CROSS COUNTRY HEALTHCARE INC
Form 10-K
March 17, 2009

**UNITED STATES**

**SECURITIES AND EXCHANGE COMMISSION**

**Washington, D.C. 20549**

**FORM 10-K**

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**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

**For the Fiscal Year Ended December 31, 2008**

**or**

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**TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

**For the transition period from _____ to _____**

**Commission file number 0-33169**

**Cross Country Healthcare, Inc.**

(Exact name of registrant as specified in its charter)

| **Delaware** | **13-4066229** |
|---|---|
| (State or other jurisdiction of incorporation or organization) | (I.R.S. Employer Identification No.) |

**6551 Park of Commerce Boulevard, N.W.**

**Boca Raton, Florida 33487**

(Address of principal executive offices, zip code)

Registrant s telephone number, including area code: **(561) 998-2232**

**Securities registered pursuant to Section 12(b) of the Act:**

| **Title of each class** | **Name of each exchange on which registered** |
|---|---|
| Common Stock, par value $0.0001 per share | The NASDAQ Stock Market |

Securities registered pursuant to Section 12(g) of the act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No þ

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No þ

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 period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) 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. þ

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act: Large accelerated filer ¨ Accelerated filer þ Non-accelerated filer ¨ Smaller reporting company ¨

Indicate by check mark whether the Registrant is a shell company (as defined by Rule 12b-2 of the Act). Yes ¨ No þ

The aggregate market value of the voting stock held by non-affiliates of the Registrant, based on the closing price of Common Stock on June 30, 2008 of $14.41 as reported on the NASDAQ National Market, was $399,989,005. This calculation does not reflect a determination that persons are affiliated for any other purpose.

As of February 29, 2009, 30,774,868 shares of Common Stock, $0.0001 par value per share, were outstanding.

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the Registrant s definitive proxy statement, for the 2009 Annual Meeting of Stockholders, which statement will be filed pursuant to Regulation 14A not later than 120 days after the end of the fiscal year covered by this Report, are incorporated by reference into Part III hereof.

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All references to we, us, our, or Cross Country in this Report on Form 10-K means Cross Country Healthcare, Inc., subsidiaries and affiliates.

**Forward-Looking Statements**

In addition to historical information, this Form 10-K contains statements relating to our future results (including certain projections and business trends) that are forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended (the Exchange Act), and are subject to the safe harbor created by those sections. Words such as expects , anticipates , intends , plans , believes , estimates , suggests , seeks , will and variations of such words and similar expressio intended to identify forward-looking statements. These statements involve known and unknown risks, uncertainties and other factors that may cause our actual results and performance to be materially different from any future results or performance expressed or implied by these forward-looking statements. Factors that might cause such differences include, but are not limited to, those discussed in the section entitled Item 1A Risk Factors. Readers should carefully review the Risk Factors section contained in other documents we file from time to time with the Securities and Exchange Commission, including the Quarterly Reports on Form 10-Q to be filed by us in fiscal year 2009.

Although we believe that these statements are based upon reasonable assumptions, we cannot guarantee future results and readers are cautioned not to place undue reliance on these forward-looking statements, which reflect management s opinions only as of the date of this filing. There can be no assurance that (i) we have correctly measured or identified all of the factors affecting our business or the extent of these factors likely impact, (ii) the available information with respect to these factors on which such analysis is based is complete or accurate, (iii) such analysis is correct or (iv) our strategy, which is based in part on this analysis, will be successful. The Company undertakes no obligation to update or revise forward-looking statements.

## PART I

**Item 1.**

**Business.**

**Overview of Our Company**

We are a diversified leader in healthcare staffing services. We offer a comprehensive suite of staffing and outsourcing services to the healthcare market, which include being a leading national provider of nurse and allied staffing services and multi-specialty locum tenens (temporary physician staffing) services; a provider of clinical trials services to global pharmaceutical and biotechnology customers; and a provider of other human capital management services focused on healthcare.

We have a diversified revenue mix across business sectors and healthcare customers. For the fourth quarter ended December 31, 2008, our nurse and allied staffing business segment was 60% of our revenue and is comprised of travel and per diem nurse staffing and travel allied health staffing. Travel nurse staffing is our largest business. Our physician staffing business segment was 22% of our revenue and consists of temporary physician staffing (locum tenens) services. Our clinical trials services business segment was 12% of our revenue and consists of service offerings that include traditional staffing, as well as clinical trials management, drug safety monitoring and regulatory consulting services to pharmaceutical and biotechnology customers. Our other human capital management services business segment was 6% of our revenue and consists of education and training as well as retained search services related to physicians and healthcare executives. We have more than 5,000 contracts with hospitals and healthcare facilities, pharmaceutical and biotechnology customers, and other healthcare organizations to provide our healthcare

staffing and outsourcing solutions. In 2008, no single client accounted for more than 3% of our revenue. In addition, our fees are paid directly by our clients and in certain cases by third-party administrative payers. As a result, we have no direct exposure to Medicare or Medicaid reimbursements.

In September 2008, we acquired substantially all of the assets of privately-held MDA Holdings, Inc. (MDA) and its subsidiaries for $112.3 million in cash, plus additional earn-out payments based on 2008 and 2009 performance criteria. Headquartered in Norcross, Georgia, MDA provides multi-specialty temporary physician staffing (locum tenens) and allied staffing services to the healthcare industry in all 50 states. The locum tenens portion of MDA s business is accounted for in our physician staffing business segment and the allied portion is accounted for in our nurse and allied staffing business segment.

In conjunction with this transaction, we entered into a $200.0 million syndicated credit facility with Wachovia Capital Markets, LLC and certain of its affiliates, Banc of America Securities, LLC, and certain other lenders. Pursuant to this financing, we amended and kept in place our existing $75.0 million revolving loan facility and entered into a new $125.0 million 5-year term loan, from which the proceeds were used to finance the MDA acquisition and for future general corporate purposes.

For the year ended December 31, 2008, our revenue was $734.2 million and we had a net loss of $142.9 million, or ($4.61) per diluted share, including pre-tax non-cash goodwill and other intangible asset impairment charges. The net loss was a result of recording $244.1 million ($167.0 million after taxes, or $5.39 per diluted share) in impairment charges in the fourth quarter of 2008, primarily related to our annual goodwill impairment testing. During 2008, we generated $51.0 million in cash flow from operations. At year-end 2008 we had total debt of $133.1 million and $10.2 million of unrestricted cash on our balance sheet, resulting in a debt, net of unrestricted cash, to total capitalization ratio of 33.5% as of December 31, 2008.

**Healthcare and Demographic Influences on Our Business**

According to a 2009 government report published in *Health Affairs*, healthcare spending in the U.S. increased 6.1% to $2.2 trillion in 2007. Spending on hospital services increased 7.3% and comprised nearly one-third of all healthcare spending. Spending for physicians and clinical services grew by 6.5%, which was similar to the prior year. According to forecasts from the Centers for Medicare and Medicaid Services (CMS), healthcare spending is expected to almost double to approximately $4.3 trillion in 2017 and account for 19.5% of the U.S. gross domestic product (GDP), up from 16.3% in 2007. Of this projected increase, spending on hospital services will rise to more than $1.3 trillion by 2017 and represent 30% of overall healthcare spending.

This significant expansion in spending is expected to be driven, in large part, by greater demand for healthcare services due to an increasing and aging population:

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The U.S. population grew by 31% or by 70 million people between 1980 and 2005. As baby boomers age, the number of Americans over age 65 will double by 2030 from 35 million to 71 million, according to U.S. Census Bureau projections. And by 2050, the U.S. population will expand to 420 million people, of which the number of people age 65 and older is expected to approach 87 million, according to a Congressional Research Service report (March 2007). Meanwhile, the 55-to-64 age group is expected to increase to 40 million by 2014, including the oldest baby-boomers who turn 65 years of age and become eligible for Medicare beginning in 2011.

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Healthcare spending is higher for older people than younger people. Patients age 65 and older typically average six to seven doctor visits per year compared to two to four visits annually for those under age 65. If the annual number of visits continues at the present rate, the U.S. population will make 53% more trips to the doctor in 2020 than in 2000, according to a November 2008 report by the Association of American Medical Colleges (AAMC). Additionally, the most costly illnesses are more common among the elderly. As medical advances extend survival rates and improve quality of life for those with chronic conditions, the need for ongoing healthcare services will increase. The U.S. Centers for Disease Control and Prevention reported that 80% of people 65 and older have at least one chronic condition, such as diabetes, arthritis or cancer. Life expectancy for Americans is nearly 78 years, the highest in U.S. history, according to government statistics for 2005. Hospital utilization is significantly higher among older people. In 2005, the U.S. Department of Health and Human Services reported that people over the age of 65 comprised 38% of all inpatients. Projections from the American Hospital Association (AHA) expect hospital admissions for the over-age 65 group to rise to 56% in 2030 from 38% in 2004, while for the under-age 65 group decrease to 44% from 62% over the same period.

Overlaid on this expected increase in demand for healthcare services is an insufficient supply of registered nurses (RNs) and physicians to provide quality medical care. The RN workforce is aging and the nurse education system is constrained by an aging faculty and lack of teaching facilities, while at the same time there is a growing shortage of physicians in both hospitals and practice groups.

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The nursing shortage is expected to expand to 340,000 unfilled RN positions by 2020 due to a combination of an aging RN workforce that is unable to offset increasing numbers of RNs retiring from the workforce over the coming years with the number of new RNs entering the workforce (*Health Affairs,* January/February 2007). The average age of RNs is approximately 47 years, up from age 45 in 2000. By 2012, RNs in their fifties will comprise the largest age group in the profession, and by 2020, baby-boomer nurses will be in their sixties, although most are expected to have retired from working in acute care hospitals. Approximately 478,000 RNs are expected to retire between 2002 and 2012.

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Physicians are in short supply as well. While the root cause of this shortage dates back to the 1980s and 1990s when medical schools capped enrollment, researchers had earlier predicted a 50,000 shortfall by 2010 and 200,000 by 2020 (*Health Affairs January/February 2002*). However, a November 2008 report from the AAMC projects a shortage of 124,000 physicians by 2025. Nonetheless, both studies expect the shortage to be most severe among family physicians and general surgeons. Further, researchers believe it already is too late to avert a shortage since one-third of the nation s physicians (approximately 250,000) are age 55 and older and approximately 38% are considering retirement in the next one to three years. And while the number of applicants to U.S. medical schools is increasing, it has not kept on pace to

counter the expected future demand given the number of post-graduate years of training required. Surgical training, for example, requires eight to fourteen years.

Hospital and healthcare facility customers comprise the majority of our revenue base. Typically, they provide medical care 24x7, which requires RNs, physicians and other healthcare professionals to be staffed around the clock. Labor has historically been the largest component of a hospital s operating budget representing approximately 50% of the budget with nursing care accounting for about half or a quarter of total expenditures. Hospitals are capital-intensive organizations that are paid for their services through reimbursements from the Centers for Medicare & Medicaid Services (CMS), by insurance companies paying their members covered claims, and by private-pay individuals. Our fees are paid directly by our clients and in certain cases, by third-party administrative payers. As a result, we have no direct exposure to any Medicare or Medicaid reimbursements.

Since the beginning of 2003, growth in hospital in-patient admissions has been flat-to-down. In addition, hospitals, healthcare facilities and physician practice groups have had to contend with changes in government reimbursements for their services, changes in legislation and agency regulations, a large universe of uninsured patients compounded by rising unemployment and consumerism for those with health insurance coverage, and rising bad debt and professional liability related to medical errors. More recently, hospitals and healthcare facilities have been affected by the financial and credit crisis, which has reduced their ability to access capital and/or substantially increased the cost of capital they are able to obtain. Also hospital expansion and construction projects, which experienced a robust up-surge during the past few years, have largely come to an abrupt halt.

The combination of these factors, as well as a weakening of the national labor market that triggered RNs to provide more hours of service directly to hospital employers at wages hospitals are willing and able to pay, has resulted in a decline in the demand for our nurse and allied staffing services while our physician staffing business continues to experience growth. Physicians are revenue generators for hospitals, healthcare facilities and practice groups while nurses are an un-reimbursed cost in the delivery of care.

The shortage of RNs and physicians is likely to increase over time, and could worsen by the adoption of universal healthcare coverage, according to a report by the AAMC in November 2008. Such broad-based healthcare coverage could add 4% to overall demand for physicians and increase the projected physician shortfall by 25%, or 31,000 physicians.

