

Emergency Medical Services L.P.
Form 10-K
February 19, 2010

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**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K**

Mark one:

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

For the year ended December 31, 2009

Or

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

**For the transition period from to
Commission file numbers:
001-32701
333-127115**

**EMERGENCY MEDICAL SERVICES CORPORATION
EMERGENCY MEDICAL SERVICES L.P.**

(Exact name of Registrant as Specified in its Charter)

Delaware
(State or other jurisdiction of
incorporation or organization)

**20-3738384
20-2076535**
(IRS Employer Identification Number)

**6200 S. Syracuse Way
Suite 200
Greenwood Village, CO**
(Address of principal executive offices)

80111
(Zip Code)

Registrant's telephone number, including area code: **303-495-1200**

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

Title of each class	Name of each exchange on which registered
Class A Common Stock, \$.01 par value	New York Stock Exchange
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 ☐

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

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Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter 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 ☒ 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 (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☒ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2009, the aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, computed by reference to the closing price for the registrant's class A common stock on the New York Stock Exchange on such date was \$385.4 million (10,467,280 shares at a closing price per share of \$36.82).

Shares of class A common stock outstanding at February 16, 2010 29,578,911; shares of class B common stock outstanding at February 16, 2010 65,052; LP exchangeable units outstanding at February 16, 2010 13,724,676.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant's definitive proxy statement to be used in connection with its 2010 Annual Meeting of Stockholders and to be filed within 120 days of December 31, 2009 are incorporated by reference into Part III, Items 10-14, of this Form 10-K.

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DECEMBER 31, 2009

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EMERGENCY MEDICAL SERVICES CORPORATION

ANNUAL REPORT ON FORM 10-K

FORWARD-LOOKING STATEMENTS AND FACTORS THAT MAY AFFECT RESULTS

This Annual Report on Form 10-K contains "forward-looking statements." Forward-looking statements give our current expectations or forecasts of future events. Forward-looking statements generally can be identified by the use of forward-looking terminology such as "may," "will," "expect," "intend," "estimate," "anticipate," "believe," "project," or "continue," or other similar words. These statements reflect management's current views with respect to future events and are subject to risks and uncertainties, both known and unknown. Our actual results may vary materially from those anticipated in forward-looking statements. We caution investors not to place undue reliance on any forward-looking statements.

Important factors that could cause actual results to differ materially from forward-looking statements include, but are not limited to:

the impact on our revenue of changes in volume, mix of insured and uninsured patients, and third party and governmental reimbursement rates,

the adequacy of our insurance coverage and insurance reserves,

potential penalties or changes to our operations if we fail to comply with extensive and complex government regulation of our industry,

the impact of potential changes in the healthcare industry generally resulting from legislation currently under consideration,

our ability to recruit and retain qualified physicians and other healthcare professionals, and enforce our non-compete agreements with our physicians,

our ability to generate cash flow to service our debt obligations,

the cost of capital expenditures to maintain and upgrade our vehicle fleet and medical equipment,

the loss of services of one or more members of our senior management team,

the outcome of government investigations of certain of our business practices,

our ability to successfully restructure our operations to comply with future changes in government regulation,

the loss of existing contracts and the accuracy of our assessment of costs under new contracts,

the high level of competition in our industry,

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our ability to maintain or implement complex information systems,

our ability to implement our business strategy,

our ability to successfully integrate strategic acquisitions, and

our ability to comply with the terms of our settlement agreements with the government.

These factors are not exhaustive, and new factors may emerge or changes to the foregoing factors may occur that could impact our business. Except to the extent required by law, we undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise.

Readers should review carefully Item 1A, "Risk Factors" and Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" in this Annual Report on Form 10-K for a more complete discussion of these and other factors that may affect our business.

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Emergency Medical Services Corporation ("EMSC", "we", "us", "our", or the "Company") is a leading provider of emergency medical services and facility-based outsourced physician services in the United States. We operate our business and market our services under the AMR and EmCare brands, which represent American Medical Response, Inc. and EmCare Holdings Inc., respectively. AMR, with more than 50 years of operating history, is a leading provider of ground and fixed-wing air ambulance services in the United States based on net revenue and number of transports. EmCare, with more than 35 years of operating history, is a leading provider of outsourced physician services to healthcare facilities in the United States, based on number of contracts with hospitals and affiliated physician groups. Through EmCare, we provide outsourced facility-based physician services for emergency departments and hospitalist/inpatient, anesthesiology, radiology and teleradiology programs. Approximately 90% of our net revenue for the year ended December 31, 2009 was generated under exclusive contracts. During 2009, we provided services in approximately 13 million patient encounters in more than 2,200 communities nationwide and generated net revenue of \$2.6 billion, of which AMR and EmCare represented 52% and 48%, respectively. All references in this Item to number of contracts and employees are as of December 31, 2009.

We offer a broad range of essential emergency and non-emergency medical services through our two business segments:

	AMR	EmCare
Core Services:	Pre- and post-hospital medical transportation Emergency ("911") and non-emergency ambulance transports Managed transportation services Fixed-wing air ambulance services	Facility-based physician services Emergency department staffing and related management services Hospitalist/inpatient services, radiology, teleradiology and anesthesiology
Customers:	Communities Government agencies Healthcare facilities Insurers	Healthcare facilities Independent physician groups Attending medical staff
National Market Position:	#1 provider of ambulance transports 9% share of total ambulance market 25% of private provider ambulance market	#1 provider of outsourced emergency department services 8% share of emergency department services market 12% of outsourced emergency department services market
Number of Contracts at December 31, 2009:	172 "911" contracts 3,400 non-emergency transport arrangements	527 facility contracts
Volume for the year ended December 31, 2009:	3.2 million transports	9.8 million patient encounters

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General Development of our Business

Company History

AMR was founded in 1992 through the consolidation of several well-established regional ambulance companies, and since then has grown organically and through more than 200 acquisitions. In February 1997, AMR merged with another leading ambulance company and became the largest ambulance service provider in the United States.

EmCare was founded in Dallas, Texas, in 1972 and initially grew by providing emergency department staffing and related management services to larger hospitals in the Texas marketplace. EmCare then expanded its presence nationally, primarily through a series of acquisitions in the 1990's.

AMR and EmCare were acquired by Laidlaw International, Inc., previously Laidlaw Inc., or Laidlaw, in 1997 and became wholly-owned subsidiaries.

Effective January 31, 2005, an investor group led by Onex Partners LP and Onex Corporation, or Onex, and including members of our management, purchased our operating subsidiaries AMR and EmCare from Laidlaw through a holding company, Emergency Medical Services L.P., or EMS LP, a limited partnership formed at the time of this acquisition.

From the completion of our acquisition of AMR and EmCare, we operated through the holding company, EMS LP, until the formation of EMSC, a Delaware corporation. A re-organization was effected concurrently with our initial public offering of common stock on December 21, 2005, which resulted in AMR, EmCare and EMS LP becoming subsidiaries of EMSC, and EMSC controlling 100% of the voting power of EMS LP. As of December 31, 2009 we own 68.3%, and Onex owns 31.7%, of the equity in EMS LP. Onex's equity interest is held through LP exchangeable units that are immediately exchangeable for, and substantially equivalent to, our class B common stock. Although Onex owns a minority of EMS LP, Onex controls EMSC through a majority ownership of our voting stock.

Description of our Business

Industry Overview

We operate in the ambulance and facility-based physician services markets, two large and growing segments of the healthcare market. Our facility-based physician services segment includes emergency department, hospitalist/inpatient, anesthesiology, radiology and teleradiology services. By law, most communities are required to provide emergency ambulance services and most hospitals are required to provide emergency department services. Emergency medical services are a core component of the range of care a patient could potentially receive in the pre-hospital and hospital-based settings. Accordingly, we believe that expenditures for these services will continue to correlate closely to growth in the U.S. hospital market and further, that the following key factors will continue to drive growth in all our medical services markets:

Increase in outsourcing. Communities, government agencies and healthcare facilities are under significant pressure both to improve the quality and to reduce the cost of care. The outsourcing of certain medical services has become a preferred means to alleviate these pressures.

Favorable demographics. The growth and aging of the population will be a significant demand driver for healthcare services, and we believe it will result in an increase in ambulance transports, emergency department visits and demand for our other services.

Additional factors that may affect the emergency medical services industry are described elsewhere in this report. See Item 1A, "Risk Factors Risk Factors Related to Healthcare Regulation" and "Business Regulatory Matters."

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Ambulance Services

We believe the ambulance services market represents annual expenditures of approximately \$13.5 billion. The ambulance services market is highly fragmented, with more than 15,000 private, public and not-for-profit service providers accounting for an estimated 40 million ambulance transports in 2009. There are a limited number of regional ambulance providers and we are one of only two national ambulance providers.

Ambulance services encompass both 911 emergency response and non-emergency transport services, including critical care transfers, wheelchair transports and other inter-facility transports. Emergency response services include the dispatch of ambulances equipped with life support equipment and staffed with paramedics and/or emergency medical technicians, or EMTs, to provide immediate medical care to injured or ill patients. Non-emergency services utilize paramedics and/or EMTs to transport patients between healthcare facilities or between facilities and patient residences.

911 emergency response services are provided primarily under long-term contracts with communities and government agencies. Non-emergency services generally are provided pursuant to non-exclusive contracts with healthcare facilities, managed care and insurance companies. Usage tends to be controlled by the facility discharge planners, nurses and physicians who are responsible for requesting transport services. Non-emergency services are provided primarily by private ambulance companies. Quality of service, dependability and name recognition are critical factors in winning non-emergency business.

Facility-Based Services

Emergency Department

We believe the physician reimbursement component of the emergency department services market represents annual expenditures of approximately \$15 billion. There are nearly 4,900 hospitals in the United States that operate emergency departments, of which approximately 65% outsource their physician staffing and management for this department. The market for outsourced emergency department staffing and related management services is highly fragmented, with more than 800 national, regional and local providers. We believe we are one of only 6 national providers.

Between 1996 and 2006, the total number of patient visits to hospital emergency departments increased from 90 million to 119 million, an increase of approximately 32%. At the same time, the number of hospital emergency departments declined 5%. As a result, the average number of patient visits per hospital emergency department increased substantially during that period. We believe increased volumes through emergency departments and cost pressures facing hospitals have resulted in an increased focus by facilities on their emergency departments.

Other Facility-Based Services

We provide inpatient service physicians, hospitalists, for patients who are admitted to hospitals and either have no primary care physician or the attending physician requests our hospitalist to manage the patient. This program benefits hospitals by optimizing the average length of stay for patients; certain studies also indicate better patient outcomes and lower mortality rates with these hospitalist programs. This healthcare specialty, with estimated annual expenditures of \$18 billion, is expected to continue to grow as hospitals face additional cost pressures and added focus on improving clinical outcomes.

We provide radiology, including teleradiology, services to hospitals. The industry for these service lines is composed of a number of smaller local and regional groups, who are at a disadvantage compared to national providers who have the ability to recruit, train, and leverage existing capital and infrastructure support. Teleradiology, the process whereby digital radiologic images are sent from one point to another, has become a fast growing component of the healthcare arena. This technology allows

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hospitals to have access to full-time radiology support even when access to full-time radiologists may be limited. The market for radiology and teleradiology services has estimated annual expenditures of \$10 billion.

We also provide anesthesiology services to hospitals and free-standing surgery centers. These services are performed by anesthesiologists and certified registered nurse anesthetists. The anesthesiology market is highly fragmented and estimated to have annual expenditures of \$17 billion.

Business Segments and Services

We operate our business and market our services under our two business segments: AMR and EmCare. We provide ambulance transport services in 38 states and the District of Columbia and provide facility-based physician services in 39 states and the District of Columbia.

The following is a detailed business description for our two business segments.

AMERICAN MEDICAL RESPONSE

American Medical Response, Inc., or AMR, has developed the largest network of ambulance services in the United States. AMR and our predecessor companies have been providing services to some communities for more than 50 years. As of December 31, 2009 we had a 9% share of the total ambulance services market and a 25% share of the private provider ambulance market. During 2009, AMR treated and transported approximately 3.2 million patients in 38 states utilizing more than 4,100 vehicles that operated out of more than 200 sites. AMR has approximately 3,600 contracts with communities, government agencies, healthcare providers and insurers to provide ambulance transport services. AMR's broad geographic footprint enables us to contract on a national and regional basis with managed care and insurance companies.

For 2009, approximately 58% of AMR's net revenue was generated from emergency 911 ambulance services. These services include treating and stabilizing patients, transporting the patient to a hospital or other healthcare facility and providing attendant medical care en-route. Non-emergency ambulance services, including critical care transfer, wheelchair transports and other interfacility transports, accounted for 29% of AMR's net revenue for the same period. The remaining balance of net revenue for 2009 was generated from fixed-wing air ambulance services, Medicare and Medicaid managed transportation services, and the provision of training, dispatch and other services to communities and public safety agencies.

As derived from our annual consolidated financial statements, AMR's revenues, income from operations, and total identifiable assets were as follows for each of the periods indicated (amounts in thousands):

	As of and for the year ended December 31,		
	2009	2008	2007
Net revenue	\$ 1,343,857	\$ 1,401,801	\$ 1,219,212
Income from operations	73,539	72,261	33,284
Total identifiable assets	730,956	789,180	870,845

See Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" for further information on AMR's financial results.

