SELECT MEDICAL CORP
Form 10-K405
March 05, 2002

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U.S. SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

For the Fiscal Year Ended December 31, 2001

or

Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
For the Period From _____ to _____

Commission File Number: 000-32499

SELECT MEDICAL CORPORATION
(Exact name of Registrant as specified in its charter)

Delaware	**23-2872718**
(State or other jurisdiction of incorporation or organization)	(I.R.S. employer identification number)

4716 Old Gettysburg Road
P.O. Box 2034
Mechanicsburg, Pennsylvania 17055

(Address of principal executive offices and zip code)

(717) 972-1100
(Registrant s telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act: None

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Securities registered pursuant to Section 12(g) of the Act: Common Stock, par value $.01 per share

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Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter periods as the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES X NO _____ YES X NO___

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. X

The aggregate market value of the registrant s voting common stock held by non-affiliates, based on the closing sale price of $12.66 per share as reported on The Nasdaq National Market on February 28, 2002 was $252,259,261.

As of February 28, 2002, the number of outstanding shares of the Registrant s Common Stock was 46,140,304.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of Registrant s Proxy Statement to be filed with the Securities and Exchange Commission for the Registrant s 2002 Annual Meeting are incorporated by reference into Part III.

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PART I

Forward-Looking Statements

This discussion contains forward-looking statements relating to the financial condition, results of operations, plans, objectives, future performance and business of Select Medical Corporation. These statements include, without limitation, statements preceded by, followed by or that include the words believes, expects, anticipates, estimates or similar expressions. These forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements due to factors including the following:

- general economic, demographic and business conditions, both nationally and in regions where we operate;
- the effect of existing or future governmental regulation and federal and state legislative and enforcement initiatives on our business including the Balanced Budget Act of 1997;
- a change in government reimbursement for our services that would affect our revenue;
- the failure of our long-term acute care hospitals to maintain their status as such, which could negatively impact our profitability;
- private third party payors of our services may undertake cost containment initiatives that would decrease our revenue;
- shortages in qualified nurses could increase our operating costs significantly;
- future acquisitions may use significant resources and expose us to unforeseen risks; and
- the effect of liability and other claims asserted against us.

For a discussion of these and other factors affecting our business, see the section captioned Risk Factors under Item 1. Business.

ITEM 1. BUSINESS

Overview

We are the largest operator of specialty acute care hospitals for long term stay patients in the United States based on the number of facilities. We are also the second largest operator of outpatient rehabilitation clinics in the United States based on the number of clinics. As of December 31, 2001, we operated 64 specialty acute care hospitals in 22 states and 717 outpatient rehabilitation clinics in 31 states, the District of Columbia and seven Canadian provinces. We began operations in 1997 under the leadership of our current management team, including our co-founders, Rocco A. Ortenzio and Robert A. Ortenzio, both of whom have significant experience in the healthcare industry. Under this leadership, we have grown our business through strategic acquisitions and internal development initiatives. For the year ended December 31, 2001, we had net operating revenues of $959.0 million and EBITDA (defined as net income (loss) before interest, income taxes, depreciation and amortization and special charges, other income, minority interest, and extraordinary items) of $112.0 million. In 2001, we earned 54% of our net operating revenues from our specialty acute care hospitals and 46% from our outpatient rehabilitation business. In April 2001, we completed a $98.3 million initial public offering of our common stock, and in June 2001 we completed a $175 million offering of 9 1/2% senior subordinated notes.

Specialty Acute Care Hospitals

As of December 31, 2001, we operated 64 specialty acute care hospitals, 56 of which were certified by the federal Medicare program as long term acute care hospitals. The remaining eight hospitals are in the process of becoming certified as long term acute care hospitals.

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These hospitals generally have 30 to 40 beds, and as of December 31, 2001, we operated a total of 2,307 available licensed beds. Our specialty acute care hospitals employ approximately 7,000 people, with the majority being registered or licensed nurses and respiratory therapists. In these specialty hospitals we treat patients with serious and often complex medical conditions such as respiratory failure, neuromuscular disorders, cardiac disorders, non-healing wounds, renal disorders and cancer.

Patients are admitted to our specialty acute care hospitals from general acute care hospitals in our markets. These general acute care hospitals are frequently not the optimum setting in which to treat these patients, because they require longer stays and a higher level of clinical attention than the typical acute care patient. Furthermore, general acute care hospitals reimbursement rates usually do not adequately compensate them for the treatment of this type of patient. The differences in clinical expertise and reimbursement rates provide general acute care hospitals and their physicians with incentives to discharge longer stay, medically complex patients to our facilities. As a result of these dynamics, we continually seek to increase our admissions by expanding and improving our relationships with the physicians and general acute care hospitals in our markets that refer patients to our facilities.

Below is a table that shows the distribution by medical condition of patients in our hospitals for the year ended December 31, 2001.

Medical Condition	Distribution of Patients
Respiratory failure	30%
Neuromuscular disorder	26
Cardiac disorder	12
Wound care	10
Renal disorder	5
Cancer	3
Other	14
Total	100%

When a patient is referred to one of our hospitals by a physician, case manager, health maintenance organization or insurance company, a nurse liaison makes an assessment to determine the degree of care required and expected length of stay. This initial patient assessment is critical to our ability to provide the appropriate level of patient care. Based on the determinations reached in this clinical assessment, an admission decision is made by the attending physician.

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

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

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Hospital within a Hospital Model

Of the 64 specialty hospitals we operated as of December 31, 2001, two are freestanding facilities and 62 are located in leased space within a host general acute care hospital. These leased spaces are separately licensed hospitals and are commonly referred to as a hospital within a hospital. As of December 31, 2001, we operated the largest number of specialty acute care hospitals operating with this hospital within a hospital model in the United States. We believe this model provides several advantages to patients, host hospitals, physicians and us.

The host hospital s patients benefit from being admitted to a setting specialized to meet their unique medical needs without having the disruption of being transferred to another location.

In addition to being provided with a place to transfer high-cost, long-stay patients, host hospitals benefit by receiving payments from us for rent and ancillary services.

Physicians affiliated with the host hospital are provided with the convenience of being able to monitor the progress of their patients without traveling to another location.

We benefit from the ability to operate specialty hospitals without the capital investment often associated with buying or building a freestanding facility. We also gain operating cost efficiencies by contracting with these host hospitals for selected services at discounted rates.

In addition, our specialty hospitals serve the broader community where they operate, treating patients from other general acute care hospitals in the local market. During the year ended December 31, 2001, 51% of the patients in our hospital within a hospital facilities were referred to us from general acute care hospitals other than the host hospitals.

Specialty Acute Care Hospital Strategy

Provide High Quality and Cost Effective Care

We believe that our patients benefit from our experience in addressing the complex medical needs of long term stay patients. A typical patient admitted to our specialty hospitals has multiple medical conditions and requires a high level of attention by our clinical staff. To effectively address the complex nature of our patients medical conditions, we have developed specialized treatment programs focused solely on their needs. We have also implemented specific staffing models that are designed to ensure that patients have access to the necessary level of clinical attention. These staffing models also allow us to allocate our resources efficiently, which reduces costs.

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

We continually monitor the quality of our patient care by several measures, including patient, payor and physician satisfaction, as well as clinical outcomes. Quality measures are collected monthly and reported quarterly and annually. In order to benchmark ourselves against other healthcare organizations, we have contracted with outside vendors to collect our clinical and patient satisfaction information and compare it to other healthcare organizations. The information collected is reported back to each hospital, to the corporate office, and directly to the Joint Commission on Accreditation of Healthcare Organizations. As of December 31, 2001, all but seven of our most recently opened hospitals had been accredited by the Joint Commission on Accreditation of Healthcare Organizations. See Government Regulations Licensure Accreditation.

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Reduce Costs

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

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

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

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

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

Increase Higher Margin Commercial Volume

We typically receive higher reimbursement rates from commercial insurers than we do from the federal Medicare program. As a result, we work to expand relationships with insurers to increase commercial patient volume. Each of our hospitals has employees who focus on commercial contracting initiatives within their regions. Contracting professionals in our central office work with these hospital employees to ensure that our corporate contracting standards are met. Our goal in commercial contracting is to give discounted rates to those commercial payors that we expect to add significant patient volume to our hospitals.