In our clinical trials services segment, the pharmaceutical and biotechnology industries have historically been less impacted by downturns in the economy and more impacted by mergers and acquisitions that result in evaluation of product mix and/or funding of research and development (R&D) efforts. While an increasing amount of R&D has been outsourced over the preceding years, the current global economic environment has led pharmaceutical companies to look more to in-licensing or acquiring new technologies and potential products while refocusing or scaling-back their R&D programs. The biotechnology industry has been impacted to a much greater degree by the recent lack of available funding from private and public sources. Consequently, the current economy has resulted in a number of companies being substantially down-sized, acquired or shut down all of which have recently decreased R&D activity in this sector.

**Nurse and Allied Staffing**

We are a leading provider of travel nurse staffing services in the U.S., as well as a provider of travel allied staffing and per diem nurse staffing services. Our 2008 segment revenue was $525.8 million. We market our nurse and allied staffing services primarily to acute care hospitals, providing clients with staffing solutions through our Cross Country

Staffing, MedStaff and Allied Health Group brands. We provide credentialed RNs for travel and per diem staffing assignments at public and private healthcare facilities, as well as for-profit and not-for-profit facilities located throughout the U.S. The vast majority of our assignments are at large acute-care hospitals, including teaching institutions and trauma centers, located in and around major metropolitan areas. We also provide other healthcare professionals in a wide range of specialties that include operating room technicians and various allied health professionals, such as rehabilitation therapists, radiology technicians and respiratory therapists, nurse practitioners, physician assistants and radiation therapy technicians to assignments in hospitals and non-acute care settings such as skilled nursing facilities, nursing homes and sports medicine clinics, and, to a lesser degree, in non-clinical settings, such as schools. Cross Country Staffing is our largest brand. As a part of its business strategy, Cross Country Staffing has in-place a number of exclusive vendor-managed and preferred provider relationships with hospital clients, and continues to pursue such additional opportunities. In doing so, it provides clients with a suite of solutions to facilitate the efficient management of their temporary nursing workforce, which range from efficiency-enhancing technology to full vendor management solutions. MedStaff markets both its travel nurse staffing and per diem staffing services to public and private hospitals and healthcare facilities across the United States.

The nurse staffing businesses of our Cross Country Staffing and MedStaff brands are certified by The Joint Commission under its Health Care Staffing Services Certification Program.

*Recruiting*

We operate differentiated brands Cross Country TravCorps, MedStaff, NovaPro, Cross Country Local, Assignment America and Allied Health Group to recruit nurses and allied healthcare professionals on a domestic and international basis. We believe RNs and allied health professionals are attracted to us because we offer a wide range of diverse assignments in attractive locations, competitive compensation and benefit packages, as well as high levels of customer service.

In 2008, thousands of healthcare professionals applied with us through our recruitment brands. Historically, more than half of our field employees have been referred to us by other healthcare professionals. We also advertise in trade publications and on the Internet, which has become an important component of our recruitment efforts. We maintain a number of websites to allow potential applicants to obtain information about our brands and assignment opportunities, as well as to apply online.

Our recruiters are an essential element of our travel staffing business, responsible for establishing and maintaining key relationships with candidates for the duration of their employment with our Company. Our recruiters work with candidates throughout their initial placement process as well as on subsequent assignments. We believe our strong retention rate is a direct result of these relationships. Recruiters match the supply of qualified candidates in our databases with the demand for open orders posted by our hospital clients. At year-end 2008, we had 153 recruiters in our travel staffing business.

Our recruiters utilize our computerized databases of positions to match assignment opportunities with the experience, skills and geographic preferences of their candidates. Once an assignment is selected, our account managers review the candidate s application package before submitting it to the hospital client for consideration. Account managers are knowledgeable about the specific requirements and operating environment of the hospitals that they service. In addition, our databases of open positions are kept updated by our account managers.

We also have internal educational and training capabilities through Cross Country University, a division of Cross Country Staffing, that we believe gives us a competitive advantage by enhancing both the quality of our working nurses and the effectiveness of our recruitment efforts. Cross Country University offers our RNs and other healthcare professionals additional training, professional development and assistance in completing continuing education for state licensing requirements.

*Contracts with Field Employees and Hospital Clients*

Each of our traveling field employees works for us under a contract. Travel assignments are typically 13-weeks in duration. Our traveling field employees that are on payroll contracts are hourly employees whose contract specifies the hourly rate they will be paid and any other benefits they are entitled to receive during the contract period. We bill clients at an hourly rate and assume all employer costs, including payroll, withholding taxes, benefits, professional liability insurance and Occupational Safety and Health Administration (OSHA) requirements, as well as any travel and housing arrangements.

*Operations*

We operate our travel staffing business from a relatively centralized business model servicing all of the assignment needs of our field employees and client facilities through operation centers located in Boca Raton, Florida; Malden, Massachusetts; Tampa, Florida; Newtown Square, Pennsylvania and Norcross, Georgia. These centers perform key support activities such as coordinating assignment accommodations, payroll processing, benefits administration, billing and collections, contract processing, customer service and risk management. Our per diem staffing services are provided through a network of 15 branch offices serving major metropolitan markets predominantly located on the east and west coasts of the U.S.

Hours worked by field employees are recorded by our operations system, which then transmits the data directly to Automatic Data Processing, Inc. for payroll processing. Client billings are generated using time and attendance data captured by our payroll system. Our payroll department also provides customer support services for field employees.

During 2008, we had an average of approximately 2,400 apartments open under lease throughout the U.S. Our housing staff typically secures leases and arranges for furniture rental and utilities for field employees at their assignment locations. Apartment leases are typically three months in duration to match the assignment length of our field employees. Beyond the initial term, leases can generally be extended on a month-to-month basis. We typically provide accommodations at no cost to

the healthcare professional on assignment with us based on our respective recruitment brand s practices. We believe that our economies of scale help us secure competitive pricing and favorable lease terms.

Overview of the Nurse and Allied Staffing Industry

The temporary nurse staffing alternatives available to hospital administrators are travel nurses and per diem nurses. Travel nurse staffing involves placement of RNs on a contract basis, typically for a 13-week assignment although assignments may range from several weeks or longer than three months. Travel assignments usually involve relocation to the geographic area of the assignment. Travel nurses provide hospitals and healthcare facilities with the flexibility and variable cost to manage changes in their staffing needs due to shifts in demand, represent a pool of potential full-time job candidates, and enable healthcare facilities to provide their patients with a greater degree of continuity of care. The staffing company generally is responsible for providing travel nurses with customary employment benefits and for coordinating travel and housing arrangements. Per diem nurse staffing comprises the majority of outsourced temporary nurse staffing and involves the placement of locally-based healthcare professionals on short-term assignments, often for daily shift work, with little advance notice by the hospital client. Consequently, housing and extensive travel are generally not required for this mode of staffing.

*Demand and Supply Drivers*

Using temporary personnel enables healthcare providers to manage their total staffing levels of internal and external nursing resources to better match variability in patient admissions, seasonal fluctuations, and other factors such as facility expansion and staff training activities. The use of temporary RNs is no longer a stop-gap measure, but has become a way of life for many hospitals according to a survey by the PricewaterhouseCoopers Healthcare Research Institute in which hospital executives reported using temporary nurses for an average of 5% of all nursing hours. A separate national tracking study found as many as 75% of hospitals use temporary nurses. In addition, a study by researchers at the University of Pennsylvania s Center for Health Outcomes and Policy Research (Journal of Nursing Administration, August 2007) reported that hospital use of temporary RNs does not lower quality of care because these nurses are just as qualified and in many cases more qualified than permanent staff nurses. The study also found that temporary nurses were more likely than permanent nurses to hold a 4-year baccalaureate or more advanced degrees and more likely to have received their education in the past 10 years when compared to permanent nurses.

The market for our nurse staffing services is determined by the demand from hospital customers and the available supply of RNs and other healthcare professionals. Demand is a function of hospital admission trends and their level relative to expectations, as well as dynamics of the national labor market and its impact on RN s spouses (approximately 70% of RNs in the U.S. are married) which influences the number of shifts or hours that full-and part-time RNs are willing to work directly for hospitals at wages hospitals are able to pay. In general, we believe nurses are more willing to seek travel assignments during relatively high levels of demand for contract employment, and conversely, are more reluctant to seek travel assignments during and immediately following periods of weak demand for contract employment. We also believe demand for travel nurse staffing services will be favorably impacted in the long-term by an expanding and aging population and an increasing shortage of nurses.

The environment for our nurse and allied staffing services in 2008 reflected both hospital admission trends that have been relatively flat since the first quarter of 2003 and a deteriorating national labor market resulting in higher levels of unemployment that translates into more uninsured people and fewer people with commercial health insurance coverage. Also, high unemployment typically results in nurses being more willing to work more hours at prevailing wages, which reduces the need for our outsourced staffing services to meet demand for patient care. It is likely the business environment for nurse and allied staffing will weaken further during 2009.

However, we were able to expand our margins through continued expansion of the bill-pay spread and a moderation of housing expenses and lower insurance costs. Bill rates, as measured by revenue per hour in our travel nurse staffing business, continued to rise in the low single-digit range in 2008 consistent with our experience over the past several years.

The number of RNs in the U.S. grew 7.9% between 2000 and 2004 to 2.9 million, according to the most recent information published by the Health Resources and Services Administration (HRSA) in December 2005. Of this total, 2.4 million were employed in nursing, and approximately 1.7 million RNs (58%) were working full-time and 725,000 RNs (25%) were working part-time. According to this information, the largest and most significant employment setting for RNs was hospitals (nearly 60%) where they represented the largest share of hospital employees at 28%.

Foreign-educated RNs also play a role in providing nursing services. Nearly 90,000 foreign-educated RNs work in American hospitals, or about 3.7% of the total RN workforce, according to a 2007 study by the National Foundation for America

Policy. However, entry into the U.S. can be blocked or delayed due to immigration quotas and a lack of appropriate temporary visa categories. The Philippines provides the largest share of foreign-educated RNs to the U.S., followed by India, Canada and South Korea. California employs the most foreign RNs, followed by Florida, New York and Texas.

The average age of RNs is approximately 47 years, up from age 45 in 2000 and age 41 in 1996, according to the 2005 HRSA survey, which also indicated 41% of RNs were age 50 or older. In comparison, in 1980 the largest age group of RNs was in their mid-to-late twenties and in 2005 they were in their forties. By 2012, RNs in their fifties will be the largest age group, and by 2020, those baby boomer RNs still in the workforce will be in their sixties.

While the aging trend of RNs is an important factor, the addition of new nurses and the retirement of older nurses has also become a key dynamic. While large numbers of RNs have been passing the required national licensing exam (NCLEX) and entering the profession in their late twenties and early thirties, the number of people entering nursing in their early to mid-twenties remains at its lowest point in forty years, according to the Health Affairs (January/February 2007) study. Approximately 478,000 RNs are expected to retire between 2002 and 2012. In fact, 55% of surveyed RNs reported their intention to retire between 2011 and 2020, based on findings from the Nursing Management Aging Workforce Survey published by the Bernard Hodes Group in July 2006. New jobs plus retirements lead to projections that 1.1 million additional RNs will need to be added to the inventory of RNs between 2002 and 2012 to maintain a steady state, according to an August 2007 study in Health Research and Educational Trust. We believe as RNs age they consider retiring from the workforce or switching to part-time status and they increasingly reduce the number of hours worked directly for hospital employers because of the physical demands of the job in an acute care hospital setting. We also believe the attrition of newer RNs leaving the profession after a short period in the nursing workforce is also a factor in this equation.

*Educating Nurses*

As a result of more RNs entering the profession at an older age than they previously did, RNs are less likely to have obtained their nursing education immediately after high school, as was more common in the past. Instead, people are increasingly entering the nursing by graduating from a two-year associate degree program after a period spent in another career or not in the workforce. Additionally, people are entering nursing via accelerated bachelor-of-science degree programs designed for those with other (and usually unrelated) bachelor s degrees.

Enrollment in baccalaureate nursing programs increased 2.0% in 2008 from the prior year and graduations increased 8.2% from 2007 to 2008, according to preliminary survey data from the American Association of Colleges of Nursing (AACN) issued in December 2008. While this marks the eighth consecutive year of enrollment growth and the sixth consecutive year for graduations, this reduced level of growth in enrollments may indicate four-year nursing degree programs may have reached capacity.