We provide substantially all of our ambulance services under our AMR brand name. We operate under other names when required to do so by local statute or contractual agreement.

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Services

We provide a full range of emergency and non-emergency ambulance transport and related services, which include:

Emergency Response Services (911). We provide emergency response services primarily under long-term exclusive contracts with communities and hospitals. Our contracts typically stipulate that we must respond to 911 calls in the designated area within a specified response time. We utilize two types of ambulance units Advanced Life Support, or ALS, units and Basic Life Support, or BLS, units. ALS units, which are staffed by two paramedics or one paramedic and an emergency medical technician, or EMT, are equipped with high-acuity life support equipment such as cardiac monitors, defibrillators and oxygen delivery systems, and carry pharmaceutical and medical supplies. BLS units are generally staffed by two EMTs and are outfitted with medical supplies and equipment necessary to administer first aid and basic medical treatment. The decision to dispatch an ALS or BLS unit is determined by our contractual requirements, as well as by the nature of the patient's medical situation.

Under certain of our 911 emergency response contracts, we are the first responder to an emergency scene. However, under most of our 911 contracts, the local fire department is the first responder. In these situations, the fire department typically begins stabilization of the patient. Upon our arrival, we continue stabilization through the provision of attendant medical care and transport the patient to the closest appropriate healthcare facility. In certain communities where the fire department historically has been responsible for both first response and emergency services, we seek to develop public/private partnerships with fire departments to provide the emergency transport service. These partnerships emphasize collaboration with the fire departments and afford us the opportunity to provide 911 emergency services in communities that, for a variety of reasons, may not otherwise have outsourced this service to a private provider. In most instances, the provision of emergency services under our partnerships closely resembles that of our most common 911 contracts described above. The public/private partnerships lower our costs by reducing the number of full-time paramedics we would otherwise require. We estimate that the 911 contracts that encompass these public/private partnerships represented approximately 15% of AMR's net revenue for 2009.

Non-Emergency Transport Services. We provide transportation to patients requiring ambulance or wheelchair transport with varying degrees of medical care needs between healthcare facilities or between healthcare facilities and their homes. Unlike emergency response services, which typically are provided by communities or private providers under exclusive or semi-exclusive contracts, non-emergency transportation usually involves multiple contract providers at a given facility, with one or more of the competitors designated as the "preferred" provider. Non-emergency transport business generally is awarded by a healthcare facility, such as a hospital or nursing home, or a healthcare payor, such as an HMO, managed care organization or insurance company.

Non-emergency transport services include: (i) inter-facility critical care transport, (ii) wheelchair and stretcher-car transports, and (iii) other inter-facility transports.

Critical care transports are provided to medically unstable patients (such as cardiac patients and neonatal patients) who require critical care while being transported between healthcare facilities. Critical care services differ from ALS services in that the ambulance may be equipped with additional medical equipment and may be staffed by one of our medical specialists or by an employee of a healthcare facility to attend to a patient's specific medical needs.

Wheelchair and stretcher-car transports are non-medical transportation provided to handicapped and certain non-ambulatory persons in some service areas. In providing this service, we use vans that contain hydraulic wheelchair lifts or ramps operated by drivers who generally are trained in cardiopulmonary resuscitation, or CPR.

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Other inter-facility transports, that require advanced or basic levels of medical supervision during transfer, may be provided when a home-bound patient requires examination or treatment at a healthcare facility or when a hospital inpatient requires tests or treatments, such as magnetic resonance imaging, or MRI, testing, CAT scans, dialysis or chemotherapy treatment, available at another facility. We use ALS or BLS ambulance units to provide general ambulance services depending on the patient's needs.

Other Services. In addition to our 911 emergency and non-emergency ambulance services, we provide the following services:

Dispatch Services. Our dispatch centers manage our own calls and, in certain communities, also manage dispatch centers for public safety agencies, such as police and fire departments, aero medical transport programs and others.

Event Medical Services. We provide medical stand-by support for concerts, athletic events, parades, conventions, international conferences and VIP appearances in conjunction with local and federal law enforcement and fire protection agencies. We have contracts to provide stand-by support for numerous sports franchises, various NASCAR events, Hollywood production studios and other specialty events.

Managed Transportation Services. Managed care organizations, state agencies and insurance companies contract with us to manage a variety of their medical transportation-related needs, including call-taking and scheduling, management of a network of transportation providers and billing and reporting through our internally developed systems.

Paramedic Training. We own and operate National College of Technical Instruction, or NCTI, the largest paramedic training school in the United States and the only accredited institution of its size, with approximately 1,600 graduates in 2009.

Fixed-wing Air Ambulance Services. We own Air Ambulance Specialists, Inc., a company we acquired in 2006 that arranges world-wide fixed-wing air ambulance transportation services.

Medical Personnel and Quality Assurance

Approximately 73% of our 17,000 employees have daily contact with patients, including approximately 5,400 paramedics, 7,000 EMTs and 200 nurses. Paramedics and EMTs must be state-certified to transport patients and perform emergency care services. Certification as an EMT requires completion of a minimum of 128 hours of training in a program designated by the United States Department of Transportation, such as those offered at our training institute, NCTI. Once this program is completed, state-certified EMTs are then eligible to participate in a state-certified paramedic training program. The average paramedic program involves over 1,000 hours of academic training in advanced life support and assessment skills.

In most communities, local physician advisory boards develop medical protocols to be followed by paramedics and EMTs in a service area. In addition, instructions are conveyed on a case-by-case basis through direct communications between the ambulance crew and hospital emergency room physicians during the administration of advanced life support procedures. Both paramedics and EMTs must complete continuing education programs and, in some cases, state supervised refresher training examinations to maintain their certifications.

We maintain a commitment to provide high quality pre- and post-hospital emergency medical care. In each location in which we provide services, a physician associated with a hospital we serve monitors adherence to medical protocol and conducts periodic audits of the care provided. In addition, we hold retrospective care audits with our employees to evaluate compliance with medical and performance standards.

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Our commitment to quality is reflected in the fact that 18 of our operations across the country are accredited by the Commission on Accreditation of Ambulance Services, or CAAS, representing 15% of the total CAAS accredited centers. CAAS is a joint program between the American Ambulance Association and the American College of Emergency Physicians. The accreditation process is voluntary and evaluates numerous qualitative factors in the delivery of services. We believe communities and managed care providers increasingly consider accreditation as one of the criteria in awarding contracts.

Billing and Collections

Our internal patient billing services, or PBS, offices located across the United States invoice and collect for our services. We receive payment from the following sources:

federal and state governments, primarily under the Medicare and Medicaid programs,

health maintenance organizations and private insurers,

individual patients, and

fees for stand-by and event driven coverage, including from our national contract with the Federal Emergency Management Agency, or FEMA, and community subsidies.

The table below presents the approximate percentages of AMR's net revenue from the following sources:

	Percentage of AMR Net Revenue for the year ended December 31,		
	2009	2008	2007
Medicare	30.6%	28.5%	30.8%
Medicaid	5.7	5.3	5.9
Commercial insurance/managed care	44.9	41.5	44.3
Self-pay	5.2	5.1	5.4
Fees/subsidies	13.6	19.6	13.6
Total net revenue	100.0%	100.0%	100.0%

See "Business Regulatory Matters Medicare, Medicaid and Other Government Program Reimbursement" for additional information on reimbursement from Medicare, Medicaid and other government-sponsored programs.

We have substantial experience in processing claims to third party payors and employ a billing staff trained in third party coverage and reimbursement procedures. Our integrated billing and collection systems allow us to prepare the submission of claims to Medicare, Medicaid and certain other third party payors based on the payor's reimbursement requirements, and have the capability to electronically submit claims to the extent third party payors' systems permit. These systems also provide for tracking of accounts receivable and status of pending payments.

Companies in the ambulance services industry maintain significant provisions for doubtful accounts, or uncompensated care, compared to companies in other industries. Collection of complete and accurate patient billing information during an emergency service call is sometimes difficult, and incomplete information hinders post-service collection efforts. In addition, we cannot evaluate the creditworthiness of patients requiring emergency transport services. Our provision for uncompensated care generally is higher for transports resulting from emergency ambulance calls than for non-emergency ambulance requests. See Item 1A, "Risk Factors Risk Factors Related to Healthcare Regulation Changes in the rates or methods of third party reimbursements may adversely affect our revenue and operations."

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State licensing requirements, as well as contracts with communities and healthcare facilities, typically require us to provide ambulance services without regard to a patient's insurance coverage or ability to pay. As a result, we often receive partial or no compensation for services provided to patients who are not covered by Medicare, Medicaid or private insurance. The anticipated level of uncompensated care and uncollectible accounts is considered in negotiating a government-paid subsidy to provide for uncompensated care, and permitted rates under contracts with a community or government agency.

A significant portion of our ambulance transport revenue is derived from Medicare payments. The Balanced Budget Act of 1997, or BBA, modified Medicare reimbursement rates for emergency transportation with the introduction of a national fee schedule. The BBA provided for a phase-in of the national fee schedule by blending the new national fee schedule rates with ambulance service suppliers' pre-existing "reasonable charge" reimbursement rates. The BBA provided for this phase-in period to begin on April 1, 2002, and full transition to the national fee schedule rates became effective on January 1, 2006. In some regions, the national fee schedule would have resulted in a decrease in Medicare reimbursement rates of approximately 25% by the end of the phase-in period. Partially in response to the dramatic decrease in rates dictated by the BBA in some regions, the Medicare Prescription Drug Improvement and Modernization Act of 2003, or the Medicare Modernization Act, established regional rates, certain of which are higher than the BBA's national rates, and provided for the blending of the regional and national rates which extend the initial phase-in period until January 1, 2010. Other rate provisions included in the Medicare Modernization Act provided partial mitigation of the impact of the BBA decreases, including a provision that provided for a 1% to 2% increase for blended rates for the period from January 1, 2004 through December 31, 2006. In addition, effective July 1, 2008 the Medicare Improvement for Patients and Providers Act of 2008 provided a temporary mitigation that provided for a 2% to 3% increase for blended rates which was in effect through December 31, 2009. Because the Medicare Modernization Act relief is of limited duration, we continue to pursue strategies to offset the decreases mandated by the BBA, including seeking fee and subsidy increases.

We estimate that the impact of the ambulance service rate decreases under the national fee schedule mandated under the BBA, as modified by the phase-in provisions of the Medicare Modernization Act, resulted in a decrease in AMR's net revenue of approximately \$7 million in 2007, an increase in AMR's net revenue of approximately \$14 million in 2008, and an increase in AMR's net revenue of approximately \$24 million in 2009. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential decrease in AMR's net revenue of approximately \$30 million during 2010. We have been able to substantially mitigate the phase-in reductions of the BBA through additional fee and subsidy increases. As a 911 emergency response provider, we are uniquely positioned to offset changes in reimbursement by requesting increases in the rates we are permitted to charge for 911 services from the communities we serve. In response, these communities often permit us to increase rates for ambulance services from patients and their third party payors in order to ensure the maintenance of required community-wide 911 emergency response services. While these rate increases do not result in higher payments from Medicare and certain other public or private payors, overall they increase our net revenue.

See "Regulatory Matters Medicare, Medicaid and Other Government Program Reimbursement" for additional information on reimbursement from Medicare, Medicaid and other government-sponsored programs.

Contracts

Emergency Transport. As of December 31, 2009, we had 172 contracts with communities and government agencies to provide 911 emergency response services. Contracts with communities to provide emergency transport services are typically exclusive, three to five years in length and generally

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are obtained through a competitive bidding process. In some instances where we are the existing provider, communities elect to renegotiate existing contracts rather than initiate new bidding processes. Our 911 contracts often contain options for earned extensions or evergreen provisions. In the year ended December 31, 2009, our top ten 911 contracts accounted for approximately \$327 million, or 24% of AMR's net revenue. We have served these ten customers on a continual basis for an average of 34 years.

Our 911 emergency response arrangements typically specify maximum fees we may charge and set forth minimum requirements, such as response times, staffing levels, types of vehicles and equipment, quality assurance and insurance coverage. Communities and government agencies may also require us to provide a performance bond or other assurances of financial responsibility. The rates we are permitted to charge for services under a contract for emergency ambulance services and the amount of the subsidy, if any, we receive from a community or government agency depend in large part on the nature of the services we provide, payor mix and performance requirements.

Non-Emergency Transport. We have approximately 3,400 arrangements to provide non-emergency ambulance services with hospitals, nursing homes and other healthcare facilities that require a stable and reliable source of medical transportation for their patients. These contracts typically designate us as the preferred ambulance service provider of non-emergency ambulance services to those facilities and permit us to charge a base fee, mileage reimbursement, and additional fees for the use of particular medical equipment and supplies. We have historically provided a portion of our non-emergency transports to facilities and organizations in competitive markets without specific contracts.

Non-emergency transports often are provided to managed care or insurance plan members who are stabilized at the closest available hospital and are then moved to facilities within their health plan's network. We believe the increased prevalence of managed care benefits larger ambulance service providers, which can service a higher percentage of a managed care provider's members. This allows the managed care provider to reduce its number of vendors, thus reducing administrative costs and allowing it to negotiate more favorable rates with healthcare facilities. Our scale and broad geographic footprint enable us to contract on a national and regional basis with managed care and insurance companies. We have contracts with large healthcare networks and insurers including Kaiser, Aetna, Healthnet, Cigna and SummaCare.