We believe that commercial payors seek to contract with our hospitals because we offer patients quality, cost effective care. Although the level of care we provide is complex and staff intensive, we typically have lower operating expenses than a freestanding general acute care facility s intensive care unit because of our hospital within a hospital operating model. General acute care hospitals incur substantial overhead costs in order to provide a wide array of patient services. We provide a much narrower range of patient services, and our hospitals within a hospital lease underutilized space within a general acute care hospital. These factors permit our hospitals to operate with lower overhead costs per patient than general acute care hospitals can. As a result of these lower costs, we offer more attractive rates to commercial payors. Additionally, we provide their enrollees with customized treatment programs not offered in traditional acute care facilities.

Develop New Specialty Acute Care Hospitals

Our goal is to open eight to ten new specialty acute care hospitals each year using our hospital within a hospital model. We seek to lease space from general acute care hospitals with leadership positions in the markets in which they operate. We have successfully contracted with various types of general hospitals, including for-profit, not-for-profit and university affiliated.

We have a dedicated development team with significant market experience. When we target a host hospital, the development team conducts an extensive review of all of its discharges to determine the number of referrals we would have likely received from it on a historical basis. Next, we review the host hospital s contracts with commercial insurers to determine the market s general reimbursement trends and payor mix. Ultimately, when we sign a lease with a new host hospital, the project is transitioned to our start-up team, which is experienced in preparing a specialty hospital for opening. The start-up team oversees facility improvements, equipment purchases, licensure procedures, and the recruitment of a full-time management team. After the facility is opened, responsibility for its management is transitioned to this new management team and our corporate operations group.

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During 1999, 2000 and 2001, we had completed the development and opening of the following 26 specialty acute care hospitals:

Hospital Name	City	State	Opening Date	Licensed Beds
SSH-Wilmington	Wilmington	DE	January 1999	35
SSH-Milwaukee	Milwaukee	WI	March 1999	34
SSH-Youngstown	Youngstown	OH	April 1999	31
SSH-Mesa	Mesa	AZ	September 1999	37
SSH-Battle Creek	Battle Creek	MI	October 1999	32
SSH-Omaha	Omaha	NE	October 1999	40
SSH-Gulfport	Gulfport	MS	January 2000	38
SSH-Denver	Denver	CO	February 2000	32
SSH-Tri-Cities	Bristol	TN	March 2000	25
SSH-St. Louis	St. Louis	MO	April 2000	33
SSH-Wichita	Wichita	KS	June 2000	35
SSH-San Antonio	San Antonio	TX	July 2000	34
SSH-Greensburg	Greensburg	PA	August 2000	31
SSH-Erie	Erie	PA	October 2000	35
SSH-North Dallas	Dallas	TX	November 2000	11
SSH-Fort Smith	Fort Smith	AR	December 2000	34
SSH-Birmingham	Birmingham	AL	February 2001	38
SSH-Jefferson Parish	New Orleans	LA	February 2001	34
SSH-Pontiac*	Pontiac	MI	June 2001	30
SSH-Camp Hill*	Camp Hill	PA	June 2001	31
SSH-Wyandotte*	Wyandotte	MI	September 2001	35
SSH-Charleston*	Charleston	WV	December 2001	32
SSH-Northwest Detroit*	Detroit	MI	December 2001	36
SSH-Scottsdale*	Scottsdale	AZ	December 2001	29
SSH-Bloomington*	Bloomington	IN	December 2001	30
SSH-Phoenix-Downtown*	Phoenix	AZ	December 2001	33
Total				845

* As of December 31, 2001, certification as a long term acute care hospital pending, subject to successful completion of a start-up period and/or surveys by the applicable licensure or certifying agencies. See Governmental Regulations Licensure Certification.

Grow Through Acquisitions

In addition to our development initiatives, we intend to grow our network of specialty hospitals through strategic acquisitions. When we acquire a hospital or a group of hospitals, a team of our professionals is responsible for formulating and executing an integration plan. We have generally been able to increase margins at acquired facilities by centralizing administrative functions and implementing our standardized staffing models and resource management programs. Since our inception in 1997 we have acquired and integrated 37 hospitals which all share our centralized billing and purchasing programs and operate standardized management information systems.

Outpatient Rehabilitation

We are the second largest operator of outpatient rehabilitation clinics in the United States, based on the number of our clinics. As of December 31, 2001, we operated 622 clinics throughout 31 states and the District of Columbia and 95 clinics in seven provinces throughout

Canada. Our outpatient rehabilitation division employs approximately 8,500 people. Typically, each of our clinics is located in a freestanding facility in a highly visible medical complex or retail location. In addition to providing therapy in our outpatient clinics, we provide rehabilitation management services and staffing on a contract basis to hospitals, schools, nursing facilities and home health agencies.

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In our clinics and through our contractual relationships, we provide physical, occupational and speech rehabilitation programs and services. Our patients are typically diagnosed with musculoskeletal impairments that restrict their ability to perform normal activities of daily living. These impairments are often associated with accidents, sports injuries, strokes, heart attacks and other medical conditions. Our rehabilitation programs and services are designed to help these patients minimize physical and cognitive impairments and maximize functional ability. We also design services to prevent short-term disabilities from becoming chronic conditions. Our rehabilitation services are provided by our professionals including licensed physical therapists, occupational therapists, certified athletic trainers, psychiatrists, speech-language pathologists, respiratory therapists, exercise physiologists and physical rehabilitation counselors.

Outpatient rehabilitation patients are generally referred or directed to our clinics by a physician, employer or health insurer who believes that a patient, employee or member can benefit from the level of therapy we provide in an outpatient setting. We believe that our services are attractive to healthcare payors who are seeking to provide the most cost-effective level of care to their members. In our outpatient rehabilitation division, approximately 91% of our net operating revenues come from rehabilitation management services and commercial payors, including healthcare insurers, managed care organizations and workers compensation programs. The balance of our reimbursement is derived from Medicare and other government sponsored programs.

We have grown our outpatient rehabilitation business through acquisitions and new development. Our most significant outpatient acquisition was the purchase of the Physical Rehabilitation and Occupational Health Division of NovaCare, Inc. in November of 1999 through which we added approximately 500 outpatient rehabilitation clinics.

Outpatient Strategy

Increase Market Share

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

Expand Rehabilitation Programs and Services. We assess the healthcare needs of our markets and implement programs and services targeted to meet the demands of the local community. In designing these programs we benefit from the knowledge we gain through our national network of clinics. This knowledge is used to design programs that optimize treatment methods and measure changes in health status, clinical outcomes and patient satisfaction. Our programs and services include, among others, back care and rehabilitation; work injury management and prevention; sports rehabilitation and athletic training; and health, safety and prevention programs. Other services that vary by location include aquatic therapy, speech therapy, neurological rehabilitation and post-treatment care.

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

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Optimize the Profitability of Our Payor Contracts

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

Grow Through New Development and Disciplined Acquisitions

We intend to open new clinics in our current markets where we believe that we can benefit from existing referral relationships and brand awareness to produce incremental growth. From time to time, we also intend to also evaluate acquisition opportunities that may enhance the scale of our business and expand our geographic reach. Potential acquisitions are closely evaluated and we seek to buy only those assets that are complementary to our business and that are expected to give us a strong return on our invested capital.

Maintain Strong Employee Relations

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

Sources of Net Operating Revenues

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

	Year ended December 31,		
Net Operating Revenues by Payor Source	**2001**	**2000**	**1999**
Commercial insurance (a)	51.4%	51.2%	34.6%
Medicare	37.3	35.1	48.1
Private and other (b)	10.2	12.4	15.7
Medicaid	1.1	1.3	1.6
Total	100.0%	100.0%	100.0%

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

(b) Includes self payors, Canadian revenues, contract management services and non-patient related payments.