Enrollment in master s level nursing programs increased by 8.7% from 2007, but this represents a significantly lower growth rate similar to the decline realized in baccalaureate nursing program enrollment. Graduations from masters programs increased 10.6% in 2008, which was essentially the same growth rate compared to the prior year based on the AACN preliminary data.

Enrollment in doctoral nursing programs increased 9.7% and graduations increased 17.6% from 2007. However, the number of students enrolled in research-focused doctoral programs in 2008 decreased slightly by 0.4%, according to preliminary estimates.

Interest in the nursing profession remains high based on nursing schools continuing to receive more qualified applications than can be accommodated. The AACN preliminary data reflects that approximately 28,000 qualified applicants were turned away from baccalaureate nursing programs in 2008, with most nursing colleges and universities continuing to cite insufficient faculty, clinical placement sites, classroom space, and budget cuts as the primary reasons.

*Legislation*

In the context of a worsening nursing shortage and legislative efforts to address nurse staffing ratios and the use of mandatory overtime at hospitals and healthcare facilities, there is a growing body of research that substantiates concerns raised by consumer groups about the quality of care provided in healthcare facilities and by nursing organizations about the increased workloads and pressures on nurses. Legislation, such as outlined below, has been passed and/or introduced at federal and state levels. The passage of such legislation is expected to increase the demand for nurses.

*Nurse Staffing Plans and Ratios*

42 Code of Federal Regulations (42CFR 482.23(b) requires hospitals certified that participate in Medicare to "have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed". However, it is left to the states to ensure that staffing is appropriate to meet patients needs safely.

Reductions in nursing budgets have resulted in fewer nurses working longer hours, while caring for sicker patients. As a result, nurses have requested assistance from elected officials on the state and federal level related to adequate nurse staffing through legislative or regulatory means. Three general approaches have been proposed:

1.

Require and hold hospitals accountable for implementation of nurse staffing plans, with input from practicing nurses, to assure safe nurse to patient ratios are based on patient need and other criteria.

2.

Legislators mandate specific nurse to patient ratios in legislation or regulation.

3.

A combination of nurse staffing plans and legislated nurse to patient ratios, along with making staffing information available to the public.

Federal Legislation (pending)

The Registered Nurse Safe Staffing Act of 2007 (S. 73 / H.R. 4138) would amend title XVIII (Medicare) of the Social Security Act to: (1) require each participating hospital to adopt and implement a staffing system that ensures a number of registered nurses on each shift and in each unit of the hospital to ensure appropriate staffing levels for patient care; (2) provide for the public reporting of certain staffing information, including a daily posting for each shift in the hospital of the current number of licensed and unlicensed nursing staff directly responsible for patient care; (3) prescribe recordkeeping, data collection, and evaluation requirements for participating hospitals; (4) specify civil monetary penalties for violations of such requirements; and (5) provide whistleblower protections.

State Legislation

To date, 13 states plus the District of Columbia have enacted legislation and/or adopted regulations to address nurse staffing: CA, CT, FL, IL, ME, NV, NJ, OH, OR, RI, TX, VT, and WA. During 2008, nurse staffing legislation was introduced in: AZ, CT, FL, HI, IA, MN, MO, NJ, NM, NY, OH, VA, and WV.

*Mandatory Overtime*

Overtime is defined as the hours worked in excess of an agreed upon, predetermined, regularly scheduled full or part time work schedule, as determined by contract, established work scheduling practices, policies or procedures. Due to inadequate RN staffing, healthcare facility employers have used mandatory overtime to staff facilities. Concern for the long term effects of overtime include impact on the care-giver s health as well as the potential for errors or near misses

from fatigue and diminished quality of care provided. Research indicates that risks of making an error are significantly increased when work shifts are longer than 12 hours, when nurses worked overtime, or when they worked more than 40 hours per week. Voluntary overtime is not affected.

Federal Legislation (pending)

The Safe Nursing and Patient Care Act of 2007 (HR 2122 / S. 1842) would amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work at certain providers of services to which payments are made under the Medicare Program.

States Legislation

To date, 15 states have restrictions on the use of mandatory overtime for nurses. Twelve states have enacted legislation: CT, IL, MD, MN, NJ, NH, NY, OR, PA, RI, WA, and WV. Three states have provisions in regulations: CA, MO, and TX.

**Physician Staffing**

Today, locum tenens is most commonly used to mean temporary physicians that contract with recruitment agencies to perform medical services over a certain period of time as an independent contractor at hospitals, practice groups or other healthcare organizations.

In using temporary physicians, the staffing needs of healthcare facilities are met while physicians gain flexibility in their schedules and professional experience in multiple practice settings. The locum tenens industry is more than 20 years old and continues to grow as more physicians choose this way of practicing medicine and healthcare organizations discover the value of temporary physician staffing.

Utilization of temporary physician coverage ranges from rural solo physician practices to the country's major health systems and managed care organizations. Healthcare facilities have found that supplemental healthcare professionals are needed for a variety of reasons: to compensate for a physician shortage, to fill in for an absent staff member who may be ill, on vacation, on maternity leave or sabbatical, as well as to cover while physicians attend continuing medical education courses, to supplement regular staff during busy times, or to staff new facilities while permanent providers are recruited. Many healthcare facilities across the country use temporary physicians as an integral part of their master staffing plan. In many cases, it is less costly and more efficient for them to staff at a minimum level and use temporary physicians to supplement their permanent staff, rather than always trying to staff at the maximum level and having many periods of time when the staff are not fully utilized.

Physicians choose temporary assignments for a variety of reasons and at various points in their careers. For example, it is an especially appealing option for new physicians just out of residency training. It provides them with the opportunity to sample different practices and areas of the country before making a long-term commitment in any one spot. While medical schools and residency programs teach the art of practicing medicine, new physicians frequently emerge from training without knowing just what style of practice will suit them best and many report being unhappy with their first practice setting. With temporary physician staffing, there's no pressure to rush into a permanent decision. And there are no immediate financial burdens such as "buying in" to a practice or permanently locating to the wrong place. Physicians can even use a temporary assignment to try out a specific practice opportunity before making a permanent commitment.

Temporary staffing is also the choice of many seasoned physicians who are not ready to retire, but want to scale down the rigors and administrative burdens of full-time practice. These physicians enjoy the chance to keep more reasonable hours and combine work with travel and time spent with family and friends. Other physicians choose temporary physician staffing work in mid-career as a way to find the right position in a new area, or while they are in professional transition, such as from military to civilian practice or while in the process of starting their own business.

*Demand and Supply Drivers*

Based on the economic principles of supply and demand, there are not enough physicians to fill the number of vacancies at U.S. hospitals, practice groups and other healthcare facilities and the shortage is expected to grow even further. Due to population growth, aging and other factors, demand will outpace supply through at least 2025, according to the AAMC in its November 2008 report. Simply educating and training more physicians will not be enough to address the shortage. While the root cause of this shortage dates back to the 1980s and 1990s when medical schools capped enrollment, earlier this decade researchers predicted a 50,000 shortfall by 2010 and 200,000 by 2020 (*Health Affairs January/February 2002*). More recently, the report by the AAMC (November 2008) projects a shortage of 124,000 physicians by 2025. In either case, some of the causes behind the projected shortages include:

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Of the nearly 800,000 physicians practicing medicine today in the U.S. approximately one-third of physicians are over age 55. As the baby boomer generation begins to turn age 70, approximately 38% of these older physicians report they are considering retirement in the next one to three years, according to the American Medical Association. In absolute

terms, the number of physician retirements is expected to rise to 23,000 per year in 2025 from approximately 9,000 in 2000, according to the AAMC.

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The shortage of primary care doctors is worsening each year, as only 20% of internal medicine third-year residents chose primary care in 2005. This was a decline from nearly 55% in 1998, according to a 2008 report from the Center for Studying Health System Change.

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More than half of U.S. hospitals consistently faced substantial gaps in specialist coverage in their emergency departments between 2005 and 2007, especially in orthopedics and neurology, according to the American Medical Association.

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The Bureau of Labor Statistics set the unemployment rate among U.S. physicians and surgeons at 0.7% in 2006, which essentially means there was no unemployment among doctors.

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Shortages exist for all types of physicians, especially for physicians specializing in emergency medicine, cardiology, family practice, general surgery, internal medicine, hospital medicine (hospitalists), oncology, orthopedics, psychiatry and urology.

*Educating Physicians*

Despite the large increase in the population, the number of U.S. graduates with M.D. degrees from medical schools has remained flat at about 16,000 per year over the past several decades, although an increase in the supply of foreign-trained physicians and the number of graduates receiving Doctor of Osteopathy degrees has helped to augment the increase in demand for care, according to the AAMC Center For Workforce Studies.

In 2008, first-year enrollment at U.S. medical schools increased nearly 2% from the prior year to more than 18,000 students, the highest enrollment in history. However, the total number of applicants to medical schools leveled off at more than 42,000 after having increased in each of the prior five years. And while the overall applicant pool is one of the largest in more than a decade, where there was an average of more than 2 applicants for every available opening at a U.S. medical school, the number of first-time applicants to U.S. medical schools decreased 3% from the prior year. Looking farther out, the AAMC estimates first-year U.S. M.D. enrollment in medical school will grow by 21% in the 2012 academic year to nearly 20,000 from enrollment levels in 2002. This projected increase primarily reflects growth at existing medical schools, aided by several new medical schools hopeful of enrolling their first classes in the coming years.

*Temporary Physician Staffing Drivers*

In 2007, temporary physician staffing accounted for approximately $1.9 billion in revenue, according to estimates by the Staffing Industry Report. In addition, the locum tenens sector experienced double-digit growth in 2006 and 2007 (Staffing Industry Report - June 2008) and is projected to experience similar levels of growth in 2008 and 2009.

Physicians are attracted to the locum tenens industry at different stages of their career for a number of reasons, thereby maintaining an ongoing supply of physicians to the industry. Locum tenens gives a physician the opportunity to practice medicine and focus almost exclusively on patient care without having the administrative aspects of managing a business, reimbursement concerns, hospital politics, or malpractice costs. However, many other benefits to physicians correlate with the life stage of the physician.

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*Physicians age 35 and under.* Younger physicians who are recent residency program graduates look to experience different practice settings and locations before making more permanent career decisions. Approximately 68% of final year medical residents receive multiple job solicitations and in some specialties, such as radiology and cardiology, the number is even higher. Locum tenens allows the younger physician to try out different opportunities before settling on one. It can also assist physicians in paying-off their student loans.

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*Physicians 35-49.* Physicians in the middle stages of their career find a locum tenens practice to suit their lifestyle as a fulltime career, as a way to take a break from their current practices but remain working, as a transition opportunity or

as a means to supplement their income.

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*Physicians age 50 or older.* Older physicians at the later stages of their career normally find a diverse travel practice with decreased time requirement to be appealing. They may look for job enrichment by choosing a locum tenens position or looking for employment in or before retirement. Physicians in this category may no longer wish to operate a practice and all the administrative issues that accompany it, but wish to continue working, even if just for a few months a year.

*MDA Overview*

Founded in 1987 and based in Norcross, Georgia, MDA is one of the three largest providers of locum tenens in the U.S. In 2008, on a pro forma basis it generated revenue of $175.3 million, as compared to revenue of $158.0 million in the prior year. In 2008, MDA handled approximately 7,700 assignments for more than 1,300 clients utilizing its database of over 157,000 providers representing a wide range of medical specialties.

MDA also offers allied health providers temporary and permanent staffing opportunities at healthcare client facilities. In addition, MDA is one of only three locum tenens companies with an in-house Credentials Verification Organization certified by the NCQA (National Committee for Quality Assurance), which verifies critical credentials prior to MDA s assignments. The NCQA uses an extensive proprietary database and interfaces with MDA s professional liability carrier to obtain approvals of providers. It takes risk management decisions out of the sales process by verifying credentials of providers and approving specific assignments.

Quality medical malpractice liability insurance coverage is a critical component of the MDA business model. Clients usually require MDA to refer physicians with medical professional liability coverage, and physicians are attracted to MDA because it offers quality malpractice coverage.

MDA currently is the only multi-specialty medical staffing company that has procured an occurrence form policy from Medical Protective Company, a Berkshire-Hathaway insurance company (AAA-rated by Standard & Poor s). This represents a substantial competitive advantage in the recruitment of physicians. In addition, the occurrence based policy is of particular importance to physicians as it covers incidents occurring during the policy period regardless of when they are reported. The more common claims-made policy only covers physicians for claims reported during the policy period.