We believe that communities, government agencies, healthcare facilities, managed care companies and insurers consider the quality of care, historical response time performance and total cost to be among the most important factors in awarding and renewing contracts.

Dispatch and Communications

Dispatch centers control the deployment and dispatch of ambulances in response to calls through the use of sophisticated communications equipment 24 hours a day, seven days a week. In many operating sites, we communicate with our vehicles over dedicated radio frequencies licensed by the Federal Communications Commission. In certain service areas with a large volume of calls, we analyze data on traffic patterns, demographics, usage frequency and similar factors with the aid of System Status Management, or SSM technology, to help determine optimal ambulance deployment and selection. In addition to dispatching our own ambulances, we also provide dispatching service for 56 communities where we are not an ambulance service provider. Our dispatch centers are staffed by EMTs and other experienced personnel who use local medical protocols to analyze and triage a medical situation and determine the best mode of transport.

Emergency Transport. Depending on the emergency medical dispatch system used in a designated service area, the public authority that receives 911 emergency medical calls either dispatches our ambulances directly from the public control center or communicates information regarding the location and type of medical emergency to our control center which, in turn, dispatches ambulances to the

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scene. While the ambulance is en-route to the scene, the ambulance crew receives information concerning the patient's condition prior to the ambulance's arrival at the scene. Our communication systems allow the ambulance crew to communicate directly with the destination hospital to alert hospital medical personnel of the arrival of the patient and the patient's condition and to receive instructions directly from emergency room personnel on specific pre-hospital medical treatment. These systems also facilitate close and direct coordination with other emergency service providers, such as the appropriate police and fire departments, which also may be responding to a call.

Non-Emergency Transport. Requests for non-emergency transports typically are made by physicians, nurses, case managers and hospital discharge coordinators who are interested primarily in prompt ambulance arrival at the requested pick-up time. We also offer on-line, web-enabled transportation ordering to certain facilities. We use our Millennium software to track and manage requests for transportation services for large healthcare facilities and managed care companies.

Management Information Systems

We support our operations with integrated information systems and standardized procedures that enable us to efficiently manage the billing and collections processes and financial support functions. Our technology solutions provide information for operations personnel, including real-time operating statistics, tracking of strategic plan initiatives, electronic purchasing and inventory management solutions.

We have three management information systems that we believe have significantly enhanced our operations our e-PCR technology, an electronic patient care record-keeping system; our Millennium call-taking system, a call-taking application that tracks and manages requests for transportation services for large healthcare facilities and managed care companies; and our SSM ambulance positioning system, a technology which enables us to use historical data on fleet usage patterns to predict where our emergency transport services are likely to be required.

Sales and Marketing

Our sales and marketing team is focused on contract retention as well as generating new sales. Many new sales opportunities occur through referrals from our existing client base. These team members are frequently former paramedics or EMTs who began their careers in the emergency transportation industry and are therefore well-qualified to understand the needs of our customers.

We respond to requests for proposals that generally include demographic information of the community or facilities, response time parameters, vehicle and equipment requirements, the length of the contract, the minimum qualifications of bidders, billing information, selection criteria and the format to be followed in the bid. Prior to responding to a request for proposal, AMR's management team ensures that the proposal is in line with appropriate financial and service parameters. Management evaluates all aspects of each proposal, including financial projections, staffing models, resource requirements and competition, to determine how to best achieve our business objectives and customer goals.

Risk Management

We train and educate all new employees on our safety programs including, among others, emergency vehicle operations, various medical protocols, use of equipment and patient focused care and advocacy. Our safety training also involves continuing education programs and a monthly safety awareness campaign. We also work directly with manufacturers to design equipment modifications that enhance both patient and clinician safety.

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Our safety and risk management team develops and executes strategic planning initiatives focused on mitigating the factors that drive losses in our operations. We aggressively investigate and respond to incidents. Operations supervisors submit documentation of any incidents resulting in a claim to the third party administrator handling the claim. We have a dedicated liability unit with our third party administrator which actively engages with our staff to gain valuable information for closure of claims. Information from the claims database is an important resource for identifying trends and developing future safety initiatives.

We utilize an on-board monitoring system, Road Safety, which measures operator performance against our safe driving standards. Our operations using Road Safety have experienced improved driving behaviors within 90 days of installation. Road Safety has been implemented in approximately 60% of our vehicles in emergency response markets.

Competition

Our predominant competitors are fire departments and other governmental providers, with approximately 57% of the ambulance transport services market. Firefighters have traditionally acted as the first responders during emergencies, and in many communities provide emergency medical care and transport as well. In many communities we have established public/private partnerships, in which we integrate our transport services with the first responder services of the local fire department. We believe these public/private partnerships provide a model for us to collaborate with fire departments to increase the number of communities we serve.

Competition in the ambulance transport market is based primarily on:

pricing,

the ability to improve customer service, such as on-time performance and efficient call intake,

the ability to recruit, train and motivate employees, particularly ambulance crews who have direct contact with patients and healthcare personnel, and

billing and reimbursement expertise.

Our largest competitor, Rural/Metro Corporation, is the only other national provider of ambulance transport services and generates ambulance transport revenue less than half of AMR's net revenue. Other larger private provider competitors include Southwest Ambulance in Arizona and New Mexico, Acadian Ambulance Service in Louisiana and small, locally owned operators that principally serve the inter-facility transport market.

Insurance

Workers Compensation, Auto and General Liability. We have retained liability for the first \$1 million to \$2 million of the loss under these programs since September 1, 2001, managed either through ACE American Insurance Co. or through an insurance subsidiary of American International Group, Inc., or AIG. Generally, our umbrella policies covering claims that exceed our deductible levels have an annual cap of approximately \$100 million.

Professional Liability. Since April 15, 2001, we have a self-insured retention for our professional liability coverage, which covers the first \$2 million for the policy year ending April 15, 2002, and covers the first \$5 to \$5.5 million for policy periods after April 15, 2002. We have umbrella policies with third party insurers covering claims exceeding these retention levels with an aggregate cap of \$10 million for each separate policy period.

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Environmental Matters

We are subject to federal, state and local laws and regulations relating to the presence of hazardous materials, pollution and the protection of the environment. Such regulations include those governing emissions to air, discharges to water, storage, treatment and disposal of wastes, including medical waste, remediation of contaminated sites, and protection of worker health and safety. We believe our current operations are in substantial compliance with all applicable environmental requirements and that we maintain all material permits required to operate our business.

Certain environmental laws impose strict, and under certain circumstances joint and several, liability for investigation and remediation of the release of regulated substances into the environment. Such liability can be imposed on current or former owners or operators of contaminated sites, or on persons who dispose or arrange for disposal of wastes at a contaminated site. Releases have occurred at a few of the facilities we lease as a result of historical practices of the owners or former operators. Based on available information, we do not believe that any known compliance obligations, releases or investigations under environmental laws or regulations will have a material adverse effect on our business, financial position and results of operations. However, there can be no guarantee that these releases or newly discovered information, more stringent enforcement of or changes in environmental requirements, or our inability to enforce available indemnification agreements will not result in significant costs.

Employees

The following is the break down of our employees by job classification as of December 31, 2009.

Job Classification	Full-time	Part-time	Total
Paramedics	3,644	1,792	5,436
Emergency medical technicians	4,703	2,294	6,997
Nurses	107	97	204
Support personnel	4,103	536	4,639
Total	12,557	4,719	17,276

Approximately 45% of our employees are represented by 39 collective bargaining agreements. A total of 22 collective bargaining agreements, representing approximately 2,300 employees, are subject to renegotiation in 2010. While we believe we maintain a good working relationship with our employees, we have experienced some union work actions. We do not expect these actions to have a material adverse effect on our ability to provide service to our patients and communities.

EMCARE

EmCare is a leading provider of outsourced physician services to healthcare facilities in the United States, based on number of contracts with hospitals and affiliated physician groups. EmCare has 527 contracts with hospitals and independent physician groups to provide emergency department, hospitalist/inpatient, anesthesiology, radiology and teleradiology staffing, and other administrative services. We have added 276 net new contracts since 2001. During 2009, EmCare had approximately 9.8 million patient encounters in 39 states. As of December 31, 2009, EmCare had an 8% share of the total emergency department services market and a 12% share of the outsourced emergency department services market. In December 2009, we acquired Pinnacle Consultants Mid-Atlantic and the management services company of Pinnacle Anesthesia Consultants, P.A., collectively referred to as Pinnacle, which provide anesthesiology and management services to more than 75 hospitals and surgery centers.

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We recruit and hire or subcontract with physicians and other healthcare professionals, who then provide professional services to the facilities with whom we contract. We also have practice support agreements with independent physician groups and hospitals pursuant to which we provide unbundled management services such as billing and collection, recruiting, risk management and certain other administrative services.

As derived from our annual consolidated financial statements, EmCare's revenues, income from operations, and total identifiable assets were as follows for each of the periods indicated (amounts in thousands):

	As of and for the year ended December 31,		
	2009	2008	2007
Net revenue	\$ 1,225,828	\$ 1,008,063	\$ 887,781
Income from operations	139,597	95,960	99,295
Total identifiable assets	583,806	576,211	558,272

See Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" for further information on EmCare's financial results.

Services

We provide a full range of outsourced physician staffing and related management services for emergency department, hospitalist/inpatient services, anesthesiology, radiology and teleradiology programs, which include:

Contract Management. We utilize an integrated approach to contract management that involves physicians, non-clinical business experts, and operational and quality assurance specialists. An on-site medical director is responsible for the day-to-day oversight of the operation, including clinical quality, and works closely with the facility's management in developing strategic initiatives and objectives. A quality manager develops site-specific quality improvement programs, and a practice improvement staff focuses on chart documentation and physician utilization patterns. The regional-based management staff provides support for these efforts and ensures that each customer's expectations are identified, that service plans are developed and executed to meet those expectations, and that our and the customer's financial objectives are achieved.

Staffing. We provide a full range of staffing services to meet the unique needs of each healthcare facility. Our dedicated clinical teams include qualified, career-oriented physicians and other healthcare professionals responsible for the delivery of high quality, cost-effective care. These teams also rely on managerial personnel, many of whom have clinical experience, who oversee the administration and operations of the clinical area. Ensuring that each contract is staffed with the appropriately qualified physicians and that coverage is provided without any service deficiencies is critical to the success of the contract.

Recruiting. Many healthcare facilities lack the dedicated resources necessary to identify and attract specialized, career-oriented physicians. We have committed significant resources to the development of EmSource, a proprietary national physician database that we utilize in our recruiting programs across the country. Our marketing and recruiting staff continuously updates our database of nearly 900,000 physicians with relevant data and contact information to allow us to match potential physician candidates to specific openings based upon personal preferences. This targeted recruiting method increases the success and efficiency of our recruiters, and we believe significantly increases our physician retention rates. We actively recruit physicians through various media options including telemarketing, direct mail, conventions, journal advertising and our internet site.

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Scheduling. Our scheduling departments schedule, or assist our medical directors in scheduling, physicians and other healthcare professionals in accordance with the coverage model at each facility. We provide 24-hour service to ensure that unscheduled shift vacancies, due to situations such as physician illness and personal emergencies, are filled with alternative coverage.

Payroll Administration and Benefits. We provide payroll administration services for the physicians and other healthcare professionals with whom we contract to provide services at customer sites. Additionally, healthcare facilities benefit from the elimination of the overhead costs associated with the administration of payroll and, where applicable, employee benefits.

Customer Satisfaction Programs. We design and implement customized patient satisfaction programs for our hospital customers. These programs are designed to improve patient satisfaction through the use of communication, family inclusion and hospitality techniques. These programs are delivered to the clinical and non-clinical members of the hospital emergency department.

Other Services. We provide a substantial portion of our services to healthcare facilities through our affiliate physician groups. There are situations in which facilities and physicians are interested in receiving stand-alone management services such as billing and collection, scheduling, recruitment and risk management, and at times we unbundle our services to meet this need. Pursuant to these practice support agreements, which generally will have a term of one to three years, we provide these services to independent physician groups and healthcare facilities. During 2009, we had 12 practice support agreements which generated \$14.0 million in net revenue.

Operational Assessments. We undertake operational assessments for our hospital customers that include comprehensive reviews of critical operational matrices, including turnaround times, triage systems, "left without being seen," throughput times and operating systems. These assessments establish baseline values and develop and implement process improvement programs, and then we monitor the success of the initiatives.

Practice Improvement. We provide ongoing comprehensive documentation review and training for our affiliated physicians. We review certain statistical indicators that allow us to provide specific training to individual physicians regarding documentation, and we tailor training for broader groups of physicians as we see trends developing in documentation-related areas. Our training focuses on the completeness of the medical record or chart, specific payor requirements, and government rules and regulations.

Risk Management

We utilize our risk management function, senior medical leadership and on-site medical directors to conduct aggressive risk management and quality assurance programs. We take a proactive role in promoting early reporting, evaluation and resolution of incidents that may evolve into claims. Our risk management function is designed to mitigate risk associated with the delivery of care and to prevent or minimize costs associated with medical professional liability claims and includes:

Incident Reporting Systems. We have established a comprehensive support system for medical professionals. Our Risk Management Hotline provides each physician with the ability to discuss medical issues with a peer, an attorney or a risk management specialist.

