2013 compared to $1,494.2 million for the six months ended June 30, 2012.

Specialty Hospitals. Our specialty hospital net operating revenues increased by 0.6% to $1,117.1 million for the six months ended June 30, 2013 compared to $1,110.2 million for the six months ended June 30, 2012. The growth in net operating revenue primarily resulted from increases in

Table of Contents

our patient volume, increases in our non-Medicare reimbursement rates and increases in revenues that are generated from contracted labor services provided to our joint venture with Baylor Health Care System (the "Baylor JV"). These increases were offset in part by a 2% reduction in our Medicare payments as part of the automatic reductions in federal spending under the Budget Control Act of 2011. The reductions in our Medicare net operating revenue due to the Budget Control Act of 2011 were $9.1 million for the six months ended June 30, 2013. Our patient days increased 0.3% to 681,037 days for the six months ended June 30, 2013 as compared to the six months ended June 30, 2012. Our occupancy percentage was 73% for the six months ended June 30, 2013 compared to 72% for the six months ended June 30, 2012. Our average net revenue per patient day decreased to $1,538 for the six months ended June 30, 2013 compared to $1,539 for the six months ended June 30, 2012 and this decrease principally resulted from decreases in our average Medicare net revenue per patient day as a result of the 2% reduction in our Medicare payments as part of the automatic reductions in federal spending mandated under the Budget Control Act of 2011, offset in part by increases in our non-Medicare reimbursement rates.

Outpatient Rehabilitation. Our outpatient rehabilitation segment net operating revenues increased 1.4% to $389.2 million for the six months ended June 30, 2013 compared to $383.9 million for the six months ended June 30, 2012, more than offsetting reductions in net operating revenues of $0.4 million due to the automatic reduction of our Medicare payments mandated by the Budget Control Act of 2011 and the $1.7 million impact of the MPPR Reduction. The net operating revenues generated by our outpatient rehabilitation clinics for the six months ended June 30, 2013 increased 4.3% compared to the six months ended June 30, 2012. The increase was related to growth in both our number of visits and net revenue per visit. The number of visits in our owned outpatient rehabilitation clinics increased 2.7% for the six months ended June 30, 2013 to 2,380,221 visits compared to 2,318,759 visits for the six months ended June 30, 2012. Net revenue per visit in our owned outpatient rehabilitation clinics increased 1.0% to $104 for the six months ended June 30, 2013 compared to $103 for the six months ended June 30, 2012. Our contract services business experienced a decrease in net operating revenues of approximately $6.9 million compared to the six months ended June 30, 2012, which principally resulted from the termination of contracts.

Operating Expenses

Our operating expenses include our cost of services, general and administrative expense and bad debt expense. Our operating expenses increased by $26.6 million to $1,304.1 million for the six months ended June 30, 2013 compared to $1,277.5 million for the six months ended June 30, 2012, principally due to increases in our specialty hospital segment. As a percentage of our net operating revenues, our operating expenses were 86.6% for the six months ended June 30, 2013 compared to 85.5% for the six months ended June 30, 2012. Our cost of services, a major component of which is labor expense, were $1,250.6 million or 83.0% of net operating revenue for the six months ended June 30, 2013 compared to $1,224.3 million or 81.9% of net operating revenue for the six months ended June 30, 2012. The principal cause of the increase in cost of services as a percentage of net operating revenues resulted from inflationary increases in labor costs in our specialty hospitals and the loss of net operating revenues associated with the 2% reduction in our Medicare payments as part of the automatic reductions in federal spending mandated under the Budget Control Act of 2011 and the MPPR Reduction discussed above under "Net Operating Revenues" with no offsetting reduction in costs. Facility rent expense, which is a component of cost of services, was $61.3 million for the six months ended June 30, 2013 compared to $61.7 million for the six months ended June 30, 2012. General and administrative expenses were 2.4% of net operating revenue or $35.3 million for the six months ended June 30, 2013 compared to 2.2% of net operating revenue or $32.8 million for the six months ended June 30, 2012. Our general and administrative expenses for the six months ended June 30, 2012 were favorably impacted by a gain on the sale of a building; excluding this gain, general and administrative expenses for the six months ended June 30, 2012 would have been 2.4% of net operating revenue. Our bad debt expense was $18.2 million or 1.2% of net operating revenues for the six months ended June 30, 2013 compared to $20.4 million or 1.4% of net operating revenues for the six months ended June 30, 2012.

Table of Contents

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA for our specialty hospitals decreased 6.1% to $189.7 million for the six months ended June 30, 2013 compared to $202.1 million for the six months ended June 30, 2012. Our Adjusted EBITDA margins for the segment decreased to 17.0% for the six months ended June 30, 2013 from 18.2% for the six months ended June 30, 2012. The decrease in Adjusted EBITDA for our specialty hospitals was primarily the result of the 2% reduction in our Medicare payments as part of the automatic reductions in federal spending mandated under the Budget Control Act of 2011 as discussed above under "Net Operating Revenues," which reductions were accompanied by no offsetting reduction in costs, and increases in our operating expenses discussed above under "Operating Expenses."

Outpatient Rehabilitation. Our Adjusted EBITDA for our outpatient rehabilitation segment increased 1.2% to $48.9 million for the six months ended June 30, 2013 compared to $48.3 million for the six months ended June 30, 2012, more than offsetting reductions in net operating revenues of $0.4 million due to the automatic reduction of our Medicare payments mandated by the Budget Control Act of 2011 and the $1.7 million impact of the MPPR Reduction. Our Adjusted EBITDA margin for the outpatient rehabilitation segment was 12.6% for both the six months ended June 30, 2013 and 2012. The increase in the Adjusted EBITDA for our outpatient rehabilitation segment is principally due to growth in net operating revenues of our outpatient rehabilitation clinics discussed above under "Net Operating Revenues." The Adjusted EBITDA in our outpatient rehabilitation clinics increased by $1.8 million for the six months ended June 30, 2013 compared to the six months ended June 30, 2012. Our Adjusted EBITDA margins for our outpatient rehabilitation clinics was 14.2% for both the six months ended June 30, 2013 and 2012. The Adjusted EBITDA in our contract services business decreased by $1.2 million for the six months ended June 30, 2013 compared to the six months ended June 30, 2012. The Adjusted EBITDA margins for our contract services business declined to 7.3% for the six months ended June 30, 2013 from 8.0% for the six months ended June 30, 2012.

Other. The Adjusted EBITDA loss was $32.6 million for the six months ended June 30, 2013 compared to an Adjusted EBITDA loss of $31.1 million for the six months ended June 30, 2012. The lower Adjusted EBITDA loss for the six months ended June 30, 2012 is primarily attributable to the gain on the sale of a building during the same period last year, as described under "Operating Expenses."

Income from Operations

For the six months ended June 30, 2013 we had income from operations of $170.8 million compared to $185.1 million for the six months ended June 30, 2012. The decrease in our income from operations resulted principally from the 2% reduction in our Medicare payments as part of the automatic reductions in federal spending mandated under the Budget Control Act of 2011 and the MPPR Reduction, as discussed above under "Net Operating Revenues," and increases in labor costs in our specialty hospitals as discussed above under "Operating Expenses."

Loss on Early Retirement of Debt

On March 22, 2013 we redeemed all of our outstanding $7^5/_8$% senior subordinated notes due 2015. We recognized a loss on early retirement of debt of $0.5 million in the first quarter 2013 for the unamortized debt issuance costs associated with the redeemed debt.

On May 28, 2013, we repaid a portion of our original term loan and series A term loan of our senior secured credit facility and on June 3, 2013 we amended our existing senior secured credit facility. We recognized a loss on early retirement of debt of $17.3 million in the second quarter 2013, which included unamortized debt issuance costs, unamortized original issue discount, and certain debt issuance costs associated with refinancing activities.

Table of Contents

Equity in Earnings of Unconsolidated Subsidiaries

For the six months ended June 30, 2013, we had equity in earnings of unconsolidated subsidiaries of $1.6 million compared to equity in earnings of unconsolidated subsidiaries of $5.2 million for the six months ended June 30, 2012. The decrease in our equity in earnings of unconsolidated subsidiaries resulted from decreases in earnings contributed from the Baylor JV and losses incurred by start-up companies where we own a minority interest.

Interest Expense

Interest expense was $43.0 million for the six months ended June 30, 2013 compared to $42.2 million for the six months ended June 30, 2012. The increase in interest expense was principally due to increased borrowings that were used to refinance debt held by Holdings in both the third quarter of 2012 and the first quarter of 2013.

Income Taxes

We recorded income tax expense of $42.8 million for the six months ended June 30, 2013. The expense represented an effective tax rate of 38.3%. We recorded income tax expense of $57.2 million for the six months ended June 30, 2012. The expense represented an effective tax rate of 38.6%. Select Medical Corporation is part of the consolidated federal tax return for Select Medical Holdings Corporation. We allocate income taxes between Select and Holdings for purposes of financial statement presentation. Because Holdings is a passive investment company incorporated in Delaware, it does not incur any state income tax expense or benefit on its specific income or loss and, as such, receives a tax allocation equal to the federal statutory rate of 35% on its specific income or loss. Based upon the relative size of Holdings' income or loss, this can cause the effective tax rate for Select to differ from the effective tax rate for the consolidated company.

The decline in our effective tax rate has resulted from an increase in earnings of our consolidated subsidiaries taxed as pass-through entities where we only record income taxes on our share of the income, offset in part by an increase in our state effective tax rates that has resulted from a higher proportion of our income being generated in states with higher tax rates.

Non-Controlling Interests

Non-controlling interests in consolidated earnings were $4.5 million for the six months ended June 30, 2013 and $2.7 million for the six months ended June 30, 2012.

Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Net Operating Revenues

Our net operating revenues increased by 5.2% to $2,949.0 million for the year ended December 31, 2012 compared to $2,804.5 million for the year ended December 31, 2011.

Specialty Hospitals. Our specialty hospital net operating revenues increased by 4.9% to $2,197.5 million for the year ended December 31, 2012 compared to $2,095.5 million for the year December 31, 2011. The growth in net operating revenue for the year ended December 31, 2012 resulted from increases in patient volumes, increases in both Medicare and non-Medicare reimbursement rates and revenues generated from contracted labor services provided to the Baylor JV. Our patient days increased 1.1% compared to the year ended December 31, 2011 to 1,345,430 days for the year ended December 31, 2012. Our specialty hospital occupancy was 71% for both the years ended December 31, 2012 and 2011. Our average net revenue per patient day was $1,534 for the year ended December 31, 2012 compared to $1,497 for the year ended December 31, 2011. For the year ended December 31, 2012, we experienced increases in both our Medicare and non-Medicare net revenue per

Table of Contents

patient day from the prior year. The increase in our Medicare net revenue per patient day was due to increases in our Medicare base rate. The increases in our non-Medicare net revenue per patient day resulted from increases in our non-government payment rates that have occurred through contract renewal and from Medicaid bonus payments we received during the three months ended June 30, 2012.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues increased 6.0% to $751.3 million for the year ended December 31, 2012 compared to $708.9 million for the year ended December 31, 2011. The net operating revenues generated by our outpatient rehabilitation clinics for the year ended December 31, 2012 increased 3.0% to $561.4 million compared to $545.1 million for the year ended December 31, 2011. The increase was principally related to volume growth in our owned outpatient rehabilitation clinics and revenues we generated from contract labor services provided to the Baylor JV. The number of patient visits in our owned outpatient rehabilitation clinics increased 2.2% for the year ended December 31, 2012 to 4,568,821 visits compared to 4,470,061 visits for the year ended December 31, 2011. Net revenue per visit in our owned outpatient rehabilitation clinics was $103 for both the years ended December 31, 2012 and 2011. Our contract services business increased net operating revenues 16.0% to $189.9 million compared to $163.8 million for the year ended December 31, 2011, which primarily resulted from the addition of new contracts in the fourth quarter of 2011. During the fourth quarter of 2012, our outpatient rehabilitation operations in the mid-Atlantic and Northeastern states were adversely affected by hurricane Sandy. We currently estimate that the lost patient revenue from this event in the three months ended December 31, 2012 was approximately $3.9 million, of which $3.2 million occurred in our outpatient rehabilitation clinics and $0.7 million occurred in our contract services business.

Operating Expenses

Our operating expenses include our cost of services, general and administrative expense and bad debt expense. Our operating expenses increased by 5.2% to $2,548.8 million for the year ended December 31, 2012 compared to $2,422.3 million for the year ended December 31, 2011. As a percentage of our net operating revenues, our operating expenses were 86.4% for both the years ended December 31, 2012 and December 31, 2011. Our cost of services, a major component of which is labor expense, were $2,443.6 million or 82.9% of net operating revenues for the year ended December 31, 2012 compared to $2,308.6 million or 82.3% of net operating revenues for the year ended December 31, 2011. The increase in cost of services as a percentage of net operating revenues resulted primarily from increased relative labor costs in both our specialty hospital and our outpatient rehabilitation segments. Our specialty hospitals experienced an increase in relative labor costs due to the labor costs associated with the Baylor JV services agreement and increased staffing costs during the year ended December 31, 2012 compared to the year ended December 31, 2011. Our outpatient rehabilitation segment experienced an increase in relative labor costs associated with the Baylor JV services agreement and increased relative staffing costs of providing patient services in our outpatient rehabilitation clinics. Additionally, our outpatient rehabilitation segment experienced higher relative labor costs during the year ended December 31, 2012 as a result of hurricane Sandy, as we incurred continuing labor costs in our affected outpatient rehabilitation clinics without corresponding revenue. Facility rent expense, which is a component of cost of services, was $124.2 million for year ended December 31, 2012 compared to $118.4 million for the year ended December 31, 2011. General and administrative expenses were 2.2% of net operating revenue or $66.2 million for the year ended December 31, 2012 compared to 2.2% of net operating revenue or $62.4 million for the year ended December 31, 2011. This increase in general and administrative expense resulted principally from increases in executive compensation. Our bad debt expense was $39.1 million or 1.3% of net operating revenues for the year ended December 31, 2012 compared to $51.3 million or 1.8% for the year ended December 31. 2011. The decline in our bad debt expense was attributed to our favorable collections experience of accounts receivable in both our operating segments for the year ended December 31, 2012 as compared to the year ended December 31, 2011.

Table of Contents

Adjusted EBITDA

Specialty Hospitals. Our Adjusted EBITDA for our specialty hospitals increased by 5.2% to $381.4 million for the year ended December 31, 2012 compared to $362.3 million for the year ended December 31, 2011. Our Adjusted EBITDA margins for the segment increased to 17.4% for the year ended December 31, 2012 from 17.3% for the year ended December 31, 2011. The increase in the Adjusted EBITDA for our specialty hospitals was primarily the result of both rate improvements and patient volume increases discussed above under "Net Operating Revenues" and a reduction in bad debt expense discussed above under "Operating Expenses." The increase in the Adjusted EBITDA margin is principally due to the decline in bad debt expense, offset in part by increases in cost of services as discussed above under "Operating Expenses."

Outpatient Rehabilitation. Adjusted EBITDA for our outpatient rehabilitation segment increased 3.8% to $87.0 million for the year ended December 31, 2012 compared to $83.9 million for the year ended December 31, 2011. Our Adjusted EBITDA margins decreased to 11.6% for the year ended December 31, 2012 from 11.8% for the year ended December 31, 2011. Our Adjusted EBITDA in our outpatient rehabilitation segment was adversely affected by hurricane Sandy as discussed above under "Net Operating Revenues." The Adjusted EBITDA in our outpatient rehabilitation clinics increased by $1.3 million to $72.9 million for the year ended December 31, 2012 compared to $71.6 million for the year ended December 31, 2011. Our Adjusted EBITDA margins for our outpatient rehabilitation clinics decreased to 13.0% for the year ended December 31, 2012 from 13.1% for the year ended December 31, 2011. The decrease in our Adjusted EBITDA margin in our outpatient rehabilitation clinics was principally due to the incurrence of labor costs in the outpatient rehabilitation clinics affected by hurricane Sandy without any corresponding patient revenue as discussed above under "Net Operating Revenues." The Adjusted EBITDA in our contract services business increased by $1.8 million to $14.1 million for the year ended December 31, 2012 compared to $12.3 million for the year ended December 31, 2011. The Adjusted EBITDA margins for our contract services business declined to 7.4% for the year ended December 31, 2012 compared to 7.5% for the year ended December 31, 2011. The decline in Adjusted EBITDA margins for our contract services business was principally due to increased labor costs associated with new business and lower productivity resulting from regulatory changes that became effective on October 1, 2011.

Other. The Adjusted EBITDA loss was $62.5 million for the year ended December 31, 2012 compared to an Adjusted EBITDA loss of $60.2 million for the year ended December 31, 2011 and is principally related to increases in executive compensation that are a component of our general and administrative expense.

Income from Operations

For the year ended December 31, 2012 we had income from operations of $336.9 million compared to $310.7 million for the year ended December 31, 2011. The increase in our income from operations resulted principally from increases in our operating performance of our specialty hospital and outpatient rehabilitation segments described above and a decline in depreciation and amortization expense.

Loss on Early Retirement of Debt

On September 12, 2012 we redeemed an aggregate of $275.0 million principal amount of our $7^5/_8$% senior subordinated notes at a redemption price of 101.271% of the principal amount. We recognized a loss on early retirement of debt of $6.1 million for the year ended December 31, 2012 in connection with the redemption of the senior subordinated notes, which included the write-off of unamortized deferred financing costs and call premiums.

Table of Contents

On June 1, 2011, we refinanced our senior secured credit facility. A portion of the proceeds from this transaction were used to repurchase and retire $266.5 million of our 7⅝% senior subordinated notes. We recognized a loss on early retirement of debt of $20.4 million for the year ended December 31, 2011, which included the write-off of unamortized deferred financing costs and tender premiums.

Equity in Earnings of Unconsolidated Subsidiaries

For the year ended December 31, 2012, we had equity in earnings of unconsolidated subsidiaries of $7.7 million compared to equity in earnings of unconsolidated subsidiaries of $2.9 million for the year ended December 31, 2011. The increase in our equity in earnings of unconsolidated subsidiaries resulted principally from an increase in the income contribution from the Baylor JV.

Interest Expense

Interest expense was $83.8 million for the year ended December 31, 2012 compared to $81.2 million for the year ended December 31, 2011. The increase in interest expense resulted primarily from the refinancing of $150.0 million of Holdings' debt, for which we were not previously obligated, through indebtedness incurred under our new senior secured credit facility on June 1, 2011.

Income Taxes

We recorded income tax expense of $93.6 million for the year ended December 31, 2012. The expense represented an effective tax rate of 36.7%. We recorded income tax expense of $81.0 million for the year ended December 31, 2011. The expense represented an effective tax rate of 38.1%. Select Medical Corporation is part of the consolidated federal tax return for Select Medical Holdings Corporation. We allocate income taxes between Select and Holdings for purposes of financial statement presentation. Because Holdings is a passive investment company incorporated in Delaware, it does not incur any state income tax expense or benefit on its specific income or loss and, as such, receives a tax allocation equal to the federal statutory rate of 35% on its specific income or loss. Based upon the relative size of Holdings' income or loss, this can cause the effective tax rate for Select to differ from the effective tax rate for the consolidated company.

The decline in our effective tax rate is primarily a consequence of an Internal Revenue Service penalty abatement and a lower effective state tax rate.

Non-Controlling Interests

Non-controlling interests in consolidated earnings were $5.7 million for the year ended December 31, 2012 and $4.9 million for the year ended December 31, 2011.

Year Ended December 31, 2011 Compared to Year Ended December 31, 2010

Net Operating Revenues

Our net operating revenues increased by 17.3% to $2,804.5 million for the year ended December 31, 2011 compared to $2,390.3 million for the year ended December 31, 2010.

Specialty Hospitals. Our specialty hospital net operating revenues increased by 23.1% to $2,095.5 million for the year ended December 31, 2011 compared to $1,702.2 million for the year December 31, 2010. The Regency hospitals acquired on September 1, 2010 contributed $339.6 million of net operating revenues in 2011 and provided $245.7 million of the $393.4 million increase in net operating revenues for 2011. The remaining increase primarily resulted from an increase in patient volumes in our other specialty hospitals. Our patient days increased 18.9% to 1,330,890 days for 2011, which was principally related to the addition of the Regency hospitals. The Regency hospitals

Table of Contents

contributed a net increase in patient days of 146,065 days. Excluding the effect of the Regency hospitals, patient days would have increased 6.2% in 2011 over 2010 as a result of similar increases in both Medicare and non-Medicare volumes. The occupancy percentage increased to 71% for 2011 from 67% for 2010. Our average net revenue per patient day was $1,497 for 2011 compared to $1,474 for 2010. The increase in our net revenue per patient day was principally due to increases in our average Medicare net revenue per patient day.