Non-Government Sources

A majority of our net operating revenues come from private payor sources. These sources include insurance companies, workers compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies, and employers, as well as by patients

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directly. Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs, insurance companies, workers compensation companies, health maintenance organizations, preferred provider organizations, and other managed care companies, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. To further reduce their healthcare costs, an increasing number of insurance companies, health maintenance organizations, preferred provider organizations, and other managed care companies are negotiating discounted fee structures or fixed amounts for hospital services performed, rather than paying healthcare providers the amounts billed. If an increased number of insurance companies, health maintenance organizations, preferred provider organizations, and other managed care companies succeed in negotiating discounted fee structures or fixed amounts, our results of operations may be negatively affected.

Government Sources

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

Government Regulations

General

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

Licensure

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

Some states still require us to get approval under certificate of need regulations when we create, acquire or expand our facilities or services. If we fail to show public need and obtain approval in these states for our facilities, we may be subject to civil or even criminal penalties, lose our facility license or

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become ineligible for reimbursement if we proceed with our creation or acquisition of the new facility or service.

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

In some states, business corporations such as ours are restricted from practicing therapy through the direct employment of therapists. In those states, in order to comply with the restrictions imposed, we either contract to obtain therapy services from an entity permitted to employ therapists, or we manage the physical therapy practice owned by licensed therapists through which the therapy services are provided.

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

Accreditation. Our hospitals receive accreditation from the Joint Commission on Accreditation of Healthcare Organizations, a nationwide commission which establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. As of December 31, 2001, all but seven of our most recently opened hospitals had been accredited by the Joint Commission on Accreditation of Healthcare Organizations. Typically, we wait until our hospitals have been in operation for at least six months before applying for accreditation.

Overview of U.S. and State Government Reimbursements

Medicare. The Medicare program reimburses healthcare providers for services furnished to Medicare beneficiaries, which are generally persons age 65 and older, those who are chronically disabled, and those suffering from end stage renal disease. The program is governed by the Social Security Act of 1965 and is administered primarily by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services. For the year ended December 31, 2001, we received approximately 37.3% of our revenue from Medicare.

Long Term Acute Care Hospital Medicare Reimbursement. Our long-term acute care hospitals receive cost reimbursement, subject to a maximum cap. In contrast, Medicare inpatient costs for short-term acute care hospitals are reimbursed based upon a fixed payment amount per discharge using diagnosis related groups, commonly referred to as DRGs. The DRG payment under a prospective payment system is based upon the national average cost of treating a Medicare patient s condition. Although the average length of stay varies for each DRG, the average stay for all Medicare patients subject to prospective payment system is approximately six days. Thus, a prospective payment system creates an economic incentive for general short-term acute care hospitals to discharge medically complex Medicare patients as soon as clinically possible. We believe that the incentive for short-term acute care hospitals to discharge medically complex patients as soon as clinically possible creates a substantial referral source for our long term acute care hospitals.

Prior to qualifying as an exempt long-term acute care hospital, a new long-term acute care hospital initially receives payment under the acute care DRG-based reimbursement system. The long-term acute care hospital must continue to be paid DRGs for a minimum of six months while meeting

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certain Medicare long-term acute care hospital requirements, the most significant requirement being an average length of stay of more than 25 days. A hospital within a hospital facility must also establish itself as a hospital separate from its host by, among other things, obtaining separate licensure and certification, and limiting the services it purchases directly from its host to 15% of its total operating costs, or limiting the number of patient admissions from its host to 25% of total admissions.

Once the hospital qualifies for exempt status, long-term acute care hospitals currently are paid on the basis of Medicare reasonable costs per case subject to limits. Under cost-based reimbursement, costs accepted for reimbursement depend on a number of factors, including necessity, reasonableness, related-party principles and relatedness to patient care. Qualifying costs under Medicare s cost-reimbursement system typically include all operating costs and also capital costs that include interest expense, depreciation, amortization, and rental expense. Non-qualifying costs include marketing costs.

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

Congress has required the Secretary of the Department Health and Human Services to submit to Congress by October 1, 1999 a proposal to establish a prospective payment system for long-term acute care hospitals. This requirement was later extended until October 1, 2001, but no proposal has yet been submitted. Current law provides that a prospective payment system is to be effective for cost reporting periods beginning on or after October 1, 2002. When developing the prospective payment system, the December 2000 legislation requires the Secretary to examine the feasibility and impact of basing payment on the existing (or refined) short term acute hospital DRGs and the most recently available hospital discharge data. The Secretary is required to implement a prospective payment system using the existing short term acute hospital DRGs that have been modified where feasible, unless a different prospective payment system is implemented by October 1, 2002.

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

- schools;
- physician-directed clinics;
- hospitals; and
- skilled nursing facilities.

Essentially, all of our outpatient rehabilitation services are provided in rehabilitation agencies and are not provided through rehabilitation hospitals.

Prior to January 1, 1999, outpatient physical therapy, occupational therapy, and speech-language pathology services, which we refer to as outpatient therapy services, were reimbursed on the basis of the lower of 90% of reasonable costs or actual charges. Beginning January 1, 1999, outpatient rehabilitation services were reimbursed on a fee schedule, subject to annual limits. These outpatient rehabilitation providers receive a fixed fee for each procedure performed, which is adjusted by the geographical area in which the facility is located.

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In November 1999, the Balanced Budget Refinement Act provided some relief to providers by unbundling speech-language pathology services from other outpatient rehabilitation services. The following lists the current annual limits per Medicare beneficiary by services offered:

$1,500 for outpatient physical therapy services,

$1,500 for speech-language pathology services, and

$1,500 for outpatient occupational health services.

A moratorium has since been placed on these limits for the years 2000 through 2002 pending a review by the Secretary of the Department of Health and Human Services of the clinical needs of these patients and the appropriate level of limitations.

The Secretary of the U.S. Department of Health and Human Services is required to report the results of this review to Congress, together with any relevant legislative recommendations, potentially including revised coverage policies as an alternative to the therapy caps. The Secretary is also required to study therapy utilization patterns and report the findings to Congress. The December 2000 legislation also requires the Secretary to study the implications of eliminating the in the room supervision requirement for Medicare payment for physical therapy assistants who are supervised by physical therapists and the implications of this requirement on the physical therapy cap.

Historically, outpatient rehabilitation services have been subject to scrutiny by the Medicare program for, among other things, medical necessity for services, appropriate documentation for services, billing for group therapy, and Medicare billing practices by skilled nursing facilities. In addition, payment for rehabilitation services furnished to patients of skilled nursing facilities has been affected by the establishment of a Medicare prospective payment system and consolidated billing requirement for skilled nursing facilities. The resulting pressure on skilled nursing facilities to reduce their costs by negotiating lower payments to therapy providers, such as our contract therapy services, and the inability of the therapy providers to bill the Medicare program directly for their services have tended to reduce the amounts that rehabilitation providers can receive for services furnished to many skilled nursing facility residents.

Long Term Acute Care Hospital Medicaid Reimbursement. The Medicaid program is designed to provide medical assistance to individuals unable to afford care. The program is governed by the Social Security Act of 1965 and administered and funded jointly by each individual state government and the Centers for Medicare & Medicaid Services. Most state Medicaid payments are made under a prospective payment system or under programs that negotiate payment levels with individual hospitals. In addition, Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies and certain government funding limitations, all of which may materially increase or decrease the level of program payments to our hospitals. Medicaid payments accounted for about 1.7% of our long term acute care net operating revenues for the year ended December 31, 2001.

Workers Compensation. Workers compensation programs accounted for approximately 18.5% of our revenue from outpatient rehabilitation services for the year ended December 31, 2001. Workers compensation is a state-mandated, comprehensive insurance program that requires employers to fund or insure medical expenses, lost wages and other costs resulting from work-related injuries and illnesses. Workers compensation benefits and arrangements vary on a state-by-state basis and are often highly complex. In some states, payment for services covered by workers compensation programs are subject to cost containment features, such as requirements that all workers compensation injuries be treated through a managed care program, or the imposition of payment caps. In addition, these workers compensation programs may impose requirements that affect the operations of our outpatient rehabilitation services.

