REHAB GROUP INC
Form S-4
August 14, 2013

Use these links to rapidly review the document

Table of Contents

As filed with the Securities and Exchange Commission on August 14, 2013

Registration No. 333-

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form S-4

REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

SELECT MEDICAL CORPORATION

(Exact Name of Registrant as Specified in its Charter)

Delaware	**8060**	**23-2872718**
(State or other jurisdiction of incorporation or organization)	(Primary Standard Industrial Classification Code Number of each Registrant)	(I.R.S. Employer Identification No.)

4714 Gettysburg Road, P.O. Box 2034
Mechanicsburg, Pennsylvania 17055
(717) 972-1100
(Address, Including Zip Code, and Telephone Number, Including Area Code, of each Registrant's Principal Executive Offices)

See Table of Additional Registrants Below

Michael E. Tarvin, Esq.
Select Medical Corporation
4714 Gettysburg Road, P.O. Box 2034
Mechanicsburg, Pennsylvania 17055
(717) 972-1100
(Name, Address, Including Zip Code, and Telephone Number, Including Area Code, of Agent for Service)

Copies to:
Stephen M. Leitzell, Esquire
Dechert LLP
Cira Centre
2929 Arch Street
Philadelphia, Pennsylvania 19104
(215) 994-4000

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

If the securities being registered on this Form are being offered in connection with the formation of a holding company and there is compliance with General Instruction G, check the following box. o

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

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

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

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

If applicable, place an X in the box to designate the appropriate rule provision relied upon in conducting this transaction:

Exchange Act Rule 13e-4(i) (Cross-Border Issuer Tender Offer) o

Exchange Act Rule 14d-1(d) (Cross-Border Third-Party Tender Offer o

CALCULATION OF REGISTRATION FEE

Title of each class of securities to be registered	Amount to be registered	Proposed maximum offering price per share	Proposed maximum aggregate offering price(1)	Amount of registration fee(2)
6.375% Senior Notes due 2021	$600,000,000	100%	$600,000,000	$81,840
Guarantees of 6.375% Senior Notes due 2021	N/A	N/A	N/A	N/A(3)

(1) Estimated solely for the purpose of calculating the registration fee in accordance with Rule 457(f) of the Securities Act.

(2) The registration fee has been calculated pursuant to Rule 457(f) under the Securities Act.

(3) No additional consideration is being received for the guarantees, and, therefore no additional fee is required.

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

Table of Contents

Table of Additional Registrants

Exact Name of Additional Registrants	Jurisdiction of Incorporation	I.R.S. Employer Identification Number
PR Acquisition Corporation	CA	88-0300915
American Transitional Hospitals, Inc.	DE	76-0232151
Eagle Rehab Corporation	DE	85-0436768
GRSH ES, Inc.	DE	46-2847260
Hospital Holdings Corporation	DE	25-1813124
Intensiva HealthCare Corporation	DE	43-1690769
Kessler Orthotic & Prosthetic Services, Inc.	DE	22-2200045
Kessler Rehab Centers, Inc.	DE	04-3177708
Kessler Rehabilitation Corporation	DE	22-3486128
NovaCare Occupational Health Services, Inc.	DE	23-2884053
NovaCare Outpatient Rehabilitation East, Inc.	DE	23-2862027
OHRH ES, Inc.	DE	46-2541226
Pacific Rehabilitation & Sports Medicine, Inc.	DE	93-1072052
Professional Sports Care Management, Inc.	DE	22-3315575
RCI (Michigan), Inc.	DE	23-2768957
RCI (WRS), Inc.	DE	36-3879850
Regency Management Company, Inc.	DE	48-1278047
Rehab Provider Network East I, Inc.	DE	23-2745660
Rehab Provider Network of South Carolina, Inc.	DE	84-1699628
Rehab Provider Network of Virginia, Inc.	DE	84-1699629
RehabClinics (PTA), Inc.	DE	65-0366467
RehabClinics (SPT), Inc.	DE	23-2736153
RehabClinics, Inc.	DE	13-3595267
Rehabilitation Center of Washington, D.C., Inc.	DE	20-8938640
RPN of NC, Inc.	DE	11-3670557
Select Employment Services, Inc.	DE	25-1812245
Select Hospital Investors, Inc.	DE	51-0402736
Select Medical of Kentucky, Inc.	DE	25-1820753
Select Medical of Maryland, Inc.	DE	23-2906982
Select Medical of New York, Inc.	DE	23-2916448
Select Medical Rehabilitation Clinics, Inc.	DE	25-1883131
Select Medical Rehabilitation Services, Inc.	DE	25-1805051
Select Physical Therapy Holdings, Inc.	DE	63-1133454
Select Physical Therapy Network Services, Inc.	DE	72-1342805
Select Physical Therapy Orthopedic Services, Inc.	DE	36-3738954
Select Provider Networks, Inc.	DE	23-2935684
Select Rehabilitation Hospital Hershey, Inc.	DE	38-3695622
Select Specialty Hospital Arizona, Inc.	DE	25-1821705
Select Specialty Hospital Augusta, Inc.	DE	14-1842263
Select Specialty Hospital Charleston, Inc.	DE	25-1866522
Select Specialty Hospital Colorado Springs, Inc.	DE	84-1583613
Select Specialty Hospital Columbus, Inc.	DE	25-1816235
Select Specialty Hospital Conroe, Inc.	DE	30-0160729
Select Specialty Hospital Dallas, Inc.	DE	25-1813126
Select Specialty Hospital Danville, Inc.	DE	61-1458009
Select Specialty Hospital Daytona Beach, Inc.	DE	46-3235750
Select Specialty Hospital Denver, Inc.	DE	76-0292237
Select Specialty Hospital Durham, Inc.	DE	25-1822461
Select Specialty Hospital Erie, Inc.	DE	25-1858065