Tracking and Trending Claims. We utilize an extensive claims database developed from our experience in the emergency department setting. From this database, we track multiple data points on each professional liability claim. We utilize the database to identify claim trends and risk factors so that we can better target our risk management initiatives. Each year, we target the medical conditions associated with our most frequent professional liability claims, and provide detailed education to assist our affiliated medical professionals in treating these medical conditions.

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Professional Risk Assessment. We conduct risk assessments of our medical professionals. Typically, a risk assessment includes a thorough review of professional liability claims against the professional, assessment of issues raised by hospital risk management and identification of areas where additional education may be advantageous for the professional.

Hospital Risk Assessment. We conduct risk assessments of potential hospital customers in conjunction with our sales and contracting process. As part of the risk assessment, we conduct a detailed analysis of the hospital's operations affecting the services of our affiliated medical professionals, including the triage procedures, on-call coverage, transfer procedures, nursing staffing and related matters in order to address risk factors contractually during negotiations with potential customer hospitals.

Clinical Fail-Safe Programs. We review and identify key risk areas which we believe may result in increased incidence of patient injuries and resulting claims against us and our affiliated medical professionals. We continue to develop "fail-safe" clinical tools and make them available to our affiliated physicians for use in conjunction with their practice and to our customer hospitals for use as a part of their peer review process. These "fail-safe" tools assist physicians in identifying common patient attributes and complaints that may identify the patient as being at high risk for certain conditions (e.g., a heart attack).

Quality Improvement Programs. Our medical directors are actively engaged in their respective hospital's quality improvement committees and initiatives. In addition, we provide tools that provide guidance to the medical directors on how to conduct quality reviews of their physicians and help them track their physicians' medical practices.

Proactive Professional Liability Claims Handling. We utilize a third party claims administrator to manage professional liability claims against companies and medical professionals covered under our insurance program. For each case, detailed reports are reviewed to ensure proactively that the defense is comprehensive and aggressive. Each professional liability claim brought against an EmCare affiliated medical professional or EmCare affiliated company is reviewed by EmCare's Claims Committee, consisting of physicians, attorneys and company executives, before any resolution of the claim. The Claims Committee periodically instructs EmCare's risk management personnel to undertake an analysis of particular physicians or hospital locations associated with a given claim.

Billing and Collections

We receive payment for patient services from:

federal and state governments, primarily under the Medicare and Medicaid programs,

health maintenance organizations, preferred provider organizations and private insurers,

hospitals, and

individual patients.

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The table below presents the approximate percentages of EmCare's net revenue from the following sources:

	Percentage of EmCare Net Revenue for the year ended December 31,		
	2009	2008	2007
Medicare	14.6%	15.6%	16.6%
Medicaid	3.8	3.1	3.0
Commercial insurance/managed care	56.5	55.5	54.1
Self-pay	2.5	3.2	3.5
Subsidies/fees	22.6	22.6	22.8
Total net revenue	100.0%	100.0%	100.0%

See "Business Regulatory Matters Medicare, Medicaid and Other Government Program Reimbursement" for additional information on reimbursement from Medicare, Medicaid and other government-sponsored programs.

We code and bill for physician services through our wholly-owned subsidiary, Reimbursement Technologies, Inc. We utilize state-of-the-art document imaging and paperless workflow processes to expedite the billing cycle and improve compliance and customer service.

We do substantially all of the billing for our affiliated physicians, and we have extensive experience in processing claims to third party payors. We employ a billing staff of approximately 780 employees who are trained in third party coverage and reimbursement procedures. Our integrated billing and collection system uses proprietary software to prepare the submission of claims to Medicare, Medicaid and certain other third party payors based on the payor's reimbursement requirements and has the capability to electronically submit most claims to the third party payors' systems. We forward uncollected accounts electronically to three outside collection agencies automatically, based on established parameters. Each of these collection agencies have on-site employees working at our in-house billing company to assist in providing patients with quality customer service.

Contracts

We have contracts with (i) hospital customers to provide professional staffing and related management services, (ii) healthcare facilities and independent physician groups to provide management services, and (iii) affiliated physician groups and medical professionals to provide management services and various benefits. We also contract with large health systems as a national provider of facility-based services.

We deliver services to our hospital customers and their patients through two principal types of contractual arrangements. EmCare or a subsidiary most frequently contracts directly with the hospital to provide physician staffing and management services. In some instances, a physician-owned professional corporation contracts with the hospital to provide physician staffing and management services, and the professional corporation, in turn, contracts with us for a wide range of management and administrative services, including billing, scheduling support, accounting and other services. The professional corporation pays our management fee out of the fees it collects from patients, third party payors and, in some cases, the hospital customer. Our physicians and other healthcare professionals who provide services under these hospital contracts do so pursuant to independent contractor or employment agreements with us, or pursuant to arrangements with the professional corporation that has a management agreement with us. We refer to all of these physicians as our affiliated physicians, and these physicians and other individuals as our healthcare professionals.

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Hospital and Practice Support Contracts. As of December 31, 2009, EmCare provided services under 527 contracts. Generally, agreements with hospitals are awarded on a competitive basis, and have an initial term of three years with one-year automatic renewals and termination by either party on specified notice.

Our contracts with hospitals provide for one of three payment models:

we bill patients and third party payors directly for physician fees,

we bill patients and third party payors directly for physician fees, with the hospital paying us an additional pre-arranged fee for our services, or

we bill the hospitals directly for the services of the physicians.

In all cases, the hospitals are responsible for billing and collecting for non-physician-related services.

We have established long-term relationships with some of the largest healthcare service providers. None of these customers represent revenue that amounts to 10% of our total net revenue for the years ended December 31, 2009, 2008, or 2007. Our top ten hospital emergency department contracts represent \$120.8 million, or 10%, of EmCare's net revenue for the year ended December 31, 2009. We have maintained our relationships with these customers for an average of 14 years.

Affiliated Physician Group Contracts. In most states, we contract directly with our hospital customers to provide physician staffing and related management services. We, in turn, contract with a professional corporation that is wholly-owned by one or more physicians, which we refer to as an affiliated physician group, or with independent contractor physicians. It is these physicians who provide the medical professional services. We then provide comprehensive management services to the physicians. We typically provide professional liability and workers compensation coverage to our affiliated physicians.

Certain states have laws that prohibit or restrict unlicensed persons or business entities from practicing medicine. The laws vary in scope and application from state to state. Some of these states may prohibit us from contracting directly with hospitals or physicians to provide professional medical services. In those states, the affiliated physician groups contract with the hospital, as well as all medical professionals. We provide management services to the affiliated physician groups.

Medical Professional Contracts. We contract with healthcare professionals as either independent contractors or employees to provide services to our customers. The healthcare professionals generally are paid an hourly rate for each hour of coverage, a variable rate based upon productivity or other objective criteria, or a combination of both a fixed hourly rate and a variable rate component. We typically arrange for professional liability and workers compensation coverage for our healthcare professionals.

The contracts with healthcare professionals typically have one-year terms with automatic renewal clauses for additional one-year terms. The contracts can be terminated with cause for various reasons, and usually contain provisions allowing for termination without cause by either party upon 90 days' notice. Agreements with physicians generally contain a non-compete or non-solicitation provision and, in the case of medical directors, a non-compete provision. The enforceability of these provisions varies from state to state.

Management Information Systems

We have invested in scalable information systems and proprietary software packages designed to allow us to grow efficiently and to deliver and implement our "best practice" procedures nationally,

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while retaining local and regional flexibility. We have developed and implemented several proprietary applications that we believe provide us with a competitive advantage in our operations.

Sales and Marketing

Contracts for outsourced emergency department and other facility-based services are obtained through strategic marketing programs and responses to requests for proposals. EmCare's business development team includes Practice Development representatives located throughout the United States who are responsible for developing sales and acquisition opportunities for the operating group in his or her territory. A significant portion of the compensation program for these sales professionals is commission-based, based on the profitability of the contracts they sell. Leads are generated through regular marketing efforts by our business development group, our website, journal advertising, conventions and a lead referral program. Each Practice Development representative is responsible for working with the regional chief executive officer to structure and provide customer proposals for new prospects in their respective regions.

Emergency medicine practices vary among healthcare facilities. A healthcare facility request for proposal generally will include demographic information of the facility department, a list of services to be performed, the length of the contract, the minimum qualifications of bidders, billing information, selection criteria and the format to be followed in the bid. Prior to responding to a request for proposal, EmCare's senior management ensures that the proposal is consistent with certain financial parameters. Senior management evaluates all aspects of each proposal, including financial projections, staffing model, resource requirements and competition, to determine how to best achieve our business objectives and the customer goals.

Competition

The market for outsourced emergency department staffing and related management services is highly fragmented, with more than 800 national, regional and local providers handling an estimated 119 million patient visits in 2006. There are nearly 4,900 hospitals in the United States with emergency departments, of which approximately 65% currently outsource physician services. Of these hospitals that outsource, we believe approximately 49% contract with a local provider, 21% contract with regional provider and 30% contract with a national provider.

Team Health is our largest competitor and has the second largest share of the emergency department services market with an approximately 5% share based on number of contracts. Other national providers of outsourced emergency department services are Hospital Physician Partners, National Emergency Services Healthcare Group, Schumacher Group and California Emergency Physicians.

Insurance

Professional Liability Program. For the period January 1, 2002 through December 31, 2009, our professional liability insurance program provided "claims-made" insurance coverage with a limit of \$1 million per loss event and a \$3 million annual per physician aggregate, for all medical professionals whom we have agreed to cover under our professional liability insurance program. Our subsidiaries and affiliated corporate entities are provided with coverage of \$1 million per loss event and share a \$10 million annual corporate aggregate.

For the 2002 through 2009 calendar years, most of our professional liability insurance coverage was provided by Columbia Casualty Company and Continental Casualty Company, collectively referred to as CCC. The CCC policies have a retroactive date of January 1, 2001, thereby covering all claims occurring during the 2001 calendar year but reported in each of the 2002 through 2009 calendar years.

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Captive Insurance Arrangement. Our captive insurance company, EMCA Insurance Company, Ltd., or EMCA, is a wholly owned subsidiary of EmCare, formed under the Companies Law of the Cayman Islands. EMCA reinsures CCC for all losses associated with the CCC insurance policies under the professional liability insurance program, and provides collateral for the reinsurance arrangement through a trust agreement.

Workers Compensation Program. For the period September 1, 2002 through August 31, 2004, we procured workers compensation insurance coverage for employees of EmCare and affiliated physician groups through CCC. CCC reinsures a portion of this workers compensation exposure, on both a per claim and an aggregate basis, with EMCA.

From September 1, 2004 through August 31, 2007, EmCare insured its workers compensation exposure through The Travelers Indemnity Company, which reinsured a portion of the exposure with EMCA. From September 1, 2007 through August 31, 2009, EmCare insured its workers compensation exposure through an insurance subsidiary of AIG. Beginning September 1, 2009, EmCare insured, and continues to insure, its workers compensation exposure through Sentry Insurance Companies.

Employees and Independent Contractors

The following is the break down of our active affiliated physicians, independent contractors and employees by job classification as of December 31, 2009.

Job Classification	Full-time	Part-time	Total
Physicians	2,026	3,065	5,091
Physician assistants	340	329	669
Nurse practitioners	424	256	680
Non-clinical employees	1,491	288	1,779
Total	4,281	3,938	8,219

We believe that our relations with our employees and independent contractors are good. None of our physicians, physician assistants, nurse practitioners or non-clinical employees are subject to any collective bargaining agreement.

We offer our physicians substantial flexibility in terms of type of facility, scheduling of work hours, benefit packages, opportunities for relocation and career development. This flexibility, combined with fewer administrative burdens, improves physician retention rates and stabilizes our contract base.

EMSC Competitive Strengths

We believe the following competitive strengths position our company to capitalize on the favorable trends occurring within the healthcare industry and the emergency medical services markets.

Leading, Established Provider of Emergency Medical Services. We are a leading provider of emergency medical services and facility-based outsourced physician services in the United States. We believe our track record of consistently meeting or exceeding our customers' service expectations, coupled with our ability to leverage our infrastructure and technology to drive increased productivity and efficiency, have contributed to our ability to retain existing and win new contracts. Additionally, we have successfully leveraged our core competencies to further expand our services to include hospitalist, radiology/teleradiology, anesthesiology, fixed-wing air ambulance and managed transportation.

Significant Scale and Geographic Presence. We believe our significant scale and geographic presence provide a competitive advantage over local and regional providers in most areas. We believe we have established best operating practices across our platform, leveraged our infrastructure and

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broadened our program offerings, which has enabled us to win new contracts, enter into national and regional contracts with healthcare facilities, managed care organizations and insurance companies, and enhanced our ability to recruit and retain quality personnel. Additionally, we believe our diverse revenue base and geographic footprint limit our exposure to any single market.

Long-Term Relationships with Existing Customers. We believe our long-term, well-established relationships with communities and healthcare facilities enhance our ability to retain existing customers and win new contracts.

Strong Financial Performance. One of the key factors our potential customers evaluate is financial stability. We believe our ability to demonstrate consistently strong earnings growth and cash flows will continue to differentiate our company, has enabled us to expand our service offerings and provides a competitive advantage in winning new contracts and renewing existing contracts.

Focus on Risk Management. Our risk management initiatives at EmCare are enhanced by the use of professional liability claims data and comprehensive claims management. We analyze this data to demonstrate claim trends on a national, regional, facility, physician and procedure level, helping to manage and mitigate risk exposure. AMR's risk/safety program is aimed at reducing worker injuries through training and improved equipment, and increasing vehicle safety through the use of training and technology.