*Recruiting*

Recruiters go through extensive training in both sales and marketing specialties in order to have continuity with providers and hospitals to facilitate quick and personal service to every customer. Each recruiter covers one specialty and one geographic region whereas competitors typically have separate sales and marketing personnel that can add more contacts and confusion to the staffing process. MDA currently employs approximately 120 physician staffing recruiters throughout its organization, including its Atlanta area headquarters, as well as offices in Denver and Dallas.

*Operations*

MDA successfully operates a multi-site business model with employees/recruiters primarily staffed at several locations nationwide. Recruiters are responsible for managing accounts, and have incentives for collecting amounts due from customers. This enables MDA to have a single point of contact for customers.

When it was initially founded, the locum tenens industry primarily served clinics, group practices and rural hospitals. As the physician staffing industry matured, an increasing amount of business has been generated from serving hospitals (in both urban/suburban and rural settings). Large, nationwide hospital systems and associations continuously use MDA s services due to its ability to respond quickly to the hospital s needs, and offer quality physicians on a temporary or permanent basis. MDA also provide services to various U.S. government institutions, including the Indian Health Services, the Department of Veterans Affairs, the Army, Air Force and other agencies. In 2008, approximately 59% of MDA s business was from hospitals and approximately 41% was from physician practice groups and other healthcare facilities.

**Clinical Trials Services**

The global pharmaceutical market reached $712 billion in 2007, according to industry intelligence source IMS Health, and expects global sales to grow about 5% to more than $820 billion in 2009.

The discovery and development of a new medicine is an expensive and lengthy process. In 2007, the U.S. pharmaceutical and biotechnology industry invested $58.8 billion in research and development (R&D). The R&D process takes an average of more than 10 years to develop a drug at an estimated cost of $1.3 billion for a new medicine and $1.2 billion to develop a biological treatment, according to a recent study from the Tufts University Center for the Study of Drug Development (November 2006). For every 5,000 to 10,000 potential drug candidates that enter the discovery research stage, only about 2.5% to 5% make it to the preclinical phase. Of that percentage, only 0.05% to 0.1% will enter the clinical trial testing phase. The result of those 5,000 to 10,000 candidates is just one regulatory-approved drug to market. There are currently more than 2,700 medicines in clinical trials or undergoing

review by the U.S. Food and Drug Administration (FDA) for 4,600 indications.

*Overview of Clinical Trials*

Clinical trials are one of the most important parts of the drug development process and also one of the most time-consuming. Between 1999-2002 and 2003-2006, the length of the average clinical trial increased by nearly 70%, from 460 days to 780 days (Tufts CSDD). The clinical trial studies are not only expanding in time, but also growing in scope, as the average number of participants needed for each clinical study increased from 1,700 to 4,300 over the last three decades (CISCRP, Hoover Institution, US FDA). In addition, clinical studies are increasingly becoming more complex. In 2005, 72% of U.S. clinical studies involved more than 85 procedures, 70% more than the number of studies in 2000 (Accenture, PhRMA).

Approximately 80,000 clinical trials are conducted in the U.S. each year sponsored by both industry and government. These studies to advance medical science require the work of an estimated 200,000 research professionals and the involvement of millions of study participants each year (CenterWatch).

Clinical trials are conducted to collect data regarding the safety and efficacy of new drug and device development. There are several steps and stages of approval in the clinical trials process before a drug or device can be sold in the consumer market, if ever. Drug and device testing begins in the preclinical stage, which can involve years of experiments in animals and human cells. Before advancing to the clinical stage, researches must submit an investigational new drug application, or IND, to the FDA for approval to continue research and testing in humans. Once approved, human testing of experimental drugs and devices can begin and is typically conducted in four phases. Each phase is considered a separate trial and, after completion of each phase, investigators are required to submit their data for approval from the FDA before continuing to the next phase.

Clinical trials are conducted by teams of physicians and other clinical and data professionals in university facilities, hospitals and physician offices around the world.

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Phase I studies assess the basic safety of a drug or device, including tolerance, absorption, metabolism and excretion. This initial phase of testing, which can take several months to complete, usually includes a small number of healthy volunteers (20 to 100), who are generally paid for participating in the study. About 70% of experimental drugs pass this phase of testing (CenterWatch).

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Phase II studies test the efficacy of a drug or device. This second phase of testing can last from several months to two years, and involves approximately 100 to 500 people. About one-third of experimental drugs successfully complete both Phase I and Phase II studies (CenterWatch).

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Phase III studies involve randomized and blind testing in several hundred to several thousand patients. This large-scale testing, which can last several years, provides the pharmaceutical company and the FDA with a more thorough understanding of the effectiveness of the drug or device, the benefits and the range of possible adverse reactions. 70% to 90% of drugs that enter Phase III studies successfully complete this phase of testing (CenterWatch). Once Phase III is complete, a pharmaceutical company can request FDA approval for marketing the drug.

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Phase IV studies, often called Post Marketing Surveillance Trials, are conducted after a drug or device has been approved for consumer sale. These studies have become more prevalent in recent years as the trials can be used to monitor long-term risks and benefits, evaluate dosage levels, and to record safety and efficacy data.

*Outsourcing of Clinical Research*

Research sponsors commonly partner with outsourcing providers to take advantage of their clinical research expertise, skilled workforce and resources to help accelerate the development of treatments for the cure and prevention of disease. In 2007, pharmaceutical and biotechnology companies spent approximately $57 billion on outsourcing, according to the economics research and analytics division of Frost & Sullivan. Of this amount, approximately 25% was spent on clinical trials and is expected to increase to 35% over the next five years.

The outsourcing of clinical research and testing developed mostly in the late 1990's as pharmaceutical R&D efforts became more complex and competition in rapidly-growing therapeutic areas increased. Traditionally thought of as a short-term strategy, outsourcing is now being used to lever the pharmaceutical industry s core competencies to maximize productivity. The global market for contract clinical research services is highly fragmented and comprises contract research organizations (CROs) of varying size, as well as hundreds of niche service providers and independent consultants. In 2007, pharmaceutical and biotechnology companies spent approximately $8.5 billion on contracted clinical services.

Outsourcing offers a number of advantages to pharmaceutical and biotechnology companies. Outsourcing provides solutions to the following issues pharmaceutical and biotechnology companies may face.

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Sponsors can convert the fixed costs of maintaining the personnel, expertise and facilities into variable costs

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Supplemental expertise not available in-house

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Knowledge of regulatory affairs in a particular country of interest

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Increased complexity of clinical trials

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Necessity for medical and clinical knowledge in specific therapeutic areas or indications

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Increased amount of data required from clinical trials

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Multinational and multi-center nature of current clinical trials

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Requirement for large patient populations

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Regionalized diseases

*Current Outsourcing Market*

Over the last few years, economic and competitive forces have led pharmaceutical and biotechnology companies to reduce corporate expenses and scale down their development, manufacturing and marketing operations. Pharmaceutical companies have traditionally been highly insulated from economic down-turns because people relying on drug treatments still need their medications. Historically, the greatest influence on changes in R&D spending and the approach toward more or less outsourcing has been merger and acquisition activity where the acquirer re-evaluates the pipelines, consolidates and then moves forward again with their R&D activities. In the current economic environment, however, the global economy has negatively impacted pharmaceutical companies and, more so, smaller biotechnology companies constrained by a lack of access to private and public capital. While their research pipelines have been fairly diverse, pharmaceutical companies are now making a conscious effort to focus on their most promising development projects in their respective core clinical areas of expertise while significantly reducing or eliminating other projects. This has resulted in lay-offs, closures or sale of plant facilities, and other cost-saving measures. At the same time, pharmaceutical companies are seeking to bolster their pipelines by licensing and/or acquiring potential new products and technologies, and are also taking advantage of the current situation to acquire biotechnology companies at very low multiples.

*Our Business*

We provide a flexible range of traditional contract staffing, clinical research outsourcing, drug safety monitoring, and regulatory consulting services to pharmaceutical, biotechnology and medical device companies, as well as to contract research organization (CRO) customers. In 2008, segment revenue was $99.1 million. We market these services through multiple brand offerings, which have allowed us to establish a significant geographic footprint in the U.S. along with an important presence in the European market. The brands that comprise our clinical trials services segment are as follows:

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ClinForce provides clinical research professionals for in-sourced and out-sourced contract assignments and permanent placement services. Customers include pharmaceutical, biotechnology and medical device companies, as well as CROs. Acquired in March 2001, it is headquartered at the Research Triangle Park in Durham, North Carolina.

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Metropolitan Research Associates (MRA) provides clinical trials management services and functional drug safety solutions. MRA has extensive experience across a wide range of therapeutic areas, including: women s health, central nervous system (CNS), pain management, infectious disease and obesity. Customers include pharmaceutical,

biotechnology and medical device companies. Acquired in August 2006, it is based in New York, New York.

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AKOS provides drug safety, regulatory and clinical trial services to pharmaceutical, biotechnology and medical device companies, as well as CROs, in Europe, the U.S., Canada and Asia. Acquired in June 2007, it is based in Harpenden Hertfordshire, England and is strategically located inside what is considered to be the UK s research triangle that extends outward from London to Cambridge and Oxford Universities.

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Assent provides contract staffing services to pharmaceutical and biotechnology customers primarily in the western U.S. Acquired in July 2007, it is based in Cupertino, California.

*Recruitment*

We recruit qualified candidates for our clinical trials services segment from across the U.S. and internationally for clinical research opportunities, which include temporary and permanent positions with our clients and within our CRO services businesses. For our contract staffing services businesses, we recruit professionals from numerous clinical research disciplines, including: clinical monitors/contract research associates, clinical project managers, site coordinators/contract research coordinators, drug safety personnel, medical monitors, regulatory affairs personnel, medical writers, clinical data professionals, statistical and SAS programmers, and various preclinical related professionals. Recruiting for our CRO services businesses consist primarily of clinical monitors, clinical project managers, medical monitors, regulatory affairs personnel, and drug safety associates.

**Other Human Capital Management Services**

*Education and Training Services*

Our Cross Country Education (CCE) subsidiary, headquartered in Brentwood, Tennessee, provides continuing education programs to the healthcare industry. CCE offers one-day seminars and e-learning, as well as national and regional conferences on topics relevant to nurses and other healthcare professionals. In 2008, CCE held more than 5,500 seminars and conferences that were attended by more than 170,000 registrants in 259 cities across the U.S. We extend these educational services to our field employees on favorable terms as a recruitment and retention tool.

*Retained Search*

Our Cejka Search subsidiary, headquartered in Creve Coeur, Missouri, is a nationally recognized retained search organization that provides physician and executive search services throughout the U.S. exclusively to the healthcare industry, including physician group practices, hospitals and health systems, academic medical centers, managed care, and other healthcare organizations.

**Additional Information About Our Business**

*Growth and Investment Strategy*

Our long-term corporate strategy for growth includes: attracting additional healthcare facility customers and healthcare professional clients and providers; strengthening our market position and margins in our businesses; generating strong cash flow; making strategic acquisitions in high growth, high margin businesses that will strengthen and broaden our market presence; and maintaining a strong balance sheet to provide financial flexibility.

*Competitive Strengths*

We are a diversified provider of healthcare staffing services. This allows us to offer the most comprehensive suite of staffing and outsourcing services to the U.S. healthcare market. Effective with the MDA acquisition, we believe:

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We are one of the top two providers of nurse and allied staffing services.

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We are one of the top three providers of locum tenens and physician search services.

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We are one of the top five providers of clinical trials staffing services.

Since becoming a public company in 2001, we have significantly expanded our revenue mix across sectors of healthcare staffing services and customers. For the fourth quarter of 2008, our nurse and allied staffing business segment was 60% of our revenue; our physician staffing business segment was 22% of our revenue; our clinical trials services business segment was 12% of our revenue and our other human capital management services business

segment was 6% of our revenue. This compares to our revenue mix in 2001 in which 88% was from our nurse and allied staffing business segment, 6% from our clinical trials services business segment and 6% from our other human capital management services business segment.