Table of Contents

Exact Name of Additional Registrants	Jurisdiction of Incorporation	I.R.S. Employer Identification Number
Select Specialty Hospital Gainesville, Inc.	DE	06-1713547
Select Specialty Hospital Greensboro, Inc.	DE	71-0958380
Select Specialty Hospital Grosse Pointe, Inc.	DE	05-0597929
Select Specialty Hospital Jackson, Inc.	DE	25-1880780
Select Specialty Hospital Kalamazoo, Inc.	DE	75-2962822
Select Specialty Hospital Knoxville, Inc.	DE	25-1813122
Select Specialty Hospital Laurel Highlands, Inc.	DE	25-1855814
Select Specialty Hospital Lexington, Inc.	DE	02-0631042
Select Specialty Hospital Little Rock, Inc.	DE	25-1813121
Select Specialty Hospital Longview, Inc.	DE	47-0910358
Select Specialty Hospital Madison, Inc.	DE	73-1674792
Select Specialty Hospital McKeesport, Inc.	DE	80-0077092
Select Specialty Hospital Melbourne, Inc.	DE	46-3241394
Select Specialty Hospital Memphis, Inc.	DE	25-1813120
Select Specialty Hospital Midland, Inc.	DE	61-1410912
Select Specialty Hospital Milwaukee, Inc.	DE	25-1820734
Select Specialty Hospital Nashville, Inc.	DE	25-1813119
Select Specialty Hospital Northeast New Jersey, Inc.	DE	45-0497740
Select Specialty Hospital Northwest Detroit, Inc.	DE	25-1862677
Select Specialty Hospital Oklahoma City, Inc.	DE	25-1813118
Select Specialty Hospital Orlando, Inc.	DE	37-1426852
Select Specialty Hospital Palm Beach, Inc.	DE	03-0508559
Select Specialty Hospital Panama City, Inc.	DE	38-3647406
Select Specialty Hospital Pensacola, Inc.	DE	03-0508545
Select Specialty Hospital Phoenix, Inc.	DE	25-1813117
Select Specialty Hospital Pittsburgh/UPMC, Inc.	DE	73-1678377
Select Specialty Hospital Quad Cities, Inc.	DE	01-0804233
Select Specialty Hospital Saginaw, Inc.	DE	25-1890958
Select Specialty Hospital San Antonio, Inc.	DE	25-1843089
Select Specialty Hospital Savannah, Inc.	DE	75-2999825
Select Specialty Hospital South Dallas, Inc.	DE	25-1855474
Select Specialty Hospital Springfield, Inc.	DE	65-0366469
Select Specialty Hospital Tallahassee, Inc.	DE	56-2314944
Select Specialty Hospital TriCities, Inc.	DE	25-1813125
Select Specialty Hospital Tulsa, Inc.	DE	25-1813116
Select Specialty Hospital Western Missouri, Inc.	DE	61-1458008
Select Specialty Hospital Winston-Salem, Inc.	DE	56-2248187
Select Specialty Hospital Zanesville, Inc.	DE	03-0508537
Select Specialty Hospitals, Inc.	DE	25-1813128
Select Synergos, Inc.	DE	25-1813114
Select Transport, Inc.	DE	23-2872899
Select Unit Management, Inc.	DE	71-0776296
SelectMark, Inc.	DE	51-0400776
SemperCare, Inc.	DE	94-3322260
SLMC Finance Corporation	DE	51-0406794
Community Rehab Centers of Massachusetts, Inc.	MA	04-3428648
S.T.A.R.T., Inc.	MA	04-2710250
Advantage Rehabilitation Clinics, Inc.	MA	04-3177879
Kessler Institute for Rehabilitation, Inc.	NJ	22-3486125
Kessler Rehabilitation Services, Inc.	NJ	22-3705780
Rehab Provider Network New Jersey, Inc.	NJ	23-2745661

