CROSS COUNTRY HEALTHCARE INC
Form 10-K
March 11, 2011

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, 2010

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 whether the registrant has submitted electronically and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). o Yes o 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, 2010 of $8.99 as reported on the NASDAQ National Market, was $252,276,067. This calculation does not reflect a determination that persons are affiliated for any other purpose.

As of March 3, 2011, 31,102,682 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 2010 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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PART II

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 , appears , seeks , will and variations of such words and simil are 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 also 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 2011.

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 offering a comprehensive suite of staffing and outsourcing services to the healthcare market. We report our financial results according to four business segments: (1) nurse and allied staffing, (2) physician staffing, (3) clinical trial services and (4) other human capital management services. We believe we are one of the top two providers of nurse and allied staffing services; one of the top four providers of temporary physician staffing (locum tenens) services; and a leading provider of clinical trial staffing services, retained physician search services and educational seminars specifically for the healthcare marketplace.

The long-term macro drivers of our business are demographic in nature and consist of a growing and aging U.S. population demanding more healthcare services and an aging workforce of healthcare professionals. Additionally, there are projected shortages of healthcare professionals including registered nurses (RNs) and physicians. Demand for our nurse, allied and physician staffing services is primarily influenced by two factors: (1) national labor market dynamics that affect the number of hours worked by healthcare professionals and (2) the strength or weakness in acute care hospital admissions relative to expectations and the volume of patients at other medical facilities and physician offices. Demand for our clinical trial staffing services is primarily influenced by the level of research and development (R&D) activities by pharmaceutical and biotechnology companies.

Overall demand for our healthcare staffing services remains significantly reduced from levels in 2008 prior to the economic downturn that began during the fall of that year. However, more recently, demand for our nurse and allied staffing services and our clinical trial staffing services improved somewhat during the second half of 2010, but did not for our physician staffing services.

The supply of healthcare professionals (HCPs) in the marketplace is dependent upon the number of HCPs entering their respective professions versus those retiring from the workforce. The supply of RNs available for our staffing services is variable and influenced by current labor market dynamics, as well as by the desire of RNs to work temporary assignments versus being directly employed by hospitals as staff nurses or working in non-hospital settings such as insurance companies, health clinics and doctor offices. The supply of physicians available for our physician staffing services is variable and is influenced by several factors, including the desire of physicians to work temporary assignments versus being in private practice or directly employed at healthcare facilities, the desire of older physicians to work fewer hours, work-lifestyle balance among younger physicians, and the trend toward more female physicians in the workforce who traditionally work fewer hours than male counter-parts. The supply of clinical trial personnel in the marketplace is relatively stable and comprised primarily of individuals with an educational background and experience in life sciences, as well as healthcare professionals who have left a care giving role to pursue clinical research opportunities. The supply of people available for our clinical trial services is dependent on the number of clinical trial professionals not currently employed in ongoing trials, as well as new people entering the industry.

We have a diversified revenue mix across business sectors and healthcare customers. For the year ended December 31, 2010, our revenue was $468.6 million. Our nurse and allied staffing business segment, which represented 52% of our revenue, is comprised of travel nurse, per diem nurse and allied health staffing. Our physician staffing business segment consists of temporary physician staffing services with placements across multiple clinical specialties and represented 26% of our revenue. Our clinical trial services business segment consists primarily of contract staffing, as well as drug safety monitoring and regulatory consulting services to pharmaceutical and biotechnology customers and represented approximately 13% of our revenue. Our other human capital management services business segment consists of education and training, as well as retained search services related primarily to physicians, allied health and healthcare executives and was 9% of our revenue. For additional financial information concerning our business segments see Note 16 to the consolidated financial statements - Segment Information, contained elsewhere in this report. On a company-wide basis, we have approximately 4,200 contracts with hospitals and healthcare facilities, pharmaceutical and biotechnology customers, and other healthcare organizations to provide our healthcare staffing and outsourcing solutions. In 2010, no single client accounted for more than 4% of our revenue. Our fees are paid directly by our clients and in certain cases by third-party vendor managers. As a result, we have no direct exposure to Medicare or Medicaid reimbursements.

For the year ended December 31, 2010, we had a net loss of $2.8 million, or ($0.09) per diluted share, which included $6.6 million of after-tax trademark impairment charges related to the Medical Doctor Associates acquisition. During 2010, we generated $31.5 million in cash flow from operations. At year-end 2010, we had $11.0 million of cash and cash equivalents, and we had $53.5 million of total debt on our balance sheet resulting in a debt, net of cash, to total capitalization ratio of 14.2%. Our debt leverage ratio at December 31, 2010, (as defined in our credit agreement) was 2.1 to 1, below the 2.5 to 1 maximum allowable ratio effective for the duration of our credit agreement.

Healthcare and Demographic Influences on Our Business

Demand Influences

According to the most recent report by the Centers for Medicare & Medicaid Services (CMS), national healthcare spending in 2009 grew at the slowest rate in five decades, rising 4% to $2.5 trillion. The report indicated that the recent recession has had a strong influence on total healthcare spending. The slow down in spending was due primarily to slower growth in private insurance expenditures; a decline in capital spending on structures and equipment; and slower growth in out-of-pocket spending. Offsetting this was a 9% jump in Medicaid spending from the prior year as more Americans became eligible and enrolled in that federal program. Hospital spending increased 5.1% to $759.1 billion in 2009, but at a lower rate than in previous years. Spending for physician and clinical services increased at the slowest rate since the mid-1990s to $505.9 billion reflecting a decline in the number of visits to physician offices in 2009.

Longer-term, CMS expects national health spending to reach $4.5 trillion by 2019, driven, in large part, by greater demand for healthcare services due to both an increasing and aging population.

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The U.S. population grew by 9.7% to 308.7 million people in the decade from 2000 to 2010, according to U.S. Census Bureau 2010 data. By 2050, the U.S. population is projected to 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, beginning in 2011, the oldest baby-boomers turn 65 years of age and become eligible for Medicare and the 55-to-64 age group is expected to expand to 40 million people by 2014. Utilization of hospital services and healthcare spending is significantly higher among older people.

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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. In 2005, the U.S. Department of Health and Human Services reported that people over the age of 65 comprised 38% of all inpatients. The American Hospital Association (AHA) projects the share of hospital admissions for the over-65 age group to rise from 38% in 2004 to 56% in 2030.

Supply Influences

Overlaid on this expected increase in demand for healthcare services is a projected shortage of RNs that is characterized by an aging nurse workforce and a nurse education system constrained by both an aging faculty and lack of teaching facilities. There is also a growing shortage of physicians in both hospitals and practice groups that is influenced by constraints in the number of graduates from U.S. medical schools combined with an aging workforce that is expected to experience substantial retirements over the next decade. Healthcare reform legislation enacted earlier in 2010 is also expected to have a future impact on the shortage of RNs and physicians caused by adding tens of millions of new patients to the reimbursement system.

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Despite high unemployment rates and job losses in other sectors of the economy that continued in 2010, the U.S. healthcare workforce continued to expand and served to ease the shortage of RNs working in hospitals. The Bureau of Labor Statistics reported on January 7, 2011 that healthcare employers added 35,700 new jobs, on a seasonally adjusted basis, in the month of December 2010, bringing the 2010 total of new jobs created in this sector to 265,800. As the largest group of health professionals, RNs were likely recruited to fill many of these new positions. However, in the longer-term, by 2025, large shortages of RNs are projected nationwide (*Health Affairs,* June/July 2009). More specifically, during the past few years vacancy rates for RNs fell from a peak of 13% in 2001 to 8.1% in 2006 and to 6% in 2009, according to information from the American Hospital Association and a 2009 survey of hospital CEOs conducted by AMN Healthcare, Inc. This was due to increases in RN employment consisting of younger RNs continuing to enter the workforce and older RNs remaining in the workforce longer. These recent dynamics have led researchers to update the average age of the RN workforce downward and project a delay from earlier estimates in the onset of a substantial shortfall of RNs to around 2018 with the shortage growing to approximately 260,000 by 2025 *(Health Affairs*, June 2009*)*. More near-term, nearly one-third of RNs reported they will not be working in their current jobs in 12 months, and approximately half of the respondents stated they foresee a change in their career paths out of the nursing workforce, decreasing their hours or changing to a less demanding care-giver role, according to a *2010 Survey of Registered Nurses: Job Satisfaction and Career Plans* (*AMN Healthcare, Inc.,* January 2010). 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 *(Health Affairs*, January/February 2007). However, due to the effects of the economic downturn, many retired RNs returned to the workforce and those contemplating retirement are keeping their jobs to maintain household income.

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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, the U.S. is expected to face a shortage of 124,000 to 159,000 physicians by 2025, according to a study by the AAMC published in November 2008 that expects the shortage to be most severe among family physicians and general surgeons. In September 2010, the AAMC increased its earlier estimate of the projected shortage of physicians across all specialties by 50% to take into account the enactment of health care reform legislation giving 32 million Americans health care coverage. Contributing to this substantial worsening in the shortage of physicians is a projection by the U.S. Census Bureau for 36% growth in the number of Americans over age 65 and eligible for Medicare, and the expectation by the AAMC that nearly one-third of all physicians will retire in the next decade. Moreover, while the number of applicants to U.S. medical schools is increasing, it has not kept pace with the expected future demand given the number of post-graduate years of training required. Surgical training, for example, requires eight to fourteen years. Although helping somewhat is an expected increase in the number of medical students, adding 7,000 graduates annually over the next decade according to the AAMC.

Influences on Our Customers

Hospital and healthcare facility customers comprise the majority of our revenue base. Typically, they provide medical care on a 24 hour/7 day a week basis, which requires RNs, physicians and other healthcare professionals to be on staff around the clock. Labor costs have historically been the largest component of a hospital s operating budget with nursing care accounting for about half of this amount or a quarter of total expenditures. Hospitals are capital-intensive organizations that are paid for their services through reimbursements from the 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 vendor managers. As a result, we have no direct exposure to Medicare or Medicaid reimbursements.