Investment in Core Technologies. We utilize technology as a means to enhance the quality and reduce the cost of our service offerings, more effectively manage risk and improve our profitability. AMR uses proprietary technology to improve chart documentation, determine transportation service levels and track response times and other data for hospitals. EmCare uses proprietary physician recruitment software to improve recruitment efficiency and retention rates.

Business Strategy

Increase Revenue from Existing Customers. We believe our long track record of delivering excellent service and quality patient care, as well as the expanded breadth of our services, creates opportunities for us to increase revenue from our existing customer base. We have established strategies aimed at assisting facilities, communities and payors to manage their cost of outsourced physician services and emergency, non-emergency and managed transportation services.

Expand Our Existing Service Lines. We continue to enter complementary service lines, at both AMR and EmCare, which we believe leverage our core competencies. At EmCare, we acquired an anesthesiology company in 2008 and completed the purchase of two additional companies in 2009, which are related to each other, to further expand our presence in this field. At AMR, we continue to focus on our fixed-wing air ambulance services business and expand our managed transportation services. The market demand at both our existing customers and new customers for these services provide new growth opportunities.

Grow Our Customer Base. We believe we have a unique competency in the treatment, management and billing of episodic and unscheduled patient care. We believe our long operating history, significant scope and scale and leading market position provide us with new and expanded opportunities to grow our customer base. We have recently been successful in obtaining regional and national contracts for both operating segments with healthcare systems, free standing facilities and insurance providers for single and multiple service lines.

Pursue Select Acquisition Opportunities. The medical transportation services and outsourced physician services industries are highly fragmented, with only a few large national providers. We expect to continue pursuing select acquisitions in our existing business segments, including acquisitions to enhance our presence in existing markets and facilitate our entry into new geographic markets. We will also continue to explore the acquisition of complementary businesses and seek opportunities to expand the scope of services we provide.

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Utilize Technology to Differentiate Our Services and Improve Operating Efficiencies. We intend to continue to invest in technologies that broaden our services in the marketplace, improve patient care, enhance our billing efficiencies and increase our productivity and profitability.

Continued Focus on Risk Management. We will continue to utilize risk management programs for loss prevention and early intervention. This may include continued use of clinical "fail safes" and technology in our ambulances to reduce vehicular incidents.

Regulatory Matters

As a participant in the healthcare industry, our operations and relationships with healthcare providers such as hospitals, other healthcare facilities and healthcare professionals are subject to extensive and increasing regulation by numerous federal and state government entities as well as local government agencies. Specifically, but without limitation, we are subject to the following laws and regulations.

Medicare, Medicaid and Other Government Reimbursement Programs

We derive a significant portion of our revenue from services rendered to beneficiaries of Medicare, Medicaid and other government-sponsored healthcare programs. For 2009, we received approximately 23% of our net revenue from Medicare and 5% from Medicaid. To participate in these programs, we must comply with stringent and often complex enrollment and reimbursement requirements from the federal and state governments. We are subject to governmental reviews and audits of our bills and claims for reimbursement. Retroactive adjustments to amounts previously reimbursed from these programs can and do occur on a regular basis as a result of these reviews and audits. In addition, these programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, all of which may materially increase or decrease the payments we receive for our services as well as affect the cost of providing services. In recent years, Congress has consistently attempted to curb federal spending on such programs.

Reimbursement to us typically is conditioned on our providing the correct procedure and diagnosis codes and properly documenting both the service itself and the medical necessity for the service. Incorrect or incomplete documentation and billing information, or the incorrect selection of codes for the level of service provided, could result in non-payment for services rendered or lead to allegations of billing fraud. Moreover, third party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not reimbursable, they were for services provided that were not medically necessary, there was a lack of sufficient supporting documentation, or for a number of other reasons. Retroactive adjustments, recoupments or refund demands may change amounts realized from third party payors. Additional factors that could complicate our billing include:

disputes between payors as to which party is responsible for payment,

the difficulty of adherence to specific compliance requirements, diagnosis coding and various other procedures mandated by the government, and

failure to obtain proper physician credentialing and documentation in order to bill governmental payors.

Due to the nature of our business and our participation in the Medicare and Medicaid reimbursement programs, we are involved from time to time in regulatory reviews, audits or investigations by government agencies of matters such as compliance with billing regulations and rules. We may be required to repay these agencies if a finding is made that we were incorrectly reimbursed, or we may lose eligibility for certain programs in the event of certain types of non-compliance. Delays and uncertainties in the reimbursement process adversely affect our level of accounts receivable,

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increase the overall cost of collection, and may adversely affect our working capital and cause us to incur additional borrowing costs. Unfavorable resolutions of pending or future regulatory reviews or investigations, either individually or in the aggregate, could have a material adverse effect on our business, financial condition and results of operations.

We establish an allowance for discounts applicable to Medicare, Medicaid and other third party payors and for doubtful accounts based on credit risk applicable to certain types of payors, historical trends, and other relevant information. We review our allowance for doubtful accounts on an ongoing basis and may increase or decrease such allowance from time to time, including in those instances when we determine that the level of effort and cost of collection of certain accounts receivable is unacceptable.

We believe that regulatory trends in cost containment will continue. We cannot assure you that we will be able to offset reduced operating margins through cost reductions, increased volume, the introduction of additional procedures or otherwise.

Ambulance Services Fee Schedule. In February 2002, the Health Care Financing Administration, now renamed the Centers for Medicare and Medicaid Services, or CMS, issued the Medicare Ambulance Fee Schedule Final Rule, or Final Rule, that revised Medicare policy on the coverage of ambulance transport services, effective April 1, 2002. The Final Rule was the result of a mandate under the BBA to establish a national fee schedule for payment of ambulance transport services that would control increases in expenditures under Part B of the Medicare program, establish definitions for ambulance transport services that link payments to the type of services furnished, consider appropriate regional and operational differences and consider adjustments to account for inflation, among other provisions.

The Final Rule provided for a five-year phase-in of a national fee schedule, beginning April 1, 2002. Prior to that date, Medicare used a charge-based reimbursement system for ambulance transport services and reimbursed 80% of charges determined to be reasonable, subject to the limits fixed for the particular geographic area. The patient was responsible for co-pay amounts, deductibles and the remaining balance of the transport cost, if we did not accept the assigned reimbursement, and Medicare required us to expend reasonable efforts to collect the balance. In determining reasonable charges, Medicare considered and applied the lowest of various charge factors, including the actual charge, the customary charge, the prevailing charge in the same locality, the amount of reimbursement for comparable services, and the inflation-indexed charge limit.

The Final Rule categorizes seven levels of ground ambulance services, ranging from basic life support to specialty care transport, and two categories of air ambulance services. Ground providers are paid based on a base rate conversion factor multiplied by the number of relative value units assigned to each level of transport, plus an additional amount for each mile of patient transport. The base rate conversion factor for services to Medicare patients is adjusted each year by the Consumer Price Index. Additional adjustments to the base rate conversion factor are included to recognize differences in relative practice costs among geographic areas, and higher transportation costs that may be incurred by ambulance providers in rural areas with low population density. The Final Rule requires ambulance providers to accept assignment on Medicare claims, which means a provider must accept Medicare's allowed reimbursement rate as full payment. Medicare typically reimburses 80% of that rate and the remaining 20% is collectible from a secondary insurance or the patient. Originally, the Final Rule called for a five-year phase-in period to allow providers time to adjust to the new payment rates. The national fee schedule was to be phased in at 20% increments each year, with payments being made at 100% of the national fee schedule in 2006 and thereafter.

With the passage of the Medicare Modernization Act, temporary modifications were made to the amounts payable under the ambulance fee schedule in order to mitigate decreases in reimbursement in some regions caused by the Final Rule. The Medicare Modernization Act established regional fee

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schedules based on historic costs in each region. Effective July 1, 2004, in those regions where the regional fee schedule exceeds the national fee schedule, the regional fee schedule is blended with the national fee schedule on a temporary basis, until this year. In addition to the regional fee schedule change, the Medicare Modernization Act included other provisions for additional reimbursement for ambulance transport services provided to Medicare patients. Among other relief, the Medicare Modernization Act provided for a 1% increase in reimbursement for urban transports and a 2% increase for rural transports for the remainder of the original phase-in period of the national ambulance fee schedule, through December 31, 2006. In addition, effective July 1, 2008 the Medicare Improvement for Patients and Providers Act of 2008 provided a temporary mitigation that provided for a 2% to 3% increase for blended rates which was in effect through December 31, 2009.

We estimate that the impact of the ambulance service rate decreases under the national fee schedule, as modified by the provisions of the Medicare Modernization Act, resulted in a decrease in AMR's net revenue of approximately \$7 million in 2007, an increase in AMR's net revenue of approximately \$14 million in 2008, and an increase in AMR's net revenue of approximately \$24 million in 2009. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential decrease in AMR's net revenue of approximately \$30 million for 2010. We cannot predict whether Congress may make further refinements and technical corrections to the law or pass a new cost containment statute in a manner and in a form that could adversely impact our business.

Local Ambulance Rate Regulation. State or local government regulations or administrative policies regulate rate structures in some states in which we provide ambulance transport services. For example, in certain service areas in which we are the exclusive provider of ambulance transport services, the community sets the rates for emergency ambulance services pursuant to an ordinance or master contract and may also establish the rates for general ambulance services that we are permitted to charge. We may be unable to receive ambulance service rate increases on a timely basis where rates are regulated or to establish or maintain satisfactory rate structures where rates are not regulated.

Medicare Physician Fee Schedule. Medicare pays for all physician services based upon a national fee schedule, or Fee Schedule, which contains a list of uniform rates. The payment rates under the Fee Schedule are determined based on: (1) national uniform relative value units for the services provided, (2) a geographic adjustment factor and (3) a conversion factor. Payment rates under the Fee Schedule are updated annually. The initial element in each year's update calculation is the Medicare Economic Index, or MEI, which is a government index of practice cost inflation. The update is then adjusted up or down from the MEI based on a target-setting formula system called the Sustainable Growth Rate, or SGR. The SGR is a target rate of growth in spending for physician services which is intended to control the growth of Medicare expenditures for physicians' services. The Fee Schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures. Because one of the factors for calculating the SGR system is linked to the U.S. gross domestic product, the SGR formula may result in a negative payment update if growth in Medicare beneficiaries' use of services exceeds GDP growth. Since 2002, the SGR formula has resulted in negative payment updates under the Fee Schedule which required Congress to take legislative action to reverse the scheduled payment cuts. In July of 2008, Congress passed legislation to prevent a 10.6% reduction in Medicare physician payments which was scheduled to take effect July 1, 2008. The legislation replaced the scheduled 10.6% cut with a 0.5% increase for the remainder of 2008 (retroactive to July 1, 2008) and raised reimbursement rates by an average of 1.1% in 2009. However, if Congress does not act before March 1, 2010 with further legislation, Medicare physician payments will be reduced by a projected 21% beginning as of that date. Congressional leaders have pledged to take action to prevent this pending reduction. Moreover, unless Congress takes additional action in the future to modify or reform the mechanism by which the Fee Schedule payment rates are updated, significant reductions in Medicare reimbursement will continue to occur annually, and these reductions could have a material adverse effect on our business, financial condition and results of operations.

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Medicare Reassignment. The Medicare program prohibits the reassignment of Medicare payments due to a physician or other healthcare provider to any other person or entity unless the billing arrangement between that physician or other healthcare provider and the other person or entity falls within an enumerated exception to the Medicare reassignment prohibition. Historically, there was no exception that allowed us to receive directly Medicare payments related to the services of independent contractor physicians. However, the Medicare Modernization Act amended the Medicare reassignment statute as of December 8, 2003 and now permits our independent contractor physicians to reassign their Medicare receivables to us under certain circumstances. In 2004, CMS promulgated regulations implementing this statutory change. The regulations impose two additional program integrity safeguard requirements on reassignments made under the independent contractor exception. These require that both the entity receiving payment and the physician be jointly and severally responsible for any Medicare overpayment to that entity; and the physician have unrestricted access to claims submitted by an entity for services provided by the physician. We have taken steps to ensure all reassignments by independent contractor physicians comply with these regulatory requirements.

Rules Applicable to Midlevel Practitioners. EmCare utilizes physician assistants and nurse practitioners, sometimes referred to collectively as "midlevel practitioners," to provide care under the supervision of our physicians. State and federal laws require that such supervision be performed and documented using specific procedures. For example, in some states some or all of the midlevel practitioner's chart entries must be countersigned. Under applicable Medicare rules, in certain cases, a midlevel practitioner's services are reimbursed at a rate equal to 85% of the physician fee schedule amount. However, when a midlevel practitioner assists a physician who is directly and personally involved in the patient's care, we often bill for the services of the physician at the full physician fee schedule rates and do not bill separately for the midlevel practitioner's services. We believe our billing and documentation practices related to our use of midlevel practitioners comply with applicable state and federal laws, but we cannot assure you that enforcement authorities will not find that our practices violate such laws.