Outpatient Rehabilitation. Our outpatient rehabilitation net operating revenues increased 3.0% to $708.9 million for the year ended December 31, 2011 compared to $688.0 million for the year ended December 31, 2010. The net operating revenues generated by our outpatient rehabilitation clinics in 2011 grew approximately 2.3% compared to 2010. The increase was principally related to revenues we are generating from services provided to the Baylor JV. The number of patient visits in our owned outpatient rehabilitation clinics decreased 2.1% for 2011 to 4,470,061 visits compared to 4,567,153 visits for 2010. The decrease in visits, which also slowed our revenue growth, resulted primarily from the 18 clinics in the Dallas-Fort Worth metroplex that were contributed to the Baylor JV, which is accounted for as an unconsolidated joint venture. Net revenue per visit in our clinics increased 2.0% to $103 for 2011, compared to $101 for 2010. Our contract services business experienced an increase in net operating revenues of approximately 5.4% compared to 2010 which resulted from the addition of new contracts.

Operating Expenses

Our operating expenses include our cost of services, general and administrative expense and bad debt expense. Our operating expenses increased by $336.9 million to $2,422.3 million for the year ended December 31, 2011 compared to $2,085.4 million for the year ended December 31, 2010. As a percentage of our net operating revenues, our operating expenses were 86.4% for the year ended December 31, 2011 compared to 87.2% for the year ended December 31, 2010. Our cost of services, a major component of which is labor expense, were $2,308.6 million for the year ended December 31, 2011 compared to $1,982.2 million for the year ended December 31, 2010. The principal cause of the increase in cost of services resulted from the addition of the Regency hospitals. Additionally facility rent expense, which is a component of cost of services, was $118.4 million for year ended December 31, 2011 compared to $118.3 million for the year ended December 31, 2010. General and administrative expenses were 2.2% of net operating revenue or $62.4 million for the year ended December 31, 2011 compared to 2.6% of net operating revenue or $62.1 million for the year ended December 31, 2010. In 2010, our general and administrative expenses included $9.0 million of non-recurring costs related to the transition and closing of the Regency corporate office and a $4.8 million charge due to an increase in employee healthcare costs. Additionally, in 2010 there was no incentive compensation paid to our executive officers. In 2011, our general and administrative expenses included increased legal expenses of approximately $7.8 million primarily related to the Columbus qui tam matter and increased compensation costs of approximately $8.1 million related to executive incentive compensation. These cost increases in 2011 were offset by gains of $5.4 million on the sale of assets. Our bad debt expense as a percentage of net operating revenues remained relatively stable at 1.8% for the year ended December 31, 2011 compared to 1.7% for the year ended December 31, 2010.

Adjusted EBITDA

Specialty Hospitals. Adjusted EBITDA for our specialty hospitals increased by 27.3% to $362.3 million for the year ended December 31, 2011 compared to $284.6 million for the year ended December 31, 2010. Our Adjusted EBITDA margins increased to 17.3% for the year ended December 31, 2011 from 16.7% for the year ended December 31, 2010. For the year ended December 31, 2011, the Regency hospitals acquired on September 1, 2010 contributed $45.9 million of the $77.8 million increase in specialty hospital Adjusted EBITDA for 2011. Excluding the effect of the

Table of Contents

Regency hospitals in both periods, the Adjusted EBITDA margin would have been 18.0% and 17.7% for 2011 and 2010, respectively. In addition to the contribution from the Regency hospitals, the increase in the Adjusted EBITDA for the remainder of our specialty hospitals was primarily the result of an increase in patient volumes and an increase in our Medicare net revenue per patient day described above under "Net Operating Revenues Specialty Hospitals."

Outpatient Rehabilitation. Adjusted EBITDA for our outpatient rehabilitation segment was $83.9 million for the year ended December 31, 2011 compared to $83.8 million for the year ended December 31, 2010. Our Adjusted EBITDA margins decreased to 11.8% for the year ended December 31, 2011 from 12.2% for the year ended December 31, 2010. The principal reason for the decrease in the Adjusted EBITDA margin for the segment was related to our contract services business. We experienced a decline in the Adjusted EBITDA and Adjusted EBITDA margin of our contract services business that resulted from (1) the loss of significant contracts during the second quarter of 2010 that had generated higher Adjusted EBITDA margins and (2) higher labor costs for the treatment models required by RUGS IV/MDS 3.0 rules that became effective on October 1, 2010. The Adjusted EBITDA in our outpatient rehabilitation clinics increased by $6.4 million for the year ended December 31, 2011 compared to the year ended December 31, 2010. Additionally, our Adjusted EBITDA margins for our outpatient rehabilitation clinics grew to 13.0% for the year ended December 31, 2011 from 12.1% for the year ended December 31, 2010. The increase in our Adjusted EBITDA and Adjusted EBITDA margin in our rehabilitation clinics was principally due to an improvement in the performance in the clinics acquired in 2007 from HealthSouth Corporation and the increase in our net revenue per visit.

Other. The Adjusted EBITDA loss was $60.2 million for the year ended December 31, 2011 compared to an Adjusted EBITDA loss of $61.3 million for the year ended December 31, 2010 and is primarily related to our general and administrative expenses, as described under "Operating Expenses."

Income from Operations

For the year ended December 31, 2011 we had income from operations of $310.7 million compared to $236.1 million for the year ended December 31, 2010. The increase in income from operations resulted primarily from the Regency hospitals acquired on September 1, 2010 which contributed $41.3 million of the $74.6 million increase in income from operations for the year ended December 31, 2011, and improved operating performance at our other specialty hospitals.

Loss on Early Retirement of Debt

On June 1, 2011 we refinanced our senior secured credit facility. We recognized a loss on early retirement of debt of $20.4 million for the year ended December 31, 2011 which included the write-off of unamortized deferred financing costs and tender premiums.

Interest Expense

Interest expense was $81.2 million for the year ended December 31, 2011 compared to $84.5 million for the year ended December 31, 2010. The decrease in interest expense resulted primarily from the expiration of interest rate swaps in 2010 that carried higher fixed interest rates, which was offset in part by the refinancing of $150.0 million of Holdings' debt, for which we were not previously obligated, through indebtedness incurred under our new senior secured credit facility on June 1, 2011.

Income Taxes

We recorded income tax expense of $81.0 million for the year ended December 31, 2011. The expense represented an effective tax rate of 38.1%. We recorded income tax expense of $51.4 million

Table of Contents

for the year ended December 31, 2010. The expense represented an effective tax rate of 33.8%. Select Medical Corporation is part of the consolidated federal tax return for Select Medical Holdings Corporation. We allocate income taxes between Select and Holdings for purposes of financial statement presentation. Because Holdings is a passive investment company incorporated in Delaware, it does not incur any state income tax expense or benefit on its specific income or loss and, as such, receives a tax allocation equal to the federal statutory rate of 35% on its specific income or loss. Based upon the relative size of Holdings' income or loss, this can cause the effective tax rate for Select to differ from the effective tax rate for the consolidated company. The analysis in the following paragraph discusses the change in our consolidated tax rate.

On a consolidated basis with Holdings, we recorded income tax expense of $71.0 million for the year ended December 31, 2011. The expense represented an effective tax rate of 38.6%. We recorded income tax expense of $41.6 million for the year ended December 31, 2010. The expense represented an effective tax rate of 33.6%. Although our effective tax rate for the year ended December 31, 2011 approximates our statutory tax rate, the rate was affected by two significant items that offset each other in the effective rate. We experienced an increase in our effective tax rate from a difference between the tax accounting basis and the financial accounting basis associated with a hospital exchange that occurred in early 2011 and an increase in our reserves for uncertain tax positions resulting from the settlement costs associated with the Columbus matter. These increases were offset by a release in reserves for uncertain tax positions associated with the tax basis of an acquisition we consummated in 1999. During 2011, additional information was discovered that further supported the tax basis of entities acquired through this acquisition and resulted in a change in the estimates related to this tax uncertainty. Our low effective tax rate for the year ended December 31, 2010 is below the statutory rate due to the reversal of certain valuation allowances that had been provided on losses in previous years. A substantial portion of this reversal in our valuation allowance relates to our ability to utilize a Federal capital loss generated in 2007 to offset a taxable capital gain on a recently completed transaction.

Non-Controlling Interests

Non-controlling interests in consolidated earnings were $4.9 million for the year ended December 31, 2011 and $4.7 million for the year ended December 31, 2010.

Liquidity and Capital Resources

Cash Flows for the Six Months Ended June 30, 2013 and Six Months Ended June 30, 2012

	Six Months Ended June 30,	
	2012	**2013**
	(in thousands)	
Cash flows provided by operating activities	$ 124,049	$ 27,602
Cash flows used in investing activities	(21,643)	(56,849)
Cash flows used in financing activities	(92,929)	(2,129)
Net increase (decrease) in cash and cash equivalents	9,477	(31,376)
Cash and cash equivalents at beginning of period	12,043	40,144
Cash and cash equivalents at end of period	$ 21,520	$ 8,768

Operating activities provided $27.6 million of cash flows for the six months ended June 30, 2013. Operating activities provided $124.0 million of cash flows for the six months ended June 30, 2012. The decline in operating cash flows in the six months ended June 30, 2013 compared to the six months ended June 30, 2012 is due to the timing of the periodic interim payments we receive from Medicare

Table of Contents

for the services provided at our specialty hospitals and an acceleration in the payment of accrued interest resulting from our debt refinancings.

Our days sales outstanding were 51 days at June 30, 2013 compared to 51 days at June 30, 2012 and 45 days at December 31, 2012. The increase in days sales outstanding between December 31, 2012 and June 30, 2013 is primarily related to the timing of the periodic interim payments we receive from Medicare for the services provided at our specialty hospitals.

Investing activities used $56.8 million of cash flow for the six months ended June 30, 2013. The principal use of cash included $28.0 million related to the purchase of property and equipment and $28.7 million related principally to investments in unconsolidated businesses. Investing activities used $21.6 million of cash flow for the six months ended June 30, 2012. The principal use of cash included $27.9 million related to the purchase of property and equipment and $10.0 million related primarily to an additional investment in the Baylor JV. This use of cash was offset by $16.5 million in proceeds related to the sale of a building.

Financing activities used $2.1 million of cash flow for the six months ended June 30, 2013. The financing activities included cash inflows related to $600.0 million of proceeds from the 6.375% senior notes issued on May 28, 2013. The proceeds of the senior notes were used to repay $587.0 million of our senior secured credit facility term loans and fund certain transaction costs amounting to $14.4 million. In addition, cash of $298.5 million was provided through the issuance of senior secured credit facility term loans which was used to pay dividends to Holdings to fund the redemption of $167.3 million principal amount of Holdings senior floating rate notes, repurchase $70.0 million of our 7$^{5}/_{8}$% senior subordinated notes and pay $4.2 million of transaction costs related to the financing transactions completed during the first quarter ended March 31, 2013. In addition, during the six months ended June 30, 2013 we paid dividends to Holdings to fund $14.0 million of dividends paid to Holdings' common stockholders, $10.0 million to fund Holding's repurchase of common stock and $5.6 million to fund interest payments on Holdings debt. We also made net repayments on the revolving portion of our credit facility of $25.0 million, paid $5.6 million for credit facility term loan principal maturities and received net proceeds from other debt of $2.2 million. We had proceeds of $1.6 million from bank overdrafts and used $1.5 million to make distributions to non-controlling interests. Financing activities used $92.9 million of cash flow for the six months ended June 30, 2012. The primary uses of cash related to net payments under our senior secured credit facility of $44.3 million, dividends paid to Holdings to fund interest payments and stock repurchases of $52.0 million and distributions to non-controlling interests of $1.7 million. These uses were offset by net borrowings of other debt of $0.8 million, proceeds of $0.5 million from the issuance of common stock and proceeds from bank overdrafts of $3.7 million.

Years Ended December 31, 2010, 2011 and 2012

	Year Ended December 31,		
	2010	**2011**	**2012**
	(in thousands)		
Cash flows provided by operating activities	$ 170,064	$ 240,053	$ 309,371
Cash flows used in investing activities	(216,998)	(54,735)	(72,406)
Cash flows used in financing activities	(32,381)	(177,640)	(208,864)
Net increase (decrease) in cash and cash equivalents	(79,315)	7,678	28,101
Cash and cash equivalents at beginning of period	83,680	4,365	12,043
Cash and cash equivalents at end of period	$ 4,365	$ 12,043	$ 40,144

Table of Contents

Operating activities provided $309.4 million of cash flows for the year ended December 31, 2012. The increase in cash flow provided by operating activities is principally related to a reduction in our days sales outstanding. Our days sales outstanding were 45 days at December 31, 2012 compared to 53 days at December 31, 2011. The reduction in days sales outstanding is primarily due to timing of the periodic interim payments we receive from Medicare for the services provided at our specialty hospitals and a reduction in our non-Medicare receivables.

Operating activities provided $240.1 million for the year ended December 31, 2011. The increase in cash flow provided by operating activities for the year ended December 31, 2011 is principally related to the increase in our income from operations. Additionally, we were able to offset the cash impact of an increase in our tax expense through an one-time deferral of income effectuated through a tax accounting change related to how we recognize our specialty hospital Medicare revenues for tax reporting purposes. This tax accounting change had the effect of deferring $16.5 million of tax liability in 2011. Our days sales outstanding were 53 days at December 31, 2011 compared to 51 days at December 31, 2010. The increase is principally related to the timing and settlement of our Medicare accounts receivable for services provided at our specialty hospitals.

Operating activities provided $170.1 million for the year ended December 31, 2010. The decrease in cash flow provided by operating activities in comparison to our operating cash flow provided by operating activities for the year ended December 31, 2009 is principally related to the increase in our accounts receivable at December 31, 2010. Our days sales outstanding were 51 days at December 31, 2010 compared to 49 days at December 31, 2009 and falls within our historical range of days sales outstanding.

Investing activities used $72.4 million, $54.7 million and $217.0 million of cash flow for the years ended December 31, 2012, 2011, and 2010, respectively. Of this amount, we incurred acquisition related payments of $6.0 million, $0.9 million and $165.8 million, respectively in 2012, 2011 and 2010. The acquisition payments for 2012 related principally to several small acquisitions of clinics in our outpatient rehabilitation segment. The acquisition payments for 2011 relate primarily to small acquisitions of outpatient businesses and specialty hospitals. The acquisition payments in 2010 related principally to the acquisition of Regency which was $165.6 million. Investing activities also used cash for the purchases of property and equipment of $68.2 million, $46.0 million and $51.8 million in 2012, 2011, and 2010, respectively. We sold business units and real property which generated $16.5 million, $7.9 million and $0.6 million in cash during the years ended December 31, 2012, 2011 and 2010, respectively. Investment in businesses relates to equity investments in unconsolidated businesses. The $14.7 million of investments for the year ended December 31, 2012 and $15.7 million of investments for the year ended December 31, 2011 related primarily to our investment in the Baylor JV partnership units. In addition, Select purchased minority investment interests in other healthcare related businesses that provide specialized technology, services to healthcare entities, and other healthcare services during the year ended December 31, 2012.

Financing activities used $208.9 million of cash flow for the year ended December 31, 2012. The primary use of cash related to dividends paid to Holdings of $268.5 million principally to fund the payment of dividends to Holdings' stockholders on December 12, 2012, fund Holdings' interest payments, and the repurchase of Holdings' common stock. We also used $6.5 million for debt issuances costs and paid $3.3 million in distributions to non-controlling interests, offset in part by net borrowings of debt of $66.4 million, $1.2 million of proceeds from bank overdrafts and $1.8 million of equity investment made by Holdings.

Financing activities used $177.6 million of cash flow for the year ended December 31, 2011. The primary use of cash related to dividends paid to Holdings of $245.7 million to fund interest payments, repurchase of common stock and the repurchase of all $150.0 million principal amount of Holdings' 10% senior subordinated notes. We also had $18.6 million of cash flow to fund debt issuance costs,

Table of Contents

repay bank overdrafts of $2.2 million and fund $4.6 million in distributions to non-controlling interests. These uses of cash were offset by net borrowings of debt of $93.2 million.

Financing activities used $32.4 million of cash flow for the year ended December 31, 2010. The primary usage of cash was related to dividends paid to Holdings of $69.7 million to fund Holdings' interest payments and Holdings' stock repurchases and was offset by a net borrowing under our revolving senior secured credit facility.

Capital Resources

We had net working capital of $135.4 million at June 30, 2013 compared to net working capital of $63.2 million at December 31, 2012. The increase in net working capital is primarily due to increases in accounts receivable. We had net working capital of $63.2 million at December 31, 2012 compared to net working capital of $97.3 million at December 31, 2011.

On June 1, 2011, we entered into a new senior secured credit agreement that originally provided for $1.15 billion in senior secured credit facilities comprised of an $850.0 million, seven-year term loan facility, which we refer to as the "original term loan" and a $300.0 million, five-year revolving credit facility, including a $75.0 million sublimit for the issuance of standby letters of credit and a $25.0 million sublimit for swingline loans. Borrowings under the senior secured credit facilities are guaranteed by Holdings and substantially all of our current domestic subsidiaries and will be guaranteed by 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 our foreign subsidiaries, if any. We used borrowings under the senior secured credit facilities to refinance all of our outstanding indebtedness under our then existing senior secured credit facilities, to repurchase $266.5 million aggregate principal amount of our 7$^{5}/_{8}$% senior subordinated notes due 2015 and to repay all of Holdings' 10% senior subordinated notes due 2015.

On August 13, 2012, we entered into an additional credit extension amendment to our senior secured credit facilities providing for a $275.0 million additional term loan tranche, which we refer to as the "series A term loan" to us at the same interest rate and with the same term as the original term loan. We used the net proceeds from the series A term loan and cash to repurchase $275.0 million aggregate principal amount of our 7$^{5}/_{8}$% senior subordinated notes due 2015.

Borrowings under the original term loan and the series A term loan incurred interest at a rate equal to Adjusted LIBO plus 3.75%, or Alternate Base Rate plus 2.75%. Adjusted LIBO at no time was less than 1.75%.

Borrowings under the revolving credit facility incur interest at a rate equal to Adjusted LIBO plus a percentage ranging from 2.75% to 3.75%, or Alternate Base Rate plus a percentage ranging from 1.75% to 2.75%, in each case based on our leverage ratio (the ratio of indebtedness to Consolidated EBITDA, as defined in the senior secured credit facilities).

On February 20, 2013, we entered into an additional credit extension amendment to our senior secured credit facilities providing for a $300.0 million additional term loan tranche, which we refer to as the "series B term loan". We used borrowings under the series B term loan to redeem all of our outstanding 7$^{5}/_{8}$% senior subordinated notes due 2015, to finance Holdings redemption of all of Holdings' senior floating rate notes due 2015 and to reduce a portion of the balance outstanding under our revolving credit facility.

Borrowings under the series B term loan bear interest at a rate equal to Adjusted LIBO plus 3.25%, or Alternate Base Rate plus 2.25%. The series B term loan amortizes in equal quarterly installments on the last day of each March, June, September and December in aggregate annual

Table of Contents

amounts equal to $3.0 million. The balance of the series B term loan will be payable on February 20, 2016.

On June 3, 2013, we amended our existing senior secured credit facilities in order to:

- extend the maturity date on $293.3 million of our $300.0 million revolving credit facility from June 1, 2016 to March 1, 2018;
- convert the remaining original term loan and series A term loan to a series C term loan and lower the interest rate payable on the series C term loan from Adjusted LIBO plus 3.75%, or Alternate Base Rate plus 2.75%, to Adjusted LIBO plus 3.00%, or Alternate Base Rate plus 2.00%, and amend the provision of the series C term loan from providing that Adjusted LIBO will at no time be less than 1.75% to providing that Adjusted LIBO will at no time be less than 1.00%; and
- amend the restrictive covenants governing the senior secured credit facilities in order to allow for unlimited restricted payments so long as there is no event of default under the senior secured credit facilities and the total pro forma ratio of total indebtedness to Consolidated EBITDA (as defined in our senior secured credit facilities) is less than or equal to 2.75 to 1.00.

At June 30, 2013, we had outstanding borrowings of $811.1 million (net of unamortized original issue discounts of $7.2 million) under the term loans and borrowings of $105.0 million (excluding letters of credit) under the revolving loan portion of our senior secured credit facilities. We had $153.1 million of availability under our revolving loan facility (after giving effect to $41.9 million of outstanding letters of credit) at June 30, 2013.

The applicable margin percentage for borrowings under our revolving loan is subject to change based upon the ratio of our leverage ratio (as defined in our senior secured credit facilities). The applicable interest rate for revolving loans as of June 30, 2013 was (1) Alternate Base Rate plus 2.75% for alternate base rate loans and (2) Adjusted LIBO plus 3.75% for Adjusted LIBO rate loans.

"Adjusted LIBO" is defined as, with respect to any interest period, the London interbank offered rate for such interest period, adjusted for any applicable statutory reserve requirements; provided that Adjusted LIBO, when used in reference to the series C term loan, will at no time be less than 1.00%.

"Alternate Base Rate" is defined as the highest of (a) the administrative agent's Prime Rate, (b) the Federal Funds Effective Rate plus $^1/_2$ of 1.00% and (c) the Adjusted LIBO from time to time for an interest period of one month, plus 1.00%.