Since the beginning of 2003, growth in hospital in-patient admissions has been relatively flat. In addition, hospitals, healthcare facilities and physician practice groups have had to contend with changes to government reimbursements for their services and changes in legislation and agency regulations, along with a large pool of uninsured patients. Among other things, these factors have been compounded by high unemployment, higher deductibles and co-pays for those with health insurance coverage and rising bad-debt.

In December 2007, the U.S. economy entered into a recession according to the National Bureau of Economic Research, which was followed by a severe credit crisis that unfolded in the fall of 2008, making borrowing significantly more costly or unavailable for individuals and businesses, including hospitals and healthcare facilities. Among other things, this reduced access to capital causing the cancellation or delay of hospital expansion and construction projects that during the prior few years had experienced a robust up-surge. The recession also led to a rapid and significant downturn in the national labor market, which triggered RNs to offer more hours of service directly to hospital employers at wages hospitals were willing and able to pay. These factors resulted in a steep decline in the demand for our temporary nurse and allied staffing services, and to a lesser extent, our physician staffing services. Physicians have historically been revenue generators for hospitals, healthcare facilities and practice groups while nurses are not a directly reimbursed cost in the delivery of care. More recently, a strengthening trend reveals more physician groups selling to hospitals or health systems in order to avoid the administrative responsibilities, regulatory burden and risk of owning their own medical practices, thus reducing the demand from hospitals for temporary physicians. Accordingly, the Medical Group Management Association (MGMA) annual physician compensation surveys for the past two years found that hospital-owned practices exceeded physician-owned group practices for the first time, increasing from 25.6% in 2005 to 49.5% in 2008 and to approximately 52% in 2009.

According to the AHA, hospitals continue to feel the lingering effects of the economic recession. Based on data from a March 2010 survey conducted by the AHA, patients continued to delay or forego care due to family economic reasons resulting in 70% of hospitals with lower overall patient volumes and 72% with lower levels of elective procedures. At the same time, 74% of hospitals reported reduced operating margins and 50% decreased non-operating income. To withstand the economic downturn, many hospitals cut administrative costs, reduced overall staff and limited services. Despite some actual or perceived improvement in the economy, few hospitals report they are able to return to pre-recession staff and service levels. The AHA reported that 89% of hospitals indicated they have not added back staff or increased staff hours and 98% have not restored services or programs to previous levels. In addition, 44% of hospitals reported continued difficulty accessing capital and 67% have not started or resumed capital projects put on hold due to the recession.

In our clinical trial services segment, the economic downturn was among the catalysts for numerous pharmaceutical and biotechnology company mergers and acquisitions, as well as business closures that resulted in reevaluations of clinical strategy and product mix, along with a refocusing or reduction in R&D programs. While an increasing amount of R&D had been outsourced over the preceding years, the global economic downturn substantially decreased R&D activity in this sector and reduced the demand for our clinical trial services. However, during the second half of 2010, we experienced an increase in demand as expressed by the level of requests for proposals for clinical staffing projects.

Nurse and Allied Staffing

We are a leading provider of travel nurse staffing services in the U.S., as well as a provider of allied health staffing and per diem nurse staffing services. Segment revenue was $242.2 million in 2010. We market our nurse and allied staffing services primarily to acute care hospitals, providing clients with staffing solutions through our Cross Country Staffing (CCS), MedStaff and Allied Health Group brands. We provide 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. Our Allied Health Group provides nurse practitioners and physician assistants, as well as staffing for the radiation therapy market to hospitals, healthcare facilities and physician practice groups across 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 for travel and per diem assignments in a wide range of specialties that include operating room technicians and various allied health professionals, such as rehabilitation therapists, radiology technicians, respiratory therapists and radiation therapy technicians for assignments in hospitals and non-acute care settings such as physician practice groups, skilled nursing facilities, nursing homes and sports medicine clinics, and, to a lesser degree, in non-clinical settings, such as schools.

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

CCS is our largest brand and, as a part of its business strategy, offers Managed Service Provider (MSP) solutions to our large hospital and healthcare system clients throughout the U.S. At year end 2010, approximately 30% of our nurse and allied FTEs were working at MSP client facilities. In addition to directly supplying the vast majority of client needs under these MSP programs, CCS has relationships with hundreds of subcontractors throughout the U.S. to ensure that clients have access to a large pool of candidates to meet their staffing needs.

CCS s MSP solution positions it as a single point of contact to manage a client s entire temporary healthcare staffing needs (travel and/or per diem staffing). Not only does the MSP solution result in the consistent verification and credentialing of candidates, it also provides process efficiencies and cost savings to the client. While each MSP is tailored to the specific needs of a particular client, the typical MSP contract requires CCS to: negotiate contracts with subcontractors to ensure a large pool of candidates, verify that all nurses provided both by CCS and subcontractors have certain credentials and meet other standards and testing requirements established by the client, verify insurance coverage of the subcontractors and their candidates, process orders for open positions from the client and distribute those needs to subcontractors if CCS is unable to fill them, interview eligible candidates for open positions, provide the client with one invoice for services provided by CCS and all subcontractors, make payments to subcontractors for services provided to the client, and capture and analyze data for the benefit of the client. These services are particularly beneficial to larger clients who require many healthcare professionals across a broad spectrum of medical disciplines and specialties.

Overview of the Nurse and Allied Staffing Industry

The temporary nurse staffing solutions 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 to longer than three months. Travel assignments usually involve relocation to the geographic area of the assignment. Travel nurses provide hospitals and healthcare facilities with flexibility and variable costs 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 the outsourced temporary nurse staffing market 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. According to industry sources, the nurse and allied staffing industry revenue was estimated to be approximately $6.2 billion in 2010.

In response to concerns relative to quality of care and nurse education, a study by 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 4-year baccalaureate or more advanced degrees and more likely to have received their education in the past 10 years when compared to hospital staff nurses.

Recruiting

We operate differentiated brands Cross Country TravCorps, MedStaff, NovaPro, Cross Country Local, CRU-48, Allied Health Group and Assignment America 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 a high level of customer service. In 2010, thousands of healthcare professionals applied with us through our recruitment brands. However, compared to the prior year, we experienced a decline in the supply of RN s available for our nurse staffing services due to the economic downturn and its impact on the national labor market, as previously outlined. In addition, during 2010 we did not recruit RNs from outside the U.S. due to ongoing visa restrictions by the U.S Department of State.

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 increasingly 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 before, during and after their employment with us. We believe our retention rate of healthcare professionals 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 2010, we had 106 recruiters in this segment of our business, which includes per diem branch personnel.

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

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 and may be shorter or longer. 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 through 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. In addition to the key sales and recruitment activities, these centers also perform 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 17 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 typically generated using time and attendance data captured by our payroll system. Our payroll department also provides customer support services for field employees.

During 2010, we had an average of approximately 1,100 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.

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 market for our nurse staffing services is determined by the demand from hospital customers and the available supply of RNs and other healthcare professionals. We believe demand is a function of both the dynamics of the national labor market and its impact on RNs and their spouses (approximately 75% of RNs in the U.S. are married), as well as hospital admission trends relative to expectations (Health Resources and Services Administration (HRSA), September 2010). Each of these factors 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 business environment for our nurse and allied staffing services in 2010 reflected a continuation of hospital admission trends that have been relatively flat since 2003, as well as the lingering effects of the economic downturn and weak national labor market that translated into more uninsured people and fewer people with commercial health insurance coverage. Moreover, high national unemployment typically results in RNs increasingly seeking employment as hospital staff nurses and those already employed as staff nurses become more willing to work more hours at prevailing wages. Combined, these factors reduce the need for our outsourced staffing services as reflected by the lower segment revenue and staffing volume of healthcare professionals we had on assignment in 2010 compared to the prior year. However, as 2010 progressed, we experienced an increase in demand for our travel nurse and allied staffing services that translated into sequential quarterly improvement in our relative bookings activity for future assignments and then a modest improvement in staffing volume in the fourth quarter of 2010. We were also able to improve our gross margin by reducing direct costs, including housing and some insurance expenses. Additionally, our bill-pay spread continued to improve. Bill rates, as measured by revenue per hour in our travel nurse staffing business, contracted modestly during the year compared to the prior year, but were offset by reduced wages to our field employees.

We believe our strategy of focusing on opportunities to provide our MSP services to hospital and health system clients, coupled with our success in winning a number of those MSP contracts during 2010, were important factors in our sequential improvement in relative bookings, defined as net weeks booked as a percentage of the average number of FTE s on assignment during the year. We also provided an effective staffing solution to support hospitals implementing new electronic medical records technology.

The following is a list of relevant data from the *2008 National Sample Survey of Registered Nurses (NSSRN)* published by the HRSA in September 2010:

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The number of RNs in the U.S. grew by 5.3% to 3.1 million in 2008 from 2004, representing a net growth of 153,806 RNs.

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From 2004 to 2008, an estimated 444,668 RNs received their first U.S. license, while approximately 291,000 RNs allowed their U.S. licenses to lapse, possibly indicating that the substantial retirements that have been anticipated may have begun.

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Of the total number of RNs, an estimated 2.6 million or 84.8% were employed in nursing, the highest rate of nursing employment since HRSA began the NSSRN in 1977.

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Full-time RN employment increased for the first time since 1996, increasing to 63.2% in 2008 from 58.4% in 2004.

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Hospitals remained the most common employment setting for RNs, expanding to 62.2% of employed RNs in 2008 from 57.4% in 2004.

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More than half of RNs work at least 40 hours per week in their principal nursing position.