Within our business segments, we also believe we have:

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*Brand Recognition.* We have operated in the travel nurse staffing industry for more than 30 years. Our Cross Country Staffing brand is well-recognized among leading hospitals and healthcare facilities and our Cross Country TravCorps and MedStaff brands are well-recognized by RNs and other healthcare professionals. We believe that through our relationships with hospitals and healthcare facilities in supplying our travel nurse staffing services that we also are positioned to effectively market our allied health and per diem nurse staffing services to them. Our physician staffing business was founded in 1987 and has built a strong national brand reputation among hospital and physician practice group clients as well as physician providers. It has grown to become one of the largest physician staffing companies in the U.S. while competing in what continues to be the fastest growing sector of healthcare staffing. Since entering the clinical trials services business in 1998, our business has grown organically and by acquisition into a provider of a broad range of services to pharmaceutical, biotechnology and medical device companies from our strong national footprint in the U.S. along with an international presence. Our Cejka Search brand is ranked among the top five physician placement firms in the U.S.

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*Strong and Diverse Client Relationships.* We provide healthcare staffing and outsourcing solutions to a national client base represented by more than 5,000 contracts with hospitals and healthcare facilities, pharmaceutical and biotechnology companies, and other healthcare providers. No single client accounts for more than 3% of our revenue.

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*Vendor Management Capabilities.* Our Cross Country Staffing brand offers its vendor management services to large acute care hospitals and health systems. By leveraging technology and its single-point of contact service model, Cross Country Staffing can manage all job orders, credential verification, candidate testing, invoicing, and management reporting. Cross Country Staffing also seeks to gain preferred provider relationships with hospitals and health systems.

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*Recruiting and Employee Retention.* We are a leader in recruiting and retaining highly qualified healthcare professionals from throughout the U.S. and Canada. We also recruit RNs internationally from certain other English-speaking foreign countries, assist them in obtaining U.S. nursing licenses, sponsor them for U.S. permanent residency visas, and then place them on assignments in domestic acute care hospitals. In 2008, thousands of healthcare professionals applied with us through our differentiated recruitment brands. Referrals generated a majority of our new candidates. We believe we offer appealing assignments, competitive compensation packages, attractive housing options and other valuable benefits.

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*The Joint Commission Certification.* Our nurse staffing brands of Cross Country Staffing and MedStaff are certified by The Joint Commission under its Health Care Staffing Services Certification Program.

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*Quality Assurance.* MDA s Credent credential verification division is NCQA certified, one of only a handful of competitors to achieve such certification.

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*Continuing Education.* Cross Country University, the first educational program in the travel nurse industry to be accredited by the American Nurse Credentialing Center, enables us to provide continuing education credits to our RN field employees, as well as provide accredited continuing education to other healthcare professionals.

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*Scalable and Efficient Operating Structure.* At year-end 2008, the databases for our travel nurse and allied staffing businesses included more than 250,000 RNs and other healthcare professionals who completed job applications with us. Similarly, the database for our physicians staffing business included more than 150,000 physicians representing dozens of specialties. Our size and centralized staffing structure provide us with operating efficiencies in key areas such as recruiting, marketing and advertising, training, housing and insurance. Our proprietary information systems enable us to manage our recruitment and placement operations. Our systems are scalable and designed to

accommodate significant future growth.

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*Strong Management Team with Extensive Healthcare Staffing and Acquisition Experience.* Our management team has played a key role in the growth and development of the healthcare staffing industry. Our management team averages more than 10 years of experience in the healthcare industry and has consistently demonstrated the ability to successfully identify, make and integrate strategic acquisitions.

*Competitive Environment*

All of our businesses operate in highly competitive markets. In our nurse and allied and our physician staffing businesses, the principal competitive factors in attracting and retaining healthcare clients include the ability to fill client needs on a timely basis, price, customer service, quality assurance and screening capabilities, compliance with regulatory requirements, having an understanding of the client s work environment, risk management policies and coverages, and general industry reputation. Our clinical trials services business shares these same competitive factors while also recognizing that our pharmaceutical, biotechnology and medical device company customers operate in a highly regulated environment. Being able to successfully provide our staffing and outsourcing services for various types of clinical projects includes our clinical experience and expertise, understanding of the regulatory process, price, overall project management, recruitment and project oversight of personnel, quality control, data management, communication, and timely delivery of materials, documents and data. The level of demand for our temporary staffing and outsourcing services is influenced by, among other things, the number and acuity of patients requiring medical care in hospitals and physician offices, availability and affordability of healthcare insurance coverage, national healthcare spending and reimbursement for medical care, R&D efforts and spending related to development of potential new drugs and devices, mergers and acquisitions, general economic conditions and their impact on labor markets and healthcare employment, and the corresponding supply of healthcare professionals available to us for placement on assignments.

The principal competitive factors in attracting qualified candidates for temporary employment include a large national pool of desirable assignments based on geographic location and clinical setting, wages and benefits, speed of placements, recruitment

team customer service, quality of accommodations, and overall industry reputation. We believe that healthcare professionals seeking temporary employment through us are also pursuing employment through other means, including other temporary staffing firms. Therefore, the ability to move more quickly than our competitors to candidate inquiries and submit candidates for consideration, are important factors in our ability to fill assignments. We focus on retaining field employees by providing high-quality customer service along with long-term benefits, such as 401(k) plans and bonuses. Although we believe that the relative size of our databases and economies of scale derived from the size of our operations make us attractive for healthcare professionals seeking assignment opportunities, we expect competition for candidates to continue.

Nurse and Allied Staffing

The nurse and allied staffing market is highly competitive, barriers to entry are relatively low, but achieving substantial scale is very challenging. We believe the utilization of temporary nurse staffing services by hospitals is approximately one-quarter to one-third travel nurse staffing and approximately two-thirds to three-quarters per diem nurse staffing. We compete with a relatively small number of national travel nurse staffing companies, as well as hundreds of smaller and more localized staffing firms that have the capabilities to relocate nurses. We also compete in per diem nurse staffing with a small number of national or regional staffing firms along with thousands of small local providers. National competitors in nurse staffing include AMN Healthcare Services, Inc., On Assignment, Inc., CHG Group, Medfinders, Medical Staffing Network Holdings, Inc., and Jackson Healthcare.

Physician Staffing

Our physician staffing business competes in the healthcare staffing market on a national, regional and local basis with other staffing companies that offer comprehensive and or specialized services to provide hospitals, physician practice groups, healthcare facilities and systems, and government agencies with temporary physicians to fill assignments across a wide range of specialties. We also compete in the recruitment for qualified physicians with other staffing companies as well as hospitals, physician practice groups, and healthcare facilities and systems that have their own internal recruitment capabilities to attract and retain healthcare providers. Competitors include AMN Healthcare Services, Inc., CHG Group, On Assignment, Jackson Healthcare, and several other privately-held companies providing locum tenens.

Clinical Trials Services

The clinical trials services industry is highly competitive and fragmented. In addition to the same competitive factors outlined above, our clinical trials services business has the added challenges associated with pharmaceutical, biotechnology and medical device company customers that operate in a highly regulated environment. Being able to successfully provide our staffing and outsourcing services for various types of clinical projects includes our clinical experience and expertise, understanding of the regulatory process, price, overall knowledge of project management, recruitment and project oversight of personnel, quality control, data management, communication, and timely delivery of materials, documents and data. We also compete to recruit a wide range of qualified professionals in the U.S. and internationally across numerous clinical research disciplines for our staffing, drug safety, CRO and regulatory services assignments. Competitors include divisions of publicly-held companies such as Kforce, Inc., inVentiv Health, Inc. and Kelly Services, as well as hundreds of niche service providers and free-lance consultants. We also supply our clinical trials staffing services to, and sometimes compete with, large CROs such as Quintiles, Covance Inc., Pharmaceutical Products Development, Inc. and Kendle International, among others.

*Systems*

Our placement and support operations are enhanced by sophisticated information systems that facilitate smooth interaction between our recruitment and support activities. Our proprietary information systems enable us to manage virtually all aspects of our travel staffing operations. These systems are designed to accommodate significant future growth of our business. In addition, their scalable design allows further capacity to be added to the existing hardware platform. We have proprietary software that handles most facets of our business, including contract pricing and profitability, contract processing, job posting, housing management, billing/payroll and insurance. Our systems provide support to our facility clients and field employees and enable us to efficiently fulfill and renew job assignments. Our systems also provide detailed information on the status and skill set of each registered field employee.

Our financial, management reporting and human resources systems are managed on PeopleSoft®. PeopleSoft is a leading enterprise resource planning software suite that provides modules used to manage our accounts receivable, accounts payable, general ledger, billing and human resources. This system is designed to accommodate significant future growth in our business.

*Workers Compensation and Professional Liability*

We record our estimate of the ultimate cost of, and reserves for, workers compensation and professional liability benefits based on actuarial models prepared or reviewed by an independent actuary using our loss history as well as industry statistics. Furthermore, in determining our reserve, we include reserves for estimated claims incurred but not reported. The ultimate cost of workers compensation and professional liability insurance costs will depend on actual costs incurred to settle the claims and may differ from the amounts reserved by us for those claims.

Workers compensation benefits are provided under a partially self-insured plan. For claims reported prior to September 1, 2008, the workers compensation insurance carrier required us to fund a reserve for payment of claims. Those funds are maintained by the insurance carrier. We had approximately $5.0 million and $6.7 million recorded as prepaid workers compensation expense included in other current assets on the consolidated balance sheets at December 31, 2008 and December 31, 2007, respectively. Effective September 1, 2008, we have moved from a pre-funded program to a letter of credit structure to guarantee payments of claims. At December 31, 2008, we had outstanding $3.3 million in standby letters of credit related to workers compensation policies.

Professional liability benefits are provided under various self-insured, claims-made and occurrence based plans depending on the subsidiary and the applicable policy year. Effective October 2004, we implemented individual occurrence-based professional liability insurance policies with no deductible, for virtually all of our working nurses and allied professionals, other than those employed through our MedStaff subsidiary. This coverage substantially replaced a $2.0 million per-claim layer of self-insured exposure. Effective October 1, 2008, the individual professional liability insurance policies were replaced with one policy that insures each individual nurse for $2.0 million per occurrence and $4.0 million in the aggregate, as well as the corporation which shares those limits. This policy has no deductible and does not cover healthcare professionals working through MedStaff or MDA.

Separately, our MedStaff subsidiary has a claims-made professional liability policy with a limit of $2.0 million per occurrence, $4.0 million in the aggregate and a $25,000 deductible. In addition, MDA has an occurrence-based professional liability policy with a limit of $1.0 million per occurrence, $3.0 million in the aggregate and a $0.5 million deductible for MDA, its independent contractor physicians, CRNAs and allied health professionals. MDA s $0.5 million deductible is insured by Jamestown Indemnity Ltd., a Cayman Island company and a wholly-owned subsidiary of MDA Holdings, Inc. (the Captive). Under the terms of the Captive s reinsurance policy it is required to guarantee the payment of claims to its insured party s primary medical malpractice insurance carrier via a $5.0 million letter of credit. The value of the letter of credit is secured by $5.0 million of cash held by the Captive as restricted cash.

Subject to certain limitations, we also have $5.0 million per occurrence and $10.0 million in the aggregate in umbrella liability insurance coverage, after the individual policies, MedStaff s policy and the $2.0 million self-insured primary coverage, as applicable, have been exhausted.

*Professional Licensure*

Nurses, physicians and most other healthcare professionals employed by us are required to be individually licensed or certified under applicable state law. In addition, the healthcare professionals that we staff are frequently required to be certified to provide certain medical care, such as cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS), depending on the positions in which they are placed. Our comprehensive compliance program is designed to ensure that our employees possess all necessary licenses and certifications, and we endeavor to ensure that our employees, including nurses and therapists, comply with all applicable state laws.

*Business Licenses*

A number of states require state licensure for businesses that, for a fee, employ and assign personnel, including healthcare personnel, to provide services on-site at hospitals and other healthcare facilities to support or supplement the hospitals or healthcare facilities workforces. A number of states also require state licensure for businesses that operate placement services for individuals attempting to secure employment. Failure to obtain the necessary licenses can result in injunctions against operating, cease and desist orders, and/or fines. We endeavor to maintain in effect all required state licenses.

*Regulations Affecting Our Clients*

Many of our clients are reimbursed under the federal Medicare program and state Medicaid programs for the services they provide. In recent years, federal and state governments have made significant changes in these programs that have reduced reimbursement rates. In addition, insurance companies and managed care organizations seek to control costs by requiring that

healthcare providers, such as hospitals, discount their services in exchange for exclusive or preferred participation in their benefit plans. Future federal and state legislation or evolving commercial reimbursement trends may further reduce, or change conditions for, our clients reimbursement. Such limitations on reimbursement could reduce our clients cash flows, hampering their ability to pay us. Pharmaceutical, biotechnology and medical diagnostic companies are subject to regulations of the FDA in the U.S. and similar regulatory agencies in other countries.