We will be required to prepay borrowings under the senior secured credit facilities with (1) 100% of the net cash proceeds received from non-ordinary course asset sales or other dispositions, or as a result of a casualty or condemnation, subject to reinvestment provisions and other customary carveouts and the payment of certain indebtedness secured by liens subject to a first lien intercreditor agreement, (2) 100% of the net cash proceeds received from the issuance of debt obligations other than certain permitted debt obligations, and (3) 50% of excess cash flow (as defined in the senior secured credit facilities) if our leverage ratio is greater than 3.75 to 1.00 and 25% of excess cash flow if our leverage ratio is less than or equal to 3.75 to 1.00 and greater than 3.25 to 1.00, in each case, reduced by the aggregate amount of term loans optionally prepaid during the applicable fiscal year. We will not be required to prepay borrowings with excess cash flow if our leverage ratio is less than or equal to 3.25 to 1.00.

The senior secured credit facilities require us to maintain a leverage ratio (based upon the ratio of indebtedness to consolidated EBITDA, as defined in the senior secured credit facilities), which is tested quarterly, and prohibits us from making capital expenditures in excess of $125.0 million in any fiscal year (subject to a 50% carry-over provision). As of June 30, 2013, we were required to maintain our leverage ratio at less than 4.50 to 1.00, and our leverage ratio was 3.93 to 1.00. Failure to comply with

Table of Contents

these covenants would result in an event of default under the senior secured credit facilities and, absent a waiver or an amendment from the lenders, preclude us from making further borrowings under the revolving credit facility and permit the lenders to accelerate all outstanding borrowings under the senior secured credit facilities.

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

On June 1, 2012, we used a portion of the proceeds from our senior secured credit facilities to repurchase $266.5 million aggregate principal amount of our 7$^{5}/_{8}$% senior subordinated notes. On September 12, 2012, we used the proceeds of the series A term loans and cash on hand to redeem an additional $275.0 million aggregate principal amount of our 7$^{5}/_{8}$% senior subordinated notes and on March 22, 2013, we used the borrowings under the series B term loan to redeem the remaining outstanding 7$^{5}/_{8}$% senior subordinated notes due.

On May 28, 2013, we issued and sold $600.0 million aggregate principal amount of 6.375% senior notes due 2021. The senior notes are senior unsecured obligations and are fully and unconditionally guaranteed by all of our wholly owned subsidiaries. On May 28, 2013, we used the proceeds of the senior notes to pay a portion of the amounts outstanding on the original term loan and the series A term loan, and to pay related fees and expenses.

Interest on the senior notes accrues at the rate of 6.375% per annum and is payable semi-annually in cash in arrears on June 1 and December 1 of each year, commencing on December 1, 2013. The senior notes are senior unsecured obligations and rank equally in right of payment with all of its other existing and future senior unsecured indebtedness and senior in right of payment to all of its existing and future subordinated indebtedness. The senior notes are guaranteed, jointly and severally, by our direct or indirect existing and future domestic restricted subsidiaries other than certain non-guarantor subsidiaries.

We may redeem some or all of the senior notes prior to June 1, 2016 by paying a "make-whole" premium. We may redeem some or all of the senior notes on or after June 1, 2016 at specified redemption prices. In addition, prior to June 1, 2016, we may redeem up to 35% of the senior notes with the net proceeds of certain equity offerings at a price of 106.375% plus accrued and unpaid interest, if any. We are obligated to offer to repurchase the senior notes at a price of 101% of their principal amount plus accrued and unpaid interest, if any, as a result of certain change of control events. These restrictions and prohibitions are subject to certain qualifications and exceptions.

The Indenture relating to the senior notes contains covenants that, among other things, limit our ability and the ability of certain of its subsidiaries to (i) grant liens on its assets, (ii) make dividend payments, other distributions or other restricted payments, (iii) incur restrictions on the ability of restricted subsidiaries to pay dividends or make other payments, (iv) enter into sale and leaseback transactions, (v) merge, consolidate, transfer or dispose of substantially all of their assets, (vi) incur additional indebtedness, (vii) make investments, (viii) sell assets, including capital stock of subsidiaries, (ix) use the proceeds from sales of assets, including capital stock of restricted subsidiaries, and (x) enter into transactions with affiliates. In addition, the Indenture requires, among other things, us to provide financial and current reports to holders of the senior notes or file such reports electronically with the U.S. Securities and Exchange Commission (the "SEC"). These covenants are subject to a number of exceptions, limitations and qualifications set forth in the Indenture.

Table of Contents

In connection with the issuance of the senior notes, we entered into a registration rights agreement on May 28, 2013 with certain guarantors of the notes named therein and J.P. Morgan Securities LLC, on behalf of itself and the other initial purchasers named therein (the "Registration Rights Agreement"). Pursuant to the Registration Rights Agreement, we have agreed to file an exchange offer registration statement to exchange the senior notes for substantially identical notes registered under the Securities Act unless the exchange offer is not permitted by applicable law or the policy of the SEC. We have also agreed to file a shelf registration statement to cover resales of notes under certain circumstances. We agreed to file the exchange offer registration statement with the SEC within 150 days of the issue date of the senior notes and use commercially reasonable efforts to have the exchange offer registration statement declared effective within 240 days of the issue date and to complete the exchange offer with respect to the senior notes within 30 days of effectiveness. In addition, we agreed to use commercially reasonable efforts to file the shelf registration statement on or prior to the later of (i) 120 days after a filing obligation arises and (ii) 270 days after the issue date, and to use commercially reasonable efforts to cause such shelf registration statement to be declared effective by the SEC on or prior to 210 days after such filing. If we fails to satisfy its registration obligations under the Registration Rights Agreement, it will be required to pay additional interest to the holders of the senior notes under certain circumstances.

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

Holdings' board of directors has authorized a common stock repurchase program to repurchase up to $350.0 million worth of shares of its common stock. The program will remain in effect until March 31, 2014, unless extended by the board of directors. Stock repurchases under this program may be made in the open market or through privately negotiated transactions, and at times and in such amounts as Holdings deems appropriate. Holdings is funding this program with our cash on hand and borrowings under our revolving credit facility. During the six months ended June 30, 2013, Holdings repurchased 1,115,691 shares at a cost of approximately $10.0 million, an average cost per share of $8.95, which includes transaction costs. Since the inception of the program through June 30, 2013, Holdings has repurchased 23,606,080 shares at a cost of approximately $173.6 million, or $7.36 per share, which includes transaction costs.

We believe our internally generated cash flows and borrowing capacity under our senior secured credit facility will be sufficient to finance operations over the next twelve months.

We routinely pursue opportunities to develop new joint venture relationships with significant health systems, and from time to time we may also develop new inpatient rehabilitation hospitals. With the expiration on December 28, 2012 of the moratorium on new LTCHs and new LTCH beds, we are evaluating the addition of new LTCH beds at certain of our hospitals. We also intend to open new outpatient rehabilitation clinics in local areas that we currently serve where we can benefit from existing referral relationships and brand awareness to produce incremental growth. In addition to our development activities, we may grow our network of specialty hospitals through opportunistic acquisitions.

Dividend

On August 7, 2013, Holdings' board of directors declared a quarterly cash dividend of $0.10 per share. The dividend will be payable on or about August 30, 2013 to stockholders of record as of the close of business on August 20, 2013. Holdings intends to fund this dividend through the use of our cash on hand and borrowings under our revolving credit facility.

Table of Contents

Commitments and Contingencies

The following tables summarize contractual obligations at December 31, 2012, and the effect such obligations are expected to have on liquidity and cash flow in future periods. Reserves for uncertain tax positions of $15.4 million have been excluded from the tables below as we cannot reasonably estimate the amounts or periods in which these liabilities will be paid.

Contractual Obligations	Total	2013	2014-2016	2017-2018	After 2018
			(in thousands)		
7⅝% senior subordinated notes(1)(5)	$ 70,000	$	$ 70,000	$	$
Senior secured credit facility(2)(3)(5)	1,226,641	8,584	155,860	1,062,197	
Other debt obligations	6,302	3,062	1,794	46	1,400
Total debt	1,302,943	11,646	227,654	1,062,243	1,400
Interest(4)(5)	353,704	72,209	198,682	82,757	56
Letters of credit outstanding(5)	34,072		34,072		
Purchase obligations	6,240	3,479	2,358	403	
Construction contracts	7,246	7,246			
Naming, promotional and sponsorship agreement	42,977	2,870	9,017	6,365	24,725
Operating leases	675,028	121,272	223,326	74,840	255,590
Related party operating leases	36,436	3,481	9,910	6,992	16,053
Total contractual cash obligations	$ 2,458,646	$ 222,203	$ 705,019	$ 1,233,600	$ 297,824

(1) On March 22, 2013 we redeemed all the outstanding 7⅝% senior subordinated notes due 2015 using a portion of the proceeds from the series B term loan.

(2) Reflects the balance sheet liability of the senior secured credit facility calculated in accordance with GAAP. The balance sheet liability so reflected is less than the $1,125.1 million aggregate principal amount of term loans that were issued with original issue discount. The remaining unamortized original issue discount on the term loans was $14.2 million at December 31, 2012. Interest on the senior secured credit facility accrued on the full principal amount thereof and we will be obligated to repay the full principal thereof at maturity or upon any mandatory or voluntary prepayment thereof.

(3) The balance of the term loans was to be payable on June 1, 2018 and the revolving credit facility was to be payable on June 1, 2016.

(4) The interest obligation for the senior secured credit facility term loans was calculated using the average interest rate at December 31, 2012 of 5.5% and the revolving portion was calculated at the average interest rate at December 31, 2012 of 4.3%. The interest obligation was calculated using the stated interest rate for the 7⅝% senior subordinated notes and 6.0% for the other debt obligations.

Table of Contents

(5)

The following table reflects our debt obligations as of June 30, 2013 which differ from our debt obligations presented in the table above at December 31, 2012 due to the refinancing activities we completed in 2013.

Contractual Obligations (in thousands)	Total	July 1, 2013 through December 31, 2013	2014-2016	2017-2018	After 2018
6.375% senior notes	600,000				600,000
Senior secured credit facility	916,060	6,492	304,718	604,850	
Interest(a)	454,927	38,087	214,248	110,154	92,438
Letters of Credit Outstanding	41,924			41,924	

(a)

The interest obligation for the senior secured credit facility term loans was calculated using 4.0% and the revolving portions was calculated at 4.4%. The interest obligation was calculated using the stated interest rate for the 6.375% senior notes and 6.0% for the other debt obligations.

Inflation

The healthcare industry is labor intensive and susceptible to wage increases during periods of inflation and when labor shortages occur in the marketplace. In addition, suppliers which include pharmaceutical costs, pass along rising costs to us in the form of higher prices. Our ability to pass on increased costs associated with providing healthcare to Medicare and Medicaid patients is limited due to federal and state laws that established fixed reimbursement rates. In recent years, inflation has not had a material impact on our results of operations. We cannot predict the impact that future economic conditions may have on our ability to contain or offset future cost increases.

Recent Accounting Pronouncements

In July 2012, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2012-02, "Intangibles Goodwill and Other (Topic 350): Testing Indefinite-Lived Intangible Assets for Impairment," ("Update 2012-02"). In accordance with Update 2012-02, an entity has the option to first assess qualitative factors to determine whether it is more likely than not that the fair value of an indefinite-lived intangible asset is less than its carrying value. If the entity determines that it is more likely than not that the fair value of the indefinite-lived intangible asset is less than the carrying value, the entity will be required to perform the quantitative impairment test. Update 2012-02 is effective for annual and interim impairment tests performed for fiscal years beginning after September 15, 2012. However, early adoption is permitted. Update 2012-02 will not have an impact on our consolidated financial statements.

In June 2011, the FASB issued ASU 2011-05, "Comprehensive Income (Topic 220) Presentation of Comprehensive Income" ("Update 2011-05") that improves the comparability, consistency and transparency of financial reporting and increases the prominence of items reported in other comprehensive income by eliminating the option to present components of other comprehensive income as part of the statement of changes in stockholders' equity. Update 2011-05 requires that all non-owner changes in stockholders' equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. Under either method, adjustments must be displayed for items that are reclassified from other comprehensive income ("OCI") to net income, in both net income and OCI. Update 2011-05 does not change the current option for presenting components of OCI gross or net of the effect of income taxes, provided that such tax effects are presented in the statement in which OCI is presented or disclosed in the notes to the financial statements. Additionally, Update 2011-05 does not affect the calculation or reporting of earnings per share. Update 2011-05 was effective for fiscal years, and interim periods within those years, beginning after December 15, 2011 and is to be applied retrospectively. With the adoption of Update 2011-05, the Company opted to change its presentation of its components of other comprehensive income to a single continuous statement of operations and other comprehensive income.

Table of Contents

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are subject to interest rate risk in connection with our long-term indebtedness. Our principal interest rate exposure relates to the loans outstanding under our senior secured credit facility. As of June 30, 2013, we had $818.3 million (excluding unamortized original issue discount) in term loans outstanding under our senior secured credit facility and $105.0 million in revolving loans outstanding under our senior secured credit facility, which bear interest at variable rates. Each eighth point change in interest rates on the variable rate portion of our long-term indebtedness would result in a $1.2 million annual change in interest expense. However, because the variable interest rate for an aggregate $519.8 million in series C term loan is subject to an Adjusted LIBO Rate floor of 1.00% until the Adjusted LIBO Rate exceeds 1.00%, our interest rate on this indebtedness is effectively fixed at 4.00%.

Table of Contents

OUR BUSINESS

Overview

We believe that we are one of the largest operators of both specialty hospitals and outpatient rehabilitation clinics in the United States based on number of facilities. As of June 30, 2013, we operated 109 long term acute care hospitals, or "LTCHs" and 14 inpatient rehabilitation facilities, or "IRFs" in 28 states, and 988 outpatient rehabilitation clinics in 32 states and the District of Columbia. We also provide medical rehabilitation services on a contract basis at nursing homes, hospitals, assisted living and senior care centers, schools and worksites. We began operations in 1997 under the leadership of our current management team.

We manage our company through two business segments, our specialty hospital segment and our outpatient rehabilitation segment. We had net operating revenues of $2,949.0 million for the year ended December 31, 2012. Of this total, we earned approximately 75% of our net operating revenues from our specialty hospital segment and approximately 25% from our outpatient rehabilitation segment. Our specialty hospital segment consists of hospitals designed to serve the needs of long term stay acute care patients and hospitals designed to serve patients who require intensive inpatient medical rehabilitation care. Our outpatient rehabilitation segment consists of clinics and contract therapy locations that provide physical, occupational and speech rehabilitation services.

Specialty Hospitals

We are a leading operator of specialty hospitals in the United States. As of June 30, 2013, we operated 123 facilities throughout 28 states, including 109 LTCHs, all of which are currently certified by the federal Medicare program as LTCHs, and 14 acute medical rehabilitation hospitals, 13 of which are currently certified by the federal Medicare program as IRFs and one of which is going through the process to obtain Medicare certification. For the years ended December 31, 2010, December 31, 2011 and December 31, 2012, approximately 61%, 61% and 60%, respectively, of the net operating revenues of our specialty hospital segment came from Medicare reimbursement. As of June 30, 2013, we operated a total of 5,181 available licensed beds and employed approximately 20,600 people in our specialty hospital segment, consisting primarily of registered or licensed nurses, respiratory therapists, physical therapists, occupational therapists and speech therapists.

Patients are typically admitted to our specialty hospitals from general acute care hospitals. These patients have specialized needs, and serious and often complex medical conditions such as respiratory failure, neuromuscular disorders, traumatic brain and spinal cord injuries, strokes, non-healing wounds, cardiac disorders, renal disorders and cancer. Given their complex medical needs, these patients generally require a longer length of stay than patients in a general acute care hospital and benefit from being treated in a specialty hospital that is designed to meet their unique medical needs. The average length of stay for patients in our specialty hospitals was 27 days in our LTCHs and 15 days in our IRFs, for the year ended December 31, 2012.

Table of Contents

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, 2012:

Medical Condition	Distribution of Patients
Respiratory disorders	35%
Neuromuscular disorders	32%
Cardiac disorders	10%
Wound care	6%
Infectious diseases	6%
Other	11%
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 demonstrating our quality of care and by doing so expanding and improving our relationships with the physicians and general acute care hospitals in the markets where we operate. We maintain a strong focus on the provision of high-quality medical care within our facilities and believe that this operational focus is in part reflected by the accreditation of our specialty hospitals by The Joint Commission, the American Osteopathic Association ("AOA") and the Commission on Accreditation of Rehabilitation Facilities ("CARF"). As of June 30, 2013, all of the 123 specialty hospitals we operated were accredited by either The Joint Commission or the AOA. Additionally, some of our IRFs have also applied for and received accreditation from CARF. The Joint Commission and CARF are independent, not-for-profit organizations that establish standards related to the operation and management of healthcare facilities. Each of our accredited facilities must regularly demonstrate to a survey team conformance to the applicable standards.

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

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

Each of our specialty hospitals has an interdisciplinary medical staff that is comprised of physicians that have completed the privileging and credentialing process required by that specialty hospital, and have been approved by the governing board of that specialty hospital. Physicians on the medical staff of our specialty hospitals are generally not directly employed by our specialty hospitals but instead have staff privileges at one or more hospitals. At each of our specialty hospitals, attending physicians conduct rounds on their patients on a daily basis and consulting physicians provide consulting services based on the medical needs of our patients. Our specialty hospitals also have on-call arrangements with physicians to ensure that a physician is available to care for our patients at all times. We staff our specialty hospitals with the number of physicians and other medical practitioners that we believe is

Table of Contents

appropriate to address the varying needs of our patients. When determining the appropriate composition of the medical staff of a specialty hospital, we consider (1) the size of the specialty hospital, (2) services provided by the specialty hospital, (3) if applicable, the size and capabilities of the medical staff of the general acute care hospital that hosts our hospital within hospital, or "HIH" and (4) if applicable, the proximity of an acute care hospital to a free-standing hospital. The medical staff of each of our specialty hospitals meets the applicable requirements set forth by Medicare, The Joint Commission and the state in which that specialty hospital is located.

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

We operate the majority of our LTCHs as HIHs. An LTCH that operates as an HIH leases space from a general acute care hospital, or "host hospital," and operates as a separately licensed hospital within the host hospital, or on the same campus as the host hospital. In contrast, a free-standing LTCH does not operate on a host hospital campus. We operated 109 LTCHs at June 30, 2013, of which 108 are owned and one is managed. Of the 108 LTCHs we owned, 76 were operated as HIHs and 32 were operated as free-standing hospitals.

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

Specialty Hospital Strategy

The key elements of our specialty hospital strategy are to:

Focus on Specialized Inpatient Services. We serve highly acute patients and patients with debilitating injuries and rehabilitation needs that cannot be adequately cared for in a less medically intensive environment, such as a skilled nursing facility. Generally, patients in our specialty hospitals require longer stays and can benefit from more specialized clinical care than patients treated in general acute care hospitals. Our patients' average length of stay in our specialty hospitals was 24 days for the year ended December 31, 2012.

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

Our treatment programs benefit patients because they give our clinicians access to the best practices and protocols that we have found to be most effective in treating various conditions such as respiratory failure, non-healing wounds, brain and spinal cord injuries, strokes and neuromuscular

Table of Contents

disorders. In addition, we combine or modify these programs to provide a treatment plan tailored to meet our patients' unique needs.

The quality of the patient care we provide is continually monitored using several measures, including patient satisfaction surveys, as well as clinical outcomes analyses. Quality measures are collected continuously and reported monthly, quarterly and annually. In order to benchmark ourselves against other healthcare organizations, we have contracted with outside vendors to collect our clinical and patient satisfaction information and compare it to other healthcare organizations. The information collected is reported back to each hospital, to our corporate office, and directly to The Joint Commission. As of June 30, 2013, all of the 123 specialty hospitals we operated were accredited. Some of our IRFs have also received accreditation from CARF. See " Government Regulations Licensure Accreditation."

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

- centralizing administrative functions such as accounting, treasury, payroll, legal, operational support, human resources, compliance and billing and collection;
- standardizing management information systems to aid in accounting, billing, collections and data capture and analysis; and
- centralizing sourcing and contracting to receive discounted prices for pharmaceuticals, medical supplies and other commodities used in our operations.

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

Develop Inpatient Facilities. Since our inception in 1997 we have internally developed 64 specialty hospitals. We will continue to evaluate opportunities to develop joint venture relationships with significant health systems, and from time to time we may also develop new inpatient rehabilitation hospitals.

By leveraging the experience of our senior management and dedicated development team, we believe that we are well positioned to capitalize on development opportunities. When we identify joint venture opportunities, our development team conducts an extensive review of the area's referral patterns and commercial insurance to determine the general reimbursement trends and payor mix. Ultimately, we determine the needs of a joint venture, which could include working capital, the construction of new space or the leasing and renovation of existing space. During construction or renovation, the project is transitioned to our start-up team, which is experienced in preparing a specialty hospital for opening. The start-up team oversees construction or renovation, equipment purchases and any necessary licensure procedures. While the facility is being prepared for opening, our corporate operations group is responsible for the recruitment of a full-time management team, to which responsibility for the facility's management is transitioned once the facility is opened.