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The aging of the nursing workforce slowed for the first time in the past 30 years. In 1988, half the RN workforce was less than 38 years of age, but in 2004 the age rose to 46 years and remained there in 2008. This slowdown in the aging trend resulted from an increase in employed RNs less than 30 years of age – the first increase seen in this age group since the inaugural NSSRN in 1977.

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The most recent graduates, defined as those who completed their initial nursing education between 2005 and 2008, comprised nearly 20% of all RNs in the U.S. in 2008 and about 23% of employed RNs. The average age of the recent graduates was a little over 30 years as compared to RNs who graduated from nursing programs before 2001 when the average age was 26.7 years. Hospitals employed more than 83% of the most recent graduates and more than 75% of RNs who graduated in 2001 to 2004. More specifically, nearly 85% of RNs under 30 years old work in hospitals. This compares to less than 50% of RNs age 55 and older who work in hospitals.

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Older RNs over age 50 comprised 44.7% percent of the total RN population in 2008, compared with 33.0% in 2000. RNs aged 50–54 in 2008 who were employed full-time worked an average of 43.7 hours per week, slightly more than the average for full-time nurses under age 50. Beginning at age 60, the hours worked by part-time nurses declines steadily with age. As RNs grow older, and especially for RNs older than age 60, retirement becomes an increasingly dominant reason for employment changes.

As part of a more recent statement by the Tri-Council of Nursing (July 2010), Dr. Peter Buerhaus, Associate Dean of Vanderbilt University s School of Nursing, believes it is important to look beyond the short-term environment where hospitals have largely been able to employ all the RNs they want at prevailing wages due to the uncertainty over key economic factors. Buerhaus outlined that once the jobs recovery begins and RNs spouses rejoin the labor market, many currently employed RNs could leave the workforce where their exit could be swift and deep. This includes many of the more than 100,000 RNs over the age of 50 that re-entered the workforce during 2007 and 2008, who are a part of the nearly 900,000 working RNs over the age of 50, of which Buerhaus expects large numbers of them to retire in the years ahead independent of the pace and intensity of a jobs recovery.

Internationally educated RNs whose initial nursing education took place outside of the U.S. or in the U.S. territories represent a larger percentage of the domestic nursing workforce rising to 8.1% in 2008 from 5.1% prior to 2004, according to the 2008 HRSA survey. During the past few years, the National Council of State Boards of Nursing (NCSBN) expanded the test sites for its NCLEX nurse licensing exam beyond locations in the U.S. and its territories and other international sites to include locations in Seoul, South Korea, London and Hong Kong as a convenience to foreign-educated nurse candidates. However, entry into the U.S. has been blocked or delayed due to immigration quotas and a lack of appropriate temporary visa categories.

Educating Nurses

The most commonly reported initial nursing education of RNs in the U.S. is the Associate Degree in Nursing, representing 45.4% of nurses. Bachelor s or graduate degrees were received by 34.2% of RNs, and 20.4% from hospital-based diploma programs. The average age of RNs who graduated from their initial nursing education program is rising. More than 21% of RNs earned an academic degree prior to their initial nursing degree. More than two-thirds of RNs reported working in a health occupation prior to their initial nursing education (*HRSA*, September 2010).

Enrollment in entry-level baccalaureate nursing programs increased 6.1% in 2010 from the prior year, according to preliminary survey data from the American Association of Colleges of Nursing (AACN) issued in December 2010. This marks the tenth consecutive year of enrollment growth.

Enrollment in master s and doctoral degree nursing programs increased significantly in 2010, according to the AACN. Nursing schools with master s programs reported a 9.8% increase in enrollment and a 10.1% increase in graduations. In doctoral nursing programs, enrollment increased 25.6% in 2010 from 2009, while enrollment in research-focused doctoral programs increased 4.5%.

Despite strong interest in nursing careers, nursing schools continue to receive more qualified applications than can be accommodated. The AACN preliminary data reflects that 52,115 qualified applications for entry-level baccalaureate nursing programs in 2010 were turned away. As a comparison, this far exceeds the number of students turned away each year from 2005 through 2009, which ranged from 36,400 to 42,981 applications. The primary barriers to accepting all qualified students at nursing colleges and universities continue to be a shortage of clinical placement sites and faculty.

Nursing school faculty vacancies increased slightly to 6.9% in 2010 from 6.6% in 2009, according to an AACN report (September 17, 2010). This report also stated that growth in U.S. schools of nursing is being restrained by a shortage of faculty, which is driven by a limited pool of doctoral-prepared nurses and noncompetitive faculty salaries.

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 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 who work longer hours, while caring for sicker patients. As a result, nurses have requested assistance from their elected officials to address these issues. Three general approaches have been proposed:

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

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Legislation mandating specific nurse to patient ratios in legislation or regulation.

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Combine nurse staffing plans and legislated nurse to patient ratios, and make staffing information available to the public.

To date, 12 states have enacted legislation and/or adopted regulations to address nurse staffing plans and ratios: CA, CT, IL, NV, NJ, NY, OH, OR, RI, TX, VT, and WA. At this time there is no Federal legislation pending with respect to nurse staffing plans or ratios.

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 the impact on the caregiver s health as well as the potential for errors 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 work overtime, or when nurses work more than 40 hours per week. Voluntary overtime is not affected.

To date, 17 states have legislated restrictions, have provisions in regulations or are studying the use of mandatory overtime for nurses: AK, CA, CT, IL, MD, MN, MO, NH, NJ, NY, NC, OR, PA, RI, TX, WA, and WV. At this time there is no Federal legislation pending with respect to mandatory overtime.

Physician Staffing

The physician staffing or locum tenens industry is more than 25 years old and is most commonly used to mean temporary physicians that contract with staffing agencies to perform medical services over a specified period of time as independent contractors at hospitals, group practices or other healthcare organizations. Physicians consider this way of practicing medicine an excellent alternative to traditional practice while healthcare organizations appreciate the value of this flexible staffing model.

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. Utilization of temporary physician coverage ranges from rural solo physician practices to 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 is 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 what could turn out to be the wrong place.

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

Overview of the Physician Market

Demand for physicians is projected to grow 26.3% between 2006 and 2025, from 680,500 to 859,300 FTEs, according to an AAMC report *The Complexities of Physician Supply and Demand: Projections Through 2025* (November 2008), which attributed the demand increase to both the projected growth and aging of the population, of which the majority will come from the increase in population. The AAMC report also concluded that projected growth in physician demand will vary by specialty group and by health care delivery setting, finding that specialties that predominantly serve the elderly are expected to be highest in demand, and, if current patterns continue, the hospital inpatient setting is projected to experience the greatest increase in demand of 36.6%, while all the other settings are projected to grow by increases that exceed 20%.

In the long-term, 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. The AAMC Center for Workforce Studies estimates that the U.S. will face a shortage of 124,000-159,000 physicians by 2025, with the potential for healthcare reform to add to overall demand for doctors and increase the projected shortfall by 25%. Studies by the AAMC attribute some of the causes behind the projected shortages to include:

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Of the nearly 700,000 physicians practicing medicine today in the U.S., approximately one-third of physicians are over age 55. Approximately 38% of these physicians report they are considering retirement in the next one to three years, according to the American Medical Association (AMA). 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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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 AMA.

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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. Of particular concern is the shortage of primary care physicians. The AAMC sites numerous reasons for the decline in interest in a career in primary care.

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While primary care physicians have consistently comprised about one-third of all physicians over the past 30 years, the number of U.S. medical school graduates selecting a family medicine career has fallen nearly 27% from 5,746 in 2002 to 4,210 in 2007.

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Consequently, there is a significant income gap – and perception of status and prestige – between generalists and specialists.

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Medical education and training appear to have less impact on the career choice of new physicians than the practice environment for primary care. Medical students often cite factors such as an ability to control workload, flexibility in scheduling, and career satisfaction as elements in their decisions.

On the other end of the spectrum, the physician workforce is aging with a relatively large proportion of physicians approaching retirement age just as the demand for their services is projected to surge due to an aging U.S. population. In addition to retirement, physicians also leave the workforce due to mortality, disability and career change.

According to the American Medical Association, there were 38,146 physicians age 65 and older in 1970, and by 2008, this demographic grew 408.6% to 194,014 while the total number of physicians grew by only 188.4% over this same period. As a percentage of all physicians, only 12% were 65 and older in 1970, compared to 20% in 2008. In contrast, the proportion of physicians younger than age 35 decreased from 27% in 1970 to 15% in 2008. Many of these older physicians are still in practice, either by choice or circumstance. About 40% of physicians 65 and older were in active practice in 2008, according to the 2010 edition of the AMA's *Physician Characteristics and Distribution in the U.S.* In 2005, the AAMC identified 252,000 active physicians, who were at or would pass retirement age within 10 years. Presently, nearly one fourth of the active physician workforce is age 60 or older.

In addition, physicians are looking for stability in an environment of decreasing reimbursement for professional fees, as well as increased pressure and cost for physician practices to comply with new electronic health records standards. At the same time, hospitals are trying to manage rising costs and the CMS is moving to a coordinated care model via Accountable Care Organizations (ACOs) in an effort to enable healthcare providers to control costs and improve quality by working together with other providers and payers under a structure that effectively accepts and redistributes global payments. One indicator is the growing trend of physician employment by hospitals, which has nearly doubled since 1994 (PriceWaterhouseCoopers, December 2009). The Medical Group Management Association (MGMA) reported in its 2010 *Physician Placement Starting Salary Survey* that hospital-owned practices were the most successful in attracting physicians in 2009. Approximately 65% of established physicians and 49% of physicians hired out of residency or fellowship were placed in hospital-owned practices.

Educating Physicians

The root cause of the projected physician shortage dates back to the 1980s and 1990s when enrollment in medical schools was capped. Although medical school enrollments and graduations have increased somewhat since 2005, the education and training of more physicians will not be enough to address the shortage, according to the AAMC (December 2008).