Ambulance Rates Payable by Medicare HMOs. One of the changes made by ambulance fee schedule Final Rule was to require ambulance providers to "accept assignment" from Medicare and Medicare HMOs. Medicare HMOs are private insurance companies which operate managed care plans that enroll Medicare beneficiaries who elect to enroll in a plan in lieu of regular Medicare coverage. When a provider accepts assignment, it agrees to accept the rate established by Medicare as payment in full for services covered by Medicare or the Medicare HMO and to write off the balance of its charges. Prior to the implementation of the Final Rule, ambulance providers were not required to accept assignment and could obtain payment from Medicare patients or Medicare HMOs for the provider's full charges, which typically are higher than the Medicare rate. When the requirement to accept assignment became effective on April 1, 2002, many Medicare HMOs continued to pay ambulance providers their full charges, even though they could have paid them the Medicare rate. Many Medicare HMOs subsequently have taken the position that the amount paid to such providers in excess of the Medicare rate constituted an overpayment that must be refunded by the provider. We have received such refund demands from some Medicare HMOs and, in order to minimize litigation costs, have agreed to partial repayment of amounts received from the plans in excess of the Medicare rate. We have no reason to believe that additional HMOs will make such demands, but we cannot assure you that there will be no further demands.

The SNF Prospective Payment System. Under the Medicare prospective payment system, or PPS, applicable to skilled nursing facilities, or SNFs, the SNFs are financially responsible for some ancillary services, including certain ambulance transports, or PPS transports, rendered to certain of their Medicare patients. Ambulance companies must bill the SNF, rather than Medicare, for PPS transports, but may bill Medicare for other covered transports provided to the SNF's Medicare patients. Ambulance companies are responsible for obtaining sufficient information from the SNF to determine

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which transports are PPS transports and which ones may be billed to Medicare. The Office of Inspector General of the Department of Health and Human Services, or the OIG, has issued two industry-wide audit reports indicating that, in many cases, SNFs do not provide, or ambulance companies and other ancillary service providers do not obtain, sufficient information to make this determination accurately. As a result, the OIG asserts that some PPS transports that should have been billed by ambulance providers to SNFs have been improperly billed to Medicare. The OIG has recommended that Medicare recoup the amounts paid to ancillary service providers, including ambulance companies, for such services. Although we believe AMR currently has procedures in place to correctly identify and bill for PPS transports, we cannot assure you that AMR will not be subject to such recoupments and other possible penalties.

Paramedic Intercepts. Medicare regulations permit ambulance transport providers to subcontract with other organizations for paramedic services. Generally, only the transport provider may bill Medicare, and the paramedic services subcontractor must receive any payment to which it is entitled from that provider. Based on these rules, in some jurisdictions we have established "paramedic intercept" arrangements in which we may provide paramedic services to a municipal or volunteer transport provider. Although we believe AMR currently has procedures in place to assure that we do not bill Medicare directly for paramedic intercept services we provide, we cannot assure you that enforcement agencies will not find that we have failed to comply with these requirements.

Patient Signatures. Medicare regulations require that providers obtain the signature of the patient or, if the patient is unable to provide a signature, the signature of a representative as defined in the regulations, prior to submitting a claim for payment from Medicare. Historically, until January 1, 2008, an exception existed for situations where it is not reasonably possible to obtain a patient or representative signature, provided that the reason for the exception is clearly documented and certain additional documentation was completed. This exception was historically interpreted as applying to both emergency and non-emergency transports. Effective January 1, 2008, these regulations were revised and reinterpreted by CMS to limit this exception to emergency transports, provided the ambulance company obtained the signature of a representative of the receiving facility, or other specified documentation from that facility as proof of transport and maintains certain other documentation. Following this change, until a subsequent change became effective on January 1, 2009, if we were unable to obtain the signature of a Medicare non-emergency patient or a qualified representative, we could not bill Medicare for the transport and were required to seek payment directly from the patient. These revised requirements exacerbated the difficulty ambulance providers historically had in complying with the patient signature requirements. Effective January 1, 2009, Medicare again revised the signature requirements to expand the exception to non-emergency patients for whom it is not reasonably possible to obtain a patient or representative signature, provided the specified requirements are met. Even with these changes, the requirement to obtain patient signatures or comply with the requirements for meeting the exception could adversely impact our cash flow because of the delays that may occur in meeting such requirements, or our inability to bill Medicare when we are unable to do so. Further, although we believe AMR currently has procedures in place to assure that these signature requirements are met, we cannot assure you that enforcement agencies will not find that we have failed to comply with these requirements.

Physician Certification Statements. Under applicable Medicare rules, ambulance providers are required to obtain a certification of medical necessity from the ordering physician in order to bill Medicare for repetitive non-emergency transports provided to patients with chronic conditions, such as end-stage renal disease. For certain other non-emergency transports, ambulance providers are required to attempt to obtain a certification of medical necessity from a physician or certain other practitioners. In the event the provider is not able to obtain such certification within 21 days, it may submit a claim for the transport if it can document reasonable attempts to obtain the certification. Acceptable documentation includes any U.S. postal document (e.g., signed return receipt or Postal Service Proof of

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Service Form) showing that the ordering practitioner was sent a request for the certification. Although we believe AMR currently has procedures in place to assure we are in compliance with these requirements, we cannot assure you that enforcement agencies will not find that we have failed to comply.

Coordination of Benefits Rules. When our services are covered by multiple third party payors, such as a primary and a secondary payor, financial responsibility must be allocated among the multiple payors in a process known as "coordination of benefits," or COB. The rules governing COB are complex, particularly when one of the payors is Medicare or another government program. Under these rules, in some cases Medicare or other government payors can be billed as a "secondary payor" only after recourse to a primary payor (e.g., a liability insurer) has been exhausted. In some instances, multiple payors may reimburse us an amount which, in the aggregate, exceeds the amount to which we are entitled. In such cases, we are obligated to process a refund. If we improperly bill Medicare or other government payors as the primary payor when that program should be billed as the secondary payor, or if we fail to process a refund when required, we may be subject to civil or criminal penalties. Although we believe we currently have procedures in place to assure that we comply with applicable COB rules, and that we process refunds when we receive overpayments, we cannot assure you that payors or enforcement agencies will not find that we have violated these requirements.

Consequences of Noncompliance. In the event any of our billing and collection practices, including but not limited to those described above, violate applicable laws such as those described below, we could be subject to refund demands and recoupments. If our violations are deemed to be willful, knowing or reckless, we may be subject to civil and criminal penalties under the False Claims Act or other statutes, including exclusion from federal and state healthcare programs. To the extent that the complexity associated with billing for our services causes delays in our cash collections, we assume the financial risk of increased carrying costs associated with the aging of our accounts receivable as well as increased potential for bad debts which could have a material adverse effect on our revenue, provision for uncompensated care and cash flow.

Federal False Claims Act

Both federal and state government agencies have continued civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies, and their executives and managers. Although there are a number of civil and criminal statutes that can be applied to healthcare providers, a significant number of these investigations involve the federal False Claims Act. These investigations can be initiated not only by the government but also by a private party asserting direct knowledge of fraud. These "qui tam" whistleblower lawsuits may be initiated against any person or entity alleging such person or entity has knowingly or recklessly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or has made a false statement or used a false record to get a claim approved. Penalties for False Claims Act violations include fines ranging from \$5,500 to \$11,000 for each false claim, plus up to three times the amount of damages sustained by the federal government. A False Claims Act violation may provide the basis for exclusion from the federally-funded healthcare programs. In addition, some states have adopted similar insurance fraud, whistleblower and false claims provisions.

The government and some courts have taken the position that claims presented in violation of the various statutes, including the federal Anti-Kickback Statute and the Stark Law, described below, can be considered a violation of the federal False Claims Act based on the contention that a provider impliedly certifies compliance with all applicable laws, regulations and other rules when submitting claims for reimbursement.

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Federal Anti-Kickback Statute

We are subject to the federal Anti-Kickback Statute. The Anti-Kickback Statute is broadly worded and prohibits the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, (1) the referral of a person covered by Medicare, Medicaid or other governmental programs, (2) the furnishing or arranging for the furnishing of items or services reimbursable under Medicare, Medicaid or other governmental programs or (3) the purchasing, leasing or ordering or arranging or recommending purchasing, leasing or ordering of any item or service reimbursable under Medicare, Medicaid or other governmental programs. Certain federal courts have held that the Anti-Kickback Statute can be violated if "one purpose" of a payment is to induce referrals. Violations of the Anti-Kickback Statute can result in exclusion from Medicare, Medicaid or other governmental programs as well as civil and criminal penalties, including fines of up to \$50,000 per violation and three times the amount of the unlawful remuneration. Imposition of any of these remedies could have a material adverse effect on our business, financial condition and results of operations. In addition to a few statutory exceptions, the OIG has published safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute provided all applicable criteria are met. The failure of a financial relationship to meet all of the applicable safe harbor criteria does not necessarily mean that the particular arrangement violates the Anti-Kickback Statute. In order to obtain additional clarification on arrangements that may not be subject to a statutory exception or may not satisfy the criteria of a safe harbor, Congress established a process under the Health Insurance Portability and Accountability Act of 1996 in which parties can seek an advisory opinion from the OIG.

We and others in the healthcare community have taken advantage of the advisory opinion process, and a number of advisory opinions have addressed issues that pertain to our various operations, such as discounted ambulance services being provided to skilled nursing facilities, patient co-payment responsibilities, compensation methodologies under a management services arrangement, and ambulance restocking arrangements. In a number of these advisory opinions the government concluded that such arrangements could be problematic if the requisite intent were present. Although advisory opinions are binding only on HHS and the requesting party or parties, when new advisory opinions are issued, regardless of the requestor, we review them and their application to our operations as part of our ongoing corporate compliance program and endeavor to make appropriate changes where we perceive the need to do so. See " Corporate Compliance Program and Corporate Integrity Obligations."

Health facilities such as hospitals and nursing homes refer two categories of ambulance transports to us and other ambulance companies: (1) transports for which the facility must pay the ambulance company, and (2) transports which the ambulance company can bill directly to Medicare or other public or private payors. In Advisory Opinion 99-2, which we requested, the OIG addressed the issue of whether substantial contractual discounts provided to nursing homes on the transports for which the nursing homes are financially responsible may violate the Anti-Kickback Statute when the ambulance company also receives referrals of Medicare and other government-funded transports. The OIG opined that such discounts implicate the Anti-Kickback Statute if even one purpose of the discounts is to induce the referral of the transports paid for by Medicare and other federal programs. The OIG further indicated that a violation may exist even if there is no contractual obligation on the part of the facility to refer federally funded patients, and even if similar discounts are provided by other ambulance companies in the same marketplace. Following our receipt of this Advisory Opinion in March of 1999, we took steps to bring our contracts with health facilities into compliance with the OIG's views. In 2006, we entered into a settlement with the U.S. Department of Justice and a Corporate Integrity Agreement, or CIA, to settle allegations that certain of our hospital and nursing home contracts in effect in Texas in periods prior to 2002 contained discounts in violation of the federal Anti-Kickback Statute. See Item 3, "Legal Proceedings".

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The OIG has also addressed potential violations of the Anti-Kickback Statute (as well as other risk areas) in its Compliance Program Guidance for Ambulance Suppliers. In addition to discount arrangements with health facilities, the OIG notes that arrangements between local governmental agencies that control 911 patient referrals and ambulance companies which receive such referrals may violate the Anti-Kickback Statute if the ambulance companies provide inappropriate remuneration in exchange for such referrals. Although we believe we have structured our arrangements with local agencies in a manner which complies with the Anti-Kickback Statute, we cannot assure you that enforcement agencies will not find that some of those arrangements violate that statute.

Fee-Splitting; Corporate Practice of Medicine

EmCare employs or contracts with physicians or physician-owned professional corporations to deliver services to our hospital customers and their patients. We frequently enter into management services contracts with these physicians and professional corporations pursuant to which we provide them with billing, scheduling and a wide range of other services, and they pay us for those services out of the fees they collect from patients and third-party payors. These activities are subject to various state laws that prohibit the practice of medicine by corporations and are intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment and the sharing of professional services income with nonprofessional or business interests. Activities other than those directly related to the delivery of healthcare may be considered an element of the practice of medicine in many states. Under the corporate practice of medicine restrictions of certain states, decisions and activities such as scheduling, contracting, setting rates and the hiring and management of non-clinical personnel may implicate the restrictions on corporate practice of medicine. In such states, we maintain long-term management contracts with affiliated physician groups, which employ or contract with physicians to provide physician services. We believe that we are in material compliance with applicable state laws relating to the corporate practice of medicine and fee-splitting. However, regulatory authorities or other parties, including our affiliated physicians, may assert that, despite these arrangements, we are engaged in the corporate practice of medicine or that our contractual arrangements with affiliated physician groups constitute unlawful fee-splitting. In this event, we could be subject to adverse judicial or administrative interpretations, to civil or criminal penalties, our contracts could be found legally invalid and unenforceable or we could be required to restructure our contractual arrangements with our affiliated physician groups.

Federal Stark Law

We are also subject to a provision of the Social Security Act, commonly known as the "Stark Law." Where applicable, this law prohibits a physician from referring Medicare patients to an entity providing "designated health services" if the physician or a member of such physician's immediate family has a "financial relationship" with the entity, unless an exception applies. The penalties for violating the Stark Law include the denial of payment for services ordered in violation of the statute, mandatory refunds of any sums paid for such services, civil penalties of up to \$15,000 for each violation and twice the dollar value of each such service and possible exclusion from future participation in the federally-funded healthcare programs. A person who engages in a scheme to circumvent the Stark Law's prohibitions may be fined up to \$100,000 for each applicable arrangement or scheme. Although we believe that we have structured our agreements with physicians so as to not violate the Stark Law and related regulations, a determination of liability under the Stark Law could have an adverse effect on our business, financial condition and results of operations.