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Canadian Reimbursement

The Canada Health Act governs the Canadian healthcare system, and provides for federal funding to be transferred to provincial health systems. Our Canadian outpatient rehabilitation clinics receive funding primarily through workers compensation benefits, which are administered by provincial workers compensation boards. The workers compensation boards assess employers fees based on their industry and past claims history. These fees are then distributed independently by each provincial workers compensation board as payments for healthcare services. Therefore, the payments each of our rehabilitation clinics receive for similar services can vary substantially because of the different payment regulations in each province. For the year ended December 31, 2001, we derived about 3.9% of our total net operating revenues from our operations in Canada.

Other Healthcare Regulations

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

From time to time, various federal and state agencies, such as the Department of Health and Human Services, issue a variety of pronouncements, including fraud alerts, the Office of Inspector General s Annual Work Plan and other reports, identifying practices that may be subject to heightened scrutiny. These pronouncements can identify issues relating to long-term acute care hospitals or outpatient rehabilitation services or providers. For example, the Office of Inspector General s 2002 Work Plan describes the government s intention to study providers use of satellite units and the hospital within a hospital model for furnishing long term acute care hospital services and the effectiveness of the Centers for Medicare & Medicaid Services payment safeguards relating to such services. We monitor these issuances to ensure that our resources are focused on compliance with areas targeted for enforcement.

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

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

Section 1877 of the Social Security Act, commonly known as the Stark Law, prohibits referrals for designated health services by physicians under the Medicare and Medicaid programs to other healthcare providers in which the physicians have an ownership or compensation arrangement unless an exception applies. Sanctions for violating the Stark Law include civil monetary penalties of up

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to $15,000 per prohibited service provided, assessments equal to twice the dollar value of each such service provided and exclusion from the Medicare and Medicaid programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. In addition, many states have adopted or may adopt similar anti-kickback or anti-self-referral statutes. Some of these statutes prohibit the payment or receipt of remuneration for the referral of patients, regardless of the source of the payment for the care.

Medicare-participating hospitals are also subject to the Emergency Medical Treatment and Active Labor Act, an anti-dumping statute commonly referred to as EMTALA. If a patient with an emergency condition enters a hospital with an emergency department, this federal law requires the hospital to stabilize a patient suffering from this emergency condition or make an appropriate transfer of the patient to a facility that can handle the condition. There are severe penalties under EMTALA if a hospital refuses to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient s ability to pay. Although none of our hospitals operate emergency departments, the government has interpreted EMTALA broadly to cover situations in which any type of hospital inpatient is transferred in an unstable condition.

Provider-based Status. The designation provider-based refers to circumstances in which a subordinate facility (*e.g.*, a separately-certified Medicare provider, a department of a provider or a satellite facility) is treated as part of a provider for Medicare payment purposes. In these cases, the services of the subordinate facility are included on the main provider s cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that they are shared. We operate seven long term acute care hospitals that are treated as provider-based satellites of certain of our other facilities, and we provide rehabilitation management and staffing services to hospital rehabilitation departments that may be treated as provider-based.

Health Information Practices. In addition to broadening the scope of the fraud and abuse laws, the Health Insurance Portability and Accountability Act also mandates, among other things, the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the healthcare industry. Among the standards that the Department of Health and Human Services will adopt pursuant to the Health Insurance Portability and Accountability Act are standards for the following:

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

Although the Health Insurance Portability and Accountability Act was intended ultimately to reduce administrative expenses and burdens faced within the healthcare industry, we believe the law will initially bring about significant and, in some cases, costly changes. The Department of Health and Human Services has finalized two rules to date mandating the use of new standards with respect to certain healthcare transactions and health information. The first rule requires the use of uniform standards for common healthcare transactions, including healthcare claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits.

Second, the Department of Health and Human Services has finalized new standards relating to the privacy of individually identifiably health information. These standards not only require our compliance with rules governing the use and disclosure of protected health information, but they also

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require us to impose those rules, by contract, on any business associate to whom such information is disclosed. Rules governing the security of health information and setting standards for electronic signatures have been proposed but have not yet been issued in final form.

The Department of Health and Human Services finalized the new transaction standards on August 17, 2000, with a compliance date of October 16, 2002. In December 2001, Congress enacted a law that delays the effective date until October 16, 2003 for entities that submit a plan for being compliant by that date. We have not yet determined whether we will seek to delay our effective date. The privacy standards under the Health Insurance Portability and Accountability Act were issued on December 28, 2000, and became effective on April 14, 2001. We will be required to comply with them by April 14, 2003. Once the security regulations are issued in final form, we will have approximately two years to be fully compliant. Sanctions for failing to comply with the Health Insurance Portability and Accountability Act include criminal penalties, civil sanctions, and exclusion from the Medicare program.

We are evaluating the effect of the Health Insurance Portability and Accountability Act and have developed a task force to address the Health Insurance Portability and Accountability Act regulations as they have been adopted to date and as additional standards are adopted in the coming months. At this time, we anticipate that we will be able to fully comply with those Health Insurance Portability and Accountability Act requirements that have been adopted. However, wNew Roman" SIZE="1">**Bonus**
Target Equity
Compensation

Chief Executive Officer

93.8% 6.2% 0%

President & CEO (Bank)

89.3% 10.7% 0%

Executive Vice Presidents

89.3% 10.7% 0%

In allocating compensation among base salary, annual bonus compensation and equity compensation, the Committee believes that the compensation of senior-most levels of management should begin with a base level. Bonus and equity compensation should be awarded based on Company performance. Base salaries generally represent a large portion of the executive officers total cash compensation and are generally considered to be average relative to the Company s peer financial institutions. Base salaries are also based on individual performance components.

The Committee believes that the top levels of management have the greatest ability to influence Company performance. Therefore, the Committee bases annual bonus compensation on Bank performance. When the Bank s performance is above budget, the top levels of management are rewarded. Likewise when the Bank s performance does not meet expectations, the top levels of management receive a lower bonus. In 2008, the target bonus for the NEOs was 12% of annual base salary. However, the Bank goals were not met and the bonuses actually paid for 2008 were between 6% and 8% of base salary.

In 2008, the overall compensation for executives did not include equity compensation awards. The Company had a stock option plan in place pursuant to which stock option awards could be granted and the Committee chose to grant stock options in 2007. Prior to 2007, the Committee did not grant equity compensation to executive officers for several years because the cost associated with offering equity compensation had increased due to the 2006 financial reporting requirements outlined in the Statement of Financial Accounting Standards (SFAS) No. 123R, Share-Based Payment . The Committee granted options in 2007 in an effort to retain executive talent within the organization. The stock option plan expired March 9, 2008 and has not yet been replaced.

Base Salaries

The Committee wants to provide executive management with a level of assured cash compensation in the form of base salary given their professional status and accomplishments. The Company has a compensation structure with salary ranges for management including the CEO and other executive managers. These ranges are based on peer compensation analysis discussed above. The last adjustments to the ranges were made in July 2008 in an effort to remain fair and reasonable within the Company s marketplace. The structure is designed to recruit and retain qualified personnel and is reviewed on an annual basis by the Committee to determine if adjustments to the ranges are appropriate. For 2008, the base salary ranges used for setting salaries were $175 thousand to $350 thousand for the CEO and from $120 thousand to $350 thousand for the other NEOs.

Each February, the Committee recommends the base salary of the CEO within the established range to the Board of Directors. Within this range, the CEO s base salary is determined using the peer compensation analysis in addition to the CEO s individual and Company performance during the prior year. The base salary of the CEO as of March 1, 2008 was $300,000, which reflected an 18.11% increase in base salary from 2007. This increase reflected the Committee s and the Board s view that the CEO s individual performance and Company performance, as well as the CEO s base salary level in comparison to our peer institutions, warranted an increase. The performance goals evaluated included, but were not limited to return on average assets, return on average equity, net income, asset quality, and deposit and loan growth. The Committee also gave consideration to the CEO s expected future contributions, length of service and standing within the local banking communities and general economic conditions.

For the executive officers other than the CEO, each February the Committee recommends the executive s base salary within the established range to the Board of Directors, based on the recommendation of the CEO, President & CEO (Bank), President & CEO (Trust) and the Senior Vice President of Human Resources. The base salaries of the other executive officers are determined using the peer compensation analysis in addition to the officer s individual performance during the prior year and the Company s performance during the prior year, based on the same performance objectives discussed above with respect to the CEO.