The number of applicants to U.S. medical schools increased slightly in 2010 to 42,742 from 42,269 applicants in the prior year, according to the AAMC. Total enrollment in medical schools increased 1.5% in 2010 to 18,665 students compared to approximately 18,400 students in 2009. Graduations from U.S. medical schools in 2010 increased 2% to 16,838 from 16,467 in 2009.

Temporary Physician Staffing Drivers

According to industry sources, in 2010, the temporary physician staffing industry was estimated to be approximately $1.7 billion in revenue. The physician workforce is aging and projections suggest by 2020 the annual number of retiring physicians will reach 20,000, a 60% increase from the current number of approximately 12,000 annual physician retirements, according to the December 2008 HRSA survey. While age is the most common and reliable predictor of when physicians leave the workforce, additional factors include: physician net worth, increased risk of burnout, health problems and eligibility for government programs for the elderly, as well as societal expectations, spousal preferences, and financial incentives. Physician retirement patterns could also be impacted by changes in market conditions, the health care operating environment, or government policies that affect any of these factors.

Despite the above, the retirement rate for physicians is on a five-year downward trend with the share of all physicians who have left a practice for the reason of retirement having fallen from 15% in 2004 to 11% in 2008, according to an annual physician retention study conducted by the American Medical Group Association (AMGA) and our Cejka Search subsidiary. We believe the retirement plans of permanent physicians and use of temporary physicians has been negatively impacted by the recession, the stock market decline, and the weakened housing market.

Hours of direct patient care and physician productivity are generally a function of age and can vary by specialty and geography. On average, middle-aged physicians work more hours per week and more weeks per year compared to older and younger physicians, although average hours worked for some age groups change over time, according to the HRSA study (December 2008). Physicians age 46-55 worked more hours than in earlier years, while physicians age 56-65 average hours worked was relatively constant. Physicians under age 36 worked 10% fewer hours in 2002 than they did in 1985, while there is a slight downward trend in average hours worked for physicians age 36-45, and a drop in average hours worked by physicians over age 65. In addition, approximately 1 in 4 physicians are female, but approximately half of all graduating physicians are female, so over time, women will constitute a growing proportion of the physician workforce. The AMA reported in 2001 that the median number of hours worked per week for female physicians was 49 hours compared to 57 hours for male physicians. Employment type and practice location can also influence physician productivity. AMA statistics show that self-employed physicians tend to work more hours per year in patient care compared to physicians who are independent contractors. Independent contractors, in turn, tend to work more time in patient care compared to staff physicians. Also, physicians in less populated areas tend to spend more time providing patient care than do physicians in more populated areas.

Physicians are attracted to the locum tenens industry for a number of reasons, and thus provide 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 the burden of the administrative aspects of managing a business, reimbursement concerns, hospital politics or malpractice costs. In addition, locum tenens can be an attractive career opportunity for physicians for other reasons depending on their age, financial situation and stage of career.

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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 before retirements. 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.

Our Physician Staffing Business

MDA is the fourth largest provider of physician staffing services in the U.S. It was founded in 1987 and is headquartered in Norcross, Georgia with regional offices in Dallas, Texas and Denver, Colorado. We acquired substantially all of the assets of MDA in September 2008. Segment revenue was $121.6 million in 2010. During 2010, MDA handled approximately 5,155 assignments for more than 960 clients utilizing its database of over 144,775 providers who represent a wide range of medical specialties.

During 2010, the overall economic conditions of the prior two years continued to negatively impact the historically strong growth pattern of this business segment. Projected major changes in the healthcare delivery system along with unemployment and higher under employment caused concern for clients relative to outsourcing their staffing needs. In addition, a lingering housing crisis reduced the flexibility for physicians to relocate. Despite these factors, we believe that the long-term outlook for the physician staffing industry is strong and that MDA is strategically positioned to be the quality leader in the industry.

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 a physician s assignment. This process 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.

Additionally, MDA currently is the largest multi-specialty medical staffing company that has procured an occurrence-based professional liability policy that provides coverage in all 50 states from a national insurance company, which is AA+-rated by Standard & Poor s. This is an important competitive advantage for MDA in the recruitment of physicians. 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, which may leave a physician without coverage if the claim is not timely reported or if they fail to secure tail coverage. 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 this malpractice coverage.

When it was initially founded, the locum tenens industry primarily served clinics, group practices and rural hospitals. As the physician staffing industry has matured, an increasing amount of business has been generated from serving hospitals in both urban and suburban 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 basis. MDA also provides 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 2010, approximately 45% of MDA s business was from hospitals and approximately 55% was from physician practice groups and other healthcare facilities.

Recruiting

MDA successfully operates a multi-site business model with employees/recruiters at several locations nationwide. 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. Recruiters are also responsible for managing accounts, including the responsibility for collecting amounts due from customers, enabling MDA to have a single point of contact for customers. MDA currently employs approximately 76 physician staffing recruiters throughout its organization, including its Atlanta area headquarters, as well as in its offices in Denver and Dallas.

Contracts with Physicians and Healthcare Facility Customers

MDA contracts with physicians to provide medical services at MDA s healthcare customers. Each physician is an independent contractor and enters into an agreement with MDA to provide medical services at a particular healthcare facility or physician practice group based on terms and conditions of the customer. Physicians are staffed on assignments that may last from a few days up to and including a year depending on client needs and on the willingness of a physician to agree to the duration required by a particular healthcare customer.

Operations

We operate our physician staffing business from a relatively centralized business model servicing all of the assignment needs of the independent contractor physicians through operation centers located in Norcross, Georgia; Dallas, Texas and Denver, Colorado. The support functions of credentials verification, accounts payable, billing and collections, and risk management are all performed from our Norcross, Georgia location. Assignment management is performed by recruiters in the three offices as well as remote recruiters working from their homes. Hours worked by independent contractor physicians are recorded by our operations systems, which then produces payments to the physicians and invoices to our clients.

Clinical Trial Services

Overview of the Pharmaceutical and Biotechnology Industry

Drug discovery is the process by which potential drugs are discovered or designed. Drug development refers to activities undertaken after a compound is identified as a potential drug in order to establish its suitability as a medication. Objectives of drug development are to determine appropriate formulation and dosing, as well as to establish safety. The discovery and development of a new medicine is an expensive and lengthy process which involves research that generally includes a combination of in vitro studies, in vivo studies, and clinical trials.

The global pharmaceutical market is expected to have grown 4%-5% in 2010, and grow 5%-7% in 2011 to $880 billion, according to industry intelligence source IMS Health (IMS). In characterizing the overall market, IMS believes there are significant constraints to growth in developed pharmaceutical markets that include the impact of major drug patent expirations and tighter price controls to limit drug spending that will be more than offset by rapid expansion and strong growth in emerging pharmaceutical markets. Over the coming years, IMS expects the global pharmaceutical market value to exceed $975 billion by 2013, projecting drug sales growth at a 4%-7% compounded annual growth rate.

In 2010, the U.S Food and Drug Administration (FDA) approved approximately 20 new drugs, the fewest since 2007, reflecting the agency s willingness to delay or reject medicines with potential safety risk. However, on the development side, the number of drugs in the overall pipeline increased 1.4% in 2010 to more than 9,700 and continued the upward trend of the past few years. Looking at the clinical stages of development, the trend in preclinical development was negative compared to the prior year, while the numbers for all phase development were up, including a 7.9% rise at Phase II. However, these additional 134 compounds at Phase II testing only translated to 22 compounds at Phase III testing, according to Pharma R&D Annual Review (May 2010).

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 November 2006 study from the Tufts University Center for the Study of Drug Development (Tufts CSDD). 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. In 2006, there were more than 2,700 medicines in clinical trials or undergoing review by the U.S. Food and Drug Administration (FDA) for 4,600 indications of use.

In recent years, drug developers have been under significant pressure to introduce new products while confronting escalating R&D costs, patent expirations of blockbuster drugs and heightened regulatory scrutiny. Consequently, the pharmaceutical industry has been undergoing significant change in drug development philosophy ranging from the refocusing of internal drug development projects, to outsourcing and off-shoring of clinical trials, as well as the creation of drug development alliances. These market pressures have also spawned a wave of corporate restructuring and consolidations in the pharmaceutical industry.

Another potential market for a range of outsourced clinical development activities and clinical trials is molecular medicine, or drug therapies developed from sequencing the human genome. In 2001, the first phase of the Human Genome Project, an international effort to determine the entire sequence of the human chromosome set was completed, along with a database of the most common sequence variations that distinguish one person from another. There are about 20,000-25,000 human genes, made up of 3 billion individual base pairs, the units of DNA, according to information from PhRMA, a pharmaceutical industry trade association. Each gene codes for a protein and these proteins carry out all the functions of the body, as well as being involved in disease.

The discipline that blends pharmacology with genomic capabilities is called pharmacogenomics. Within the next decade, the *Journal of Gene Medicine* (2006) expects researchers to begin to correlate DNA variants with individual responses to medical treatments, identify particular subgroups of patients, and develop drugs customized for those populations. Genomic data and technologies also are expected to make drug development faster, cheaper, and more effective. Most drugs today are based on about 500 molecular targets, but genomic knowledge of genes involved in diseases, disease pathways, and drug-response sites will lead to the discovery of thousands of additional targets. As knowledge becomes available to select patients most likely to benefit from a potential drug, pharmacogenomics will likely speed the design of these drugs and increase the number of clinical trials.

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. 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 leverage 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.