Pursue Opportunistic Acquisitions and Joint Ventures. In addition to our development initiatives, we may grow our network of specialty hospitals through opportunistic acquisitions or joint ventures. When we acquire a hospital or a group of hospitals or enter into a joint venture, a team of our professionals is responsible for formulating and executing an integration plan. We seek to improve financial performance at such facilities by adding clinical programs that attract commercial payors, centralizing administrative functions and implementing our standardized resource management programs.

Table of Contents

Outpatient Rehabilitation

We believe that we are the largest operator of outpatient rehabilitation clinics in the United States based on number of facilities, with 988 facilities throughout 32 states and the District of Columbia as of June 30, 2013. Typically, each of our clinics is located in a medical complex or retail location. We also provide medical rehabilitative services to residents and patients of nursing homes, hospitals, schools, assisted living and senior care centers and worksites. As of June 30, 2013, we provided rehabilitative services to approximately 522 contracted locations in 31 states and the District of Columbia. Our outpatient rehabilitation segment employed approximately 9,500 people as of June 30, 2013.

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 functional programs for work related injuries, hand therapy and athletic training services. 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, work related injuries or post-operative orthopedic and other medical conditions. Our rehabilitation programs and services are designed to help these patients minimize physical and cognitive impairments and maximize functional ability. We also provide services designed to prevent short term disabilities from becoming chronic conditions. Our rehabilitation services are provided by our professionals including licensed physical therapists, occupational therapists, speech-language pathologists and athletic trainers.

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 a high-quality and cost-effective level of care to their enrollees.

In our outpatient rehabilitation segment, approximately 90% of our net operating revenues come from commercial payors, including healthcare insurers, managed care organizations and workers' compensation programs, contract management services and private pay sources. The balance of our reimbursement is derived from Medicare and other government sponsored programs.

Outpatient Rehabilitation Strategy

The key elements of our outpatient rehabilitation strategy are to:

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

Increase Market Share. We strive to establish a leading presence within the local areas we serve. To increase our presence, we seek to expand our services and programs and to open new clinics in our existing markets. This allows us to realize economies of scale, heightened brand loyalty and workforce continuity. We are focused on increasing our workers' compensation and commercial/managed care payor mix.

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

Table of Contents

gain through our national network of clinics. This knowledge is used to design programs that optimize treatment methods and measure changes in health status, clinical outcomes and patient satisfaction.

Optimize the Profitability of our Payor Contracts. We review payor contracts up for renewal and potential new payor contracts to optimize our profitability. Before we enter into a new contract with a commercial payor, we evaluate it with the aid of our contract management system. We assess potential profitability by evaluating past and projected patient volume, clinic capacity, and expense trends. We create a retention strategy for the top performing contracts and a renegotiation strategy for contracts that do not meet our defined criteria. We believe that our size and our strong reputation enable us to negotiate favorable outpatient contracts with commercial insurers.

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

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

Other

Other activities include our corporate services and certain other non-consolidating joint ventures and minority investments in other healthcare related businesses. These include investments in companies that provide specialized technology, services to healthcare entities and providers of complementary services.

Our Competitive Strengths

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

Leading Operator in Distinct but Complementary Lines of Business. We believe that we are a leading operator in each of our principal business segments, based on number of facilities in the United States. Our leadership position and reputation as a high-quality, cost-effective healthcare provider in each of our business segments allows us to attract patients and employees, aids us in our marketing efforts to payors and referral sources and helps us negotiate payor contracts. In our specialty hospital segment, we operated 109 LTCHs in 28 states and 14 IRFs in six states at June 30, 2013. We derived approximately 75% of net operating revenues from these operations for the year ended December 31, 2012. In our outpatient rehabilitation segment, we operated 988 outpatient rehabilitation clinics in 32 states and the District of Columbia at June 30, 2013. We derived approximately 25% of net operating revenues from these operations for the year ended December 31, 2012. With these leading positions in the areas we serve, we believe that we are well-positioned to benefit from the rising demand for

Table of Contents

medical services due to an aging population in the United States, which will drive growth across our business lines.

Proven Financial Performance and Strong Cash Flow. We have established a track record of improving the financial performance of our facilities due to our disciplined approach to revenue growth, expense management and an intense focus on free cash flow generation. This includes regular review of specific financial metrics of our business to determine trends in our revenue generation, expenses, billing and cash collection. Based on the ongoing analysis of such trends, we make adjustments to our operations to optimize our financial performance and cash flow.

Significant Scale. By building significant scale in each of our business segments, we have been able to leverage our operating costs by centralizing administrative functions at our corporate office. As a result, we have been able to minimize our general and administrative expense as a percentage of revenues.

Experience in Successfully Completing and Integrating Acquisitions. From our inception in 1997 through 2012, we completed seven significant acquisitions for approximately $1,104.8 million in aggregate consideration. We believe that we have improved the operating performance of these facilities over time by applying our standard operating practices and by realizing efficiencies from our centralized operations and management.

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

Experienced and Proven Management Team. Prior to co-founding our company with our current Chief Executive Officer, our Executive Chairman founded and operated three other healthcare companies focused on inpatient and outpatient rehabilitation services. In addition, our senior management team has extensive experience in the healthcare industry. In recent years, we have reorganized our operations to expand executive talent and ensure management continuity.

Sources of Net Operating Revenues

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

	Year Ended December 31,		
	2010	**2011**	**2012**
Net Operating Revenues by Payor Source			
Medicare	46.7%	48.2%	46.9%
Commercial insurance(1)	44.7%	41.5%	41.9%
Private and other(2)	5.6%	7.0%	7.7%
Medicaid	3.0%	3.3%	3.5%
Total	100.0%	100.0%	100.0%

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

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

Table of Contents

Government Sources

Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, some disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to individuals who are unable to afford healthcare. As of June 30, 2013, we operated 123 specialty hospitals, 122 of which are currently certified as Medicare providers and one of which is going through the process to obtain Medicare certification. Our outpatient rehabilitation clinics regularly receive Medicare payments for their services. Additionally, many of our specialty hospitals participate in state Medicaid programs. Amounts received under the Medicare and Medicaid programs are generally less than the customary charges for the services provided. In recent years there have been significant changes made to the Medicare and Medicaid programs. Since a significant portion of our revenues come from patients under the Medicare program, our ability to operate our business successfully in the future will depend in large measure on our ability to adapt to changes in the Medicare program. See " Government Regulations Overview of U.S. and State Government Reimbursements."

Non-Government Sources

Our non-government sources of net operating revenue 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 commercial payors.

Employees

As of June 30, 2013, we employed approximately 31,000 people throughout the United States. Approximately 20,900 of our employees are full time and the remaining approximately 10,100 are part-time employees. Specialty hospital employees totaled approximately 20,600 and outpatient, contract therapy and physical rehabilitation and occupational health employees totaled approximately 9,500. The remaining approximately 900 employees were in corporate management, administration and other support services primarily residing at our Mechanicsburg, Pennsylvania headquarters.

Competition

We compete on the basis of the quality of the patient services we provide, the results that we achieve for our patients and the prices we charge for our services. 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 LTCHs and IRFs that compete with our hospitals, including large operators of similar facilities, such as Kindred Healthcare Inc. and HealthSouth Corporation and rehabilitation units and stepdown units operated by acute care hospitals in the markets we serve. The competitive position of any hospital is also affected by the ability of its management to negotiate contracts with purchasers of group healthcare services, including private employers, managed care companies, preferred provider organizations and health maintenance organizations. Such organizations attempt to obtain discounts from established hospital charges. The importance of obtaining contracts with preferred provider organizations, health maintenance organizations and other organizations which finance healthcare, and its effect on a hospital's competitive position, vary from area to area, depending on the number and strength of such organizations.

Table of Contents

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

Government Regulations

General

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

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, not only at scheduled intervals but also in response to complaints from patients and others. While our facilities intend to comply with existing licensing and Medicare certification requirements and accreditation standards, there can be no assurance that regulatory authorities will determine that all applicable requirements are fully met at any given time. A determination by an applicable regulatory authority that a facility is not in compliance with these requirements could lead to the imposition of corrective action, assessment of fines and penalties, or loss of licensure, Medicare certification or accreditation. These consequences could have an adverse effect on our company.

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

Professional Licensure and Corporate Practice

Healthcare professionals at our hospitals and outpatient rehabilitation clinics are required to be individually licensed or certified under applicable state law. We take steps to ensure that our employees and agents possess all necessary licenses and certifications. Some states prohibit the "corporate practice of therapy" so that business corporations such as ours are restricted from practicing therapy through the direct employment of therapists. The laws relating to corporate practice vary from state to state and are not fully developed in each state in which we have outpatient clinics. We believe that each of our outpatient therapy clinics complies with any current corporate practice prohibition of the state in which it is located. For example, in those states that apply the corporate practice prohibition, we either

Table of Contents

contract to obtain therapy services from an entity permitted to employ therapists or we manage the physical therapy practice owned by licensed therapists through which the therapy services are provided. However, future interpretations of the corporate practice prohibition, enactment of new legislation or adoption of new regulations could cause us to have to restructure our business operations or close our clinics in a particular state. If new legislation, regulations or interpretations establish that our clinics do not comply with state corporate practice prohibition, we could be subject to civil, and perhaps criminal, penalties. Any such restructuring or penalties could have a material adverse effect on our business.

Certification

In order to participate in the Medicare program and receive Medicare reimbursement, each facility must comply with the applicable regulations of the United States Department of Health and Human Services relating to, among other things, the type of facility, its equipment, its personnel and its standards of medical care, as well as compliance with all applicable state and local laws and regulations. As of June 30, 2013, 122 of the 123 specialty hospitals we operated were certified as Medicare providers and one was going through the process to obtain certification. In addition, we provide the majority of our outpatient rehabilitation services through clinics certified by Medicare as rehabilitation agencies or "rehab agencies."

Accreditation

Our specialty hospitals receive accreditation from The Joint Commission, AOA, CARF and/or other healthcare accrediting organizations. As of June 30, 2013, all of the 123 specialty hospitals we operated were accredited by either The Joint Commission or the AOA. In addition, some of our IRFs have also applied for and received accreditation from CARF.

Overview of U.S. and State Government Reimbursements

Medicare Program in General

The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services, or "CMS." Net operating revenues generated directly from the Medicare program represented approximately 47% of our consolidated net operating revenues for the year ended December 31, 2010, 48% for the year ended December 31, 2011 and 47% for the year ended December 31, 2012.

The Medicare program reimburses various types of providers, including LTCHs, IRFs and outpatient rehabilitation providers, using different payment methodologies. The Medicare reimbursement systems specific to LTCHs, IRFs and outpatient rehabilitation providers, as described below, are different than the system applicable to general acute care hospitals. If our hospitals fail to comply with the requirements for payment under the Medicare reimbursement system for LTCHs or IRFs, our hospitals will be paid under the system applicable to general acute care hospitals. For general acute care hospitals, Medicare payments are made under IPPS under which a hospital receives a fixed payment amount per discharge (adjusted for area wage differences) using Medicare severity diagnosis-related groups, or "MS-DRGs." The general acute care hospital MS-DRG payment rate is based upon the national average cost of treating a Medicare patient's condition, based on severity levels of illness, in that type of facility. Although the average length of stay varies for each MS-DRG, the average stay of all Medicare patients in a general acute care hospital is substantially less than the average length of stay in LTCHs and IRFs. Thus, the prospective payment system for general acute care hospitals creates an economic incentive for those hospitals to discharge medically complex Medicare patients to a

Table of Contents

post-acute care setting as soon as clinically possible. Effective October 1, 2005, CMS expanded its post-acute care transfer policy under which general acute care hospitals are paid on a per diem basis rather than the full MS-DRG rate if a patient is discharged early to certain post-acute care settings, including LTCHs and IRFs. When a patient is discharged from selected MS-DRGs to, among other providers, an LTCH, the general acute care hospital is reimbursed below the full MS-DRG payment if the patient's length of stay is less than the geometric mean length of stay for the MS-DRG.

Long Term Acute Care Hospital Medicare Reimbursement

The Medicare payment system for LTCHs is based on a prospective payment system specifically applicable to LTCHs. LTCH-PPS was established by CMS final regulations published on August 30, 2002, and applies to LTCHs for cost reporting periods beginning on or after October 1, 2002. Under LTCH-PPS, each patient discharged from an LTCH was assigned to a distinct LTC-DRG and an LTCH is generally paid a pre-determined fixed amount applicable to the assigned LTC-DRG (adjusted for area wage differences), subject to exceptions for short stay and high cost outlier patients (described below). Beginning with discharges on or after October 1, 2007, CMS implemented a new patient classification system with categories referred to as "MS-LTC-DRGs." The new classification categories take into account the severity of the patient's condition. CMS assigned relative weights to each MS-LTC-DRG to reflect their relative use of medical care resources. The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in an LTCH.

Standard Federal Rate

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

Short Stay Outlier Policy

CMS established a different payment methodology for Medicare patients with a length of stay less than or equal to five-sixths of the geometric average length of stay for that particular MS-LTC-DRG, referred to as a SSO. SSO cases are paid based on the lesser of (1) 100% of the average cost of the case; (2) 120% of the MS-LTC-DRG specific per diem amount multiplied by the patient's length of stay; (3) the full MS-LTC-DRG payment; or (4) a per diem rate derived from blending 120% of the MS-LTC-DRG specific per diem amount with a per diem rate based on the general acute care hospital IPPS.

Modification of Short Stay Outlier Policy

The SSO rule was revised adding a category referred to as a "very short stay outlier" for discharges occurring after July 1, 2007. For cases with a length of stay that is less than the average length of stay plus one standard deviation for the same MS-DRG under IPPS, referred to as the so-called "IPPS comparable threshold," the rule lowers the LTCH payment to a rate based on the general acute care hospital IPPS per diem. SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the SSO payment policy. The SCHIP Extension Act, as amended by the ARRA and the PPACA prevented CMS from applying the very short-stay outlier policy during the period from December 29, 2007 through December 28, 2012. The very short-stay outlier policy is again applicable to discharges occurring on or after December 29, 2012 and will continue to be applied unless Congress or CMS takes further action.

Table of Contents

High Cost Outliers

Some cases are extraordinarily costly, producing losses that may be too large for hospitals to offset. Cases with unusually high costs, referred to as "high cost outliers," receive a payment adjustment to reflect the additional resources utilized. CMS provides an additional payment if the estimated costs for the patient exceed the adjusted MS-LTC-DRG payment plus a fixed-loss amount that is established in the annual payment rate update.

Interrupted stays

An interrupted stay is defined as a case in which an LTCH patient is admitted upon discharge to a general acute care hospital, IRF or skilled nursing facility/swing-bed and returns to the same LTCH within a specified period of time. If the length of stay at the receiving provider is equal to or less than the applicable fixed period of time, it is considered to be an interrupted stay case and is treated as a single discharge for the purposes of payment to the LTCH.

Freestanding, HIH and Satellite LTCHs

LTCHs may be organized and operated as freestanding facilities or as HIHs. As its name suggests, a freestanding LTCH is not located on the campus of another hospital. For such purpose, "campus" means the physical area immediately adjacent to a hospital's main buildings, other areas and structures that are not strictly contiguous to a hospital's main buildings but are located within 250 yards of its main buildings, and any other areas determined, on an individual case basis by the applicable CMS regional office, to be part of a hospital's campus. Conversely, an HIH is an LTCH that is located on the campus of another hospital. An LTCH, whether freestanding or an HIH, that uses the same Medicare provider number of an affiliated "primary site" LTCH is known as a "satellite." Under Medicare policy, a satellite LTCH must be located within 35 miles of its primary site LTCH and be administered by such primary site LTCH. A primary site LTCH may have more than one satellite LTCH. CMS sometimes refers to a satellite LTCH that is freestanding as a "remote location."

Facility Certification Criteria

The LTCH-PPS regulations define the criteria that must be met in order for a hospital to be certified as an LTCH. To be eligible for payment under the LTCH-PPS, a hospital must be primarily engaged in providing inpatient services to Medicare beneficiaries with medically complex conditions that require a long hospital stay. In addition, by definition, LTCHs must meet certain facility criteria, including (1) instituting a review process that screens patients for appropriateness of an admission and validates the patient criteria within 48 hours of each patient's admission, evaluates regularly their patients for continuation of care and assesses the available discharge options; (2) having active physician involvement with patient care that includes a physician available on-site daily and additional consulting physicians on call; and (3) having an interdisciplinary team of healthcare professionals to prepare and carry out an individualized treatment plan for each patient.

An LTCH must have an average inpatient length of stay for Medicare patients (including both Medicare covered and non-covered days) of greater than 25 days. LTCHs that fail to exceed an average length of stay of 25 days during any cost reporting period may be paid under the general acute care hospital IPPS if not corrected within established timeframes. CMS, through its contractors, determines whether an LTCH has maintained an average length of stay of greater than 25 days during each annual cost reporting period. In the preamble to the final rule for fiscal year 2012, CMS clarified its policy on the calculation of the average length of stay by specifying that all data on all Medicare inpatient days, including Medicare Advantage days, must be included in the average length of stay calculation effective for cost reporting periods beginning on or after January 1, 2012.

Table of Contents

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

25 Percent Rule

The "25 Percent Rule" is a downward payment adjustment that applies to Medicare patients discharged from LTCHs who were admitted from an individual hospital (regardless of whether the referring hospital is co-located with the LTCH or LTCH satellite) exceed the applicable percentage threshold during a particular cost reporting period, the payment rate for those discharges would be subject to a downward payment adjustment. Cases admitted in excess of the applicable threshold are reimbursed at a rate comparable to that under general acute care IPPS, which is generally lower than LTCH-PPS rates. Cases that reach outlier status in the referring hospital do not count toward the limit and are paid under LTCH-PPS.

For HIHs that meet specified criteria and were in existence as of October 1, 2004, the Medicare percentage thresholds were phased in over a four year period starting with hospital cost reporting periods that began on or after October 1, 2004. For HIHs opened after October 1, 2004, the Medicare percentage threshold has been established at 25% except for HIHs located in rural areas or co-located with an MSA dominant hospital or single urban hospital (as defined by current regulations) where the percentage is no more than 50%, nor less than 25%.

The SCHIP Extension Act as amended by ARRA and the PPACA has limited the application of the Medicare percentage threshold to HIHs in existence on October 1, 2004 and subject to the four year phase in described above. For these HIHs, the percentage threshold is no lower than 50% for a five year period to commence on an LTCH's first cost reporting period to begin on or after October 1, 2007, except for HIHs located in rural areas and those which receive referrals from MSA dominant hospitals or single urban hospitals, in which cases the percentage threshold is no more than 75% during the same five cost reporting years.

For cost reporting periods beginning on or after July 1, 2007, CMS expanded the 25 Percent Rule to apply a payment adjustment to Medicare patients admitted from any individual hospital in excess of the specified percentage threshold. Previously, the percentage threshold payment adjustment was applicable only to Medicare admissions from hospitals co-located with an LTCH or satellite of an LTCH. The expanded 25 Percent Rule subjects free-standing LTCHs, grandfathered HIHs and grandfathered satellites to the Medicare percentage threshold payment adjustment, as well as HIHs that admit Medicare patients from non-co-located hospitals. Grandfathered HIHs refer to certain HIHs that were in existence on or before September 30, 1995, and grandfathered satellite facilities refer to satellites of grandfathered HIHs that were in existence on or before September 30, 1999.

The SCHIP Extension Act, as amended by the ARRA, postponed the application of the percentage threshold to all free-standing and grandfathered HIHs for a three year period commencing on an LTCH's first cost reporting period on or after July 1, 2007. However, the SCHIP Extension Act did not postpone the application of the percentage threshold, or the transition period, to those Medicare patients discharged from an LTCH HIH or satellite that were admitted from a non-co-located hospital. The ARRA limits application of the percentage threshold to no more than 50% of Medicare admissions to grandfathered satellites from a co-located hospital for a three year period commencing on the first cost reporting period beginning on or after July 1, 2007. The PPACA included a two-year extension of the limits placed on the 25 Percent Rule by the SCHIP Extension Act, as amended by the ARRA.