Other Federal Healthcare Fraud and Abuse Laws

We are also subject to other federal healthcare fraud and abuse laws. Under the Health Insurance Portability and Accountability Act of 1996, there are two additional federal crimes that could have an

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impact on our business: "Healthcare Fraud" and "False Statements Relating to Healthcare Matters." The Healthcare Fraud statute prohibits knowingly and recklessly executing a scheme or artifice to defraud any healthcare benefit program, including private payors. A violation of this statute is a felony and may result in fines, imprisonment and/or exclusion from government-sponsored programs. The False Statements Relating to Healthcare Matters statute prohibits knowingly and willfully falsifying, concealing or covering up a material fact by any trick, scheme or device or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. A violation of this statute is a felony and may result in fines and/or imprisonment. This statute could be used by the government to assert criminal liability if a healthcare provider knowingly fails to refund an overpayment.

Another statute, commonly referred to as the Civil Monetary Penalties Law, imposes civil administrative sanctions for, among other violations, inappropriate billing of services to federally funded healthcare programs, inappropriately reducing hospital care lengths of stay for such patients, and employing or contracting with individuals or entities who are excluded from participation in federally funded healthcare programs.

Although we intend and endeavor to conduct our business in compliance with all applicable fraud and abuse laws, we cannot assure you that our arrangements or business practices will not be subject to government scrutiny or be found to violate applicable fraud and abuse laws.

Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996

The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, required the Department of Health and Human Services, or HHS, to adopt standards to protect the privacy and security of health-related information. All healthcare providers were required to be compliant with the new federal privacy requirements enacted by HHS no later than April 14, 2003. We believe we have taken reasonable measures to comply with these requirements.

In addition to enacting the foregoing privacy requirements, HHS issued a final rule creating security requirements for healthcare providers and other covered entities on February 20, 2003. The final security rule required covered entities to meet specified standards by April 25, 2005. The security standards contained in the final rule do not require the use of specific technologies (e.g., no specific hardware or software is required), but instead require healthcare providers and other covered entities to comply with certain minimum security procedures in order to protect data integrity, confidentiality and availability. We believe we have taken reasonable steps to comply with these standards.

HIPAA also required HHS to adopt national standards establishing electronic transaction standards that all healthcare providers must use when submitting or receiving certain healthcare transactions electronically. Although these standards were to become effective October 2002, Congress extended the compliance deadline until October 2003 for organizations, such as ours, that submitted a request for an extension. We believe we have taken reasonable steps to comply with these standards.

The Health Information Technology for Economic and Clinical Health Act, or the HITECH Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009, or ARRA, significantly expands the scope of the privacy and security requirements under HIPAA and increases penalties for violations. See Item 1A, "Risk Factors Risk Factors Related to Healthcare Regulation Under recently enacted amendments to federal privacy law, we are subject to more stringent penalties in the event we improperly use or disclose protected health information regarding our patients."

Fair Debt Collection Practices Act

Some of our operations may be subject to compliance with certain provisions of the Fair Debt Collection Practices Act and comparable statutes in many states. Under the Fair Debt Collection

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Practices Act, a third party collection company is restricted in the methods it uses to contact consumer debtors and elicit payments with respect to placed accounts. Requirements under state collection agency statutes vary, with most requiring compliance similar to that required under the Fair Debt Collection Practices Act. We believe we are in substantial compliance with the Fair Debt Collection Practices Act and comparable state statutes where applicable.

State Fraud and Abuse Provisions

We are subject to state fraud and abuse statutes and regulations. Most of the states in which we operate have adopted a form of anti-kickback law, almost all of those states also have adopted self-referral laws and some have adopted separate false claims or insurance fraud provisions. The scope of these laws and the interpretations of them vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion. Generally, state laws cover all healthcare services and not just those covered under a federally-funded healthcare program. A determination of liability under such laws could result in fines and penalties and restrictions on our ability to operate in these jurisdictions.

Although we intend and endeavor to conduct our business in compliance with all applicable fraud and abuse laws, we cannot assure you that our arrangements or business practices will not be subject to government scrutiny or be found to violate applicable fraud and abuse laws.

Licensing, Certification, Accreditation and Related Laws and Guidelines

In certain jurisdictions, changes in our ownership structure require pre- or post-notification to governmental licensing and certification agencies. Relevant laws and regulations may also require reapplication and approval to maintain or renew our operating authorities or require formal application and approval to continue providing services under certain government contracts. For example, in connection with our acquisition of AMR from Laidlaw, two of our subsidiaries were required to apply for state and local ambulance operating authority in New York. See Item 1A, "Risk Factors Risk Factors Related to Healthcare Regulation Changes in our ownership structure and operations require us to comply with numerous notification and reapplication requirements in order to maintain our licensure, certification or other authority to operate, and failure to do so, or an allegation that we have failed to do so, can result in payment delays, forfeiture of payment or civil and criminal penalties."

We and our affiliated physicians are subject to various federal, state and local licensing and certification laws and regulations and accreditation standards and other laws, relating to, among other things, the adequacy of medical care, equipment, personnel and operating policies and procedures. We are also subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditations. Failure to comply with these laws and regulations could result in our services being found to be non reimbursable or prior payments being subject to recoupments, and can give rise to civil or criminal penalties. We have taken steps we believe were required to retain or obtain all requisite licensure and operating authorities. While we have made reasonable efforts to substantially comply with federal, state and local licensing and certification laws and regulations and standards as we interpret them, we cannot assure you that agencies that administer these programs will not find that we have failed to comply in some material respects.

Because we perform services at hospitals and other types of healthcare facilities, we and our affiliated physicians may be subject to laws which are applicable to those entities. For example, our operations are impacted by the Emergency Medical Treatment and Active Labor Act of 1986, which prohibits "patient dumping" by requiring hospitals and hospital emergency departments and others to assess and stabilize any patient presenting to the hospital's emergency department or urgent care center requesting care for an emergency medical condition, regardless of the patient's ability to pay. Many

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states in which we operate have similar state law provisions concerning patient dumping. Violations of the Emergency Medical Treatment and Active Labor Act of 1986 can result in civil penalties and exclusion of the offending physician from the Medicare and Medicaid programs.

In addition to the Emergency Medical Treatment and Active Labor Act of 1986 and its state law equivalents, significant aspects of our operations are affected by state and federal statutes and regulations governing workplace health and safety, dispensing of controlled substances and the disposal of medical waste. Changes in ethical guidelines and operating standards of professional and trade associations and private accreditation commissions such as the American Medical Association and the Joint Commission on Accreditation of Healthcare Organizations may also affect our operations. We believe our operations as currently conducted are in substantial compliance with these laws and guidelines.

EmCare's professional liability insurance program, under which insurance is provided for most of our affiliated medical professionals and professional and corporate entities, is reinsured through our wholly-owned subsidiary, EMCA Insurance Company, Ltd. The activities associated with the business of insurance, and the companies involved in such activities, are closely regulated. Failure to comply with applicable laws and regulations can result in civil and criminal fines and penalties and loss of licensure.

While we have made reasonable efforts to substantially comply with these laws and regulations, and utilize licensed insurance professionals where necessary or appropriate, we cannot assure you that we will not be found to have violated these laws and regulations in some material respects.

Antitrust Laws

Antitrust laws such as the Sherman Act and state counterparts prohibit anticompetitive conduct by separate competitors, such as price fixing or the division of markets. Our physician contracts include contracts with individual physicians and with physicians organized as separate legal professional entities (e.g., professional medical corporations). Antitrust laws may deem each such physician/entity to be separate, both from EmCare and from each other and, accordingly, each such physician/practice is subject to antitrust laws that prohibit anti-competitive conduct between or among separate legal entities or individuals. Although we believe we have structured our physician contracts to substantially comply with these laws, we cannot assure you that antitrust regulatory agencies or a court would not find us to be non-compliant.

Corporate Compliance Program and Corporate Integrity Obligations

We have developed a corporate compliance program in an effort to monitor compliance with federal and state laws and regulations applicable to healthcare entities, to ensure that we maintain high standards of conduct in the operation of our business and to implement policies and procedures so that employees act in compliance with all applicable laws, regulations and Company policies. Our program also attempts to monitor compliance with our Corporate Compliance Plan, which details our standards for: (1) business ethics, (2) compliance with applicable federal, state and local laws, and (3) business conduct. We have an Ethics and Compliance Department whose focus is to prevent, detect and mitigate regulatory risks. We attempt to accomplish this mission through:

providing guidance, education and proper controls based on the regulatory risks associated with our business model and strategic plan,

conducting internal audits and reviews to identify any improper practices that may be occurring,

resolving regulatory matters, and

enhancing the ethical culture and leadership of the organization.

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The OIG has issued a series of Compliance Program Guidance documents in which the OIG has set out the elements of an effective compliance program. We believe our compliance program has been structured appropriately in light of this guidance. The primary compliance program components recommended by the OIG, all of which we have attempted to implement, include:

formal policies and written procedures,

designation of a Compliance Officer,

education and training programs,

internal monitoring and reviews,

responding appropriately to detected misconduct,

open lines of communication, and

discipline and accountability.

Our corporate compliance program is based on the overall goal of promoting a culture that encourages employees to conduct activities with integrity, dignity and care for those we serve, and in compliance with all applicable laws and policies. Notwithstanding the foregoing, we audit compliance with our compliance program on a sample basis. Although such an approach reflects a reasonable and accepted approach in the industry, we cannot assure you that our program will detect and rectify all compliance issues in all markets and for all time periods.

As do other healthcare companies which operate effective compliance programs, from time to time we identify practices that may have resulted in Medicare or Medicaid overpayments or other regulatory issues. For example, we have previously identified situations in which we may have inadvertently utilized incorrect billing codes for some of the services we have billed to government programs such as Medicare or Medicaid, or billed for services which may not meet medical necessity guidelines. In such cases, if appropriate, it is our practice to disclose the issue to the affected government programs and to refund any resulting overpayments. The government usually accepts such disclosures and repayments without taking further enforcement action, and we generally expect that to be the case with respect to our past and future disclosures and repayments. However, it is possible that such disclosures or repayments will result in allegations by the government that we have violated the False Claims Act or other laws, leading to investigations and possibly civil or criminal enforcement actions.

When the United States government settles a case involving allegations of billing misconduct with a healthcare provider, it typically requires the provider to enter into a CIA with the OIG for a set period of years. As a condition to settlement of government investigations, certain of our operations are subject to two separate CIAs with the OIG for the period July 2004 through September 2011. As part of these CIAs, AMR is required to establish and maintain a compliance program that includes the following elements: (1) a compliance officer and committee, (2) written standards including a code of conduct and policies and procedures, (3) general and specific training and education, (4) claims review by an independent review organization, (5) disclosure program for reporting of compliance issues or questions, (6) screening and removal processes for ineligible persons, (7) notification of government investigations or legal proceedings, (8) establishment of safeguards applicable to our contracting processes and (9) reporting of overpayments and other "reportable events."

If we fail or if we are accused of failing to comply with the terms of our existing CIAs, we may be subject to additional litigation or other government actions, including being excluded from participating in the Medicare program and other federal healthcare programs. If we enter into any settlements with the U.S. government in the future we may be required to enter into additional CIAs.

See Item 1A, "Risk Factors Risk Factors Related to Healthcare Regulation" for additional information related to regulatory matters.

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Additional Information

We file annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, registration statements, proxy statements, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities and Exchange Act of 1934, as amended ("Exchange Act"). The SEC maintains an internet website, www.sec.gov, that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC. Copies of materials that we file with the SEC can also be obtained at the SEC's Public Reference Room at 100 F Street, N.E., Washington, D.C. 20549. Information on the operation of the SEC's Public Reference Room can be obtained by calling the SEC at 1-800-SEC-0330.

Our website address is www.emsc.net. Under the "Investor Relations" heading on our website we make available, free of charge, our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, registration statements, proxy statements, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act of 1934 as soon as reasonably practicable after such forms are electronically filed with or furnished to the SEC.

Copies of our key corporate governance documents, code of ethics, and charters of our audit, compensation, compliance, and corporate governance and nominating committees are also available on our website www.emsc.net under the headings "Corporate Governance" and "Code of Business Conduct and Ethics."

The website addresses for our business segments are www.amr.net and www.emcare.com.

Information contained on these websites is not part of this Annual Report on Form 10-K and is not incorporated in this Report by reference.

ITEM 1A. RISK FACTORS

You should carefully consider the factors described below, in addition to the other information set forth in this Annual Report, when evaluating us and our business. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also materially and adversely affect our business operations. Any of the following risks could materially adversely affect our business, financial condition or results of operations.

Risk Factors Related to our Capital Structure

The interests of our controlling stockholders may conflict with interests of other stockholders.