*Immigration*

Changes in immigration law and procedures following September 11, 2001, have slowed our ability to recruit foreign nurses to meet demand, and changes to such procedures in the future could further hamper our overseas recruiting efforts. In addition, the use of foreign nurses entails greater difficulty in ensuring that each professional has the proper credentials and licensure.

*Regulations Applicable to Our Business*

Our business is subject to extensive regulation by numerous governmental authorities in the United States and the foreign jurisdictions in which we operate. In the U.S., complex federal and state laws and regulations govern, among other things, the eligibility of our foreign nurses to work in the U.S., the licensure of professionals, the payment of our employees (e.g. wage and hour laws, employment taxes and income tax withholdings, etc.) and the operations of our business generally. We conduct business on a national basis and are subject to the laws and regulations applicable to our business in such states, which may be amended from time to time. Future federal and state legislation or interpretations thereof may require us to change our business practices. Compliance with all of these applicable rules and regulations require a significant amount of resources. We endeavor to be in compliance with all such rules and regulations.

**Employees**

As of December 31, 2008, we had approximately 1,430 corporate employees and during 2008, we had an average of 4,463 full-time equivalent field employees in our nurse and allied staffing segment. We are not subject to a collective bargaining agreement with any of our employees. We consider our relationship with employees to be good.

**Available Information**

Financial reports and filings with the Securities and Exchange Commission (SEC), including this Annual Report on Form 10-K, are available free of charge as soon as reasonably practicable after filing such material with, or furnishing it to, the SEC, on or through our corporate website at www.crosscountryhealthcare.com.

**Item 1A.**

**Risk Factors.**

*You should carefully consider the following risk factors, as well as the other information contained in this Annual Report on Form 10-K.*

***We may be unable to recruit enough healthcare professionals to meet our clients demands.***

We rely significantly on our ability to attract, develop and retain healthcare professionals who possess the skills, experience and, as required, licensure necessary to meet the specified requirements of our healthcare clients. We compete for healthcare staffing personnel with other temporary healthcare staffing companies, as well as actual and potential clients such as healthcare facilities, physician groups and pharmaceutical and biotechnology companies, some of which seek to fill positions with either regular or temporary employees. Currently, there is a shortage of certain qualified nurses and physicians in most areas of the United States and competition for these professionals remains intense. The current slowdown in the economy may make these healthcare professionals less willing to travel to temporary assignments, thus further intensifying the competition with other temporary healthcare staffing companies to recruit these healthcare professionals. Although demand by our clients has slowed, at this time we still do not have enough nurses and physicians to meet all of our clients demands for these staffing services. This shortage of healthcare professionals generally and their willingness to leave stable full-time jobs to travel on temporary assignments in the current environment may limit our ability to increase the number of healthcare professionals that we successfully recruit, decreasing our ability to grow our business.

***The costs of attracting and retaining healthcare professionals may rise more than we anticipate.***

We compete with hospitals, healthcare facilities, physician groups and other healthcare staffing companies for qualified healthcare professionals. Because there is currently a shortage of qualified healthcare professionals, competition for them is intense. Our ability to recruit and retain healthcare professionals depends on our ability to, among other things, offer assignments that are attractive to healthcare professionals and offer them competitive wages and benefits or payments, as

applicable. Our competitors might increase hourly wages or other benefits to induce healthcare professionals to take assignments with them. If we do not raise wages or other benefits in response to such increases by our competitors, we could face difficulties attracting and retaining qualified healthcare professionals. In addition, if we raise wages in response to our competitors wage increases and are unable to pass such cost increases on to our clients, our margins could decline.

***Our costs of providing housing for our healthcare professionals may be higher than we anticipate and, as a result, our margins could decline.***

We provide housing for certain of our healthcare professionals when on an assignment with us. At any given time, we have several thousand apartments on lease throughout the U.S. Typically, the length of an apartment lease is coterminous with the length of the assignment of a nurse or allied healthcare professional. If the costs of renting apartments and furniture for these healthcare professionals increase more than we anticipate and we are unable to pass such increases on to our clients, our margins may decline. To the extent the length of a nurse s housing lease exceeds the term of the nurse s staffing contract, we bear the risk that we will be obligated to pay rent for housing we do not use. To limit the costs of unutilized housing, we try to secure leases with term lengths that match the term lengths of our staffing contracts, typically 13 weeks. In some housing markets we have had, and believe we will continue to have, difficulty identifying short-term leases. If we cannot identify a sufficient number of appropriate short-term leases in regional markets, or, if for any reason, we are unable to efficiently utilize the apartments we do lease, we may be required to pay rent for unutilized housing, or, to avoid such risk, we may have to forego otherwise profitable opportunities.

***Our clients may terminate or not renew their contracts with us.***

Our arrangements with hospitals, healthcare facilities and physician group clients are generally terminable upon 30 to 90 days notice. We may have fixed costs, including housing costs, associated with terminated arrangements that we will be obligated to pay post-termination. Our clinical trials services business is conducted under longer-term contracts with individual clients that may perform numerous clinical trials. Some of these contracts are terminable by the clients without cause upon 30 to 60 days notice. Sponsors may decide to immediately discontinue trials at any time if compounds or biologics being studied do not meet targeted expectations. Clients utilizing our clinical trials services may also decide to offshore work outside of the United States to countries where we do not currently provide those services and this could adversely impact our business. Clients may also develop their own in-house capabilities that may replace their need to utilize our staffing and outsourcing clinical trials services. The delay, loss, termination or unfavorable change in the scope of work performed under a clinical trials services contract could negatively impact our business.

***Decreases in demand by our clients may adversely affect the profitability of our business.***

Among other things, changes in the economy which result in higher unemployment and low job growth, a decrease or stagnation in the general level of in-patient admissions at our clients facilities and the willingness of our hospital, healthcare facilities and physician group clients to develop their own temporary staffing pools and increase the productivity of their permanent staff may, individually or in the aggregate, significantly affect demand for our temporary healthcare staffing services and hamper our ability to attract, develop and retain clients. When a hospital s admissions increase, temporary employees or other healthcare professionals are often added before full-time employees are hired. As admissions decrease, clients may reduce their use of temporary employees or other healthcare professionals before undertaking layoffs of their regular employees. In a down market, healthcare professionals may

be less likely to leave a full-time position to work on temporary assignments and clients are also more likely to focus on internal solutions for their temporary staffing needs. In addition, we also may experience more competitive pricing pressure during periods when in-patient admissions are stagnant for periods of time or declining. In addition, if a trend emerges toward providing healthcare in alternative settings, as opposed to acute care hospitals, in-patient admissions at our clients facilities could decline. These events individually or in the aggregate may cause a reduction in admissions that could negatively affect the demand for our services. Decreases in demand for our services may affect our ability to provide attractive assignments to our healthcare professionals thereby reducing our profitability.

***Any failure by our clinical trials services business to comply with certain policies and procedures and regulations specific to that business could harm our reputation and operating results.***

Our clinical trials service business operates in a highly regulated industry. Any failure on our part to comply with the policies and procedures established for a trial or to comply with existing regulations could result in the termination of ongoing research or the disqualification of data for submission to the Federal Drug Administration ( FDA ) and other regulatory authorities. This could harm our reputation, our ability to win future business and our operating results. In addition, if the

FDA or another similar regulatory body finds a material breach by us of sound clinical practices, it could result in the termination of a clinical trial and that could harm our reputation, our ability to win future business and our operating results.

***The nature of our clinical trials services contracts could hurt our operating results.***

Some of our contracts are fixed price and, as such, we have limits on the amounts we can charge for our clinical trials services. As a result, the profitability of this business could be negatively impacted due to changes in the timing and progress of large contracts. In addition, we may be responsible for cost overruns on certain contracts unless the scope of work is revised from the original contract terms and we are able to negotiate an amendment with the client shifting the additional cost to the client. If we experience significant cost overruns, it may result in lower gross margins on those projects.

***Our clinical trials business exposes us to potential liability for personal injury and wrongful death claims that could affect our reputation and operating results.***

Our clinical trials services business is involved in the testing of new drugs and medical devices on volunteer human beings. Due to the risk of personal injury or death to patients participating in clinical trials, we are at risk for being sued in personal injury or wrongful death lawsuits due to possible unforeseen adverse side effects or the improper administration of a drug or device. Many of these patients are already seriously ill. Under our contracts, we are typically indemnified unless the resulting damages were caused by our negligence (e.g. serious adverse event is not reported timely to a sponsor or unblinding of material for a study is not done timely to respond with appropriate information for patient safety reasons). We have limited insurance coverage for certain events, however, the amount of our liability could materially impact our operating performance and our reputation and our insurance program may not cover such event.

***We are dependent on the proper functioning of our information systems.***

We are dependent on the proper functioning of our information systems in operating our business. Critical information systems used in daily operations identify and match staffing resources and client assignments and perform billing and accounts receivable functions. Additionally, we rely on our information systems in managing our accounting and financial reporting. If these systems are damaged or disrupted and unable to function properly in order to support our business operations or require significant costs to repair, maintain or further develop, our business and financial results could be materially adversely affected. Our information systems are protected through a secure hosting facility and additional backup remote processing capabilities also exist in the event our primary systems fail or are not accessible. However, the business is still vulnerable to fire, storm, flood, power loss, telecommunications failures, physical or software break-ins and similar events which may prevent personnel from gaining access to systems necessary to perform their tasks in an automated fashion. In the event that critical information systems fail or are otherwise unavailable, these functions would have to be accomplished manually, which could impact our ability to identify business opportunities quickly, to maintain billing and clinical records reliably, to bill for services efficiently and to maintain our accounting and financial reporting accurately.

***Losses caused by natural disasters, such as hurricanes could cause us to suffer material financial losses.***

Catastrophes can be caused by various events, including, but not limited to, hurricanes and other severe weather. The incidence and severity of catastrophes are inherently unpredictable. The extent of losses from a catastrophe is a function of both the total amount of insured exposure and the severity of the event. We do not maintain business interruption insurance for these events. We could suffer material financial losses as a result of such catastrophes.

***If applicable government regulations change, we may face increased costs that reduce our revenue and profitability.***

The temporary healthcare staffing industry is regulated in many states. For example, in some states, firms such as our nurse staffing companies must be registered to establish and advertise as a nurse-staffing agency or must qualify for an exemption from registration in those states. If we were to lose any required state licenses, we could be required to cease operating in those states. The introduction of new regulatory provisions could substantially raise the costs associated with hiring temporary employees. For example, some states could impose sales taxes or increase sales tax rates on temporary healthcare staffing services. These increased costs may not be able to be passed on to clients without a decrease in demand for temporary employees. In addition, if government regulations were implemented that limited the amounts we could charge for our services, our profitability could be adversely affected.

***If certain of our healthcare professionals are reclassified from independent contractors to employees our profitability could be materially adversely impacted.***

Federal or state taxing authorities could re-classify our locum tenens physicians and certified registered nurse anesthetists as employees, despite both the general industry standard to treat them as independent contractors and many state laws prohibiting non-physician owned companies from employing physicians (e.g. the corporate practice of medicine ). If they were re-classified as employees, we would be subject to, among other things, employment and payroll-related tax claims, as well as any applicable penalties and interest. Any such reclassification would have a material adverse impact on our business model for that business segment and would negatively impact our profitability.

***We are exposed to increased costs and risks associated with complying with increasing and new regulation of corporate governance and disclosure standards.***

We are spending an increased amount of management s time and resources, since the inception of the Sarbanes-Oxley Act of 2002, to comply with changing laws, regulations and standards relating to corporate governance and public disclosures. The compliance requires management s annual review and evaluation of our internal control systems and attestations of the effectiveness of these systems by our independent auditors. This process has required us to hire additional personnel and has resulted in additional accounting and legal expenses. We may encounter problems or delays in completing the review and evaluation, the implementation of improvements and the receipt of a positive attestation by our independent auditors. If we are not able to timely comply with the requirements set forth in Section 404 of the Sarbanes-Oxley Act of 2002, we might be subject to sanctions or investigation by regulatory authorities. Any such action could adversely affect our business and financial results.