Table of Contents

CMS adopted through regulations an additional one-year extension of relief from the full application of Medicare admission thresholds. As a result, full implementation of the Medicare admission thresholds will not go into effect until cost reporting periods beginning on or after October 1, 2013, except for certain LTCHs with cost reporting periods that begin between July 1, 2012 and through September 30, 2012. Specifically, those freestanding facilities, grandfathered HIHs and grandfathered satellites with cost reporting periods beginning on or after July 1, 2012 and through September 30, 2012 were subject to a modified 25 Percent Rule for discharges occurring in a three month period between July 1, 2012 and September 30, 2012. The following table describes the types of LTCHs and the statutory and regulatory relief they have received from the payment adjustment for these discharges:

Type of LTCH	Non Co-located Admissions	Co-located Admissions
Non-grandfathered HIHs opened before October 1, 2004 (58 owned hospitals)	Not subject to any extensions of the admissions thresholds under the 25 Percent Rule. LTCHs in this category are subject to a payment adjustment for discharged Medicare patients exceeding 25% of the LTCH's total Medicare population.	Percentage admissions threshold was raised from 25% to 50%. This relief is now effective for six years starting with cost reporting periods beginning on or after October 1, 2007. In the special case of rural LTCHs, LTCHs co-located with an urban single hospital, or LTCHs co-located with an MSA-dominant hospital the referral percentage was raised to 75%.
Non-grandfathered satellite facilities opened before October 1, 2004 (nine owned hospitals)	Not subject to any extensions of the admissions thresholds under the 25 Percent Rule. LTCHs in this category are subject to a payment adjustment for discharged Medicare patients exceeding 25% of the LTCH's total Medicare population.	Percentage admissions threshold was raised from 25% to 50%. This relief is now effective for five years starting with cost reporting periods beginning on or after October 1, 2007. In the special case of rural LTCHs, LTCHs co-located with an urban single hospital, or LTCHs co-located with an MSA-dominant hospital the referral percentage was raised to 75%.
Grandfathered HIHs (two owned hospitals)	Percentage admissions threshold is suspended for five years starting with cost reporting periods beginning on or after July 1, 2007, plus one additional year starting with cost reporting periods beginning on or after October 1, 2012.	Percentage admission threshold is suspended for five years starting with cost reporting periods beginning on or after July 1, 2007, plus one additional year starting with cost reporting periods beginning on or after October 1, 2012.

Table of Contents

Type of LTCH	Non Co-located Admissions	Co-located Admissions
Grandfathered satellites (no owned hospitals)	Not subject to any extensions of the admissions thresholds under the 25 Percent Rule. LTCHs in this category are subject to a payment adjustment for discharged Medicare patients exceeding 25% of the LTCH's total Medicare population.	Percentage admissions threshold was raised from 25% to 50%. This relief is now effective for five years starting with cost reporting periods beginning on or after July 1, 2007, plus one additional year starting with cost reporting periods beginning on or after October 1, 2012. In the special case of rural LTCHs, LTCHs co-located with an urban single hospital, or LTCHs co-located with an MSA-dominant hospital the referral percentage was raised to 75%.
Freestanding facilities (32 owned hospitals)	Percentage admissions threshold is suspended for five years starting with cost reporting periods beginning on or after July 1, 2007, plus one additional year starting with cost reporting periods beginning on or after October 1, 2012.	25 Percent Rule not applicable.
Facilities co-located with a provider-based, off-campus, non-inpatient location of an inpatient prospective payment system hospital (no owned hospitals)	Percentage admissions threshold is suspended for five years starting with cost reporting periods beginning on or after July 1, 2007, plus one additional year starting with cost reporting periods beginning on or after October 1, 2012.	Percentage admission threshold is suspended for five years starting with cost reporting periods beginning on or after July 1, 2007, plus one additional year starting with cost reporting periods beginning on or after October 1, 2012.
HIHs and satellite facilities opened on or after October 1, 2004 (seven owned hospitals)	LTCHs in this category are subject to a payment adjustment for discharged Medicare patients exceeding 25% of the LTCH's total Medicare population.	LTCHs in this category are subject to a payment adjustment for discharged Medicare patients exceeding 25% of the LTCH's total Medicare population. In the special case where an LTCH is co-located with an MSA-dominant hospital, the referral percentage is no more than 50%, nor less than 25%.

After the expiration of the regulatory relief, as described above, our LTCHs (whether freestanding, HIH or satellite) will be subject to a downward payment adjustment for any Medicare patients who were admitted from a co-located or a non-co-located hospital and that exceed the applicable percentage threshold of all Medicare patients discharged from the LTCH during the cost reporting period. These regulatory changes will have an adverse financial impact on the net operating revenues and profitability of many of these hospitals for cost reporting periods on or after October 1, 2013.

In the preamble to the proposed update to the Medicare policies and payment rates for fiscal year 2014, CMS seeks public comments on adoption of a payment adjustment based on whether a particular

Table of Contents

case qualifies as chronically critically ill/medically complex ("CCI/MC"). CMS is considering a change to the LTCH-PPS payment policies that would limit full LTCH PPS payment to those patients meeting the definition of CCI/MC while they were in an IPPS hospital inpatient setting and subsequently directly admitted to an LTCH. Payment for non-CCI/MC patients would be made at an "IPPS comparable amount," that is, an amount comparable to what would have been paid under the IPPS calculated as a per diem rate with total payments capped at the full IPPS MS-DRG payment rate. We cannot predict whether CMS will adopt additional patient-level criteria in the future or, if adopted, how such criteria would affect the application of the 25 Percent Rule to our LTCHs.

Moratorium on New LTCHs, LTCH Satellite Facilities and LTCH beds

The SCHIP Extension Act imposed a moratorium on the establishment and classification of new LTCHs, LTCH satellite facilities and LTCH beds in existing LTCHs or satellite facilities. The PPACA extended this moratorium by two years. The moratorium expired on December 28, 2012. Unless Congress or CMS take further action, new LTCHs, LTCH satellite facilities and LTCH beds may be established and enrolled in the Medicare program.

One-Time Budget Neutrality Adjustment

Congress required that the LTC-DRG payment rates maintain budget neutrality during the first years of the prospective payment system with total expenditures that would have been made under the previous reasonable cost-based payment system. The LTCH-PPS regulations give CMS the ability to make a one-time adjustment to the standard federal rate to correct any "significant difference between actual payments and estimated payments for the first year" of LTCH-PPS. The SCHIP Extension Act precluded CMS from implementing the one-time prospective adjustment to the LTCH standard federal rate for a period of three years. The PPACA extended the stay on CMS's ability to adopt a one-time budget neutrality adjustment to LTCH-PPS through December 28, 2012. In the update to the Medicare policies and payment rates for fiscal year 2013, CMS adopted a one-time budget neutrality adjustment that results in a permanent negative adjustment of 3.75% to the LTCH base rate. CMS is implementing the adjustment over a three-year period by applying a factor of 0.98734 to the standard federal rate in fiscal years 2013, 2014 and 2015, except that the adjustment would not apply to payments for discharges occurring on or after October 1, 2012 through December 28, 2012.

Proposed Legislation

On August 2, 2011, the "Long-Term Care Hospital Improvement Act of 2011," was introduced in the United States Senate and referred to the Senate Finance Committee. The proposed legislation would have implemented new patient-level and facility-level criteria for LTCHs, including a standardized preadmission screening process, specific criteria for admission and continued stay in an LTCH, and a list of core services that an LTCH must offer. In addition, the legislation would have required LTCHs to meet additional classification criteria to continue to be paid under LTCH-PPS. After a phase-in period, a threshold percentage of an LTCH's Medicare fee-for-service discharges would have been required to meet specified criteria. The proposed legislation would have repealed, and prohibited CMS from applying, the 25 Percent Rule that applies to Medicare patients discharged from LTCHs who were admitted from a co-located hospital or a non-co-located hospital and caused the LTCH to exceed the applicable percentage thresholds for discharged Medicare patients.

Though no action was taken by Congress with respect to the proposed legislation, hospital industry groups continue to press for similar legislation. We cannot predict whether legislation similar to the legislation previously proposed will be enacted in the future or, if enacted, to what degree such legislation will resemble the provisions described here.

Table of Contents

Annual Payment Rate Update

Fiscal Year 2011. On August 16, 2010, CMS published the policies and payment rates for LTCH-PPS for fiscal year 2011 (affecting discharges and cost reporting periods beginning on or after October 1, 2010 through September 30, 2011). The standard federal rate for fiscal year 2011 was $39,600, which was a decrease from the fiscal year 2010 standard federal rate of $39,897 in effect from October 1, 2009 to March 31, 2010 and the fiscal year 2010 standard federal rate of $39,795 that went into effect on April 1, 2010. The update to the standard federal rate for fiscal year 2011 included a market basket increase of 2.5%, less a reduction of 2.5% to account for what CMS attributed as an increase in case-mix in prior periods that resulted from changes in documentation and coding practices, less an additional market basket reduction of 0.5% as mandated by the PPACA. The final rule established a fixed-loss amount for high cost outlier cases for fiscal year 2011 of $18,785, which was an increase from the fiscal year 2010 fixed-loss amount of $18,425 in effect from October 1, 2009 to March 31, 2010 and the $18,615 fixed-loss amount that went into effect on April 1, 2010.

Fiscal Year 2012. On August 18, 2011, CMS published the policies and payment rates for LTCH-PPS for fiscal year 2012 (affecting discharges and cost reporting periods beginning on or after October 1, 2011 through September 30, 2012). The standard federal rate for fiscal year 2012 was $40,222, which was an increase from the fiscal year 2011 standard federal rate of $39,600. The update to the standard federal rate for fiscal year 2012 included a market basket increase of 2.9%, less a productivity adjustment of 1.0%, and less an additional market basket reduction of 0.1% as mandated by the PPACA. The final rule established a fixed-loss amount for high cost outlier cases for fiscal year 2012 of $17,931, which was a decrease from the fixed-loss amount in the 2011 fiscal year of $18,785.

Fiscal Year 2013. On August 1, 2012, CMS published the final rule updating the policies and payment rates for LTCH-PPS for fiscal year 2013 (affecting discharges and cost reporting periods beginning on or after October 1, 2012 through September 30, 2013). Two different standard federal rates apply during fiscal year 2013. The standard federal rate for discharges on or after October 1, 2012 and before December 29, 2012 is $40,916 and the standard federal rate for discharges on or after December 29, 2012 for the remainder of fiscal year 2013 is $40,398, both of which are an increase from the fiscal year 2012 standard federal rate of $40,222. The update to the standard federal rate for fiscal year 2013 through December 28, 2012 included a market basket increase of 2.6%, less a productivity adjustment of 0.7%, and less an additional market basket reduction of 0.1% as mandated by the PPACA. The standard federal rate for the period of December 29, 2012 through the remainder of fiscal 2013 is further reduced by a portion of the one-time budget neutrality adjustment of 1.266%, as discussed above. The final rule establishes a fixed-loss amount for high cost outlier cases for fiscal year 2013 of $15,408, which is a decrease from the fixed-loss amount in the 2012 fiscal year of $17,931.

Fiscal Year 2014. On August 1, 2013, CMS released an advanced copy of the final rule updating policies and payment rates for LTCH-PPS for fiscal year 2014 (affecting discharges and cost reporting periods beginning on or after October 1, 2013 through September 30, 2014). The standard federal rate was set at $40,607, an increase from the standard federal rate applicable during the period from December 29, 2012 through September 30, 2013 of $40,398. The update to the standard federal rate for fiscal year 2014, includes a market basket increase of 2.5%, less a productivity adjustment of 0.5%, less a reduction of 0.3% mandated by the PPACA, and less a budget neutrality adjustment of 1.266%, as discussed above. The fixed-loss amount for high cost outlier cases was set at $13,314, which is a decrease from the fixed-loss amount in the 2013 fiscal year of $15,408.

Medicare Market Basket Adjustments

The PPACA instituted a market basket payment adjustment to LTCHs. In fiscal year 2014 the market basket update will be reduced by 0.3%. In fiscal years 2015 and 2016 the market basket update will be reduced by 0.2%. Finally, in fiscal years 2017 through 2019, the market basket update will be

Table of Contents

reduced by 0.75%. The PPACA specifically allows these market basket reductions to result in less than a 0% payment update and payment rates that are less than the prior year.

Medicare Reimbursement of Inpatient Rehabilitation Facility Services

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

Facility Certification Criteria

Our rehabilitation hospitals must meet certain facility criteria to be classified as an IRF by the Medicare program, including: (1) a provider agreement to participate as a hospital in Medicare; (2) a preadmission screening procedure; (3) ensuring that patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services; (4) a full-time, qualified director of rehabilitation; (5) a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; (6) a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment. Failure to comply with any of the classification criteria may result in the denial of claims for payment or cause a hospital to lose its status as an IRF and be paid under the prospective payment system that applies to general acute care hospitals.

Patient Classification Criteria

Under the IRF certification criteria that has 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 10 conditions specified in the regulation. We refer to such 75% requirement as the "75 Percent Rule."

New IRF certification criteria became effective for cost reporting periods beginning on or after July 1, 2004 as a result of the major changes that CMS adopted on May 7, 2004 to the 75 Percent Rule that: (1) temporarily lowered the 75% compliance threshold (starting at 50% and phasing to 75% over four years), (2) modified and expanded from 10 to 13 the medical conditions used to determine whether a hospital qualifies as an IRF, (3) identified the conditions under which comorbidities can be used to verify compliance with the 75 Percent Rule, and (4) changed the timeframe used to determine compliance with the 75 Percent Rule 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 as an IRF for its cost reporting period that begins immediately after the 12-month review period.

Under the Deficit Reduction Act of 2005, enacted on February 8, 2006, Congress extended the phase-in period for the 75 Percent Rule by maintaining the compliance threshold at 60% (rather than

Table of Contents

increasing it to the scheduled 65%) during the 12-month period beginning on July 1, 2006. The compliance threshold was then to increase to 65% for cost reporting periods beginning on or after July 1, 2007 and again to 75% for cost reporting periods beginning on or after July 1, 2008. However, the SCHIP Extension Act included a permanent freeze in the 75 Percent Rule patient classification criteria compliance threshold at 60% (with comorbidities counting toward this threshold) and a payment freeze from April 1, 2008 through September 30, 2009.

Compliance with the patient classification criteria is demonstrated through either medical review or the "presumptive" method, in which a patient's diagnosis codes are compared to a "presumptive compliance" list. CMS has announced that it will remove a number of diagnosis codes from the presumptive compliance list. According to CMS, these conditions do not demonstrate the need for intensive inpatient rehabilitation services in the absence of additional facts that would have to be pulled from a patient's medical record. As a result, beginning on or after October 1, 2014, a number of diagnosis codes previously on the presumptive compliance list will be removed, including diagnosis codes in the following categories: non specific diagnosis codes, arthritis diagnosis codes, unilateral upper extremity amputations diagnosis, some congenital anomalies diagnosis codes, other miscellaneous diagnosis codes.

Annual Payment Rate Update

Fiscal Year 2011. On July 22, 2010, CMS published an update to the payment rates for IRF-PPS for fiscal year 2011 (affecting discharges and cost reporting periods beginning on or after October 1, 2010 through September 30, 2011). The standard payment conversion factor for discharges during fiscal year 2011 was $13,860, which was an increase from the standard payment conversion factor for fiscal year 2010 of $13,627. The update to the standard payment conversion factor for fiscal year 2011 included a market basket increase of 2.5%, less a market basket reduction of 0.25% as mandated by the PPACA. CMS increased the outlier threshold amount for fiscal year 2011 to $11,410 from $10,721 established in the revised final rule for fiscal year 2010.

Fiscal Year 2012. On August 5, 2011, CMS published the policies and payment rates for IRF-PPS for fiscal year 2012 (affecting discharges and cost reporting periods beginning on or after October 1, 2011 through September 30, 2012). The standard payment conversion factor for discharges during fiscal year 2012 was $14,076, which was an increase from the fiscal year 2011 standard payment conversion factor of $13,860. The update to the standard payment conversion factor for fiscal year 2012 included a market basket increase of 2.9%, less a productivity adjustment of 1.0%, and less an additional market basket reduction of 0.1% as mandated by the PPACA CMS decreased the outlier threshold amount for fiscal year 2012 to $10,660 from $11,410 established in the final rule for fiscal year 2011. In a notice published September 26, 2011, CMS corrected its calculation of the outlier threshold amount for fiscal year 2012 to $10,713.

Fiscal Year 2013. On July 30, 2012, CMS published the policies and payment rates for IRF-PPS for fiscal year 2013 (affecting discharges and cost reporting periods beginning on or after October 1, 2012 through September 30, 2013). The standard payment conversion factor for discharges during fiscal year 2013 is $14,343, which is an increase from the fiscal year 2012 standard payment conversion factor of $14,076. The update to the standard payment conversion factor for fiscal year 2013 includes a market basket increase of 2.7%, less a productivity adjustment of 0.7%, less an additional reduction of 0.1% as mandated by the PPACA. CMS decreased the outlier threshold amount for fiscal year 2013 to $10,466 from $10,713 established in the final rule for fiscal year 2012.

Fiscal Year 2014. On July 31, 2013, CMS released an advanced copy of the final rule updating policies and payment rates for IRF-PPS for fiscal year 2014 (affecting discharges and cost reporting periods beginning on or after October 1, 2013 through September 30, 2014). The standard payment conversion factor for discharges for fiscal year 2014 is $14,846, which is an increase from the fiscal year

Table of Contents

2013 standard payment conversion factor of $14,343. The update to the standard payment conversion factor for fiscal year 2014 includes a market basket increase of 2.6%, less a productivity adjustment of 0.5%, less an additional reduction of 0.3% as mandated by the PPACA. CMS decreased the outlier threshold amount for fiscal year 2014 to $9,272 from $10,466 established in the final rule for fiscal year 2013.

Medicare Market Basket Adjustments

The PPACA instituted a market basket payment adjustment for IRFs. For fiscal year 2014, the reduction is 0.3%. For fiscal years 2015 and 2016, the reduction is 0.2%. For fiscal years 2017 through 2019, the reduction is 0.75%.

Medicare Reimbursement of Outpatient Rehabilitation Services

The Medicare program reimburses outpatient rehabilitation providers based on the Medicare physician fee schedule. The Medicare physician fee schedule rates are automatically updated annually based on a formula, called the sustainable growth rate, or "SGR," formula, contained in legislation. The SGR formula has resulted in automatic reductions in rates every year since 2002; however, for each year through 2013 CMS or Congress has taken action to prevent the SGR formula reductions. The American Taxpayer Relief Act of 2012 froze the Medicare physician fee schedule rates at 2012 levels through December 31, 2013, averting a scheduled 26.5% cut as a result of the SGR formula that would have taken effect on January 1, 2013. On March 5, 2013, CMS estimated a 24.4% reduction in the Medicare physician fee schedule payment rates for calendar year 2014, unless Congress again takes legislative action to prevent the SGR formula reductions from going into effect. If Congress takes such legislative action, the projected impact of the proposed 2014 Medicare physician fee schedule rule on outpatient physical therapy services would be a positive 1% in aggregate for calendar year 2014. However, the amount of payment for each service would vary depending on the CPT codes billed and the geographic practice cost indices adjustments among localities. For the year ended December 31, 2012, we received approximately 10% of our outpatient rehabilitation net operating revenues from Medicare.

In addition, MedPAC recommended that Congress direct CMS to collect data on provider service volume and work time to establish more accurate relative value unit payment rates and to identify and reduce overpriced fee schedule services. Similarly, the PPACA requires CMS to identify and review potentially misvalued codes and make appropriate adjustments to the relative values of those services identified as being misvalued. In the final update to the Medicare physician fee schedule for calendar year 2012 CMS identified several CPT codes used by physical therapists as codes they will review.

Therapy Caps

Beginning on January 1, 1999, the Balanced Budget Act of 1997 subjected certain outpatient therapy providers reimbursed under the Medicare physician fee schedule to annual limits for therapy expenses. Effective January 1, 2013, the annual limit on outpatient therapy services is $1,900 for combined physical and speech language pathology services and $1,900 for occupational therapy services. The per beneficiary caps were $1,880 for calendar year 2012. It is anticipated that in calendar year 2014 the therapy cap will be the 2013 rate increased by the percentage increase in the Medicare Economic Index. The annual limits for therapy expenses historically did not apply to services furnished and billed by outpatient hospital departments. Although, the American Taxpayer Relief Act of 2012 extended the annual limits on therapy expenses and manual medical review thresholds to services furnished in hospital outpatient department settings from October 1, 2012 through December 31, 2013. The application of annual limits to hospital outpatient department settings will sunset at the end of 2013 unless Congress extends it into 2014. We operated 979 outpatient rehabilitation clinics at December 31, 2012, of which 145 were provider-based outpatient rehabilitation clinics operated as departments of the inpatient rehabilitation hospitals we operated.

Table of Contents

In the Deficit Reduction Act of 2005, Congress implemented an exceptions process to the annual limit for therapy expenses. Under this process, a Medicare enrollee (or person acting on behalf of the Medicare enrollee) is able to request an exception from the therapy caps if the provision of therapy services was deemed to be medically necessary. Therapy cap exceptions have been available automatically for certain conditions and on a case-by-case basis upon submission of documentation of medical necessity. The American Taxpayer Relief Act of 2012 extends the exceptions process for outpatient therapy caps through December 31, 2013. Unless Congress extends the exceptions process, the therapy caps will apply to all outpatient therapy services beginning January 1, 2014, except those services furnished and billed by outpatient hospital departments.