Bonuses

The bonus incentive plan, which is referred to as the Management Incentive Plan, is designed to motivate and reward participants for the achievement of fiscal year financial and non-financial objectives that directly contribute to the overall success of the Company. Non-commissioned exempt employees, except the CEO, hired no later than the last day of the prior year and employed through year-end of the current year are eligible to participate in the annual bonus incentive plan. This plan includes all of the Company s NEOs except the CEO.

The target incentive award is the amount that the participant is eligible to receive if the combined, weighted performance against the plan objectives equals an overall achievement level. Goals and incentive awards are established under the plan for the Company and are based on the operating budget. Depending upon the participant s officer level in the Company for 2008, target incentive awards ranged from 3% to 12% of annualized base salary. All the NEOs, except the CEO, in 2008 were eligible for a bonus award equaling 12% of annualized base salary if all objectives were met, or a lower amount if not all of the objectives were met. The CEO s bonus award is determined in February after year-end so that the Committee can evaluate year-end results. The bonus awards for the other NEOs are determined before the end of the year and are based on actual year-to-date and estimated end-of-year performance of the established goals.

The bonus award for the CEO under the plan is both objectively and subjectively determined. The Committee considers the general performance of the Company in the prior year as well as the incentive award earned by the Executive Vice Presidents for the prior year to determine an appropriate bonus for the CEO. The Committee considers each of these factors but does not assign a specific value to any factor. For 2007 the CEO s bonus was $19,160**,** which amounted to 7.6% of his 2007 base salary.

As mentioned above, the Company did not meet its goals under the bonus incentive plan in 2008. However, the Committee felt that the compensation granted to the CEO for 2008 performance should be based on past performance, and the possibility and potential for positive change in earnings for 2009. For 2008, the CEO s bonus was $15,000, which amounted to 5.13% of his 2008 salary and was paid in 2009.

The bonus awards under the bonus incentive plan for the Bank NEOs other than the CEO are objectively determined, based on achieving predetermined financial goals such as deposit, loan and income growth during the year. The Board of Directors has discretion to increase or decrease the award based on non-financial goal achievements. A list of various projects and the completion status is reviewed in November of each year. Based on the status of these projects to the goals established at the beginning of the year, the Board of Directors determines the non-financial goal achievement level. In 2008 this level was set at 80%. Because the Bank did not meet its goal under the bonus incentive plan in 2008, the bonus awards to the NEOs equaled between 6% and 8% of their annualized salaries rather than the target bonus awards of 12% of annualized salary.

Equity Compensation

Historically, the primary form of equity compensation has been incentive stock options. The Company used stock options because of the favorable accounting treatment and the near universal expectation by employees in the industry that they would receive stock options. The Company had not issued stock options since August 2004 until October 2007. Beginning in 2006 the accounting treatment for stock options changed as a result of SFAS No. 123R, making the accounting treatment of stock options less attractive to the Company; however, with the Committee s approval, the Company issued stock options using a multi-year vesting approach which spread the financial impact to the Company over a five-year period. There were no incentive stock options granted in 2008. The Company s stock option plan expired in 2008. No additional equity awards may be granted until the Company establishes a new stock incentive plan, which will require shareholder approval.

Severance Pay

The Company does not have any employment contracts with our NEOs. Therefore, their severance pay is determined on a case-by-case basis by the Committee and the Board of Directors.

Perquisites and Other Compensation

None of the NEOs received perquisites or other personal benefits in excess of $10,000 in 2008.

The Committee reviews any perquisites that its CEO and the other NEOs may receive on an annual basis. In general, the Company does not provide its executives with many of the types of perquisites that other companies offer their executives, such as personal use of a company vehicle or vehicle allowances. In addition to the base salary and incentive compensation described above, the Company provides its NEOs with the same benefit package available to all of its salaried employees. This package includes:

- Medical and dental insurance (portion of costs);
- Medical/dependent care reimbursement plan;
- Life insurance;
- Short and Long-term disability insurance; and
- Participation in the Company s 401(k) plan, including the Company match.

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Until September 30, 2006, the Company maintained a traditional defined benefit pension plan (the Employee Retirement Plan). However, since September 30, 2006, no new participants are being added to the plan, and the benefits under the plan for existing participants have been frozen. As a counterbalance, the Committee enhanced the 401(k) plan effective January 1, 2007. The Company provides an immediately vested safe harbor match of 100% up to 4% of an employee s deferral contribution.

The Company also offers post-retirement life insurance benefits to senior management in the form of a split dollar plan. The Company owns the policy and cash values provide an annual return to the Company while providing a term insurance benefit to the individual employee. In 2002, the Committee recommended and approved a plan to provide pre- and post-retirement life insurance benefits to the senior officer group utilizing Bank Owned Life Insurance (BOLI) with a portion of the death benefit endorsed to the insured officer through a split dollar agreement. All the NEOs took advantage of this benefit upon eligibility except for Robert F. Shuford, Jr. who is covered under a term life insurance policy provided by the Company in an amount equal to two times his annual base compensation. The amount endorsed under the BOLI equaled 300% of the current base salary, with the amount to increase 4% each year through termination or retirement. If the officer remained in the Company s employment through retirement, a post-retirement benefit equal to 50% of the benefit provided just prior to retirement would be provided.

Due to the new accounting rules issued by The Emerging Issues Task Force of the Financial Accounting Standards Board, the economics of the BOLI have changed for the Company. In 2008, in lieu of the BOLI, the NEOs that were fully vested in the split dollar plan became eligible to participate in the Management Section 162 Life Insurance Plan which offers key executives permanent life insurance protection which they own and control from inception of the policy. The premiums to purchase the 162 Life Insurance Plan were included in the NEO s compensation in 2008 as indicated in footnote 3 of the All Other Compensation table on page 19.

Relocation Benefits

The Company does not have a policy providing relocation benefits.

Deductibility of Executive Compensation

As part of its role, the Committee reviews and considers the deductibility of executive compensation under Section 162(m) of the Internal Revenue Code, which provides that the Company may not deduct compensation of more than $1 million that is paid to certain individuals. To date, the Company s compensation practices have not caused this limit to be reached or exceeded.

Stock Ownership Guidelines

Although the Committee believes that significant levels of stock ownership will assist in retaining qualified and motivated executive officers, the Committee has not established stock ownership guidelines for any of its officers.

The following table summarizes the total compensation for the years ended December 31, 2008, December 31, 2007 and December 31, 2006 of the Company s CEO, Executive Vice President and CFO (Bank), and each of the Company s next three most highly compensated officers.

Summary Compensation Table

Fiscal 2006, 2007 & 2008

Name and Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards ($)	Option Awards ($) (2)	Non-Equity Incentive Plan Compensation (3) ($)	Change in Pension Value and Nonqualified Deferred Compensation Earnings ($) (4)	All Other Compensation ($) (5)	Total ($)
Robert F. Shuford, Sr., Chairman, President & CEO (Company)	2008	$ 292,333	$ 15,000		$ 5,410	$ 4,206	$ 13,438	$ 97,802	$ 428,189
	2007	$ 252,000 (1)	$ 19,160		$ 1,211	$ 4,712	$ 29,971	$ 17,191	$ 324,245
	2006	$ 240,867	$ 11,100			$ 3,738	$ 12,467	$ 14,472	$ 282,644
Laurie D. Grabow EVP/CFO (Bank)	2008	$ 145,000			$ 3,395	$ 13,686	$ 5,163	$ 70,048	$ 237,292
	2007	$ 134,967			$ 760	$ 13,321		$ 8,352	$ 157,400
	2006	$ 124,000				$ 8,138	$ 9,421	$ 6,331	$ 147,890
Louis G. Morris, President & CEO (Bank)	2008	$ 243,333			$ 5,410	$ 18,501	$ 10,775	$ 84,867	$ 362,886
	2007	$ 208,333 (1)			$ 1,211	$ 20,562		$ 13,075	$ 243,181
	2006	$ 199,533				$ 13,017	$ 20,896	$ 10,332	$ 243,778
Margaret P. Causby EVP/ RMO (Bank)	2008	$ 149,167			$ 3,395	$ 14,079	$ 2,721	$ 82,627	$ 251,989
	2007	$ 144,417			$ 760	$ 14,254		$ 9,325	$ 168,756

Margaret P. Causby Continued	2006	$ 140,583		$ 9,226	$ 7,610	$ 8,104	$ 165,523
Robert F. Shuford, Jr., COO (Bank)	2008	$ 148,333	$ 3,395	$ 14,001	$ 446	$ 8,530	$ 174,705

(1) Robert F. Shuford, Sr., and Louis G. Morris serve as inside directors. In 2006, $8,200 and $4,800 were added respectively to the base salary of Mr. Shuford, Sr. and Mr. Morris, to compensate them for their Board service in lieu of paying them separate Board fees in the future.