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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Conversion of the fixed costs of maintaining the personnel, expertise and facilities into variable costs

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Supplement 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

During the past decade, contract research, manufacturing and service providers benefited from a trend of increased outsourcing by pharmaceutical companies. However, in 2009, many contract organizations experienced significant cancellations and delays of Phase II and Phase III clinical trials, and this dynamic continued into 2010 due to increased uncertainty over healthcare reform and tighter spending controls. In response to the clinical market dynamics that have put pressure on pharmaceutical companies and the reduction in demand for traditional outsourced clinical research services, large sponsor companies and CROs are entering into large scale, multi-year drug discovery and development service contracts that emphasize outsourcing relationships that capture cost benefits, efficiency and flexibility. These contracts are tailored to meet operational and strategic requirements to best provide long-term success for product development while reducing the need to manage multiple vendors across unique projects. In addition, vendor management programs are also being implemented and expanded upon throughout the clinical research sector in order to streamline the outsourcing process and achieve cost effective results across the drug development continuum.

Nonetheless, the trend of pharmaceutical companies spending significant amounts of money on late-stage services (Phase II IV clinical trials) should be on the rise as companies seek to accelerate the commercialization of drug candidates to compensate for upcoming patent expirations and conduct post-marketing trials as required by the FDA (Contract Pharma, June 2010). Contract clinical research is projected to total $20 billion in 2010, representing approximately one-third of total pharmaceutical and biotechnology R&D spending, according to the Association of Clinical Research Organizations.

In 2009, domestic private sector R&D spending in the biopharmaceutical industry was estimated to be $65 billion (PhRMA 2010). While data for 2009 has not been finalized, industry and financial analysts are projecting that R&D spending in 2009 may be as much as 18% to 20% below 2008 levels in certain areas due to the global financial crisis that began at the end of 2008 and was followed by a severe and lengthy worldwide recession (Applied Clinical Trials, March 2010). This resulted in a significant number of mergers and acquisitions, divestitures and closures among pharmaceutical, biotechnology, and medical device companies that led to portfolio rationalization, changes in operating strategies, and project suspensions and terminations, which combined to impact R&D spending unfavorably.

Consequently, the landscape for outsourcing clinical services has changed. Several years ago, pharmaceutical and biotechnology companies utilized integrated alliance-based relationships with clinical research organizations and other outsourcing partners. Almost half of all companies reported they had entered into typical functional service provider arrangements and approximately 20% reported having entered into a strategic alliance, according to a study conducted by

Tufts CSDD in 2008. Since the end of 2008, many sponsor companies have opted to utilize a hybrid relationship model that allows them to pick and choose elements from transactional, full service, functional and alliance relationships with two primary objectives in mind: (1) to achieve higher levels of operating efficiency through integration and the transfer of non-core responsibilities, and (2) to lower the overall cost of outsourcing (Contract Pharma, October 2010).

Overview of Clinical Trials

Clinical trials are conducted to collect data regarding the safety and efficacy of new drugs or medical devices. The clinical trials are typically conducted by teams of physicians and other clinical and data professionals in university facilities, hospitals and physician offices around the world. 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 on 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 to test 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.

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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.

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 (Center for Information and Study on Clinical Research Participation, Hoover Institution, and 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).

Our Clinical Trial Services Business

We primarily provide traditional contract staffing and outsourcing services, as well as drug safety monitoring and regulatory consulting services to pharmaceutical, biotechnology and medical device companies, as well as to CRO customers. In 2010, segment revenue was $62.0 million. We market these services through the following brands:

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ClinForce, which provides clinical research professionals for in-sourced and out-sourced contract assignments and direct placement services. Acquired in March 2001, it is headquartered at the Research Triangle Park in Durham, North Carolina.

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Assent, which provides contract staffing and direct placement services to biotechnology and pharmaceutical customers. Acquired in July 2007, it has offices located in Cupertino, California and Solana Beach, California.

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AKOS, which provides drug safety and regulatory services. Acquired in June 2007, it is based in Harpenden Hertfordshire, England.

We recruit qualified candidates for our clinical trial services segment from across the U.S. and internationally for clinical research opportunities, which include temporary and permanent positions with our clients. 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 non-staffing services consist primarily of regulatory affairs personnel, pharmacovigilance and drug safety associates and other clinical professionals.

During the prior two years, pharmaceutical, biotechnology and medical device companies and clinical research organizations were negatively impacted by economic factors and financial market conditions that led to numerous mergers, acquisitions and business closures, along with a reduction in R&D activities that created a historically high cancellation rate among service providers. In 2010, the business environment for clinical trial services improved as the year progressed as some of the post-acquisition transition and integration plans became clearer and these companies began to bring forward some of the projects that were previously put on hold. In addition, many large pharmaceutical and biotechnology companies started to re-focus their efforts on later stage R&D activities to combat the prospect of numerous patent expirations of blockbuster drugs in the coming years. In 2010, the staffing component of our clinical trial services business, which represented more than 90% of segment revenue, experienced a modest up-tick in demand represented by improved client requests for proposals, bid defenses and contract awards, as well as an increased need for permanent placement positions by our client base. However, our drug safety monitoring and regulatory compliance advisory businesses continued to remain weak in 2010, reflecting the industry downturn in demand for many early stage clinical services and focus on later stage R&D activities, as well as some clients taking their pharmacovigilance activities in-house following mergers with larger entities.

Other Human Capital Management Services

We provide education and training programs to the healthcare industry and we also provide retained search services for physicians and healthcare executives. Segment revenue was $42.8 million in 2010.

Education and Training Services

Our Cross Country Education (CCE) subsidiary, headquartered in Brentwood, Tennessee, provides regulatory and clinical skill-based continuing education development for healthcare professionals. CCE is an approved provider of continuing education with more than 35 professional healthcare associations, and also works with national and state boards and associations. CCE offers one-day seminars and e-learning, as well as national and regional conferences on topics relevant to healthcare professionals. Since 1995, CCE has trained over 1,000,000 licensed professionals in the fields of physical and occupational therapy, behavioral health, nursing, long-term care, coding and billing, regulatory compliance, dentistry, health information and healthcare administration. In 2010, CCE held approximately 5,500 seminars and conferences that were attended by nearly 163,000 registrants in 182 cities in the U.S. and Canada. We extend these educational services to our field employees on favorable terms as a recruitment and retention tool.

In 2010, CCE s business experienced a resurgence of professionals attending its live continuing education seminars. CCE s largest markets are the mental health and allied health sectors, which together represent approximately 74% of its seminar offerings. Combined, these markets had 4% higher attendance from the prior year. The most significant growth market for CCE in 2010 was seminar attendance by Nurse Practitioners and Physician Assistants, which increased 21% year-over-year. We believe our business and the continuing education industry is beginning to reap some benefit from the health care reform regulations implemented to-date. However, the most significant opportunities may be realized as compliance with the new healthcare reform regulations become mandatory for healthcare practitioners.

Retained Physician/Executive Search

Our Cejka Search subsidiary is headquartered in Creve Coeur, Missouri, a business district centered within the St. Louis metropolitan area. Cejka Search has been a leading physician, allied health and healthcare executive search firm for 30 years, recruiting top healthcare talent for organizations nationwide through a team of experienced professionals, award-winning recruitment technology and commitment to service excellence. Serving clients nationwide, Cejka Search annually completes hundreds of search assignments for organizations spanning the continuum of healthcare, including physician group practices, hospitals and health systems, academic medical centers, managed care and other healthcare organizations.

In 2010, growth in demand for recruitment services was impacted by the lingering effects of the economic downturn and weak national labor market that translated into lower procedural volume and revenue for many healthcare providers. Other factors that continued to limit or delay implementation of medical and administrative staff recruitment plans included uncertainty related to the implementation of healthcare reform and the Medicare reimbursement rules. At the same time, depressed housing values, reduced employment opportunities for trailing spouses and slow recovery in retirement portfolios made relocation and retirement unattractive to physicians, which impacted revenue from both search assignments and placements.

Internally, during the later part of 2009 and throughout 2010, Cejka Search made strategic changes to its business model to be more competitive in the current market for retained search services, which reduced operating expenses and resulted in a higher number of engagements in both physician and executive search. The changes included introducing shared risk search products and unbundled recruiter support and sourcing services. Previously, full cycle search was the only option available to clients. Despite these improvements, revenue growth was impacted slightly due to a change in the mix of business and less overall placements being made. Based on operational efficiencies and marketing improvements made in 2010, we believe Cejka Search is well-positioned to benefit from the continuing physician shortages in most specialties and growing demand for advanced practitioners, allied health professionals and healthcare executive leadership as the U.S. population continues to age.

Additional Information About Our Business

Growth and Investment Strategy

Our long-term corporate strategy for growth includes:

- attracting additional healthcare customers, healthcare professionals and providers;
- seeking additional MSP contracts with hospitals and health systems;
- 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 what we believe is the most comprehensive suite of staffing and outsourcing services to the U.S. healthcare market. Since becoming a public company in 2001, we have significantly expanded our revenue mix across sectors of healthcare staffing services and customers. In 2010, our nurse and allied staffing business segment was 52% of our revenue; our physician staffing business segment was 26% of our revenue; our clinical trial services business segment was 13% of our revenue and our other human capital management services business segment was 9% of our revenue. This compares to our revenue mix in 2001 in which 87% was from our nurse and allied staffing business segment, 6% from our clinical trial services business segment and 7% from our other human capital management services business segment.

Within our business segments, we also believe we benefit from the following:

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Brand Recognition. We have operated in the travel nurse staffing industry for more than 25 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, Medical Doctor Associates, 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. Since entering the clinical trial services business in 2001, our core clinical staffing business has been a strong service provider to pharmaceutical, biotechnology and medical device companies and our acquisitions have broadened our services offerings in such areas as drug safety monitoring and regulatory services. We are well positioned to offer these services to our customers in the U.S. and certain international markets. Our Cejka

Search brand is ranked among the top five physician placement firms in the U.S. Our Cross Country Education business is a leading provider of regulatory and clinical skill-based continuing professional development for healthcare professionals.