The Middle Class Tax Relief and Job Creation Act of 2012 made several changes to the exceptions process to the annual limit for therapy expenses. For any claim above the annual limit, the claim must contain a modifier indicating that the services are medically necessary and justified by appropriate documentation in the medical record. Effective October 1, 2012, all claims exceeding $3,700 are subject to a manual medical review process. The $3,700 threshold is applied separately to the combined physical therapy/speech therapy cap and the occupational therapy cap. The American Taxpayer Relief Act of 2012 extends through December 31, 2013 the requirement that Medicare perform manual medical review of therapy services when an exception is requested for cases in which the beneficiary has reached a specified dollar aggregate threshold. Effective October 1, 2012, all therapy claims, whether above or below the annual limit, must include the national provider identifier (NPI) of the physician responsible for certifying and periodically reviewing the plan of care.

Several government agencies are expected to release reports on aspects of the Medicare payment system for therapy services. In the final 2011 Medicare physician fee schedule rule, CMS indicated the agency is evaluating alternative payment methodologies that would provide appropriate payment for medically necessary and effective therapy services furnished to Medicare beneficiaries based on patient needs rather than the current therapy caps. The Middle Class Tax Relief and Job Creation Act of 2012 directed MedPAC to submit a report to Congress by June 15, 2013 making recommendations on how to reform the payment system to better reflect acuity, condition, and the therapy needs of the patient. The MedPAC report is to include an examination of private sector initiatives related to therapy benefits. In addition, the Government Accountability Office, or "GAO," was directed to issue a report no later than May 1, 2013 regarding implementation of the manual medical review process instituted by the Middle Class Tax Relief and Job Creation Act of 2012. The report must detail the number of beneficiaries subject to the process, the number of reviews conducted, and the outcome of the reviews. Finally, The Middle Class Tax Relief and Job Creation Act of 2012 directed CMS to implement a claims-based data collection effort. Specifically, beginning on January 1, 2013, CMS is required to collect additional data on therapy claims related to patient function during the course of therapy in order to better understand patient conditions and outcomes. While reporting of data will begin on January 1, 2013, the first 6 months of the year will be a testing period for providers. Beginning on July 1, 2013, CMS will reject claims that do not include the required data codes and modifiers. The stated purpose of the claims based data collection effort is to assist in reforming the Medicare payment system for outpatient therapy services.

Multiple Procedure Payment Reduction

CMS adopted a multiple procedure payment reduction for therapy services in the final update to the Medicare physician fee schedule for calendar year 2011. This multiple procedure payment reduction policy became effective January 1, 2011 and applies to all outpatient therapy services paid under Medicare Part B. Furthermore, the multiple procedure payment reduction policy applies across all therapy disciplines occupational therapy, physical therapy and speech-language pathology. Under the policy, the Medicare program pays 100% of the practice expense component of the therapy procedure or unit of service with the highest Relative Value Unit, and then reduces the payment for the practice expense component for the second and subsequent therapy procedures or units of service furnished

Table of Contents

during the same day for the same patient, regardless of whether those therapy services are furnished in separate sessions. In 2011 and 2012, the second and subsequent therapy service furnished during the same day for the same patient were reduced by 20% in office and other non-institutional settings and by 25% in institutional settings. The American Taxpayer Relief Act of 2012 increases the payment reduction to 50%, in either setting, effective April 1, 2013. Our outpatient rehabilitation therapy services are primarily offered in institutional settings and, as such, are subject to the applicable 25% payment reduction in the practice expense component for the second and subsequent therapy services furnished by us to the same patient on the same day until April 1, 2013 when the payment reduction increased to 50%. In 2013, this reduction will be partially offset due to the phase in of the final year of the transition to the new practice expense relative value units that resulted from CMS's use of new survey data.

Other Requirements for Payment

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

Budget Control Act of 2011

The Budget Control Act of 2011, enacted on August 2, 2011, increased the federal debt ceiling in connection with deficit reductions over the next ten years. The Budget Control Act of 2011 requires automatic reductions in federal spending by approximately $1.2 trillion split evenly between domestic and defense spending. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. The American Taxpayer Relief Act of 2012 temporarily delays the automatic, across-the-board "sequestration" cuts in federal spending imposed by the Budget Control Act of 2011, which are expected to reduce Medicare payments by more than $9.5 billion in fiscal year 2013 and $123 billion over the period of fiscal years 2013 to 2021. On April 1, 2013, a 2% reduction to Medicare payments was implemented. For the three months ended June 30, 2013, this reduction has reduced our net operating revenues and income from operations by approximately $9.5 million. We have estimated that this reduction will reduce our net operating revenues and income from operations by approximately $16.0 million to $17.0 million for the remainder of 2013.

Specialty Hospital Medicaid Reimbursement

The Medicaid program is designed to provide medical assistance to individuals unable to afford care. The program is governed by the Social Security Act of 1965, funded jointly by each individual state and the federal government, and administered by state agencies. Medicaid payments are made under a number of different systems, which include cost based reimbursement, prospective payment systems or programs that negotiate payment levels with individual hospitals. In addition, Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may increase or decrease the level of program payments to our hospitals. Net operating revenues generated directly from the Medicaid program represented approximately 5% of our specialty hospital net operating revenues for the year ended December 31, 2012.

Table of Contents

Workers' Compensation

Workers' compensation is a state mandated, comprehensive insurance program that requires employers to fund or insure medical expenses, lost wages and other costs resulting from work related injuries and illnesses. Workers' compensation benefits and arrangements vary 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. Net operating revenues generated directly from workers' compensation programs represented approximately 18% of our net operating revenue from outpatient rehabilitation services and 1% of our net operating revenue from our specialty hospitals for the year ended December 31, 2012.

Other Medicare Regulations

Medicare Quality Reporting

The PPACA established quality reporting requirements for LTCHs and IRFs. These programs are mandatory. For fiscal year 2014 and each subsequent year, LTCHs and IRFs that do not submit the required quality data will be subject to a 2 percentage point reduction in their annual payment update. The reduction can result in payment rates less than the prior year. However, the reduction will not carry over into the subsequent fiscal years.

Medicare Productivity Adjustment

The PPACA implemented a separate annual productivity adjustment for the first time for hospital inpatient services beginning in fiscal year 2012 for LTCHs and IRFs. This provision applied a negative productivity adjustment to the market basket that is used to update the standard federal rate on an annual basis. The market basket does not currently account for increases in provider productivity that could reduce the actual cost of providing services (e.g., through new technology or fewer inputs). The productivity adjustment will equal the 10-year moving average of changes in the annual economy-wide private non-farm business multi-factor productivity. This is a statistic reported by the Bureau of Labor Statistics and updated in the spring of each year. While this adjustment will change each year, it is currently estimated that this adjustment to the market basket will be approximately minus 1.0% on average.

Hospital Wage Index

As part of the methodology for determining prospective payments to LTCHs and IRFs, CMS adjusts the standard payment amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. This adjustment factor is the hospital wage index. CMS currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas established by the Office of Management and Budget. The PPACA calls for CMS to develop and present to Congress a comprehensive reform plan using Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved. In the preamble to the proposed rule for LTCH-PPS for fiscal year 2012, CMS solicited public comments on ways to redefine the geographic reclassification requirements to more accurately define labor markets. To date CMS has not presented a comprehensive reform plan to Congress.

Independent Payment Advisory Board

The PPACA established an independent board called the Independent Payment Advisory Board that will develop and submit proposals to the President and Congress beginning in 2014. The

Table of Contents

Independent Payment Advisory Board's proposals must be designed to reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending under current law. The Independent Payment Advisory Board's first proposal with savings recommendations could be submitted by January 14, 2014, for implementation in 2015, if the Medicare per capita target growth rate is exceeded, as described in the PPACA. However, the Independent Payment Advisory Board is precluded from submitting proposals that reduce Medicare payments prior to December 31, 2019 for providers scheduled to receive a reduction in their payment updates as a result of the Medicare productivity adjustment (discussed above).

Physician-Owned Hospital Limitations

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

Under the transparency and program integrity provisions of the PPACA, the exception to the federal self-referral law, or "Stark law," that permits physicians to refer patients to hospitals in which they have an ownership or investment interest has been dramatically curtailed. Only hospitals, including LTCHs, with physician ownership and a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the percentage of physician ownership or investment interests held in the hospital after March 23, 2010. In addition, physician-owned hospitals are prohibited from increasing the number of licensed beds after March 23, 2010, unless meeting specific exceptions related to the hospital's location and patient population. In order to retain their exemption from the general ban on self-referrals, our physician-owned hospitals are required to adopt specific measures relating to conflicts of interest, bona fide investments and patient safety. As of December 31, 2012, we operated ten hospitals that are owned in-part by physicians.

Provider and Employee Screening

The PPACA imposed new screening requirements on all Medicare providers, including LTCHs, IRFs and outpatient rehabilitation providers. The screening must include a licensure check and may include other procedures such as a criminal background check, fingerprinting, unscheduled and unannounced site visits, database checks, and other screening techniques CMS deems appropriate to prevent fraud, waste and abuse. Effective March 23, 2011, Medicare providers and suppliers submitting new enrollment applications or revalidating their existing enrollment status are required to pay a $500 application fee that is adjusted annually by the percentage change in the consumer price index. The PPACA also imposed new disclosure requirements and authorizes surety bonds for the enrollment of new providers and suppliers.

In addition, the PPACA requires LTCHs to conduct national and state criminal background checks, including fingerprint checks of their employees and contractors who have (or may have) one-on-one contact with patients. Our LTCHs are prohibited from hiring or retaining workers with a history of patient or resident abuse.

Table of Contents

Medicare Compliance Requirements and Penalties

The PPACA included new compliance requirements and increases existing penalties for non-compliance with federal law and the Medicare conditions of participation. In addition, Medicare claims will be paid only if submitted within 12 months. Penalties for submitting false claims and for submitting false statements material to a false claim will be increased. The Secretary will be granted the authority to suspend payments to a provider pending an investigation of credible allegations of fraud. Further, the Recovery Audit Contractor program has been extended to Medicare Parts C and D and Medicaid.

Other Healthcare Regulations

Medicare Recovery Audit Contractors. The Tax Relief and Health Care Act of 2006 instructed CMS to contract with third-party organizations, known as Recovery Audit Contractors, or "RACs," to identify Medicare underpayments and overpayments, and to authorize RACs to recoup any overpayments. The compensation paid to each RAC is based on a percentage of overpayment recoveries identified by the RAC. CMS has selected and entered into contracts with four RACs, each of which has begun their audit activities in specific jurisdictions. RAC audits of our Medicare reimbursement may lead to assertions that we have been overpaid, require us to incur additional costs to respond to requests for records and pursue the reversal of payment denials, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict the impact of future RAC reviews on our results of operations or cash flows.

Fraud and Abuse Enforcement. Various federal and state laws prohibit the submission of false or fraudulent claims, including claims to obtain payment under Medicare, Medicaid and other government healthcare programs. Penalties for violation of these laws include civil and criminal fines, imprisonment and exclusion from participation in federal and state healthcare programs. In recent years, federal and state government agencies have increased the level of enforcement resources and activities targeted at the healthcare industry. In addition, the federal False Claims Act and similar state statutes allow individuals to bring lawsuits on behalf of the government, in what are known as qui tam or "whistleblower" actions, alleging false or fraudulent Medicare or Medicaid claims or other violations of the statute. The use of these private enforcement actions against healthcare providers has increased dramatically in recent years, in part because the individual filing the initial complaint is entitled to share in a portion of any settlement or judgment. Revisions to the False Claims Act enacted in 2009 expanded significantly the scope of liability, provided for new investigative tools, and made it easier for whistleblowers to bring and maintain False Claims Act suits on behalf of the government. See " Legal Proceedings."

From time to time, various federal and state agencies, such as the Office of Inspector General of the Department of Health and Human Services, or "OIG," issue a variety of pronouncements, including fraud alerts, the OIG's Annual Work Plan and other reports, identifying practices that may be subject to heightened scrutiny. These pronouncements can identify issues relating to LTCHs, IRFs or outpatient rehabilitation services or providers. For example, the OIG's 2010 and 2011 Work Plans identified as an area of concern whether the patient assessment instruments prepared by IRFs were submitted in accordance with Medicare regulations. Among other things, the 2011 Work Plan indicated that CMS would review the appropriateness of provider-based designations for outpatient clinics, outlier payments made to hospitals for beneficiaries who incur unusually high costs, and the effectiveness of a claims processing edit designed to capture hospital readmissions that are subject to a single payment for both inpatient stays. The 2012 Work Plan identified the appropriateness of admissions to IRFs as an area subject to review. The OIG indicated that it would examine the level of therapy being provided in IRFs and how much concurrent and group therapy IRFs are providing. Under the 2012 work plan, the OIG also will review the quality of care and safety of Medicare beneficiaries transferred from general acute care hospitals to IRFs and LTCHs. We monitor government publications applicable to us to supplement and enhance our compliance efforts.

Table of Contents

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

Remuneration and Fraud Measures. The federal anti-kickback statute prohibits some business practices and relationships under Medicare, Medicaid and other federal healthcare programs. These practices include the payment, receipt, offer or solicitation of remuneration in connection with, to induce, or to arrange for, the referral of patients covered by a federal or state healthcare program. Violations of the anti-kickback law may be punished by a criminal fine of up to $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.

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

Provider-Based Status. The designation "provider-based" refers to circumstances in which a subordinate facility (e.g., a separately certified Medicare provider, a department of a provider or a satellite facility) is treated as part of a provider for Medicare payment purposes. In these cases, the services of the subordinate facility are included on the "main" provider's cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that they are shared. As of December 31, 2012, we operated 18 specialty hospitals that were treated as provider-based satellites of certain of our other facilities, 145 of the outpatient rehabilitation clinics we operated were provider-based and are operated as departments of the IRFs we operated, 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. HIPAA mandates the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the healthcare industry, while maintaining the privacy and security of health information. Among the standards that the Department of Health and Human Services has adopted or will adopt pursuant to HIPAA are standards for electronic transactions and code sets, unique identifiers for providers (referred to as National Provider Identifier), employers, health plans and individuals, security and electronic signatures, privacy and enforcement. If we fail to comply with the HIPAA requirements, we could be subject to criminal penalties and civil sanctions. The privacy, security and enforcement provisions of HIPAA were enhanced by the HITECH Act which was included in the ARRA. Among other things, HITECH establishes security breach notification requirements, allows enforcement of HIPAA by state attorneys general, and increases penalties for HIPAA violations.

Table of Contents

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

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

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

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

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

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

Compliance Program

Our Compliance Program

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

Compliance and Internal Audit Committee

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

Table of Contents

Operating Our Compliance Program

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

Compliance Issue Reporting

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

Compliance Monitoring and Auditing/Comprehensive Training and Education

Monitoring reports and the results of compliance for each of our business segments are reported to the compliance and internal audit 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 acknowledge and certify that the employee has read, understood and has agreed to abide by the code of conduct. Additionally, all employees are required to re-certify compliance with the code on an annual basis.

Policies and Procedures Reflecting Compliance Focus Areas

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

Internal Audit

In addition to and in support of the efforts of our compliance and audit department, during 2001 we established an internal audit function. The vice president of compliance and audit services manages the combined compliance and audit department and meets with the audit and compliance committee of the board of directors on a quarterly basis to discuss audit results and provide an overview of the activities and operation of our compliance program.

Properties

We currently lease most of our facilities, including clinics, offices, specialty hospitals and our corporate headquarters. We own 25 of our specialty hospitals.

We lease all but two of our outpatient rehabilitation clinics and related offices, which, as of June 30, 2013 included 870 leased outpatient rehabilitation clinics throughout the United States. We also lease the majority of our LTCH facilities except for the facilities described above. As of June 30, 2013, in our specialty hospitals we had 74 HIH leases and 17 free-standing building leases.

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 145,000 square feet and is located in Mechanicsburg, Pennsylvania. We lease several other administrative spaces

Table of Contents

related to administrative and operational support functions. As of June 30, 2013, this was comprised of 11 locations throughout the United States with approximately 50,000 square feet in total.

The following is a list by state of the number of our consolidated hospitals and related beds we operated as of June 30, 2013.

	Specialty Hospitals			
	Long Term Acute Care	Inpatient Rehabilitation	Outpatient Clinics	Total Facilities
Alabama	1			1
Alaska			5	5
Arizona	3	1	13	17
Arkansas	4		1	5
California			8	8
Colorado	3		17	20
Connecticut			39	39
District of Columbia			2	2
Delaware	1		1	2
Florida	9	1	102	112
Georgia	5		24	29
Illinois			41	41
Indiana	5		20	25
Iowa	1			1
Kansas	3		15	18
Kentucky	2		42	44
Louisiana	1		3	4
Maine			12	12
Maryland			23	23
Massachusetts			9	9
Michigan	11		13	24
Minnesota	1		25	26
Mississippi	5			5
Missouri	3	2	62	67
Nebraska	1			1
Nevada			6	6
New Hampshire			4	4
New Jersey	1	3	141	145
New Mexico			2	2
North Carolina	3		34	37
Ohio	14		58	72
Oklahoma	2		20	22
Pennsylvania	9	1	112	122
South Carolina	2		14	16
South Dakota	1			1
Tennessee	5		10	15
Texas	9	6	89	104
Virginia			21	21
West Virginia	1			1
Wisconsin	3			3
Total Company	109	14	988	1,111
			104	

Table of Contents

Legal Proceedings

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

We are subject to legal proceedings and claims that arise in the ordinary course of business, which include malpractice claims covered under insurance policies, subject to self-insured retention of $2.0 million per medical incident for professional liability claims and $2.0 million per occurrence for general liability claims. In our opinion, the outcome of these actions, individually or in the aggregate, will not have a material adverse effect on its financial position, results of operations, or flows.

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

On January 8, 2013, a federal magistrate judge unsealed an Amended Complaint in United States of America and the State of Indiana, ex rel. Doe I, Doe II and Doe III v. Select Medical Corporation, Select Specialty Hospital-Evansville, Evansville Physician Investment Corporation, Dr. Richard Sloan and Dr. Jeffrey Selby. The Amended Complaint, which was served on the Company on February 15, 2013, is a civil action filed under seal on September 28, 2012 in the United States District Court for the Southern District of Indiana by private plaintiff-relators on behalf of the United States and the state of Indiana under the federal False Claims Act and Indiana False Claims and Whistleblower Protection Act. Although the Amended Complaint identifies the relators by fictitious pseudonyms, on March 28, 2013, the relators filed a Notice identifying themselves as the former CEO at the Company's long term acute care hospital in Evansville, Indiana ("SSH-Evansville") and two former case managers at SSH-Evansville. The named defendants include the Company, SSH-Evansville, and two physicians who have practiced at SSH-Evansville. On March 26, 2013, the defendants, relators and the United States filed a joint motion seeking a stay of the proceedings, in which the United States notified the court that its investigation has not been completed and therefore it is not yet able to decide whether or not to intervene, and on March 29, 2013, the magistrate judge granted the motion and stayed all deadlines in the case for 90 days. On June 26, 2013, the United States filed a motion seeking to extend such stay of the proceedings for an additional 90 days, and on June 27, 2013, the defendants each filed a notice of consent to the requested stay. On August 12, 2013, the court granted the motion and stayed all deadlines in the case until October 1, 2013.

The Amended Complaint alleges that the defendants manipulated the length of stay of patients at SSH-Evansville in order to maximize reimbursement under the Medicare prospective payment system applicable to long term acute care hospitals. It also alleges that the defendants manipulated the discharge of patients to other facilities and the timing of readmissions from those facilities in order to enable SSH-Evansville to receive two separate Medicare payments and causing the other facility to submit claims for unnecessary services. The Amended Complaint discusses the federal Stark Law and Anti-Kickback Statute and implies that the behavior of physicians referring to or providing services at SSH-Evansville was based on their financial interests. The Amended Complaint further alleges that Dr. Selby, a pulmonologist formerly on the medical staff of SSH-Evansville, performed unnecessary

Table of Contents

bronchoscopies at the hospital with the knowledge of the Company, and that Dr. Sloan, the Chief Medical Officer and an attending physician at SSH-Evansville, falsely coded the diagnoses of Medicare patients in order to increase SSH-Evansville's reimbursement. Moreover, the Amended Complaint alleges that the practices at SSH-Evansville involved corporate policies of the Company used to maximize profit at all Select long term acute care hospitals. The Amended Complaint alleges that, through these acts, the defendants have violated the federal False Claims Act and Indiana False Claims and Whistleblower Protection Act and are liable for unspecified treble damages and penalties.

As previously disclosed, beginning in April 2012, the Company and SSH-Evansville have received various subpoenas and demands for documents relating to SSH-Evansville, including a request for information and subpoenas from the Office of Inspector General of the U.S. Department of Health and Human Services and subpoenas from the Office of Attorney General for the State of Indiana, and the Evansville (Indiana) Police Department has executed a search warrant at SSH-Evansville. The Company has produced and will continue to produce documents in response to, and intends to fully cooperate with, these governmental investigations. At this time, the Company is unable to predict the timing and outcome of this matter.