(2) The amounts in this column reflect the dollar amount expensed for financial statement reporting purposes for the fiscal years ended December 31, 2008, 2007 and 2006 respectively, in accordance with SFAS No. 123R for stock option awards pursuant to the 1998 Stock Option Plan. There were no option awards granted in 2006 or 2008.

(3) The amounts in this column reflect the dollar amounts expensed for the non-equity bonus incentive plan and the cash portion of the profit sharing plan. Messrs. Morris, and Shuford, Jr. and Messes. Causby and Grabow participate in the Company s bonus incentive plan described in the Compensation Discussion and Analysis. Mr. Shuford, Sr. also participates in the bonus incentive plan, but his awards for 2006, 2007 and 2008 did not satisfy the criteria for a non-equity incentive plan award, so his bonus incentive plan awards for 2006, 2007 and 2008 are reported in the bonus column. All the NEO s participate in the profit sharing plan.

(4) The amounts in this column reflect the change in the actuarial present value of the named executive officer s benefits under the Employee Retirement Plan determined using interest rate and mortality rate assumptions consistent with those used in Note 12 in the Company s Annual Report on Form 10-K to the Company s audited financial statements for the years ended December 31, 2006, 2007 and 2008, and include amounts which the named executive officer may not currently be entitled to receive because such amounts are not vested. The Company does not offer any nonqualified deferred compensation plans.

(5) Amounts shown in the All Other Compensation column are detailed in the chart below.

All Other Compensation Fiscal 2008

Name	Perquisites and Other Personal Benefits (1)	Tax Gross-Ups and Reimbursements	Dividends Paid on Stock Awards	Discounted Securities Purchases	Payments/ Accruals on Termination Plans	Company Contributions to Defined Contribution Plans (2)	Company-Paid Life Insurance Premiums (3)	Other
Robert F. Shuford, Sr.						$ 15,894	$ 81,908	
Laurie D. Grabow						$ 7,884	$ 62,164	
Louis G. Morris						$ 13,230	$ 71,637	
Margaret P. Causby						$ 8,110	$ 74,517	
Robert F. Shuford, Jr.						$ 8,065	$ 465	

(1) None of the NEOs received perquisites or other personal benefits in excess of $10,000 in 2008.
(2) Reflects 401(k) plan Company deferral match and a profit sharing contribution.
(3) The amounts in this column reflect the amounts paid for BOLI as follows: Mr. Shuford, Sr. $0; Mrs. Grabow, $84; Mr. Morris, $288; and Mrs. Causby, $362. In addition the amounts paid for the conversion of the split dollar life insurance plan to the 162 life insurance plan are included: Mr. Shuford, Sr., $81,908; Mrs. Grabow, $62,080; Mr. Morris, $71,349; Mrs. Causby, $74,155. Mr. Shuford, Jr. did not participate in the BOLI plan. His amount in this column reflects the amount of insurance premiums the Company paid for 2008 in connection with Mr. Shuford, Jr. s term life insurance policy.

The following table summarizes certain information with respect the Company s annual bonus incentive plan and reflects the amounts that could have been paid under each such award for 2008. No option awards were granted in 2008.

Grants of Plan-Based Awards

Fiscal 2008

Name	Grant Date	Estimated Possible Payouts Under Non-Equity Incentive Plan Awards (1)			Estimated Possible Payouts Under Equity Incentive Plan Awards			All Other Stock Awards: Number of Shares of Stock or Units	All Other Option Awards: Number of Securities Underlying Options	Exercise or Base Price of Option Awards	Grant Date Fair Value of Stock and Option Awards
		($) Threshold	($) Target	($) Maximum	(#) Threshold	(#) Target	(#) Maximum	(#)	(#)	($/Sh)	($)
Robert F. Shuford, Sr.											
Laurie D. Grabow		$ 11,600	$ 17,400	$ 40,600							
Louis G. Morris		$ 19,467	$ 29,200	$ 68,133							
Margaret P. Causby		$ 11,933	$ 17,900	$ 41,767							
Robert F. Shuford, Jr.		$ 11,867	$ 17,800	$ 41,533							

(1) Actual amounts earned are reported as Non-Equity Incentive Plan Compensation in the Summary Compensation Table. The annual bonus incentive plan is designed to motivate and reward participants for the achievement of fiscal year financial and non-financial objectives that directly contribute to the success of the Company. Participants are paid at the end of the year for that same year s performance. The threshold is the amount received if 60% of the objectives are met. The target is the amount that the participant receives if all targeted achievements are met and the maximum is the amount received if all objectives are exceeded and reach the maximum level of performance allowed by the program s design. Depending on the participant s officer level in the Company, incentives ranged from 0% to 12% of annual base salary for 2008. All exempt employees are eligible for this program except Robert F. Shuford, Sr., CEO.

The following table includes certain information with respect to all unexercised options held by the NEOs at December 31, 2008. None of the NEOs held any unvested restricted stock at December 31, 2008.

Outstanding Equity Awards at 2008 Fiscal Year-End

	Option Awards					Stock Awards			
Name	Number of Securities Underlying Unexercised Options (#)(1) Exercisable	Number of Securities Underlying Unexercised Options (#) Unexercisable	Equity Incentive Plan Awards: Number of Securities Underlying Unexercised Unearned Options (#)	Option Exercise Price ($)	Option Expiration Date	Number of Shares or Units of Stock That Have Not Vested (#)	Market Value of Shares or Units of Stock That Have Not Vested ($)	Equity Incentive Plan Awards: Number of Unearned Shares, Units or Other Rights That Have Not Vested (#)	Equity Incentive Plan Awards: Market or Payout Value of Unearned Shares, Units or Other Rights That Have Not Vested ($)
Robert F. Shuford, Sr.	996	3,984		$ 20.05	10/18/2017				
	4,125			$ 23.83	8/9/2014				
	7,500			$ 12.91	8/13/2011				
Laurie D. Grabow	625	2,500		$ 20.05	10/18/2017				
	3,125			$ 23.83	8/9/2014				
Louis G. Morris	996	3,984		$ 20.05	10/18/2017				
	4,125			$ 23.83	8/9/2014				
	7,020			$ 12.91	8/13/2011				
	7,500			$ 9.81	9/11/2010				
Margaret P. Causby	625	2,500		$ 20.05	10/18/2017				
	3,125			$ 23.83	8/9/2014				
	4,687			$ 12.91	8/13/2011				
Robert F. Shuford, Jr.	625	2,500		$ 20.05	10/18/2017				
	3,125			$ 23.83	8/9/2014				

(1) All outstanding options with expiration dates of August 9, 2014, August 13, 2011 and September 11, 2010 were vested on the first anniversary of the grant date. Options expiring on October 18, 2017 are vested equally over a five year period beginning October 18, 2008 and will be fully vested on October 18, 2012.

The following table summarizes certain information with respect to options that were exercised by the NEOs during 2008. None of our NEOs held restricted stock that vested during 2008.

Option Exercises and Stock Vested

	Option Awards		Stock Awards	
Name	**Number of Shares Acquired on Exercise (#)**	**Value Realized on Exercise ($)(1)**	**Number of Shares Acquired on Vesting (#)**	**Value Realized on Vesting ($)**
Robert F. Shuford, Sr.				
Laurie D. Grabow				
Louis G. Morris				
Margaret P. Causby				
Robert F. Shuford, Jr.	2,812	$ 11,397		

(1) Value realized is the gross number of options exercised multiplied by difference between the closing market price of the Company s common stock on the date of exercise and the exercise price.