***Substantial changes in healthcare reform or reimbursement trends could hinder our clients ability to pay us.***

While in most cases our fees are paid directly by our clients rather than by governmental or third-party payers, many of our clients are reimbursed under the federal Medicare program and state Medicaid programs for the services they provide. Changes made by federal and state governments could reduce reimbursement rates. In addition, insurance companies and managed care organizations seek to control costs by requiring that healthcare providers, such as hospitals, discount their services in exchange for exclusive or preferred participation in their benefit plans. Future federal and state legislation or evolving commercial reimbursement trends may further reduce, or change conditions for, our clients reimbursement. Limitations on reimbursement could reduce our clients cash flows, hampering their ability to pay us.

***Competition for acquisition opportunities may restrict our future growth by limiting our ability to make acquisitions at reasonable valuations and lack of liquidity in the credit markets may restrict our ability to make certain acquisitions.***

Our business strategy includes strategic acquisitions of companies that complement or enhance our business. We have historically faced competition for acquisitions. In the future, this could limit our ability to grow by acquisition or could raise the prices of acquisitions and make them less accretive to our earnings. In addition, even if we are able to negotiate acceptable terms at reasonable valuations, there can be no assurance that there will be sufficient liquidity available on terms favorable to us to complete such acquisition. If we are unable to secure necessary financing under our credit facility or otherwise, we may be unable to complete desirable acquisitions. Certain restrictive covenants in our credit facility may also limit our ability to complete acquisitions.

***We may face difficulties integrating our acquisitions into our operations and our acquisitions may be unsuccessful, involve significant cash expenditures or expose us to unforeseen liabilities.***

We continually evaluate opportunities to acquire companies that would complement or enhance our business and at times have preliminary acquisition discussions with some of these companies.

These acquisitions involve numerous risks, including:

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Potential loss of key employees or clients of acquired companies;

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Difficulties integrating acquired personnel and distinct cultures into our business;

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Difficulties integrating acquired companies into our operating, financial planning and financial reporting systems;

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Diversion of management attention from existing operations; and

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Assumptions of liabilities and exposure to unforeseen liabilities of acquired companies, including liabilities for their failure to comply with healthcare and tax regulations.

These acquisitions may also involve significant cash expenditures, debt incurrence and integration expenses that could have a material adverse effect on our financial condition and results of operations. Any acquisition may ultimately have a negative impact on our business and financial condition.

***We operate our business in a regulated industry and modifications, inaccurate interpretations or violations of any applicable statutory or regulatory requirements may result in material costs or penalties to our Company and could reduce our revenue and earnings per share.***

Our industry is subject to many complex federal, state and international laws and regulations related to, among other things, the eligibility of our foreign nurses to work in the U.S., the licensure of professionals, the payment of our field employees (e.g., wage and hour laws, employment taxes and income tax withholdings, etc.) and the operations of our business generally. If we do not comply with the laws and regulations that are applicable to our business (both domestic and foreign), we could incur civil and/or criminal penalties or be subject to equitable remedies.

***Impairment in the value of our goodwill or other intangible assets could adversely affect us.***

We are required to test goodwill and intangible assets with indefinite lives annually, including the goodwill associated with past acquisitions and any future acquisitions, to determine if impairment has occurred. Interim reviews must also be performed whenever events or changes in circumstances indicate that impairment may have occurred. If the testing performed indicates that impairment has occurred, we are required to record a non-cash impairment charge for the difference between the value of the goodwill or other intangible assets and the implied fair value of the goodwill or other intangible assets in the period the determination is made. During the fourth quarter of 2008, we recorded impairment charges of $244.1 million, pretax, pursuant to these assessments. The testing of goodwill and other intangible assets for impairment requires us to make significant estimates about our future performance and cash flows, as well as other assumptions. These estimates can be affected by numerous factors, including changes in economic, industry or market conditions, changes in business operations, changes in competition or potential changes in our stock price and market capitalization. Changes in these factors, or changes in actual performance compared with estimates of our future performance, could affect the fair value of goodwill or other intangible assets, which may result in an impairment charge. We cannot accurately predict the amount and timing of any impairment of assets. Should the value of goodwill or other intangible assets become impaired, there could be an adverse effect on us. At December 31, 2008, goodwill and other identifiable intangible assets (net of amortization) represented 93.8% of our total assets.

***Significant legal actions could subject us to substantial uninsured liabilities.***

In recent years, healthcare providers have become subject to an increasing number of legal actions alleging malpractice, vicarious liability, violation of certain consumer protection acts, negligent hiring, product liability or related legal theories. We may be subject to liability in such cases even if the contribution to the alleged injury was minimal. Many of these actions involve large claims and significant defense costs. In addition, we may be subject to claims related to torts or crimes committed by our corporate employees or healthcare professionals. In most instances, we are required to indemnify clients against some or all of these risks. A failure of any of our corporate employees or healthcare professionals to observe our policies and guidelines intended to reduce these risks, relevant client policies and guidelines or applicable federal, state or local laws, rules and regulations could result in negative publicity, payment of fines or other damages.

A key component of our business is the credentialing process. Ultimately, any hospital or other health care provider is responsible for its own internal credentialing process, and the provider typically makes the decision to allow a healthcare professional to provide services on behalf of the client. Nevertheless, in many situations, the provider will be relying upon the reputation and screening process of our Company. Errors in this process or failure to detect a poor or incorrect history could have a material effect on our reputation. In addition, we may not have access to all of the resources that are available to hospitals to check credentials.

To protect ourselves from the cost of these types of claims, we maintain professional malpractice liability insurance and general liability insurance coverage in amounts and with deductibles that we believe are appropriate for our operations. Our coverage is, in part, self-insured. However, our insurance coverage may not cover all claims against us or continue to be available to us at a reasonable cost. If we are unable to maintain adequate insurance coverage, we may be exposed to substantial liabilities.

***If our insurance costs increase significantly, these incremental costs could negatively affect our financial results.***

The costs related to obtaining and maintaining professional and general liability insurance and health insurance for healthcare providers has been increasing. If the cost of carrying this insurance continues to increase significantly, we will recognize an

associated increase in costs, which may negatively affect our margins. This could have an adverse impact on our financial condition.

***If we become subject to material liabilities under our self-insurance programs, our financial results may be adversely affected.***

We provide workers compensation coverage through a program that is partially self-insured. In addition, we provide medical coverage to our employees through a partially self-insured preferred provider organization. A portion of our medical malpractice coverage is also through a partially self-insured program. If we become subject to substantial uninsured workers compensation, medical coverage or medical malpractice liabilities, our financial results may be adversely affected.

***We are subject to litigation, which could result in substantial judgment or settlement costs.***

We are party to various litigation claims and legal proceedings. We evaluate these litigation claims and legal proceedings to assess the likelihood of unfavorable outcomes and to estimate, if possible, the amount of potential losses. Based on these assessments and estimates, if any, we establish reserves and/or disclose the relevant litigation claims or legal proceedings, as appropriate. These assessments and estimates are based on the information available to management at the time and involve a significant amount of management judgment. While we do have certain business insurance, it may not be sufficient to cover our need. We caution you that actual outcomes or losses may differ materially from those estimated by our current assessments which would impact our profitability. Adverse developments in existing litigation claims or legal proceedings involving our Company or new claims could require us to establish or increase litigation reserves or enter into unfavorable settlements or satisfy judgments for monetary damages for amounts in excess of current reserves, which could adversely affect our financial results for future periods.

***Until the sale by certain selling stockholders of a significant portion of their remaining shares, those selling stockholders will be able to substantially influence the outcome of all matters submitted to our stockholders for approval, regardless of the preferences of other stockholders.***

Charterhouse Equity Partners III (CEP III) and CHEF Nominees Limited (CHEF) own approximately 8% of our outstanding common stock and continue to have two designees serving on our Board of Directors (which is currently comprised of seven members). Accordingly, they will be able to substantially influence:

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the election of Directors

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management and policies; and

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the outcome of any corporate transactions or other matters submitted to our stockholders for approval, including mergers, consolidations and the sale of substantially all of our assets.

Under our stockholders agreement, the CEP Investors had the right to designate two directors for nomination to our Board of Directors. This number decreased (i) to one director when CEP reduced its ownership pursuant to a Secondary Offering in November 2006 by more than 50% of their holdings prior to our initial public offering and (ii) the number will decrease to zero upon a reduction of ownership by more than 90% of their holdings prior to our initial public offering. Their interests may conflict with the interests of the other holders of our common stock.

***A registration statement under the Securities Act covering resale of CEP III s stock is presently in effect and sales of this stock could cause our stock price to decline.***

We presently maintain an effective shelf registration under the Securities Act covering the resale of stock held by CEP III. These shares represent approximately 8% of our outstanding common stock and sales of the stock could cause our stock price to decline. In addition, we registered 4,398,001 shares of common stock for issuance under our 1999 stock option plans and 1,500,000 shares of common stock for our 2007 Stock Incentive Plan. Options to purchase 2,059,974 shares of common stock were issued and outstanding as of February 28, 2009 of which, options to purchase 2,046,514 shares were vested. In addition, 316,164 shares of stock appreciation rights were issued and outstanding as of February 28, 2009, 40,626 of which were vested. Shares of restricted stock outstanding as of February 28, 2009, were 179,884. Common stock issued upon exercise of stock options, stock appreciation rights and restricted stock, under our benefit plans, is eligible for resale in the public market without restriction.

We cannot predict what effect, if any, market sales of shares held by any stockholder or the availability of these shares for future sale will have on the market price of our common stock.

***If provisions in our corporate documents and Delaware law delay or prevent a change in control of our Company, we may be unable to consummate a transaction that our stockholders consider favorable.***

Our certificate of incorporation and by-laws may discourage, delay or prevent a merger or acquisition involving us that our stockholders may consider favorable. For example, our certificate of incorporation authorizes our Board of Directors to issue up to 10,000,000 shares of blank check preferred stock. Without stockholder approval, the Board of Directors has the authority to attach special rights, including voting and dividend rights, to this preferred stock. With these rights, preferred stockholders could make it more difficult for a third party to acquire us. Delaware law may also discourage, delay or prevent someone from acquiring or merging with us.

***Terrorist attacks or armed conflict could adversely affect our normal business activity and results of operations.***

In the aftermath of the terrorist attacks on September 11, 2001, we experienced a temporary interruption of normal business activity. Similar events in the future or armed conflicts involving the United States could result in additional temporary or longer-term interruptions of our normal business activity and our results of operations. Future terrorist attacks could also result in reduced willingness of nurses to travel to staffing assignments by airplane or otherwise.

***Market disruptions may adversely affect our operating results and financial condition.***

The current recessionary conditions and the continuation or intensification of any continued volatility in the financial markets may have an adverse impact on the availability of credit to our customers and businesses generally and could lead to a further weakening of the U.S. and global economies. To the extent that disruption in the financial markets continues and/or intensifies, it has the potential to materially affect our customers ability to tap into debt and/or equity markets to continue their ongoing operations, have access to cash and/or pay their debts as they come due, all of which could reasonably be expected to have an adverse impact on the number of open positions for healthcare staff they request, as well as their ability to pay for our temporary staffing services. Conditions in the credit markets and the economy generally could adversely impact our business and frustrate or prohibit us from refinancing the revolving loan portion of our indebtedness on terms favorable to us when it comes due on November 10, 2010.

The disruptions that the financial markets are currently undergoing have led to unprecedented governmental intervention on an emergency basis. The results of these actions have been unclear, resulting in confusion and uncertainty which in itself has been materially detrimental to the efficient functioning of the markets. It is impossible to predict what, if any, additional interim or permanent governmental restrictions may be imposed on the markets and/or the effect of such restrictions on us, our customers and the operations of corporate entities generally in the United States.

***We could fail to generate sufficient cash to fund our liquidity needs and/or fail to satisfy the financial and other restrictive covenants to which we are subject under our existing indebtedness.***

Our existing credit facility currently contains financial covenants that require us to operate at or below a maximum leverage ratio. Further deterioration in our operating results could result in our inability to comply with these covenants which would result in a default under our credit facility. If an event of default exists, our lenders could call the indebtedness and we may be unable to renegotiate or secure other financing.

***Our results may be adversely affected by the impact that disruptions in the credit and financial markets have on our customers.***

The deterioration of the financial markets and the economy generally have created increasingly difficult conditions for our hospital clients and the financial institutions they rely on for access to liquidity. In recent months, such volatility has reached unprecedented levels. These events could negatively impact our results of operations and financial conditions if this economic downturn persists as it may negatively impact our clients financial conditions and their ability to pay for our healthcare staffing services. Although we monitor our credit risks to specific clients that we believe may present credit concerns, default risk or lack of access to liquidity may result from events or circumstances that are difficult to detect or foresee.