Table of Contents

DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

General

Our board of directors and executive officers are identical to those of Holdings, our sole stockholder. Information regarding the directors, executive officers and corporate governance of Holdings is set forth below.

Directors

The current members of the Board of Directors, together with certain information about them, are set forth below.

Name	Age	Director Since	Term Expires
Russell L. Carson	70	2005	2013
James S. Ely III	55	2008	2013
William H. Frist	61	2010	2013
Bryan C. Cressey	63	2005	2014
Robert A. Ortenzio	56	2005	2014
Leopold Swergold	73	2005	2014
James E. Dalton, Jr.	70	2005	2015
Rocco A. Ortenzio	80	2005	2015
Thomas A. Scully	55	2005	2015

Russell L. Carson has served as a director since February 1997. 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 15 institutionally funded limited partnerships with total capital of more than $20 billion and has invested in more than 200 companies. Before co-founding Welsh, Carson, Anderson & Stowe, Mr. Carson was employed by Citicorp Venture Capital Ltd., a subsidiary of Citigroup, Inc., and served as its Chairman and Chief Executive Officer from 1974 to 1978. He currently serves on the board of directors of Ardent Health Services, Inc.

James S. Ely III has served as a director since November 2008. Mr. Ely founded Priority Capital Management LLC in 2009 and serves as its Chief Executive Officer. From 2001 to 2008, Mr. Ely served as a Managing Director in the Syndicated and Leveraged Finance group at J.P. Morgan Securities Inc. From 1995 to 2000, Mr. Ely served as a Managing Director in the Global Syndicated Finance group of Chase Securities Inc. and its predecessor Chemical Securities Inc. Mr. Ely also serves as a director of Community Health Systems, Inc.

William H. Frist, M.D. has served as a director since May 2010. Dr. Frist is a heart and lung transplant surgeon, former United States Senator from Tennessee from 1995 to 2007 and former United States Senate Majority Leader from 2002 to 2007. Dr. Frist has been a partner at Cressey & Company, L.P., a private investment firm focused on healthcare, since 2007. Dr. Frist is currently an Adjunct Professor of Surgery at Vanderbilt University and a Clinical Professor of Surgery at Meharry Medical College. Dr. First serves as Chairman of the Nashville-based global health organization, Hope Through Healing Hands. Dr. Frist is a Senior Fellow and Co-Chair of the Health Project at the Bipartisan Policy Center. He also serves on the boards of URS Corporation, the Robert Wood Johnson Foundation, the Henry J. Kaiser Family Foundation and the Center for Strategic and International Studies.

Bryan C. Cressey has served as a director since February 1997. He is a partner of Cressey & Company, which he founded in 2007. He is a managing partner of Thoma Cressey Bravo, which he co-founded in June 1998. Prior to that time he was a principal, partner and co-founder of Golder,

Table of Contents

Thoma, Cressey and Rauner, the predecessor of GTCR Golder Rauner, LLC, since 1980. Mr. Cressey also serves as a director and chairman of Belden Inc. and several private companies and served as a director of Jazz Pharmaceuticals, Inc. from 2006 to 2012.

Robert A. Ortenzio co-founded us and has served as a director since February 1997. Mr. Ortenzio has served as the Chief Executive Officer of Holdings 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. Until August 17, 2010, Mr. Ortenzio served on the board of directors of Odyssey Healthcare, Inc., a hospice healthcare company. Mr. Ortenzio also served on the board of directors of US Oncology, Inc. until December 30, 2010. Mr. Ortenzio is the son of Rocco A. Ortenzio, the Company's Executive Chairman.

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

James E. Dalton, Jr. served as a director of Select from December 2000 until February 24, 2005, and became a director of Holdings in August 2005. From January 2006 until December 2012, Mr. Dalton was non-executive Chairman of Signature Hospital Corporation. From 2001 to 2007, Mr. Dalton served as President of Edinburgh Associates, Inc. Mr. Dalton served as President, Chief Executive Officer and as a director of Quorum Health Group, Inc. from May 1, 1990 until it was acquired by Triad Hospitals, Inc. in April 2001. Mr. Dalton served on the board of directors of US Oncology, Inc. until December 30, 2010. He serves as a Trustee for the Universal Health Services Realty Income Trust. Mr. Dalton is a Life Fellow of the American College of Healthcare Executives.

Rocco A. Ortenzio co-founded us and served as our Chairman and Chief Executive Officer from February 1997 until September 2001. Mr. Ortenzio has served as our Executive Chairman since September 2001, and became Executive Chairman of Holdings in February 2005. 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, Holdings Chief Executive Officer.

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

Table of Contents

Director Qualifications

The Board of Directors believes that each of the directors and nominees for director listed above has the sound character, integrity, judgment and record of achievement necessary to be a member of the Board of Directors. In addition, each of the directors and nominees for director has exhibited during his prior service as a director the ability to operate cohesively with the other members of the Board of Directors and to challenge and question management in a constructive way. Moreover, the Board of Directors believes that each director and nominee for director brings a strong and unique background and skill set to the Board of Directors, giving the Board of Directors as a whole competence and experience in diverse areas, including corporate governance and board service, finance, management and healthcare industry experience. Set forth below are certain specific experiences, qualifications and skills that led to the Board of Directors' conclusion that each of the directors and nominees for director listed above should continue to serve as a director.

Mr. Carson has extensive experience in managing investments in healthcare companies as a co-founder of Welsh, Carson, Anderson & Stowe, a private equity firm specializing in healthcare industry companies. He brings to the Board of Directors an in-depth knowledge of the regulatory and competitive environment of the healthcare industry. Also, Mr. Carson has over a decade of experience with us and Holdings, providing him with comprehensive knowledge of each company's structure, policies and management team. In addition, Mr. Carson's experience in overseeing the management of healthcare industry companies gives him the insight to advise the Board of Directors on corporate governance and compensation matters.

Mr. Cressey has extensive experience in managing investments in healthcare companies as a private equity investor with a focus on investments in the healthcare industry. He brings to the Board of Directors an in-depth knowledge of the regulatory and competitive environment of the healthcare industry. Also, Mr. Cressey has over a decade of experience with us and Holdings, providing him with comprehensive knowledge of each company's and its structure, policies and management team. In addition, Mr. Cressey's experience in overseeing the management of healthcare industry companies gives him insight on corporate governance and compensation matters, which he utilizes in his role as a member of the Compensation Committee.

Mr. Dalton has over a decade of experience with us and Holdings, providing him with comprehensive knowledge of each company's structure, policies and management team. Mr. Dalton has also served as Chief Executive Officer and a director of Quorum Health Group, Inc. and served on the boards of directors of various other healthcare companies, including Signature Hospital Corporation and US Oncology, Inc. Mr. Dalton draws on this experience while advising the Board of Directors on corporate governance matters within the healthcare industry. Additionally, Mr. Dalton utilizes his experience overseeing the finance and accounting systems of the companies he has managed in his service on the Audit and Compliance Committee.

Mr. Ely brings to the Board of Directors a wealth of experience structuring and arranging syndicated loans and high yield issues in the healthcare sector during his service at financial services companies, including J.P. Morgan Securities Inc. He provides the Board of Directors with a thorough understanding of the capital markets, in particular with regard to companies in the healthcare industry. Mr. Ely's experience in financial services also provides him with extensive finance and accounting knowledge, and he applies this expertise in his service on the Audit and Compliance Committee.

Dr. Frist brings to the Board of Directors over ten years of experience as a United States Senator. He provides the Board of Directors with insight into the federal healthcare regulations that affect us. In addition, Dr. Frist has extensive experience as a board certified heart and lung transplant surgeon, which allows him to bring to the Board of Directors the perspective of an experienced healthcare professional. Dr. Frist's service on the boards of directors of other healthcare organizations provides

Table of Contents

him with a wide range of experience in corporate governance matters, including those particular to companies in the healthcare industry, which he draws on in his service on the Board of Directors.

Robert A. Ortenzio, as co-founder and our President and Chief Executive Officer and then Chief Executive Officer of Holdings, provides the Board of Directors with a comprehensive knowledge of each company and its history and businesses. In addition, Mr. Ortenzio brings to the Board of Directors his insight into the healthcare industry from over 25 years of leadership experience in executive positions in healthcare companies, including Horizon/CMS Healthcare Corporation, Continental Medical Systems, Inc. and Rehab Hospital Services Corporation. Mr. Ortenzio also advises the Board of Directors on the evolving healthcare regulatory environment through his in-depth and current knowledge and insight into such matters. Additionally, Mr. Ortenzio provides the Board of Directors with a wealth of experience in corporate governance matters, including through his previous service on the boards of directors of other public healthcare companies.

Rocco A. Ortenzio, as co-founder and our Chief Executive Officer and then Executive Chairman of Holdings, provides the Board of Directors with a comprehensive knowledge of each company's history and businesses. In addition, Mr. Ortenzio brings to the Board of Directors his insight into the healthcare industry from over four decades of leadership experience in executive positions in healthcare companies, including Continental Medical Systems, Inc. and Rehab Hospital Services Corporation. Mr. Ortenzio uses this experience to advise the Board of Directors on corporate governance matters. This experience also gives him significant leadership experience specific to healthcare companies, which he utilizes in his leadership of the Board of Directors.

Mr. Scully brings to the Board of Directors his experience as a past Administrator of CMS, which allows him to provide the Board of Directors with valuable insight into the regulatory regime and requirements of the healthcare industry. In addition, Mr. Scully has experience in analyzing healthcare company investments as a general partner at Welsh, Carson, Anderson and Stowe and advising clients on healthcare related issues at the law firm of Alston & Bird. Mr. Scully utilizes this experience to advise the Board of Directors on healthcare related issues.

Mr. Swergold brings to the Board of Directors over twenty-five years of experience at investment banking firms, during which he gained valuable insight into effective management of investments in the healthcare industry. Mr. Swergold utilizes this insight to advise the Board of Directors on financial and investment matters. Also, Mr. Swergold has significant experience with us and Holdings dating back to 2001, providing him with comprehensive knowledge of each company's structure, policies and management team. Mr. Swergold also has significant experience in finance and accounting, which he uses in his service on the Audit and Compliance Committee.

Table of Contents

Executive Officers

The following table sets forth the names, ages and titles, as well as a brief account of the business experience, of each person who was an executive officer of ours as of June 30, 2013:

Name	Age	Position
Rocco A. Ortenzio	80	Executive Chairman
Robert A. Ortenzio	56	Chief Executive Officer
Patricia A. Rice	66	Executive Advisor to the Chief Executive Officer
David S. Chernow	56	President and Chief Administrative Officer
Martin F. Jackson	59	Executive Vice President and Chief Financial Officer
John A. Saich	45	Executive Vice President and Chief Human Resources Officer
James J. Talalai	52	Executive Vice President and Chief Operating Officer
Michael E. Tarvin	53	Executive Vice President, General Counsel and Secretary
Scott A. Romberger	53	Senior Vice President, Controller and Chief Accounting Officer
Robert G. Breighner, Jr.	44	Vice President, Compliance and Audit Services and Corporate Compliance Officer

Rocco A. Ortenzio co-founded us and served as our Chairman and Chief Executive Officer from February 1997 until September 2001. Mr. Ortenzio has served as our Executive Chairman since 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 us and has served as a director since February 1997. 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. Until August 17, 2010, Mr. Ortenzio served on the board of directors of Odyssey Healthcare, Inc., a hospice healthcare company. Mr. Ortenzio also served on the board of directors of US Oncology, Inc. until December 30, 2010. Mr. Ortenzio is the son of Rocco A. Ortenzio, our Executive Chairman.

Patricia A. Rice has served as our Executive Advisor to the Chief Executive Officer since July 1, 2013. She served as our President from January 2005 through June 2013. She also served as our Chief Operating Officer from January 2002 through December 2011. Prior to this, she served 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 S. Chernow has served as our President and Chief Administrative Officer since March 2012. Prior to such time, Mr. Chernow served as our President and Chief Development and Strategy Officer from September 13, 2010. Mr. Chernow served as a director of ours from January 2002 until February 2005 and from August 2005 until September 2010. From May 2007 to February 2010, Mr. Chernow

Table of Contents

served as the President and Chief Executive Officer of Oncure Medical Corp., one of the largest providers of free-standing radiation oncology care in the United States. From July 2001 to June 2007, Mr. Chernow served as the President and Chief Executive Officer of JA Worldwide, a nonprofit organization dedicated to the education of young people about business (formerly, Junior Achievement, Inc.). From 1999 to 2001, he was the President of the Physician Services Group at US Oncology, Inc. Mr. Chernow co-founded American Oncology Resources in 1992 and served as its Chief Development Officer until the time of the merger with Physician Reliance Network, Inc., which created US Oncology, Inc. in 1999.

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

John A. Saich has served as our Executive Vice President and Chief Human Resources Officer since December 15, 2010. He served as our Senior Vice President, Human Resources from February 2007 to December 2010. He served as our Vice President, Human Resources from November 1999 to January 2007. He joined the Company as Director, Human Resources and HRIS in February 1998. Previously, Mr. Saich served as Director of Benefits and Human Resources for Integrated Health Services in 1997 and as Director of Human Resources for Continental Medical Systems, Inc. from August 1993 to January 1997.

James J. Talalai has served as our Executive Vice President and Chief Operating Officer since January 2012. Prior to this, he served as our Executive Vice President and Chief Information Officer from February 2007 to December 2011. He served as our Senior Vice President and Chief Information Officer from August 2001 to February 2007. He joined the Company in May 1997 and served in various leadership capacities within Information Services. Before joining us, Mr. Talalai was Director of Information Technology for Horizon/ CMS Healthcare Corporation from 1995 to 1997. He also served as Data Center Manager at Continental Medical Systems, Inc. in the mid-1990s.

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

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

Robert G. Breighner, Jr. has served as our Vice President, Compliance and Audit Services since August 2003. He served as our Director of Internal Audit from November 2001 to August 2003. Previously, Mr. Breighner was Director of Internal Audit for Susquehanna Pfaltzgraff Co. from

Table of Contents

June 1997 until November 2001. Mr. Breighner held other positions with Susquehanna Pfaltzgraff Co. from May 1991 until June 1997.

Corporate Governance

In accordance with the Delaware General Corporation Law and Holdings' Restated Certificate of Incorporation and Amended and Restated Bylaws, its business, property and affairs are managed under the direction of the Board of Directors. Although Holdings' non-management directors are not involved in the day-to-day operating details, they are kept informed of our business through written reports and documents provided to them regularly, as well as by operating, financial and other reports presented by the officers at meetings of the Board of Directors and committees of the Board of Directors.

Independence

In 2013, the Board of Directors undertook a review of the independence of Holdings' directors and considered whether any director has a material relationship with us that could compromise his ability to exercise independent judgment in carrying out his responsibilities. The Board of Directors has determined that five of Holdings' nine current directors are "independent" as defined in the applicable listing standards of the New York Stock Exchange, or the "NYSE". The following directors were determined to be independent: Bryan C. Cressey, James E. Dalton, Jr., James S. Ely III, William H. Frist, M.D. and Leopold Swergold.

Meetings of the Board of Directors and Stockholders

It is the policy of the Board of Directors to meet at least quarterly. The Board of Directors held five meetings in fiscal year 2012. During fiscal year 2012, each of the current directors attended all of the meetings of the Board of Directors and the meetings of any committee of which they are a member, except Dr. Frist did not attend the October 18, 2012 meeting of the Board of Directors. It is also the policy of the Board of Directors that the independent members of the Board of Directors meet at regularly scheduled executive sessions of the Board of Directors without management. An independent director serves as the presiding director over such executive sessions, or the "Presiding Director". The independent director serving as the Presiding Director rotates quarterly, based on alphabetical order by last name. In addition, Holdings' directors are expected to attend annual meetings of stockholders, and all of Holdings' directors who were serving as directors at the time of the 2012 annual meeting, except for Mr. Scully, attended the 2012 annual meeting of stockholders.

Corporate Governance Matters

The Board of Directors adopted corporate governance guidelines in September 2009, which can be found on our website at *www.selectmedicalholdings.com*. Under these guidelines, directors are expected to advise the Chairman of the Board of Directors and the Chairman of the Nominating and Corporate Governance Committee prior to accepting any other public company directorship or any assignment to the audit committee or compensation committee of the board of directors of any public company of which such director is a member. Directors are also expected to report changes in their business or professional affiliations or responsibilities, including retirement, to the Chairman of the Board of Directors and the Chairman of the Nominating and Corporate Governance Committee. A director is expected to offer to resign if the Nominating and Corporate Governance Committee concludes that the director no longer meets our requirements for service on the Board of Directors. There are no pre-determined limitations on the number of other boards of directors on which our directors may serve; however, the Board of Directors expects individual directors to use their judgment in accepting other directorships and to allow sufficient time and attention to company matters. There are no set

Table of Contents

term limits for directors. As an alternative to term limits, the Nominating and Corporate Governance Committee will review each director's continuation on the Board of Directors every three years.

Communications with the Board of Directors

If you would like to communicate with all of the directors, please send a letter to the following address: Select Medical Corporation, Attention: Board of Directors c/o Michael E. Tarvin, Executive Vice President, General Counsel and Secretary, 4714 Gettysburg Road, Mechanicsburg, Pennsylvania, 17055. The Secretary will forward such communication to each of the members of the Board of Directors.

If you would like to communicate with the independent members of the Board of Directors, including the Presiding Director, please send a letter to the following address: Select Medical Corporation, Attention: Chairperson of the Nominating and Corporate Governance Committee c/o Michael E. Tarvin, Executive Vice President, General Counsel and Secretary, 4714 Gettysburg Road, Mechanicsburg, Pennsylvania, 17055. The Secretary will forward such communication to the independent members of the Board of Directors.

Code of Conduct and Code of Ethics

We are committed to ethical business practices. In 1998, we voluntarily adopted a Code of Conduct. The Code of Conduct is reviewed and amended as necessary and is the basis for our compliance program. The Code of Conduct provides guidelines for principles and regulatory rules that are applicable to our patient care and business activities. These guidelines are implemented by a compliance officer, a compliance committee, and employee education and training. We have also established a reporting system, auditing and monitoring programs, and a disciplinary system as a means for enforcing the Code of Conduct's policies. This Code of Conduct applies to all of our employees and directors. In September 2009, Holdings adopted a Code of Ethics for Senior Financial Officers, which includes the code of ethics for our principal executive officer, principal financial officer and principal accounting officer within the meaning of the SEC regulations adopted under the Sarbanes-Oxley Act of 2002. The Code of Conduct and Code of Ethics for Senior Financial Officers can be found on our website at *www.selectmedicalholdings.com*. Any amendments to the Code of Conduct or Code of Ethics for Senior Financial Officers or waivers from the provisions of the Code of Conduct or the Code of Ethics for Senior Financial Officers for Holdings' principal executive officer, principal financial officer and principal accounting officer will be disclosed on our website promptly following the date of such amendment or waiver. Please note that none of the information on Holdings' website is incorporated by reference in this Registration Statement.

Board Leadership

The Board of Directors does not have a formal policy on whether the roles of Chief Executive Officer and Chairman of the Board of Directors should be separate. However, since its inception, Holdings had separate individuals serve in those positions. Since 2005, its Board of Directors has been led by Rocco A. Ortenzio as Executive Chairman, and Robert A. Ortenzio has served as its Chief Executive Officer. The Board of Directors has carefully considered its leadership structure and believes at this time that Holdings and its stockholders are best served by having the positions of Executive Chairman and Chief Executive Officer filled by different individuals. This allows the Chief Executive Officer to, among other things, focus on our day-to-day business, while allowing the Executive Chairman to lead the Board of Directors in its fundamental role of providing advice and oversight of management. Further, the Board of Directors believes that having the Executive Chairman serve dual roles as chairman of the Board of Directors and as an executive officer of Holdings promotes information flow between management and the Board of Directors, effective decision making and an alignment of corporate strategy. Moreover, the Board of Directors believes that its other structural

Table of Contents

features, including five independent directors and seven non-management directors on a board consisting of nine directors, regular meetings of independent directors in executive session and key committees consisting wholly of independent directors, provide for substantial independent oversight of our and Holdings' management. However, the Board of Directors recognizes that depending on future circumstances, other leadership models may become more appropriate. Accordingly, the Board of Directors will continue to periodically review its leadership structure.

Risk Oversight

We face a number of risks, including regulatory risk, credit risk, liquidity risk, reputational risk and risk from adverse fluctuations in interest rates. Management is responsible for the day-to-day management of risks faced by us, while the Board of Directors, as a whole and through its committees, has responsibility for the oversight of risk management. In its risk oversight role, the Board of Directors seeks to ensure that the risk management processes designed and implemented by management are adequate. The Board of Directors periodically consults with management regarding our risks.