Securities Authorized for Issuance Under Equity Compensation Plans

The following table sets forth information as of December 31, 2008 with respect to certain compensation plans under which equity securities of the Company are authorized for issuance.

Equity Compensation Plan Information

Plan Category	**(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights**	**(b) Weighted-average exercise price of outstanding options, warrants and rights**	**(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)**
Equity compensation plans approved by stockholders [1]	286,899	$ 18.25	-0-[2]
Equity compensation plans not approved by stockholders			
Total	286,899	$ 18.25	-0-

(1) These plans consist of the 1989 Stock Option Plan and the 1998 Stock Option Plan.

(2) Includes zero shares available to be granted in the form of options under the 1989 Stock Option Plan, and zero shares available to be granted in the form of options under the 1998 Stock Option Plan. The 1989 & 1998 Stock Option Plans are both expired and no further awards may be granted under the plans.

The following table shows the present value of accumulated benefits payable to each of the NEOs, including the number of years of service credited to each NEO under the Employee Retirement Plan, which is described in more detail in the Compensation Discussion and Analysis.

The Employee Retirement Plan, which covers substantially all full-time employees of the Company and its subsidiaries who had completed one year of service as of September 30, 2006. This plan was frozen as of September 30, 2006. The present value of the accumulated benefit is the value that the officer will receive at retirement or termination of the plan whichever comes first. A participant s monthly retirement benefit (if he or she has 25 years of benefit service at his normal retirement date) is 20% of his final five-year s average salary plus 15% of final five-year s average salary in excess of the participant s Social Security Covered Pay. The Social Security Covered Pay is the average pay of the calendar year prior to the year the participant attains his Social Security Retirement Age. If the participant has less than 25 years of benefit service at his normal retirement date, the participant s monthly retirement benefit will be actuarially reduced by 1/25 for each year of benefit service less than 25 years. Cash benefits under the plan generally commence on retirement, death or other termination of employment and are payable in various forms at the election of the participant.

Pension Benefits

Fiscal 2008

Name	Plan Name	Number of Years Credited Service (#)	Present Value of Accumulated Benefit ($) (1)	Payments During Last Fiscal Year ($)
Robert F. Shuford, Sr.	Employee Retirement Plan	42	$ 717,415	
Laurie D. Grabow	Employee Retirement Plan	21	$ 92,271	
Louis G. Morris	Employee Retirement Plan	24	$ 219,708	
Margaret P. Causby	Employee Retirement Plan	38	$ 231,186	
Robert F. Shuford, Jr.	Employee Retirement Plan	8	$ 14,865	

(1) The amounts in this column reflect the actuarial present value of each NEO s accumulated benefit under the Employee Retirement Plan determined using interest rate and mortality rate assumptions consistent with those used in Note 12 to the Company s audited financial statements for the year ended December 31, 2008, and include amounts which the named executive officer may not currently be entitled to receive because such amounts are not vested.

Nonqualified Deferred Compensation

The Company does not offer any nonqualified deferred compensation plans.

Potential Payments upon Termination or Change-in-Control

The Company has not entered into employment agreements with any of its executive officers. Therefore, the only payments upon termination that the NEO s would have received, assuming a termination as of December 31, 2008, would have been salary earned through December 31, 2008 and any vested 401(k) Plan or Employee Retirement Plan payouts, which payments would not have been increased or accelerated due to the termination. Our stock option agreements provide that upon a change-in-control, all unvested stock options will immediately vest, provided

they were granted not less than six months prior to a change in control public announcement. This accelerated vesting occurs with respect to all stock option awards granted by the Company, and not only those granted to the named executive officers. If the change-in-control had occurred on December 31, 2008,

our named executive officers would not have received any value from this accelerated vesting because the exercise price of all unvested options exceeded the $19.13 closing price per share of the Company s common stock on December 31, 2008.

The following table provides compensation information for the year ended December 31, 2008 for each non-employee member of the Company s Board of Directors.

Director Compensation

Fiscal 2008

Name (1)	Fees Earned or Paid in Cash ($)	Stock Awards ($)	Option Awards ($) (2)	Non-Equity Incentive Plan Compensation ($)	Change in Pension Value and Nonqualified Deferred Compensation Earnings	All Other Compensation ($)	Total ($)
David L. Bernd	$ 11,500		$ 1,370				$ 12,870
James Reade Chisman	$ 18,050		$ 1,370				$ 19,420
Dr. Richard F. Clark	$ 21,050		$ 1,370				$ 22,420
Russell Smith Evans, Jr.	$ 17,550		$ 1,370				$ 18,920
Dr. Arthur D. Greene	$ 17,000		$ 1,370				$ 18,370
Stephen D. Harris	$ 15,550		$ 1,370				$ 16,920
John Cabot Ishon	$ 23,900		$ 1,370				$ 25,270
Eugene M. Jordan (3)	$ 12,450		$ 1,370				$ 13,820
John B. Morgan, II	$ 16,800		$ 1,370				$ 18,170
Robert L. Riddle	$ 20,750		$ 1,370				$ 22,120
Dr. H. Robert Schappert	$ 16,600		$ 1,370				$ 17,970
Ellen Clark Thacker	$ 20,250		$ 1,370				$ 21,620
Joseph R. Witt (4)	$ 21,300		$ 1,370				$ 22,670
Melvin R. Zimm	$ 13,800		$ 1,370				$ 15,170

(1) Robert F. Shuford, Sr., the Company s CEO, Louis G. Morris, the Bank s President and CEO, and Robert F. Shuford, Jr., the Bank s COO, are not included in this table as they are employees of the Company and the Bank. Their compensation, including any compensation for Board service, is reported in the Summary Compensation Table on page 18.

As of December 31, 2008, each director had the following number of stock options outstanding: Shuford, Sr. 16,605; Bernd 1,250; Chisman 2,500; Clark 6,250; Evans 6,250; Greene 6,250; Harris 6,250; Ishon 6,250; Jordan 2,500; Morgan 4,375; Morris 23,625; Riddle 1,250; Schappert 2,500; Thacker 2,500; Witt 1,250; and Zimm 2,500.

(2) The amounts in this column reflect the dollar amount expensed for financial statement reporting purposes for the fiscal years ended December 31, 2008 in accordance with SFAS No. 123R for stock option awards pursuant to the 1998 Stock Option Plan. There were no option awards granted in 2006 or 2008.
(3) Mr. Jordan served as a director until his passing on November 16, 2008.
(4) Mr. Witt became an employee of the Company December 1, 2008.

The fees paid in cash were for non-employee director attendance at Board meetings and committee meetings. In addition, each non-employee director was paid an annual retainer fee. Non-employee directors of the Bank and Trust Company receive $400 and $250, respectively, for each Board meeting they attend. The non-employee directors of the Bank and Trust Company received $150 for each committee meeting they attend. In addition, non-employee directors of the Bank and Trust Company receive an annual retainer fee of $8,000 and $3,000, respectively, except that directors serving on the Bank board who also serve on the Trust Company board receive an additional $1,000 instead of $3,000 annual retainer for serving on the Trust Company board. In addition, the chairman of the Audit Committee received an additional $2,000 annual retainer. Non-employee directors were eligible to receive awards of non-qualified stock options under the Company s 1998 Stock Option Plan, although the 1998 Stock Option Plan expired on March 9, 2008, and no further awards may be granted under the plan. The Company also pays for all directors and their spouses to attend Board seminars. The Executive Committee discusses Board compensation on an annual basis based on an informal survey of board compensation paid by peer financial institutions. Any recommendations for changes in Board compensation by the Executive Committee are presented to the full Board for approval.

Prior to March 2006, directors who were also employees of the Company or its subsidiaries received the stated fees for attendance at Board meetings, but did not receive any fees for committee meetings and did not receive annual retainer fees. Effective March 2006, Mr. Shuford, Sr. and Mr. Morris each received an increase to base salary in lieu of receiving payment for any future Board meetings or other Board service.