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Strong and Diverse Client Relationships. We provide healthcare staffing and outsourcing solutions to a national client base represented by approximately 4,200 contracts with hospitals and healthcare facilities, pharmaceutical and biotechnology companies, and other healthcare providers. No single client accounts for more than 4% of our revenue.

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Managed Service Provider Capabilities. Our Cross Country Staffing brand offers its MSP 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.

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Recruiting and Placement of Healthcare Professionals. We are a leader in recruiting and retaining highly qualified healthcare professionals from the U.S. and Canada. In 2010, thousands of healthcare professionals applied with us through our differentiated recruitment brands. We believe we offer appealing assignments, competitive compensation packages, attractive housing options and other valuable benefits.

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Joint Commission Certification. The staffing businesses of our Cross Country Staffing, MedStaff and Allied Health Group brands 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. We have internal educational and training capabilities through Cross Country University (CCU), a division of CCS, that we believe give us a competitive advantage by enhancing both the quality of our working nurses and the effectiveness of our recruitment efforts. CCU is the first educational program in the travel nurse industry to be accredited by the American Nurse Credentialing Center, and enables us to provide continuing education credits to our RN field employees, as well as to provide accredited continuing education to healthcare professionals not on an assignment with us. CCU offers our RNs and other healthcare professionals additional training, professional development and assistance in completing continuing education for state licensing requirements.

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Scalable and Efficient Operating Structure. At year-end 2010, 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 has played a key role in the growth and development of the healthcare staffing industry. Our management 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 and regulated 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. In our clinical trial services business, we also possess a high degree of 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 in order to successfully provide our services for various types of clinical projects. 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, pay and benefits, speed of placements, customer service to both healthcare professionals and client facilities, quality of accommodations, and overall industry reputation. We believe that healthcare professionals seeking temporary assignments through us are also pursuing assignments through other means, including other temporary staffing firms. Therefore, the ability to respond more quickly than our competitors to candidate inquiries and submit candidates for consideration, are important factors in our ability to fill assignments. In our nurse and allied staffing segment, we focus on retaining healthcare professionals by providing high-quality customer service as well as providing long-term benefits, such as 401(k) plans and bonuses for field employees. 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. While barriers to entry historically had been relatively low, they have increased significantly and the achievement of substantial scale is very challenging. We believe the utilization of temporary nurse staffing services by hospitals has historically been 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 hundreds of small local providers. National competitors include AMN Healthcare Services, Inc., On Assignment, Inc., CHG Group, and Medical Staffing Network Holdings, Inc.

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 providing 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, Inc., Jackson Healthcare, Team Health and several other privately-held companies providing locum tenens.

Clinical Trial Services

The clinical trial services industry is highly competitive and fragmented. In addition to the same competitive factors outlined above, our clinical trial 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, and regulatory services assignments. Competitors include divisions of public and privately-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 trial staffing services to, and sometimes compete with, large clinical research organizations 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 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, field employees and independent contractors, 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 and independent contractor. In addition to our domestic information systems team, certain software development and information technology support is provided by our employees based in Pune, India.

Our financial, management reporting and human resources systems are managed on PeopleSoft, 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 Insurance, Professional Liability Coverage and Health Care Benefits

We provide workers compensation insurance coverage, professional liability coverage and health care benefits for our eligible temporary healthcare professionals. 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 reserves, we include reserves for estimated claims incurred but not reported. The health care insurance accrual is for claims that have occurred but have not been reported and is based on our historical claim submission patterns. The ultimate cost of workers compensation, professional liability and health insurance claims will depend on actual amounts incurred to settle those claims and may differ from the amounts reserved by us for those claims.

Workers compensation benefits are provided under a partially self-insured plan. We have a letter of credit structure to guarantee payments of claims. At December 31, 2010 and 2009, respectively, we had outstanding approximately $7,199,000 and $7,149,000 standby letters of credit as collateral to secure the self-insured portion of this plan.

Since October 2009, all professional liability insurance has been provided under occurrence-based plans. Prior to that period, professional liability coverage was provided under various self-insured, claims-made and occurrence-based plans depending on the subsidiary and the applicable policy year. In October 2004, we secured individual occurrence-based professional liability insurance policies with no deductible for virtually all of our working nurses and allied professionals, except those employed through our MedStaff subsidiary. These occurrence-based individual policies replaced a $2,000,000 per-claim layer of self-insured exposure. We continued to provide primary coverage through a $2,000,000 self-insured retention for nurses and allied professionals who did not qualify for the individual occurrence-based coverage, as well as for our independent liabilities (such as negligent hiring) during these policy years. Effective October 1, 2008, the individual professional liability insurance policies were replaced with one policy that insured each individual nurse for $2,000,000 per occurrence and $4,000,000 in the aggregate, as well as the corporation which shared those limits. This policy had no deductible and did not cover healthcare professionals working through MedStaff or MDA Holdings, Inc. or its subsidiaries (collectively, MDA). Separately, prior to October 1, 2009, our MedStaff subsidiary had a claims-made professional liability policy with a limit of $2,000,000 per occurrence, $4,000,000 in the aggregate and a $25,000 deductible per claim.

In October 2009, we purchased an occurrence-based professional liability policy that provides each working nurse and each allied healthcare professional with coverage of $1,000,000 per occurrence and $3,000,000 in the aggregate. Those individual limits are shared with the healthcare provider s employer (e.g. Cross Country Travcorps or MedStaff) in the event of vicarious liability and/or negligent hiring allegations on a claim. This policy does not have a deductible. In addition, in October 2009, we purchased an excess layer of professional liability insurance having limits of $1,000,000 per occurrence and $6,000,000 in the aggregate for all working nurses and allied healthcare professionals of Cross Country Travcorps and $1,000,000 per occurrence and $3,000,000 in the aggregate for all working nurses of MedStaff. Those limits are also shared with the corporations on applicable claims. MedStaff also secured insurance coverage having the same terms as the primary and excess coverage described above for acts occurring on or after October 25, 2002.

MDA has an occurrence-based professional liability policy with a limit of $1,000,000 per occurrence, $3,000,000 in the aggregate and a $500,000 deductible for MDA, its independent contractor physicians, CRNAs and allied health professionals. MDA s $500,000 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 there is a requirement to guarantee the payment of claims to its insured party s primary medical malpractice insurance carrier via a letter of credit. The value of the letter of credit was secured by $5,000,000 of cash held by the Captive as restricted cash at December 31, 2008. During 2009, the cash was released from restriction and replaced by a letter of credit under our credit facility. As of December 31, 2010 and 2009, the value of the letter of credit was $5,532,724.

Subject to certain limitations, we also have $5,000,000 per occurrence and $10,000,000 in the aggregate in umbrella liability coverage after $2,000,000 is exhausted under the primary and excess professional liability policies covering the working nurses and allied healthcare professionals. While this umbrella coverage does not extend to professional liability claims against MDA, its independent contractor physicians, CRNAs and allied health professionals, it does cover claims brought against all of our subsidiaries for non-patient general liability ($250,000 deductible), employee liability ($1,000,000 deductible), non-owned hired auto ($1,000,000 deductible) and clinical trials/errors and omissions ($500,000 deductible and a cap of $5,000,000 in coverage under the umbrella policy).

Professional Licensure

Nurses and most other healthcare professionals employed by us and physicians contracted by us are required to be individually licensed or certified under applicable state law. Our comprehensive compliance and credentials verification programs are designed to ensure that employed and contracted providers possess all necessary licenses and certifications, and we endeavor to ensure that our employees (including nurses and therapists) and contractors (including physicians and other mid-level providers), 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.

The Health Information Technology for Economic and Clinical Act (HITECH Act) was adopted on February 17, 2009 as part of the American Recovery and Reinvestment Act and it became effective on February 17, 2010. Among other things, this legislation established a process for the development of standards for the secure electronic exchange and use of health information by hospitals, physicians, and others. The general purpose of the HITECH Act is to improve the quality of healthcare by reducing medical errors and lowering costs through the computerization of America s medical records by 2015. Approximately $20 billion was allocated to the HITECH Act incentives to encourage and accelerate the widespread adoption of electronic healthcare records (EHR) by physicians, hospitals and others. The Medicare and Medicaid EHR incentive programs provide incentives payments to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade or demonstrate the meaningful use of certified EHR technology. To further promote the timely adoption of EHR, the HITECH Act penalizes eligible healthcare providers and hospitals that do not adopt and use EHR that meets the federal requirements by 2015. For example, under the Medicare EHR Incentive Program, Medicare eligible professionals, hospitals and critical access hospitals that do not successfully show meaningful use of EHR will have a payment adjustment in their Medicare reimbursement. The Medicaid EHR Incentive Program is being voluntarily offered by individual states and states can receive a 90% federal funding match for incentive payments distributed to Medicaid providers who adopt EHRs under the meaningful use criteria. As a result, many eligible hospitals are implementing new or enhanced EHR technology to capitalize on these incentives and avoid the penalties and their staff must undergo training of the new technology systems out of the clinical setting, which creates an opportunity for our healthcare professionals to fill positions on a temporary basis while full-time staff is receiving such training.

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 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 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 primarily in the U.S. 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, 2010, we had approximately 1,100 corporate employees. During 2010, we maintained an average of 2,185 full-time equivalent field employees in our nurse and allied staffing segment. In our physician staffing segment, we utilized 1,593 independent contractor physicians and 101 independent contractors related to non-physician staffing during the course of the year. In our clinical trial services segment, we maintained an average of 394 full-time equivalent field employees and utilized 117 independent contractors during the course of the year. 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.

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 typically reduce their use of temporary employees or other healthcare professionals before undertaking layoffs of their permanent 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 the trend towards providing healthcare in alternative settings, as opposed to acute care hospitals intensifies, it could result in a decline in in-patient admissions at our clients facilities. 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.