While the Board of Directors is ultimately responsible for risk oversight, Holdings' four board committees assist the Board of Directors in fulfilling its oversight responsibilities in certain areas of risk. The Audit and Compliance Committee assists the Board of Directors in overseeing risk management in the areas of financial reporting, internal controls and compliance with legal and regulatory requirements, and periodically reviews with management, internal auditors and independent auditors the adequacy and effectiveness of our policies for assessing and managing risk. The Compensation Committee assists the Board of Directors in oversight and management of risks related to our and Holdings' compensation policies and programs. The Nominating and Corporate Governance Committee assists the Board of Directors in oversight and management of risk associated with board organization, membership and structure, succession planning for Holdings' directors and officers and corporate governance. The Quality of Care and Patient Safety Committee assists the Board of Directors in the oversight and management of risk associated with our policies and procedures relating to the delivery of quality medical care to patients.

Committees of the Board of Directors

The Board of Directors currently has four standing committees. Charters for each of these committees can be found on Holdings' website at *www.selectmedicalholdings.com*.

Audit and Compliance Committee The Audit and Compliance Committee is governed by a written charter adopted in February 2010. The primary responsibility of the Audit and Compliance Committee is to oversee Holdings' financial reporting process and compliance program on behalf of the Board of Directors and to regularly report the results of its activities to the Board of Directors. The Audit and Compliance Committee assists the Board of Directors in the oversight of the integrity of Holdings' financial statements and financial reporting process, the systems of internal accounting and financial controls, the performance of Holdings' internal audit function and independent auditors, the independent auditor's qualifications and independence, the annual independent audit of Holdings' financial statements, the selection and performance of Holdings' compliance officer, the effectiveness of the structure and operations of Holdings' compliance program, our compliance with each of Holdings' Code of Conduct and the Code of Ethics for Senior Financial Officers and other legal compliance and ethics programs established by management and the Board of Directors and Holdings' compliance with applicable legal and regulatory requirements. In so doing, the Audit and Compliance Committee is responsible for maintaining free and open communication among its members, the independent registered public accounting firm, the internal auditors and our management. A detailed list of the Audit and Compliance Committee's functions is included in its charter. The Audit and Compliance

Table of Contents

Committee charter is annually reviewed and ratified by the Audit and Compliance Committee and the Board of Directors.

The current members of the Audit and Compliance Committee are Messrs. Dalton, Ely and Swergold. The composition of the Audit and Compliance Committee satisfies the independence and financial literacy requirements of the NYSE and the SEC. The financial literacy standards require that each member of the Audit and Compliance Committee be able to read and understand fundamental financial statements. In addition, at least one member of the Audit and Compliance Committee must qualify as an "audit committee financial expert," as defined by the rules and regulations of the SEC, and have financial sophistication in accordance with the rules of the NYSE. The Board of Directors has determined that each of the Audit and Compliance Committee members qualifies as an "audit committee financial expert" as defined in Item 407(d)(5) of Regulation S-K. Also, each member of the Audit and Compliance Committee is independent, as independence for audit committee members is defined in the applicable NYSE listing standards. The Audit and Compliance Committee held six meetings during fiscal year 2012.

Compensation Committee The Compensation Committee is governed by a written charter adopted in September 2009, which became effective as of the time our common stock was first listed on the NYSE. The Compensation Committee has overall responsibility for evaluating and approving Holdings' executive officer and director compensation plans, policies and programs, as well as all equity-based compensation plans and policies. The Compensation Committee is also responsible for preparing the Compensation Discussion and Analysis report for inclusion in our annual proxy statement filed with the SEC. The Compensation Committee charter is annually reviewed and ratified by the Compensation Committee and the Board of Directors.

The current members of the Compensation Committee are Messrs. Cressey and Swergold, both of whom the Board of Directors has determined in its business judgment are independent as defined in the applicable NYSE listing standards. The Compensation Committee held five meetings during fiscal year 2012.

Nominating and Corporate Governance Committee The Nominating and Corporate Governance Committee is governed by a written charter adopted in September 2009, which became effective as of the time our common stock was first listed on the NYSE. The Nominating and Corporate Governance Committee is appointed to (i) identify individuals qualified to serve on the Board of Directors and board committees; (ii) recommend to the Board of Directors nominees for election to the Board of Directors at annual meetings of stockholders; (iii) recommend to the Board of Directors nominees to serve on each of the board committees; (iv) lead the Board of Directors in its annual review of the performance of the Board of Directors and management; (v) monitor Holdings' corporate governance structure; and (vi) develop and recommend to the Board of Directors any proposed changes to Holdings' corporate governance guidelines. The Nominating and Corporate Governance Committee identifies individuals, including those recommended by stockholders, believed to be qualified as candidates for Board of Directors membership. The Nominating and Corporate Governance Committee has the authority to retain search firms to assist it in identifying candidates to serve as directors. In addition to any other qualifications the Nominating and Corporate Governance Committee may in its discretion deem appropriate, all director candidates, at a minimum, should possess the highest personal and professional ethics, integrity and values and be committed to representing the best interests of the stockholders. In identifying candidates, the Nominating and Corporate Governance Committee will also take into account other factors it considers appropriate, which include ensuring a majority of directors satisfy the independence requirements of the NYSE, the SEC or other appropriate governing body and that the Board of Directors as a whole is comprised of directors who have the appropriate experience, expertise and perspective that will enhance the quality of the Board of Directors' deliberations and decisions. While the Nominating and Corporate Governance Committee does not have a formal policy with regard to the consideration of diversity in identifying director nominees, the Nominating and

Table of Contents

Corporate Governance Committee and the Board of Directors believe it is essential that the Board of Directors is able to draw on a wide variety of backgrounds and professional experiences among its members. The Nominating and Corporate Governance Committee desires to maintain the Board of Directors' diversity through the consideration of factors such as education, skills and relevant professional experience. The Nominating and Corporate Governance Committee does not intend to nominate representational directors, but instead considers the entirety of each candidate's credentials in the context of these standards and the characteristics of the Board of Directors in its entirety. The Nominating and Corporate Governance Committee will conduct appropriate inquiries with respect to the backgrounds and qualifications of all director candidates. Once the Nominating and Corporate Governance Committee has completed its review of a candidate's qualifications and conducted the appropriate inquiries, the Nominating and Corporate Governance Committee will make a determination whether to recommend the candidate for approval by the Board of Directors. If the Nominating and Corporate Governance Committee decides to recommend the director candidate for nomination by the Board of Directors and such recommendation is accepted by the Board of Directors, the form of proxy solicited by the Company will include the name of the director candidate. The Nominating and Corporate Governance Committee charter is annually reviewed and ratified by the Nominating and Corporate Governance Committee and the Board of Directors.

The Nominating and Corporate Governance Committee considers stockholder nominees for directors in the same manner as nominees for director from other sources. Stockholder suggestions for nominees for director should be submitted to the Secretary or Assistant Secretary no later than the date by which stockholder proposals for action must be submitted and should include the following information: (i) the name and address of the stockholder making the recommendations, (ii) a representation that the stockholder is a holder of record, which should include the number of shares presently held and how long the shares have been held, (iii) a description of any and all arrangements or understandings between the stockholder making the recommendation and the director candidate, and (iv) all information regarding the director candidate that is required to be included in a proxy solicitation for the election of directors.

The current members of the Nominating and Corporate Governance Committee are Messrs. Dalton and Swergold, both of whom the Board of Directors has determined in its business judgment are independent as defined in the applicable NYSE listing standards. The Nominating and Corporate Governance Committee held two meetings during fiscal year 2012.

Quality of Care and Patient Safety Committee The Quality of Care and Patient Safety Committee is governed by a written charter adopted in May 2012. The Quality of Care and Patient Safety Committee is appointed to assist the Board of Directors in fulfilling its oversight responsibilities relating to the review of our and Holdings' policies and procedures relating to the delivery of quality medical care to patients. The Quality of Care and Patient Safety Committee maintains communication between the Board of Directors and the senior officers with management responsibility for medical care and reviews matters concerning or relating to the quality of medical care delivered to patients, efforts to advance the quality of medical care provided and patient safety. The Quality of Care and Patient Safety Committee charter is annually reviewed and ratified by the Quality of Care and Patient Safety Committee and the Board of Directors.

The current members of the Quality of Care and Patient Safety Committee are Messrs. Frist and Scully. The Quality of Care and Patient Safety Committee held three meetings during fiscal year 2012.

Table of Contents

EXECUTIVE COMPENSATION

General

Set forth below is a discussion of the executive compensation of Holdings, our sole stockholder.

Compensation Consultant

The Compensation Committee has the authority under its charter to engage the services of outside advisors, experts and others to assist the Compensation Committee. The Compensation Committee did not engage a compensation consultant during the 2012 fiscal year. In fiscal year 2011, the Compensation Committee engaged McDaniel & Associates, Inc. to provide an analysis of Holdings' executive officer and non-employee director compensation programs, as well as an analysis of its equity compensation programs. This engagement is described in detail below in the section titled "*Committee Process; Compensation Consultant*" in the Compensation Discussion and Analysis section of this prospectus.

Role of Executive Officers

At the request of the Compensation Committee, Holdings' Chief Executive Officer participates in Compensation Committee meetings and recommends levels of compensation for the other "named executive officers" or "NEOs". However, the Compensation Committee makes the final determination regarding the compensation of the NEOs. No other executive officer participates in determining or recommending the amount or form of executive compensation.

Compensation Committee Interlocks and Insider Participation

No current member of the Compensation Committee is or has been at any time one of our or Holdings' officers or employees. None of our or Holdings' executive officers currently serves, or has served during the last completed fiscal year, as a member of the board of directors or compensation committee of any entity that has one or more executive officers serving as a member of the Holdings' Board of Directors or Compensation Committee. Bryan C. Cressey and Leopold Swergold serve on Holdings' Compensation Committee.

Compensation Discussion and Analysis

General

Since our executive officers are identical to those of Holdings, set forth below is the compensation discussion and analysis of Holdings.

Objectives of the Company's Executive Compensation Policy

Introduction. This Compensation Discussion and Analysis, or "CD&A", provides an overview of Holdings' executive compensation program, together with a description of the material factors underlying the decisions which resulted in the compensation provided for 2012 to Holdings' Executive Chairman, Chief Executive Officer, President, President and Chief Administrative Officer and Executive Vice President and Chief Financial Officer, as presented in the tables which follow this CD&A. This CD&A contains statements regarding certain performance targets and goals Holdings has used or may use to determine appropriate compensation. These targets and goals are disclosed in the limited context of Holdings' compensation program and should not be understood to be statements of management's expectations or estimates of financial results or other guidance. Holdings specifically cautions investors not to apply these statements to other contexts.

Table of Contents

Compensation Philosophy. Holdings' compensation philosophy for NEOs is designed with the primary goals of rewarding the contributions of NEOs to the Company's financial performance and providing overall compensation sufficient to attract and retain highly skilled NEOs who are properly motivated to contribute to Holdings' financial performance. Holdings generally seeks to achieve its goals with respect to the NEOs' compensation by implementing and maintaining incentive plans for such executive officers that tie a substantial portion of each NEO's overall compensation to pre-determined financial goals relating to Holdings' return on equity and earnings per share. The Compensation Committee also grants the NEOs restricted stock awards from time to time which, subject to limited exceptions, require the NEO's continued employment for a minimum of three years prior to vesting.

Committee Process; Compensation Consultant. The Compensation Committee meets as often as necessary to perform its duties and responsibilities. During 2012, the Compensation Committee met five times. The Compensation Committee's meeting agenda is normally established by Holdings' Chief Executive Officer in consultation with the chairman and members of the Compensation Committee. Members of the Compensation Committee receive the agenda and related materials in advance of each meeting. Depending on the meeting's agenda, such materials may include financial reports regarding Holdings' performance, reports on achievement of individual and company objectives and information regarding Holdings' compensation programs.

The Compensation Committee periodically reviews overall compensation levels to ensure that performance-based compensation represents a sufficient portion of total compensation to promote and reward executive officers' contributions to Holdings' performance. Both members of the Compensation Committee have extensive experience in the healthcare industry, including a focus on structuring appropriate executive compensation for healthcare companies. In setting the compensation for the NEOs, the Compensation Committee members draw on their collective experience in the healthcare industry and knowledge of investors' goals and do not engage in benchmarking.

The Compensation Committee did not engage a compensation consultant during the 2012 fiscal year. The Compensation Committee did engage a compensation consultant, McDaniel & Associates, Inc., or "McDaniel", during fiscal year 2011 to provide information about executive officer and non-employee director compensation for comparable companies within Holdings' industry. In preparing this information, McDaniel reviewed compensation information from the Towers/Watson Healthcare Management Compensation Survey (for those organizations in the healthcare sector with annual revenue ranging between $1 billion and $5 billion median annual revenue for the surveyed companies was $2.8 billion) and the Integrated Healthcare Strategies Executive Compensation Report (for healthcare companies with revenues ranging between $1 billion and $3 billion median revenues for the surveyed companies was $1.9 billion). McDaniel also reviewed publicly available compensation information from 17 companies in the healthcare facilities and services business with revenues ranging between $900 million and $5 billion (median revenue was $1.9 billion) and market capitalization ranging between $615 million and $3.6 billion (median market capitalization was $1.8 billion). These 17 companies include:

Amedisys, Inc.	Emeritus Corp.	Mednax, Inc.
Brookdale Senior Living, Inc.	Gentiva Health Services, Inc.	Rehabcare Group
Catalyst Health Solutions, Inc.	Health Management Associates, Inc.	Res-Care, Inc.
Chemed Corp.	Healthsouth Corp.	Sunrise Senior Living, Inc.
Community Health Systems, Inc.	Lifepoint Hospitals, Inc.	Team Health Holdings, Inc.
Emergency Medical Services Corp.	Lincare Holdings, Inc.	

Table of Contents

The information prepared by McDaniel revealed that Holdings' executive officers (including executives who are not NEOs) received base salary and target bonus opportunities in the aggregate at or near the median of the companies reviewed. In addition, Holdings' executive officers were eligible for maximum bonus opportunities in the aggregate that were above the median of the companies reviewed and received equity compensation in the aggregate below the median of the companies reviewed.

At its December 15, 2011 meeting, the Compensation Committee considered the information prepared by McDaniel in making the following changes to NEO compensation for fiscal year 2012:

Base Salary: Mr. Rocco A. Ortenzio's base salary was increased to $950,000; Mr. Robert A. Ortenzio's base salary was increased to $995,000; Ms. Rice's base salary was increased to $900,000; Mr. Chernow's base salary was increased to $740,000; and Mr. Jackson's base salary was increased to $600,000.

Annual Bonus Opportunity: Messrs. Chernow's and Jackson's target and maximum bonus opportunities for the 2012 fiscal year were increased to 80% of base salary and 200% of base salary, respectively; and Mr. Robert A. Ortenzio's target and maximum bonus opportunities for the 2012 fiscal year were increased to 100% of base salary and 250% of base salary, respectively.

The Compensation Committee believes that these base salary increases were appropriate because Messrs. Rocco A. Ortenzio and Robert A. Ortenzio and Ms. Rice had not received any base salary increases since April 1, 2009, Mr. Jackson had not received a base salary increase since August 28, 2010 and Mr. Chernow's base salary was still set at his initial hire rate. In addition, the Compensation Committee determined that it was appropriate to bring the bonus opportunities for Messrs. Chernow and Jackson in line with the bonus opportunities for the other NEOs (other than Holdings' chief executive officer), as well as to accurately reflect their roles and level of responsibility in the Company. The Compensation Committee decided to increase the bonus opportunities for Mr. Robert A. Ortenzio to better reflect his role as Holdings' chief executive officer and the level of his responsibilities compared to the other NEOs. The Compensation Committee believes that, after considering the compensation information prepared by McDaniel, the base salary and bonus opportunity increases for the NEOs make their total compensation package competitive within our industry.

The Compensation Committee did not engage in any benchmarking or otherwise attempt to set compensation levels within a specific range of any of the companies identified by McDaniel. Instead, the base salary and bonus opportunity adjustments were determined by the Compensation Committee using its collective experience in the healthcare industry.

Role of Chief Executive Officer in Compensation Decisions. At the request of the Compensation Committee, Holdings' Chief Executive Officer participates in Compensation Committee meetings and recommends levels of compensation for the other NEOs. However, the Compensation Committee makes the final determination regarding the compensation of the NEOs.

Risk Assessment.

The Compensation Committee meets periodically each fiscal year to review Holdings' executive compensation policies and programs to ensure that they are appropriate. The Compensation Committee also determines each year whether incentive compensation will be awarded to our and Holdings' non-executive employees. After considering the various forms of compensation paid to our and Holdings' employees, the Compensation Committee has concluded that our and Holdings' compensation policies and programs are not reasonably likely to have a material adverse effect on us or Holdings. This conclusion is based on the following factors:

A majority of our employees do not receive any performance-based compensation;

Table of Contents

A significant portion of the compensation paid to our and Holdings' employees who are eligible to receive performance-based compensation consists of base salary, which is not dependent upon our or Holdings' performance;

Holdings' bonus program for executive officers includes safeguards that reduce the incentive to engage in risky behavior. For example, Holdings' Executive Bonus Plan limits the amount of bonus compensation that participants may receive (regardless of how well the Company performs) and provides the Compensation Committee with the discretion to reduce the bonus awards otherwise payable to participants thereunder; and

Holdings' executive officers currently own, and historically have owned, a significant percentage of its outstanding common stock. Such ownership interest reduces the incentive for Holdings' executive officers to engage in actions designed to achieve only short-term results.

Elements of Compensation

Executive compensation for any fiscal year generally consists of a combination of the following elements, each of which is discussed in further detail in the sections that follow:

Base Salary;

Annual Performance-Based Bonuses;

Equity Compensation;

Perquisites and Personal Benefits; and

General Benefits.

In addition to the compensation components listed above, each of the NEOs is party to either an employment agreement or a change in control agreement with us that provides for post-employment severance payments and benefits in the event of employment termination under certain circumstances.

In determining the different elements of compensation to provide to the NEOs in any given year, the Compensation Committee does not adhere to a specific allocation between short-term and long-term compensation, or between cash and non-cash compensation. Instead, the Compensation Committee determines the elements of NEO compensation for any given year in a manner designed to further its goals of rewarding strong financial performance, providing overall compensation opportunities that are sufficient to attract and retain highly skilled NEOs and ensuring that the NEOs' interests are aligned with those of Holdings' stockholders. This may result in the NEOs receiving all cash compensation in some years (through base salary and annual performance-based bonuses) and a combination of cash and equity compensation in other years (through base salary, annual performance-based bonuses and long-term equity awards).

Base Salary

Base salaries are provided to the NEOs to compensate them for services rendered during the year. Consistent with Holdings' philosophy of placing increasing emphasis on performance-based compensation, the Compensation Committee sets the base salaries for the NEOs at levels which it believes are competitive for the healthcare industry when combined with Holdings' incentive programs. The Compensation Committee periodically reviews base salaries for the NEOs. As described above in the section titled "*Committee Process; Compensation Consultant*," in December 2011, the Compensation Committee approved increases to the annual base salary for each NEO effective January 1, 2012.

2012 Named Executive Officer Annual Performance-Based Bonuses

Annual cash bonuses are included as part of the executive compensation program because the Compensation Committee believes that a significant portion of each NEO's compensation should be

Table of Contents

contingent on Holdings' financial performance. Accordingly, Holdings has historically maintained a bonus plan under which NEOs are eligible to receive annual cash bonuses based upon the achievement of specific performance measures.

For the 2012 fiscal year, each of the NEOs participated in Holdings' Executive Bonus Plan, or the "Executive Bonus Plan". The Executive Bonus Plan was implemented to provide the Compensation Committee with the discretion to grant bonus compensation to the NEOs that can qualify as "performance-based compensation" under Section 162(m) ("Section 162(m)") of the Internal Revenue Code of 1986, as amended, or the "Code". Compensation that qualifies as "performance-based compensation" is not subject to the $1 million cap on deductibility imposed by Section 162(m). The Compensation Committee also retains discretion to grant bonus compensation to the NEOs and other employees outside of the Executive Bonus Plan.

Under the terms of the Executive Bonus Plan, eligible employees, including the NEOs, may earn bonus compensation based on the achievement of pre-determined performance goals, such as earnings per share, return on equity, return on assets, sales, stock price and operating income. In connection with establishing the performance goals for each performance period, the Compensation Committee will determine the amount of bonus compensation that may be paid to participants upon the achievement of the relevant performance goals. The amount of any compensation paid under the terms of the Executive Bonus Plan is limited to $2.5 million. In addition, the Compensation Committee may decrease each participant's bonus award under the Executive Bonus Plan in its sole discretion. In the event that a participant earns a bonus under the Executive Bonus Plan, such bonus will be paid either in cash or in shares of restricted stock under Holdings' equity compensation plans.

Consistent with prior years, NEO bonuses for the 2012 fiscal year were based on Holdings' achievement of specified levels of earnings per share and return on equity. The Compensation Committee selected earnings per share and return on equity as the performance measures for 2012 bonuses because the Compensation Committee believes that each of these metrics is directly related to the creation of stockholder value. For 2012, the Compensation Committee established target and maximum earnings per share levels of $0.899 and $