Compensation Committee Report

Following the drafting of the Compensation Discussion and Analysis CD&A , the Compensation Committee reviewed and discussed the final CD&A with management during the Committee meeting held in January 2009. Based on such review and discussions, the Compensation Committee recommended to the Board of Directors that the CD&A be included in this proxy statement at the February 2009 meeting.

Compensation Committee

John B. Morgan, II (Chairman)

David L. Bernd

Dr. Richard F. Clark

Russell Smith Evans, Jr.

Report of the Audit Committee

The Audit Committee of the Board of Directors (for purposes of this report, the Committee) is composed of four non-employee directors, each of whom satisfies the requirements of FDICIA for Audit Committee members and the independence requirements of the SEC and the NASDAQ Stock Market s listing standards. In addition, the Board of Directors has also determined that Mr. Evans qualifies as an audit committee financial expert within the meaning of applicable regulations of the SEC, promulgated pursuant to the Sarbanes-Oxley Act of 2002.

The Committee oversees the Company s financial reporting process on behalf of the Board. Management is responsible for the Company s internal controls, financial reporting process and compliance with applicable laws and regulations and ethical business standards. The independent accountants are responsible for performing an independent audit of the Company s consolidated financial statements in accordance with accounting principles generally accepted in the United States of America and for issuing a report thereon. The Committee monitors and oversees these processes and has sole responsibility for the appointment, compensation and evaluation of the Company s independent accountants.

In this context, the Committee met and held discussions with management and the independent accountants. Management represented to the Committee that the Company s audited consolidated financial statements were prepared in accordance with generally accepted accounting principles, and the Committee has reviewed and discussed the audited consolidated financial statements with management and the independent accountants. The Committee also discussed with management, the independent accountants and the Company s internal auditors the adequacy of the Company s system of internal controls.

The Committee discussed with the independent accountants matters required to be discussed by Statement on Auditing Standards No. 61 (Communication with Audit Committees), as amended, including their judgments about the quality, not just the acceptability, of the Company s accounting principles and underlying estimates in the Company s consolidated financial statements; all critical accounting policies and practices to be used; all alternative treatments within generally accepted accounting principles for policies and practices related to material terms that have been discussed with management of the Company; and other material written communication between the independent accountants and the management of the Company, such as any management letter or schedule of unadjusted differences.

The Company s independent accountants also provided to the Committee the written disclosures and letter required by the applicable requirements of the Public Company Accounting Oversight Board regarding the independent accountants communications with the Committee concerning independence and the Committee discussed with the independent accountants that firm s independence.

The Committee also discussed with the Company s internal auditors and independent accountants the overall scope and plans for their respective audits. The Committee met with the internal auditors and independent accountants, with and without management present, to discuss the results of their examinations, the evaluations of the Company s internal controls, and the overall quality of the Company s financial reporting.

Based upon the Committee s discussions with management and the independent accountants and the Committee s review of the representation of management and the written disclosures and report of the independent accountants to the Committee, the Committee recommended to the Board of Directors that the audited consolidated financial statements be included in the Company s Annual Report on Form 10-K for the year ended December 31, 2008, for filing with the SEC.

Audit Committee

Ellen Clark Thacker (Chairman)

Russell Smith Evans, Jr.

Dr. Arthur D. Greene

Stephen D. Harris

Independent Registered Public Accountants

Yount, Hyde & Barbour, P.C. rendered audit services to the Company during the fiscal year ended December 31, 2008. The Audit Committee has selected Yount, Hyde & Barbour, P.C. as the Company s independent registered public accountants for the current fiscal year ending December 31, 2009. A representative of Yount, Hyde & Barbour, P.C. will be present at the Annual Meeting and will be given the opportunity to make a statement and respond to appropriate questions from stockholders.

Principal Accountant Fees

The following table presents the fees for professional audit services rendered by Yount, Hyde & Barbour, P.C., for the audit of the Company s annual financial statements for the years ended December 31, 2008 and 2007, as well as fees billed for other services rendered by Yount, Hyde & Barbour, P.C. during 2008 and 2007. All fees reflected below for 2008 and 2007 were pre-approved in accordance with the Audit Committee Pre-Approval Policy discussed below.

	Years Ended December 31,	
	2008	2007
Audit fees [1]	$ 130,000	$ 122,100
Audit-related fees [2]	7,500	7,500
Tax fees [3]	8,000	7,200
All other fees	0	0
Total fees	$ 145,500	$ 136,800

(1) Audit fees consist of audit and review services, consents, report on internal control over financial reporting and review of documents filed with the SEC.

(2) Audit-related fees consist of pre-approved consultation concerning financial accounting and reporting standards.

(3) Tax fees consist of preparation of federal and state income tax returns and consultation regarding tax compliance issues.

The Audit Committee considers the provision of all of the above services to be compatible with maintaining the independence of the Company s independent accountants, Yount, Hyde & Barbour, P.C.

Audit Committee Pre-Approval Policy

Pursuant to the terms of the Company s Audit Committee Charter, the Audit Committee is responsible for the appointment, compensation and oversight of the work performed by the Company s independent accountants. As part of this responsibility, the Audit Committee, or a designated member of the Audit Committee, must pre-approve all audit (including audit-related) and non-audit services performed by the independent accountants in order to assure that the provision of such services does not impair the accountants independence. The Audit Committee has adopted, and the Board of Directors has ratified, an Audit Committee Pre-Approval Policy, which sets forth the procedures and the conditions pursuant to which services proposed to be performed by the independent auditors may be pre-approved. The Audit Committee has delegated interim pre-approval authority to Mrs. Thacker, Chairman of the Audit Committee. Any interim pre-approval of permitted non-audit services is required to be reported to the Audit Committee at its next scheduled meeting. The Audit Committee does not delegate its responsibilities to pre-approve services performed by the independent accountants to management.

Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Exchange Act requires directors, executive officers, and 10% beneficial owners of the Company s common stock to file reports concerning their ownership of and transactions in the Company s common stock. Based on a review of the reports of changes in beneficial ownership of Company common stock and written representations made to the Company, the Company believes that its officers, directors and 10% beneficial owners complied with all filing requirements under Section 16(a) during 2008, with the exception of the late filing of one Form 4 by Dr. Arthur D. Greene, to report one transaction and the late filing of one Form 4 by Robert F. Shuford, Jr. to report one transaction.

STOCKHOLDER PROPOSALS FOR 2010 ANNUAL MEETING

In accordance with the bylaws of the Company as currently in effect, the 2010 Annual Meeting of Stockholders will be held on April 27, 2010.

If any stockholder intends to propose a matter for consideration at the Company s 2010 Annual Meeting (other than a director nomination), notice of the proposal must be received in writing by the Company s Secretary by February 1, 2010. If any stockholder intends to present a proposal to be considered for inclusion in the Company s proxy materials in connection with the 2010 Annual Meeting, the proposal must be in proper form and must be received by the Company at its main office in Hampton, Virginia, on or before November 18, 2009.

In addition, the proxy solicited by the Board of Directors for the 2010 Annual Meeting will confer discretionary authority to vote on any stockholder proposal presented at the meeting if the Company has not received notice of such proposal by February 1, 2010, in writing delivered to the Company s Secretary.

OTHER MATTERS

As of the date of this Proxy Statement, management of the Company has no knowledge of any matters to be presented for consideration at the Annual Meeting other than proposal 1 referred to above. If any other matters properly come before the Annual Meeting, the persons named in the accompanying proxy intend to vote such proxy, to the extent entitled, in accordance with their best judgment.

By Order of the Board of Directors,

/s/ Louis G. Morris
Louis G. Morris
Secretary to the Board

ANNUAL REPORT ON FORM 10-K

A copy of the Company s Annual Report on Form 10-K as filed with the Securities and Exchange Commission for the year ended December 31, 2008, will be furnished without charge to stockholders upon written request directed to:

Laurie D. Grabow

Executive Vice President/Finance

The Old Point National Bank of Phoebus

1 West Mellen Street

Hampton, Virginia 23663

(757) 728-1251

The Company s Annual Report on Form 10-K can also be viewed on the Investor Relations link on the Company s Internet website at http://www.oldpoint.com.