Table of Contents

Exact Name of Additional Registrants	Jurisdiction of Incorporation	I.R.S. Employer Identification Number
Metro Therapy, Inc.	NY	11-3068922
Select NovaCare PBG, Inc.	NY	59-3779977
Joyner Sportsmedicine Institute, Inc.	PA	23-2696896
Rehab Provider Network Pennsylvania, Inc.	PA	23-2745659
Select Subsidiaries, Inc.	PA	23-2626897
Argosy Health, LLC	DE	04-3436823
Kessler Professional Services, LLC	DE	32-0113297
Regency Hospital Company of Macon, L.L.C.	DE	58-2658683
Regency Hospital Company of Meridian, L.L.C.	DE	64-0947034
Regency Hospital Company of South Atlanta, L.L.C.	DE	58-2658680
Regency Hospital Company of South Carolina, L.L.C.	DE	57-1124822
Regency Hospital Company, L.L.C.	DE	58-2617175
Regency Hospital of Cincinnati, LLC	DE	20-0436973
Regency Hospital of Columbus, LLC	DE	56-2569339
Regency Hospital of Covington, LLC	DE	20-0437002
Regency Hospital of Fort Worth Holdings, LLC	DE	n/a
Regency Hospital of Greenville, LLC	DE	20-0122559
Regency Hospital of Jackson, LLC	DE	20-1268582
Regency Hospital of Minneapolis, LLC	DE	20-1186605
Regency Hospital of North Central Ohio, LLC	DE	20-5457719
Regency Hospital of North Dallas Holdings, LLC	DE	46-2911162
Regency Hospital of Northwest Arkansas, LLC	DE	20-0226432
Regency Hospital of Northwest Indiana, LLC	DE	16-1647691
Regency Hospital of Odessa Limited Partner, LLC	DE	n/a
Regency Hospital of Southern Mississippi, LLC	DE	20-5457617
Regency Hospital of Toledo, LLC	DE	20-3802570
Regency Hospitals, LLC	DE	20-3695110
Select Medical Property Ventures, LLC	DE	30-0255029
Select Specialty Hospital Northern Kentucky, LLC	DE	25-1816237
Select Specialty Hospital Tulsa/Midtown, LLC	DE	20-1047631
West Gables Rehabilitation Hospital, L.L.C.	DE	20-2971876
Regency Hospital of Odessa, LLLP	DE	56-2296429
Select Physical Therapy Limited Partnership for Better Living	DE	63-1186126
Select Physical Therapy of Albuquerque, Ltd.	AL	62-1403979
Select Physical Therapy of Birmingham, Ltd.	AL	63-0885596
Select Physical Therapy of Blue Springs Limited Partnership	AL	63-1066232
Select Physical Therapy of Cave Springs Limited Partnership	AL	63-1150194
Select Physical Therapy of Colorado Springs Limited Partnership	AL	63-1074874
Select Physical Therapy of Connecticut Limited Partnership	AL	63-1155914
Select Physical Therapy of Denver, Ltd.	AL	84-1036747
Select Physical Therapy of Green Bay Limited Partnership	AL	63-1054106
Select Physical Therapy of Illinois Limited Partnership	AL	63-1093574
Select Physical Therapy of Kendall, Ltd.	AL	59-2719911
Select Physical Therapy of Knoxville Limited Partnership	AL	63-1120816
Select Physical Therapy of Lorain Limited Partnership	AL	63-1007432
Select Physical Therapy of Louisville, Ltd.	AL	31-1262978
Select Physical Therapy of Ohio Limited Partnership	AL	63-1184830
Select Physical Therapy of Portola Valley Limited Partnership	AL	63-1059425
Select Physical Therapy of Scottsdale Limited Partnership	AL	63-1002997
Select Physical Therapy of St. Louis Limited Partnership	AL	36-3372626
Select Physical Therapy of West Denver Limited Partnership	AL	63-1033534