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. These arrangements may also require us to, among other things, guarantee a percentage of open positions that we will fill, and if we are unable to meet those obligations a client may terminate our contract which could have a negative impact on our profitability. We may have fixed costs, including housing costs, associated with terminated arrangements that we will be obligated to pay post-termination. Our clinical trial 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 trial 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 trial services. The delay, loss, termination or unfavorable change in the scope of work performed under a clinical trial services contract could negatively impact our business.

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 permanent or temporary employees. Currently, there is a shortage of certain qualified nurses and physicians in many areas of the United States and competition for these professionals remains intense. The current economic conditions 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 is below historically normal levels, 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 certain 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 the value of benefits to induce healthcare professionals to take assignments with them. If we do not raise wages or increase the value of benefits in response to such increases by our competitors, we could face difficulties attracting and retaining qualified healthcare professionals. 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 over a 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.

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

Our clinical trial services 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 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 which could also harm our reputation, our ability to win future business and our operating results.

The nature of our clinical trial 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 trial 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 trial business exposes us to potential liability for personal injury and wrongful death claims that could affect our reputation and operating results.

Our clinical trial 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 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 acquisitions. 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, the HITECH Act, 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 acquisitions, to determine if impairment has occurred. Long-lived assets and identifiable intangible assets are also reviewed for impairment whenever events or changes in circumstances indicate that amounts may not be recoverable. If the testing performed indicates that impairment has occurred, we are required to record a non-cash impairment charge for the difference between the carrying amount 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 quarters of 2010 and 2009, we recorded impairment charges of $10.8 million, pretax, and $1.7 million, pretax, respectively, 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, 2010, goodwill and other identifiable intangible assets (net of amortization) represented 89.5% of our stockholders equity.

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 its behalf. 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.

We purchase various insurance policies to limit or transfer certain risks inherent in our operations. The costs related to obtaining and maintaining professional and general liability insurance and health insurance for healthcare providers has generally been increasing. If the cost of carrying these insurance policies 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 needs. 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 3,500,000 shares of common stock for our 2007 Stock Incentive Plan. Options to purchase 620,246 shares of common stock were issued and outstanding as of February 28, 2011 of which, options to purchase 619,622 shares were vested. In addition, 1,070,898 shares of stock appreciation rights were issued and outstanding as of February 28, 2011, 307,302 of which were vested. Shares of restricted stock outstanding as of February 28, 2011, were 501,699. 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.

Economic conditions and volatility in the financial markets may have an adverse impact on the availability of credit to our customers and businesses generally. To the extent that disruption in the financial markets occurs, 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. These events could negatively impact our results of operations and financial conditions. 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. Conditions in the credit markets and the economy generally could adversely impact our business and frustrate or prohibit us from refinancing our credit facility on terms favorable to us when it comes due in September 2013.

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.

If our healthcare facility clients increase the use of intermediaries it could impact our profitability.

We have seen an increase in the use of intermediaries by our clients, including both vendor management companies (who solely provide technology) and managed service providers (who provide staffing services). These intermediaries typically enter into contracts with our clients and then subcontract with us and other agencies to provide staffing services, thus interfering to some extent in our relationship with our clients. Each of these intermediaries charges an administrative fee. If managed service providers win business with our current customers, the number of professionals we have on assignment at those clients could decrease. If we are unable to negotiate hourly rates with intermediaries for the services we provide at these clients which are sufficient to cover administrative fees charged by those intermediaries, it could impact our profitability. If those intermediaries become insolvent or fail to pay us for our services, it could impact our bad debt expense and thus our overall profitability.

We also provide vendor management services directly to certain of our clients. While such contracts typically improve our market share at these facilities, they could result in less diversification of our customer base and increased liability. The loss of one or more of our large vendor management accounts could materially affect our profitability.

We are subject to business risks associated with international operations.

As of December 31, 2010, we had international operations in the United Kingdom where our AKOS Limited (AKOS) business is headquartered and India where our Cross Country Infotech, Pvt Ltd. (Infotech) subsidiary is located. AKOS is a provider of drug safety, regulatory and clinical trial services to pharmaceutical and biotechnology companies in Europe, the United States, Canada and Asia. Infotech provides in-house information systems development and support services as well as some back-office processing services. We have limited experience in supporting our services outside of North America. Operations in certain markets are subject to risks inherent in international business activities, including: fluctuations in currency exchange rates; changes in regulations, varying economic and political conditions; overlapping or differing tax structures; and regulations concerning compensation and benefits, vacation and the termination of employment. Our inability to effectively manage our international operations could result in increased costs and adversely affect our results of operations.

Item 1B.

Unresolved Staff Comments.

None.

Item 2.

Properties.

We do not own any real property. Our principal leases as of December 31, 2010 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, 2011 and February 28, 2014 (a)
Durham, North Carolina	Clinical trial staffing headquarters	37,851	September 30, 2013
Newtown Square, Pennsylvania	Nurse and allied staffing administration and general office use	31,959	January 17, 2014
Creve Coeur, Missouri	Retained search headquarters	27,051	June 14, 2017
Malden, Massachusetts	Nurse and allied staffing administration and general office use	22,767	June 30, 2017
Pune, India	In-house information systems and development support	20,700	November 30, 2015
Tampa, Florida	Nurse and allied staffing administration and general office use	15,698	February 15, 2015
Ambler, Pennsylvania	Clinical trial staffing operations site	14,459	September 30, 2013
Brentwood, Tennessee	Education training headquarters	14,157	August 31, 2014

(a)

In December 2010, the Company entered into a one year lease to rent 8,494 square feet which replaced the leased space of approximately 25,000 square feet that terminated on January 31, 2011.

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 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 corporate employees while in on-call status with 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. In December 2009, the Company reached an agreement in principle to settle this matter. As a result, the Company accrued a pre-tax charge of $345,000 (approximately $209,000 after taxes) related to this lawsuit. In October 2010, the court granted preliminary approval of the settlement.

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.

(Removed and Reserved).

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). Our common stock commenced trading on the NASDAQ National Market under the symbol CCRN on October 25, 2001. 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.

Calendar Period	Closing Sale Prices High	Closing Sale Prices Low
2010		
Quarter Ended March 31, 2010	$ 10.79	$ 8.63
Quarter Ended June 30, 2010	$ 10.99	$ 7.66
Quarter Ended September 30, 2010	$ 9.67	$ 7.09
Quarter Ended December 31, 2010	$ 9.19	$ 6.63
2009		
Quarter Ended March 31, 2009	$ 9.04	$ 5.25
Quarter Ended June 30, 2009	$ 9.20	$ 6.59
Quarter Ended September 30, 2009	$ 10.07	$ 6.30
Quarter Ended December 31, 2009	$ 10.13	$ 7.88

The graph below matches Cross Country Healthcare, Inc.'s cumulative 5-year total shareholder return on common stock with the cumulative total returns of the NASDAQ Composite index, the Dow Jones US Health Care Providers index, and the Dow Jones US Business Training & Employment Agencies index. The graph tracks the performance of a $100 investment in our common stock and in each of the indexes (with the reinvestment of all dividends) from 12/31/2005 to 12/31/2010.

	12/05	12/06	12/07	12/08	12/09	12/10
Cross Country Healthcare, Inc.	**100.00**	**122.38**	**79.87**	**49.30**	**55.58**	**47.50**
NASDAQ Composite	**100.00**	**111.16**	**124.64**	**73.80**	**107.07**	**125.99**
Dow Jones US Health Care Providers	**100.00**	**98.43**	**117.33**	**63.74**	**86.58**	**95.51**
Dow Jones US Business Training & Employment Agencies	**100.00**	**115.88**	**85.33**	**52.61**	**80.29**	**96.70**

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

As of March 3, 2011, there were 100 stockholders of record of our common stock. In addition, there are approximately 2,725 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. Covenants in our credit agreement limit our ability to repurchase our common stock and declare and pay cash dividends on our common stock. During the year ended December 31, 2010, we did not purchase any shares of our common stock. .

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 Company s May 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. Under the remainder of our current stock repurchase authorization, we can repurchase up to 1,441,139 shares of our common stock. See *Liquidity and Capital Resources* in the *Management s Discussion and Analysis of Financial Statements of Financial Condition and Results of Operation* section of this report. As of December 31, 2010, pursuant to the terms of our credit agreement covenants, we are not able to use cash for either dividends or stock repurchases.

Item 6.

Selected Financial Data.

The selected consolidated financial data as of December 31, 2010 and 2009 and for the years ended December 31, 2010, 2009, and 2008 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, 2008, 2007 and 2006 and for the years ended December 31, 2007 and 2006, 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,				
	2010	**2009**	**2008 (a)**	**2007 (b)**	**2006(c)**
	(Dollars in thousands, except share and per share data)				
Consolidated Statements of Operations Data					
Revenue from services	$ 468,562	$ 578,237	$ 734,247	$ 718,272	$ 655,152
Operating expenses:					
Direct operating expenses (d)	336,250	424,984	547,753	549,441	508,015
Selling, general and administrative expenses (d)	108,984	120,690	130,722	116,859	104,625
Bad debt expense	294		951	1,559	459
Depreciation	8,043	8,773	7,637	6,309	5,449
Amortization	3,851	4,018	3,166	2,051	1,570
Impairment charges (e)	10,764	1,726	244,094		
Legal settlement charge (f)		345		34	6,704
Secondary offering costs (g)					154
Total operating expenses	468,186	560,536	934,323	676,253	626,976
Income (loss) from operations	376	17,701	(200,076)	42,019	28,176
Other expenses (income):					
Foreign exchange loss (gain)	76	66	(132)	93	
Interest expense, net	4,072	6,174	4,225	2,587	1,464
Other income		(193)			
(Loss) income from continuing operations before income taxes	(3,772)	11,654	(204,169)	39,339	26,712
Income tax (benefit) expense	(997)	4,960	(61,224)	14,759	10,146
(Loss) income from continuing operations	(2,775)	6,694	(142,945)	24,580	16,566