**Item 1B.**

**Unresolved Staff Comments.**

None.

**Item 2.**

**Properties.**

We do not own any real property. Our principal leases as of December 31, 2008 are listed below.

| Location | Function | Square Feet | Lease Expiration |
|---|---|---|---|
| Boca Raton, Florida | Headquarters and nurse and allied staffing administration | 70,406 | May 1, 2018 |
| Norcross, Georgia | Temporary physician staffing and allied staffing offices | 50,000 | January 31, 2010 and February 28, 2014 |
| Durham, North Carolina | Clinical trials staffing headquarters | 37,851 | September 30, 2013 |
| Newtown Square, Pennsylvania | Nurse and allied staffing administration and general office use | 31,959 | February 1, 2014 |
| Malden, Massachusetts | Nurse and allied staffing administration and general office use | 31,662 | June 30, 2012 |
| Creve Coeur, Missouri | Retained search headquarters | 27,051 | June 14, 2017 |
| New York, New York | Clinical trials staffing office | 16,915 | May 30, 2010 |
| Tampa, Florida | Nurse and allied staffing administration and general office use | 15,698 | February 15, 2015 |
| Ambler, Pennsylvania | Clinical trials staffing operations site | 14,459 | September 30, 2013 |
| Brentwood, Tennessee | Education training corporate office | 14,157 | August 31, 2014 |

**Item 3.**

**Legal Proceedings.**

***Maureen Petray and Carina Higareda v. MedStaff, Inc.***

On February 18, 2005, the Company s MedStaff subsidiary became the subject of a purported class action lawsuit (*Maureen Petray and Carina Higareda v. MedStaff, Inc.)* filed in the Superior Court of California in Riverside County. The lawsuit relates to only MedStaff corporate employees working in California. The claims alleged under this lawsuit are generally similar in nature to those brought by Darrelyn Renee Henry in a lawsuit against the Company, which was dismissed (*Darrelyn Renee Henry vs. MedStaff, Inc., et.al.*).

The lawsuit alleges, among other things, violations of certain sections of the California Labor Code, the California Business and Professions Code, and recovery of unpaid wages and penalties. MedStaff currently has less than 50 corporate employees in California. The Plaintiffs, Maureen Petray and Carina Higareda, purport to sue on behalf of themselves and all others similarly situated, and allege that MedStaff failed, under California law, to provide meal periods and rest breaks and pay for those missed meal periods and rest breaks; failed to compensate the employees for all hours worked; failed to compensate the employees for working overtime; failed to keep appropriate records to keep track of time worked; failed to pay Plaintiffs and their purported class as required by law. Plaintiffs seek, among other things, an order enjoining MedStaff from engaging in the practices challenged in the complaint and for full restitution of all monies, for interest, for certain penalties provided for by the California Labor Code and for attorneys fees and costs. On February 5, 2007, the court granted class certification. On October 16, 2008, MedStaff, Inc. filed a Motion to Decertify the class which was denied on December 19, 2008. The Company is unable to determine its potential exposure, if any, and intends to vigorously defend this matter.

The Company is also subject to other legal proceedings and claims that arise in the ordinary course of its business. In the opinion of management, the outcome of these other matters will not have a significant effect on the Company s consolidated financial position or results of operations.

**Item 4.**

**Submission of Matters to a Vote of Security Holders.**

There were no matters submitted to a vote of security holders during the fourth quarter of 2008.

## PART II

**Item 5.**

**Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.**

Our common stock currently trades under the symbol CCRN on the NASDAQ Global Select Market (NASDAQ), a new market tier created by the NASDAQ Stock Market that became effective on July 1, 2006. Our common stock commenced trading on the NASDAQ National Market under the symbol CCRN on October 25, 2001. NASDAQ became operational as a stock exchange on August 1, 2006. The following table sets forth, for the periods indicated, the high and low sale prices per share of common stock reported on; such prices reflect inter-dealer prices, without retail mark-up, mark-down or commission and may not represent actual transactions.

| | Closing Sale Prices | |
|---|---|---|
| **Calendar Period** | **High** | **Low** |
| **2008** | | |
| Quarter Ended March 31, 2008 | $ 14.42 | $ 10.11 |
| Quarter Ended June 30, 2008 | $ 15.99 | $ 11.49 |
| Quarter Ended September 30, 2008 | $ 17.34 | $ 12.49 |
| Quarter Ended December 31, 2008 | $ 16.71 | $ 7.11 |
| **2007** | | |
| Quarter Ended March 31, 2007 | $ 23.24 | $ 17.29 |
| Quarter Ended June 30, 2007 | $ 20.61 | $ 16.16 |
| Quarter Ended September 30, 2007 | $ 19.32 | $ 14.15 |
| Quarter Ended December 31, 2007 | $ 19.01 | $ 12.97 |

The following graph compares the cumulative 5-year total return provided shareholders on Cross Country Healthcare, Inc.'s common stock relative to the cumulative total returns of the NASDAQ Composite index and the Dow Jones US Health Care Providers index. An investment of $100 (with reinvestment of all dividends) is assumed to have been made in our common stock and in each of the indexes on December 31, 2003, and its relative performance is tracked through December 31, 2008.

**COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN***

**Among Cross Country Healthcare, Inc., The NASDAQ Composite Index**

**And The Dow Jones US Health Care Providers Index**

*$100 invested on 12/31/03 in stock & index-including reinvestment of dividends.
Fiscal year ending December 31.

| | 12/03 | 3/04 | 6/04 | 9/04 | 12/04 | 3/05 | 6/05 | 9/05 | 12/05 | 3/06 |
|---|---|---|---|---|---|---|---|---|---|---|
| Cross Country Healthcare, Inc. | 100.00 | 111.21 | 121.16 | 103.47 | 120.69 | 111.88 | 113.48 | 123.90 | 119.03 | 129.24 |
| NASDAQ Composite | 100.00 | 100.18 | 103.16 | 96.49 | 110.08 | 101.53 | 104.08 | 109.76 | 112.88 | 120.64 |
| Dow Jones US Health Care Providers | 100.00 | 107.34 | 108.54 | 108.14 | 130.85 | 145.97 | 160.11 | 166.90 | 176.06 | 173.25 |

| 6/06 | 9/06 | 12/06 | 3/07 | 6/07 | 9/07 | 12/07 | 3/08 | 6/08 | 9/08 | 12/08 |
|---|---|---|---|---|---|---|---|---|---|---|
| 121.43 | 113.48 | 145.66 | 121.70 | 111.35 | 116.62 | 95.06 | 82.58 | 96.19 | 108.74 | 58.68 |
| 112.68 | 117.54 | 126.51 | 127.08 | 136.04 | 141.77 | 138.13 | 118.70 | 119.92 | 106.41 | 80.47 |
| 157.28 | 168.73 | 173.30 | 181.78 | 187.57 | 190.30 | 206.57 | 146.98 | 138.85 | 137.38 | 112.23 |

*The stock price performance included in this graph is not necessarily indicative of future stock price performance.*

As of March 5, 2009, there were 104 stockholders of record of our common stock. In addition, there are approximately 3,484 beneficial owners of our common stock held by brokers or other institutions on behalf of stockholders.

We have never paid or declared cash dividends on our common stock. We currently intend to use available cash from operations in the operation and expansion of our business or to retire and pay down debt. Covenants in our credit agreement limit our ability to repurchase our common stock and declare and pay cash dividends on our common stock. As of December 31, 2008, pursuant to the terms of our credit agreement covenants, we are not able to use cash for either dividend or stock repurchases.

On February 28, 2008, the Company s Board of Directors authorized a stock repurchase program whereby the Company may purchase up to an additional 1.5 million of our common shares, subject to the terms of our current credit agreement. The shares may be repurchased from time-to-time in the open market and the repurchase program may be discontinued at any time at the Company s discretion. The current stock repurchase authorization commenced upon the completion of the May 10, 2006 authorization to repurchase up to 1.5 million shares; which commenced upon the completion of the November 2002 authorization to purchase up to 1.5 million shares.

During the three month period ended December 31, 2008, we did not purchase any shares of our common stock due to a prohibition in our credit agreement that does not allow us to repurchase our shares if our debt leverage ratio is above 2 to 1.

**Item 6.**

**Selected Financial Data.**

The selected consolidated financial data as of December 31, 2008 and 2007 and for the years ended December 31, 2008, 2007, and 2006 are derived from the audited consolidated financial statements of Cross Country Healthcare, Inc., included elsewhere in this Report. The selected consolidated financial data as of December 31, 2006, 2005 and 2004 and for the years ended December 31, 2005 and 2004, are derived from the consolidated financial statements of Cross Country Healthcare, Inc., that have been audited but not included in this Report.

The following selected financial data should be read in conjunction with the consolidated financial statements and related notes of Cross Country Healthcare, Inc., Management s Discussion and Analysis of Financial Condition and Results of Operations and other financial information included elsewhere in this Report.

| | Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2008 (a) | 2007 (b) | 2006(c) | 2005 (d) | 2004 |
| | (Dollars in thousands, except share and per share data) | | | | |
| **Consolidated Statements of Operations Data** | | | | | |
| Revenue from services | $ 734,247 | $ 718,272 | $ 655,152 | $645,393 | $ 654,111 |
| Operating expenses: | | | | | |
| Direct operating expenses | 541,660 | 543,608 | 502,468 | 503,103 | 509,571 |
| Selling, general and administrative expenses | 136,815 | 122,692 | 110,172 | 104,647 | 99,531 |
| Bad debt expense | 951 | 1,559 | 459 | 1,177 | 957 |
| Depreciation | 7,637 | 6,309 | 5,449 | 5,159 | 5,140 |
| Amortization | 3,166 | 2,051 | 1,570 | 1,424 | 1,580 |
| Impairment charges (e) | 244,094 | | | | |
| Legal settlement charge (f) | | 34 | 6,704 | | |
| Secondary offering costs (g) | | | 154 | 151 | 4 |
| Total operating expenses | 934,323 | 676,253 | 626,976 | 615,661 | 616,783 |
| (Loss) income from operations | (200,076 ) | 42,019 | 28,176 | 29,732 | 37,328 |
| Other expenses: | | | | | |
| Foreign exchange (gain) loss | (132 ) | 93 | | | |
| Interest expense, net | 4,225 | 2,587 | 1,464 | 3,458 | 4,789 |
| Loss on early extinguishment of debt (h) | | | | 1,359 | |

| | | | | | |
|---|---|---|---|---|---|
| (Loss) income from continuing operations before income taxes | (204,169 ) | 39,339 | 26,712 | 24,915 | 32,539 |
| Income tax (benefit) expense | (61,224 ) | 14,759 | 10,146 | 9,575 | 11,936 |
| (Loss) income from continuing operations | (142,945 ) | 24,580 | 16,566 | 15,340 | 20,603 |
| Discontinued operations, net of income taxes: | | | | | |
| Income (loss) from discontinued operations (i) | | | 70 | (588 ) | 56 |
| Net (loss) income | $ (142,945 ) | $ 24,580 | $ 16,636 | $ 14,752 | $ 20,659 |
| Net (loss) income per common share basic: | | | | | |
| (Loss) income from continuing operations | $ (4.64 ) | $ 0.77 | $ 0.52 | $ 0.48 | $ 0.65 |
| Discontinued operations | | | 0.00 | (0.02 ) | 0.00 |
| Net (loss) income | $ (4.64 ) | $ 0.77 | $ 0.52 | $ 0.46 | $ 0.65 |
| Net (loss) income per common share diluted: | | | | | |
| (Loss) income from continuing operations | $ (4.61 ) | $ 0.76 | $ 0.51 | $ 0.47 | $ 0.63 |
| Discontinued operations | | | 0.00 | (0.02 ) | 0.00 |
| Net (loss) income | $ (4.61 ) | $ 0.76 | $ 0.51 | $ 0.45 | $ 0.63 |
| Weighted-average common shares outstanding: | | | | | |
| Basic | 30,825,099 | 31,972,681 | 32,077,240 | 32,228,978 | 31,992,752 |
| Diluted | 31,007,352 | 32,484,241 | 32,737,419 | 32,773,634 | 32,578,319 |

| | Year Ended December 31, | | |
|---|---|---|---|
| | **2008** | **2007** | **2006** |