Table of Contents

Exact Name of Additional Registrants	Jurisdiction of Incorporation	I.R.S. Employer Identification Number
Select Physical Therapy Texas Limited Partnership	AL	63-1134324
Select NovaCare PIT, Inc.	AZ	04-3792234
Rehab Provider Network of Colorado, Inc.	CO	93-1204512
Madison Rehabilitation Center, Inc.	CT	06-1046526
PTSMA, Inc.	CT	06-1026153
Baseline Rehabilitation, Inc.	FL	59-3569218
Dade Prosthetics & Orthotics, Inc.	FL	59-2394368
Gulf Breeze Physical Therapy, Inc.	FL	59-2202550
Rehab Provider Network of Florida, Inc.	FL	65-0426653
Sports & Orthopedic Rehabilitation Services, Inc.	FL	59-2922487
Victoria Healthcare, Inc.	FL	25-1897325
Georgia Physical Therapy, Inc.	GA	58-1305983
GP Therapy, L.L.C.	GA	58-2216877
RehabClinics (GALAXY), Inc.	IL	36-3382403
Select Physical Therapy of Chicago, Inc.	IL	36-3662703
Indianapolis Physical Therapy and Sports Medicine, Inc.	IN	35-1436134
Rehab Provider Network Indiana, Inc.	IN	35-1900442
NovaCare Outpatient Rehabilitation, Inc.	KS	48-0916409
Kentucky Rehabilitation Services, Inc.	KY	61-1205126
Crowley Physical Therapy Clinic, Inc.	LA	72-1207656
Fine, Bryant & Wah, Inc.	MD	52-1022420
Rehab Provider Network East II, Inc.	MD	23-2796898
C.E.R. West, Inc.	MI	38-3027085
Metro Rehabilitation Services, Inc.	MI	38-2371931
Rehab Provider Network-Michigan, Inc.	MI	23-2804801
NovaCare Rehabilitation, Inc.	MN	36-4071272
Intensiva Hospital of Greater St. Louis, Inc.	MO	43-1726282
Select Specialty Hospital Ann Arbor, Inc.	MO	38-3389548
Select Specialty Hospital Beech Grove, Inc.	MO	43-1726278
Select Specialty Hospital Cincinnati, Inc.	MO	31-1574892
Select Specialty Hospital Evansville, Inc.	MO	43-1726283
Select Specialty Hospital Flint, Inc.	MO	38-3329100
Select Specialty Hospital Fort Smith, Inc.	MO	71-0813112
Select Specialty Hospital Fort Wayne, Inc.	MO	35-1994301
Select Specialty Hospital Johnstown, Inc.	MO	52-2110603
Select Specialty Hospital Kansas City, Inc.	MO	43-1732618
Select Specialty Hospital Macomb County, Inc.	MO	38-3345654
Select Specialty Hospital North Knoxville, Inc.	MO	62-1684861
Select Specialty Hospital Northeast Ohio, Inc.	MO	43-1742017
Select Specialty Hospital Omaha, Inc.	MO	47-0815478
Select Specialty Hospital Pontiac, Inc.	MO	38-3389212
Select Specialty Hospital Sioux Falls, Inc.	MO	91-1773396
Select Specialty Hospital Topeka, Inc.	MO	74-2826467
Select Specialty Hospital Western Michigan, Inc.	MO	38-3297128
Select Specialty Hospital Wichita, Inc.	MO	48-1196430
Select Specialty Hospital Wilmington, Inc.	MO	51-0382465
Select Specialty Hospital Youngstown, Inc.	MO	34-1880514
Pro Active Therapy of North Carolina, Inc.	NC	56-1818102
Pro Active Therapy, Inc.	NC	56-1859040
Rehab Provider Network of North Carolina, Inc.	NC	56-2099749
New England Rehabilitation Center of Southern New Hampshire, Inc.	NH	02-0385727

Table of Contents

Exact Name of Additional Registrants	Jurisdiction of Incorporation	I.R.S. Employer Identification Number
Rehab Provider Network of New Mexico, Inc.	NM	74-2796295
Select NovaCare KOP, Inc.	NV	23-2790203
Johnson Physical Therapy, Inc.	OH	34-1666735
NovaCare Rehabilitation of Ohio, Inc.	OH	34-1021034
Professional Therapeutic Services, Inc.	OH	31-0792815
Rehab Provider Network-Ohio, Inc.	OH	23-2804807
Pro Active Therapy of South Carolina, Inc.	SC	84-1699628
Professional Therapy Systems, Inc.	TN	62-1348358
The Rehab Group, Inc.	TN	62-1329329
The Rehab Group-Murfreesboro, LLC	TN	62-1591801
Rehab Provider Network of Texas, Inc.	TX	74-2796265
Theraworks, Inc.	TX	13-4227507
GH General-San Antonio, LLC	TX	26-2112902
GR General-Scottsdale, LLC	TX	27-3999078
Douglas Avery & Associates, Ltd.	VA	54-1323120
Pro Active Therapy of Virginia, Inc.	VA	58-2342213

Table of Contents

The information in this prospectus is not complete and may be changed. We may not sell these securities until the registration statement filed with the Securities and Exchange Commission is effective. This preliminary prospectus is not an offer to sell these securities and it is not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED AUGUST 14, 2013

PRELIMINARY 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 , 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 , 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 , 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 , 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 , 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.

7

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 $266.5 million of our 7$^{5}/_{8}$% 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 $275.0 million principal amount of our outstanding 7$^{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.

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 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)	Total	Year Ended December 31, 2011 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)	Total	Year Ended December 31, 2010 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 34.2% 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 54.7% 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	