Discontinued operations, net of income taxes:										
Income from discontinued operations (h)										70
Net (loss) income	$	(2,775)	$	6,694	$	(142,945)	$	24,580	$	16,636
Net (loss) income per common share basic:										
(Loss) income from continuing operations	$	(0.09)	$	0.22	$	(4.64)	$	0.77	$	0.52
Discontinued operations										0.00
Net (loss) income	$	(0.09)	$	0.22	$	(4.64)	$	0.77	$	0.52
Net (loss) income per common share diluted (i):										
(Loss) income from continuing operations	$	(0.09)	$	0.22	$	(4.64)	$	0.76	$	0.51
Discontinued operations										0.00
Net (loss) income	$	(0.09)	$	0.22	$	(4.64)	$	0.76	$	0.51
Weighted average common shares outstanding:										
Basic		31,060,426		30,824,660		30,825,099		31,972,681		32,077,240
Diluted (i)		31,060,426		30,999,446		30,825,099		32,484,241		32,737,419

	Year Ended December 31,									
		2010		**2009**		**2008**		**2007**		**2006**
Other Operating Data										
Nurse and allied staffing statistical data:										
FTEs (j)		2,185		2,735		4,463		5,025		5,001
Days worked (k)		797,525		998,275		1,633,594		1,834,125		1,825,365
Average revenue per FTE per day (l)	$	304	$	314	$	322	$	314	$	304
Physician staffing statistical data (a):										
Days filled (m)		78,346		95,253		34,863		NA		NA
Revenue per day filled (n)	$	1,552	$	1,594		1,622		NA		NA

	Year Ended December 31, 2010	2009	2008 (in thousands)	2007	2006
Cash flow data (o):					
Net cash provided by operating activities	$ 31,522	$ 72,400	$ 51,085	$ 35,880	$ 32,918
Net cash used in investing activities	$ (16,199)	$ (11,713)	$ (129,561)	$ (35,328)	$ (27,848)
Net cash (used in) provided by financing activities	$ (11,191)	$ (64,217)	$ 79,985	$ 8,431	$ (5,070)
Consolidated Balance Sheet Data					
Working capital (o)	$ 67,511	$ 71,177	$ 107,059	$ 98,193	$ 84,732
Cash and cash equivalents (o)	$ 10,957	$ 6,861	$ 10,173	$ 9,067	$
Total assets (o)	$ 348,208	$ 356,589	$ 425,849	$ 535,005	$ 500,926
Total debt	$ 53,513	$ 62,514	$ 133,080	$ 39,451	$ 21,529
Stockholders equity	$ 246,009	$ 246,071	$ 234,023	$ 390,437	$ 374,856

NA not applicable

(a)

On September 9, 2008, the Company consummated the acquisition of substantially all of the assets of privately-held MDA Holdings, Inc. and its subsidiaries and all of the outstanding stock of a subsidiary of MDA Holdings, Inc. (collectively, MDA). Our 2008 results include results from the acquisition of MDA from September 1, 2008, the agreed upon effective date for accounting purposes. Refer to further discussion in our notes to the consolidated financial statements (Note 4 -Acquisitions).

(b)

Our 2007 results include results from the acquisitions of AKOS Limited (AKOS) and Assent Consulting (Assent) from their acquisition dates of June 6, 2007 and July 18, 2007, respectively. Refer to further discussion in our notes to the consolidated financial statements (Note 4 Acquisitions).

(c)

Our 2006 results include the results from the acquisition of substantially all of the assets of Metropolitan Research Associates, LLC and Metropolitan Research Staffing Associates, LLC (collectively Metropolitan Research) from August 31, 2006, the date of acquisition. Refer to further discussion in our notes to the consolidated financial statements (Note 4-Acquisitions).

(d)

In 2010, the Company reevaluated the classifications of certain expenses related to its retained search business segment. To better reflect the costs that are most variable with revenue, the Company reclassified certain costs from selling, general and administrative expenses to direct costs. Prior years have been reclassified to conform to the 2010 presentation.

(e)

Impairment charges include goodwill and other intangible asset impairment charges pursuant to the *Intangibles-Goodwill and Other* Topic of the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) and the *Impairment or Disposal of Long-Lived Asset* subsection of the *Property, Plant and Equipment* Topic of the FASB ASC. In the fourth quarter of 2010, the Company recorded noncash pretax impairment charges of $10.8 million, related to the impairment of specific trademarks in its physician and nurse and allied staffing business segments related to its acquisition of MDA. In the fourth quarter of 2009, the Company recorded a noncash pretax impairment charge of $1.7 million, related to the change in utilization of a specific trademark and database in its clinical trial services business segment. As a result of its annual goodwill impairment analysis, in the fourth quarter of 2008, the Company recorded a $241.0 million, pretax, goodwill impairment related to its nurse and allied staffing business segment. In addition, in the fourth quarter of 2008, the Company recorded a $3.1 million, pretax, impairment charge related to a specific customer relationship in its clinical trial services business segment. Refer to further discussion of these impairment charges in our notes to the consolidated financial statements (Note 3 Goodwill and Other Identifiable Intangible Assets).

(f)

During the fourth quarter of 2009, the Company reached an agreement in principle to settle a class action lawsuit, *Maureen Petray and Carina Higareda v. MedStaff, Inc*., which the court granted preliminary approval in October 2010. In the fourth quarter of 2009, the Company accrued a pretax charge of $0.3 million ($0.2 million after taxes) related to this lawsuit. During the third quarter of 2006, we agreed, in principle, to settle a wage and hour class action lawsuit, *Cossack, et.al. v. Cross Country TravCorps and Cross Country Nurses, Inc.* On March 5, 2007, a final settlement of the matter was approved by the court. During 2006, the Company accrued a pretax charge of $6.7 million ($4.2 million after taxes), representing the final settlement amount, which was paid in 2007.

(g)

Secondary offering costs include registration statement filings and public offering expenses incurred as a result of our secondary offerings in September 2006. We did not register any shares of our common stock pursuant to these registration statements. Accordingly, we did not receive any proceeds from these offerings and, did not capitalize any of the associated costs. Refer to discussion in our notes to the consolidated financial statements (Note 13 Stockholders Equity).

(h)

Income from discontinued operations reflects the results of Cross Country Consulting, Inc. The Company s consulting practice was shut down in the third quarter of 2005.

(i)

For purposes of calculating diluted earnings per common share in 2010 and 2008, the Company excluded potentially dilutive shares from the calculation as their effect would have been anti-dilutive, due to the Company's net loss in those years. The Company recalculated the previously reported 2008 net (loss) income per common share-diluted to reflect this immaterial correction.

(j)

FTEs represent the average number of nurse and allied contract staffing personnel on a full-time equivalent basis.

(k)

Days worked is calculated by multiplying the FTEs by the number of days during the respective period.

(l)

Average nurse and allied staffing revenue per FTE per day is calculated by dividing the nurse and allied staffing revenue by the number of days worked in the respective periods. Nurse and allied staffing revenue includes revenue from permanent placement of nurses.

(m)

Days filled is calculated by dividing the total hours filled during the period by 8 hours.

(n)

Revenue per day filled is calculated by dividing the applicable revenue generated by the Company s physician staffing segment by days filled for the period presented.

(o)

The Company s balance sheet and statement of cash flows have been reclassified to conform to the current period s presentation. The Company has classified its consolidated balance sheets for the years ended December 31, 2009 through 2006, in accordance with the provisions of the *Insurance Costs* subtopic of the *Other Expenses* Topic of the FASB ASC as explained in the notes to the consolidated financial statements (Note 2 - Summary of Significant Accounting Policies). The Company has presented the current and non-current portions of its workers compensation and certain professional liability accounts as of December 31, 2010, 2009, 2008 and 2007, and has reclassified its balance sheet as of December 31, 2006 to conform to the current presentation. The Company has reclassified certain other assets and liabilities from current to other long-term assets or long-term liabilities as of December 31, 2009 and 2008 to conform to the December 31, 2010 presentation. Certain prior year amounts were not reclassified due to the immaterial amounts of the liabilities.

Item 7.

Management s Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with Selected Financial Data, Risk Factors, Forward-Looking Statements and our Consolidated Financial Statements and the accompanying notes and other data, all of which appear elsewhere in this Annual Report on Form 10-K.

Certain prior year information has been reclassified to conform to the current year s presentation.

Overview

We are a diversified leader in healthcare staffing services offering a comprehensive suite of staffing and outsourcing services to the healthcare market. We report our financial results according to four business segments: (1) nurse and allied staffing, (2) physician staffing, (3) clinical trial services and (4) other human capital management services. We believe we are one of the top two providers of nurse and allied staffing services; one of the top four providers of temporary physician staffing (locum tenens) services; a leading provider of clinical trial staffing services, retained physician search services and educational seminars specifically for the healthcare marketplace.

We have a diversified revenue mix across business sectors and healthcare customers. For the year ended December 31, 2010, our nurse and allied staffing business segment represented approximately 52% of our revenue and is comprised of travel nurse and per diem nurse staffing, and allied health staffing. Travel nurse staffing represented approximately 38% of our total revenue and 74% of our nurse and allied staffing business segment revenue. Other nurse and allied staffing services include the placement of per diem nurses and allied healthcare professionals, such as radiology technicians, rehabilitation therapists and respiratory therapists. Our physician staffing business segment represented approximately 26% of 2010 revenue and consists of temporary physician staffing services (locum tenens). Our clinical trial services business segment represented approximately 13% of our revenue and consists of service offerings that include traditional staffing and functional outsourcing, as well as drug safety monitoring and regulatory services to pharmaceutical and biotechnology customers. Our other human capital management services business segment represented approximately 9% of our revenue and consists of education and training and re