Onex Partners LP and other entities affiliated with Onex Corporation, which we refer to together as the Onex entities, own all of our outstanding LP exchangeable units, which are exchangeable at any time, at the option of the holder, for our class B common stock. Our class A common stock has one vote per share, while our class B common stock has ten votes per share (reducing to one vote per share under certain limited circumstances), on all matters to be voted on by our stockholders. Prior to the exchange for class B common stock, the holders of the LP exchangeable units will be able to exercise the same voting rights with respect to EMSC as they would have after the exchange through a share of class B special voting stock. As a result, the Onex entities control 82% of our combined voting power. Accordingly, the Onex entities exercise a controlling influence over our business and affairs and have the power to determine all matters submitted to a vote of our stockholders, including the election of directors, the removal of directors, and approval of significant corporate transactions such as amendments to our certificate of incorporation, mergers and the sale of all or substantially all of our assets. The Onex entities could cause corporate actions to be taken even if the interests of these entities conflict with the interests of our other stockholders. This concentration of voting power could have the effect of deterring or preventing a change in control of EMSC that might otherwise be beneficial to our stockholders. Gerald W. Schwartz, the Chairman, President and Chief Executive

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Officer of Onex Corporation, owns shares representing a majority of the voting rights of the shares of Onex Corporation.

Onex has the voting power to elect our entire board of directors and to remove any director or our entire board without cause.

Although our current board includes "independent directors", so long as the Onex entities control more than 50% of our combined voting power we are exempt from the NYSE rule that requires that a board be comprised of a majority of "independent directors". Onex may have a controlling influence over our board, as Onex has sufficient voting power to elect the entire board, and our certificate of incorporation permits stockholders to remove directors at any time with or without cause.

As a holding company, our only material asset is our equity interest in EMS LP and our only source of revenue is distributions from EMS LP. Because the Onex entities have the voting power to control our board of directors, they could influence us, as the general partner of EMS LP, to take action at the level of EMS LP that would benefit the Onex entities and conflict with the interest of our class A stockholders.

We are a holding company, and we have no material assets other than our direct ownership of a 68% equity interest in EMS LP. EMS LP is our only source of cash flow from operations. The Onex entities hold their equity interest in us through LP exchangeable units of EMS LP. As our controlling stockholder, Onex could limit distributions to us from EMS LP, and cause us to amend the EMS LP partnership agreement in a manner that would be beneficial to the Onex entities, as limited partners of EMS LP, and detrimental to our class A stockholders.

Any decrease in our distributions from EMS LP would have a negative effect on our cash flow. In order to minimize this conflict, the EMS LP partnership agreement requires that the partnership reimburse us for all of our expenses, including all employee costs and the expenses we incur as a public company, and provides further that no distributions may be made to the Onex entities, as the holders of LP exchangeable units, unless we pay an economically equivalent dividend to all holders of our common stock.

The EMS LP partnership agreement provides that amendments to that agreement may only be proposed and authorized by us, as the general partner. The Onex entities could seek to influence our board's action with respect to any amendment and we, as the general partner of EMS LP, owe a fiduciary duty to the limited partners of the partnership. Our board also owes a fiduciary duty to our common stockholders. Because of the inherent conflict of interest we face between our fiduciary duty to our stockholders, including our class A stockholders, and the Onex entities, as limited partners in EMS LP, the EMS LP partnership agreement provides that, if there is any conflict of interest of the limited partners and our common stockholders, our board may, in the exercise of its business judgment, cause us to act in the best interests of our stockholders.

We are party to a management agreement with an affiliate of Onex which permits us to increase substantially the fee we pay to that affiliate.

The management agreement between our subsidiaries, AMR and EmCare, and an Onex affiliate provides that the annual fee may be increased from \$1.0 million to \$2.0 million. Such an increase would be detrimental to the interest of our class A stockholders if the fee were disproportionate to the benefit we derive from the services the Onex affiliate performs. In order to minimize this potential conflict of interest, the agreement requires that any increase in the fee be approved by a majority of the members of the boards of AMR and EmCare who are not affiliated with Onex. As long as the Onex entities control more than 50% of our combined voting power, they may be able to exercise a controlling influence over the election of the boards of AMR and EmCare.

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Our certificate of incorporation and our by-laws contain provisions that could discourage another company from acquiring us and may prevent attempts by our stockholders to replace or remove our current management.

Provisions of our certificate of incorporation and our by-laws may discourage, delay or prevent a merger or acquisition that stockholders may consider favorable, including transactions in which stockholders might otherwise receive a premium for their shares. In addition, these provisions may frustrate or prevent any attempts by our stockholders to replace or remove our current management by making it more difficult for stockholders to replace or remove our current board of directors. These provisions include:

providing for a classified board of directors with staggered terms,

providing for the class B special voting stock which will be voted as directed by the Onex entities,

providing for multi-vote shares of common stock which, upon exchange of LP exchangeable units, will be owned by the Onex entities,

establishing advance notice requirements for nominations for election to the board of directors or for proposing matters that can be acted on by stockholders at stockholder meetings, and

the authority of the board of directors to issue, without stockholder approval, up to 20 million shares of preferred stock with such terms as the board of directors may determine and an additional 54 million shares of common stock.

We are a "controlled company" within the meaning of the New York Stock Exchange rules and, as a result, qualify for, and intend to rely on, exemptions from certain corporate governance requirements.

Because the Onex entities own more than 50% of our combined voting power, we are deemed a "controlled company" under the rules of the New York Stock Exchange, or the NYSE. As a result, we qualify for, and rely upon, the "controlled company" exception to the board of directors and committee composition requirements under the rules of the NYSE. Pursuant to this exception, we are exempt from rules that would otherwise require that our board of directors be comprised of a majority of "independent directors," and that our compensation committee and corporate governance and nominating committee be comprised solely of "independent directors" (as defined under the rules of the NYSE), so long as the Onex entities continue to own more than 50% of our combined voting power.

We do not intend to pay cash dividends.

We do not intend to pay cash dividends on our class A common stock. We currently intend to retain all available funds and any future earnings for use in the operation and expansion of our business and do not anticipate paying any cash dividends in the foreseeable future. In addition, the terms of our current, as well as any future, financing agreements may preclude us from paying any dividends. As a result, capital appreciation, if any, of our class A common stock will be your sole source of potential gain for the foreseeable future.

Our substantial indebtedness could adversely affect our financial condition and our ability to operate our business.

We have a substantial amount of debt. At December 31, 2009, we had total debt of \$454 million, including \$200 million of borrowings under the term loan portion of our senior secured credit facility, \$250 million of our senior subordinated notes and \$3 million of capital lease obligations. We had no borrowings outstanding under our revolving credit facility and we had \$44 million of letters of credit

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outstanding. In addition, subject to restrictions in the indenture governing our notes and the credit agreement governing our senior secured credit facility, we may incur additional debt.

Our substantial debt could have important consequences to you, including the following:

it may be difficult for us to satisfy our obligations, including debt service requirements under our outstanding debt,

our ability to obtain additional financing for working capital, capital expenditures, debt service requirements or other general corporate purposes may be impaired,

we must use a significant portion of our cash flow for payments on our debt, which will reduce the funds available to us for other purposes,

we are more vulnerable to economic downturns and adverse industry conditions and our flexibility to plan for, or react to, changes in our business or industry is more limited,

our ability to capitalize on business opportunities and to react to competitive pressures, as compared to our competitors, may be compromised due to our high level of debt, and

our ability to borrow additional funds or to refinance debt may be limited.

Furthermore, all of our debt under our senior secured credit facility bears interest at variable rates. If these rates were to increase significantly, our ability to borrow additional funds may be reduced and the risks related to our substantial debt would intensify.

Servicing our debt will require a significant amount of cash. Our ability to generate sufficient cash depends on numerous factors beyond our control, and we may be unable to generate sufficient cash flow to service our debt obligations.

Our business may not generate sufficient cash flow from operating activities. The cash we require to meet contractual obligations in 2010, including our debt service, will total approximately \$96 million. Our ability to make payments on and to refinance our debt and to fund planned capital expenditures will depend on our ability to generate cash in the future. To some extent, this is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control. Lower net revenues, or higher provision for uncollectible, generally will reduce our cash flow.

If we are unable to generate sufficient cash flow to service our debt and meet our other commitments, we may need to refinance all or a portion of our debt, sell material assets or operations or raise additional debt or equity capital. We cannot assure you that we could effect any of these actions on a timely basis, on commercially reasonable terms or at all, or that these actions would be sufficient to meet our capital requirements. In addition, the terms of our existing or future debt agreements may restrict us from effecting any of these alternatives.

Restrictive covenants in our senior secured credit facility and the indenture governing our senior subordinated notes may restrict our ability to pursue our business strategies.

Our senior secured credit facility and the indenture governing our senior subordinated notes limit our ability, among other things, to:

incur additional debt or issue certain preferred stock,

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pay dividends or make distributions to our stockholders,

repurchase or redeem our capital,

make investments,

incur liens,

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make capital expenditures,

enter into transactions with our stockholders and affiliates,

sell certain assets,

acquire the assets of, or merge or consolidate with, other companies, and

incur restrictions on the ability of our subsidiaries to make distributions or transfer assets to us.

Our ability to comply with these covenants may be affected by events beyond our control, and any material deviations from our forecasts could require us to seek waivers or amendments of covenants, alternative sources of financing or reductions in expenditures. We cannot assure you that such waivers, amendments or alternative financings could be obtained, or, if obtained, would be on terms acceptable to us.

In addition, the credit agreement governing our senior secured credit facility requires us to meet certain financial ratios and restricts our ability to make capital expenditures or prepay certain other debt. We may not be able to maintain these ratios, and the restrictions could limit our ability to plan for or react to market conditions or meet extraordinary capital needs or otherwise restrict corporate activities.

If a breach of any covenant or restriction contained in our financing agreements results in an event of default, those lenders could discontinue lending, accelerate the related debt (which would accelerate other debt) and declare all borrowings outstanding thereunder to be due and payable. In addition, the lenders could terminate any commitments they had made to supply us with additional funds. In the event of an acceleration of our debt, we may not have or be able to obtain sufficient funds to make any accelerated debt payments.

Our obligations under our senior secured credit facility are secured by substantially all of our assets.

Our obligations under our senior secured credit facility are secured by liens on substantially all of our assets, and the guarantees of our subsidiaries under our senior secured credit facility are secured by liens on substantially all of those subsidiaries' assets. If we become insolvent or are liquidated, or if payment under our senior secured credit facility or of other secured obligations is accelerated, the lenders under our senior secured credit facility or the obligees with respect to the other secured obligations will be entitled to exercise the remedies available to a secured lender under applicable law and the applicable agreements and instruments, including the right to foreclose on all of our assets.

Volatility and disruption of financial markets could affect access to credit.

The current economic market environment has caused contraction in the availability of credit in the marketplace. This could potentially reduce our sources of liquidity. While there have not been changes to date regarding our ability to access credit under our revolving credit facility or additional borrowings under our senior secured facility, future volatility could have a negative impact on our financial position and performance which could put us in default of the credit conditions and impact our ability to access credit. Additionally, future volatility and financial market disruptions could impact the creditor's ability to honor the terms of our credit agreements.

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Risk Factors Related to Our Business

We could be subject to lawsuits for which we are not fully reserved.

In recent years, physicians, hospitals and other participants in the healthcare industry have become subject to an increasing number of lawsuits alleging medical malpractice and related legal theories such as negligent hiring, supervision and credentialing. Similarly, ambulance transport services may result in lawsuits concerning vehicle collisions and personal injuries, patient care incidents or mistreatment and employee job-related injuries. Some of these lawsuits may involve large claim amounts and substantial defense costs.

EmCare procures professional liability insurance coverage for most of its affiliated medical professionals and professional and corporate entities. Beginning January 1, 2002, this insurance coverage has been provided by affiliates of CNA Insurance Company, which then reinsures the entire program, primarily through EmCare's wholly-owned subsidiary, EMCA Insurance Company, Ltd., or EMCA. Workers compensation coverage for EmCare's employees and applicable affiliated medical professionals is provided under a similar structure for the period through August 31, 2007. From September 1, 2004 to the closing date of our acquisition of AMR and EmCare, AMR obtained insurance coverage for losses with respect to workers compensation, auto and general liability claims through Laidlaw's captive insurance program. In 2007, AMR transferred the Laidlaw insurance coverage to an insurance subsidiary of AIG and currently has a self-insurance program fronted by an unrelated third party for all of its insurance programs subsequent to September 1, 2001. AMR retains the risk of loss under this coverage. Under these insurance programs, we establish reserves, using actuarial estimates, for all losses covered under the policies. Moreover, in the normal course of our business, we are involved in lawsuits, claims, audits and investigations, including those arising out of our billing and marketing practices, employment disputes, contractual claims and other business disputes for which we may have no insurance coverage, and which are not subject to actuarial estimates. The outcome of these matters could have a material effect on our results of operations in the period when we identify the matter, and the ultimate outcome could have a material adverse effect on our financial position, results of operations, or cash flows.

Our liability to pay for EmCare's insurance program losses is collateralized by funds held through EMCA and, to the extent these losses exceed the collateral and assets of EMCA or the limits of our insurance policies, will have to be funded by us. Should our AMR losses with respect to such claims exceed the collateral held by AMR's insurance providers in connection with our self-insurance program or the limits of our insurance policies, we will have to fund such amounts. See Item 1, "Business American Medical Response Insurance" and "Business EmCare Insurance."

We are subject to a variety of federal, state and local laws and regulatory regimes, including a variety of labor laws and regulations. Failure to comply with laws and regulations could subject us to, among other things, penalties and legal expenses which could have a materially adverse effect on our business.

We are subject to various federal, state, and local laws and regulations including, but not limited to ERISA, and regulations promulgated by the Internal Revenue Service, the United States Department of Labor and the Occupational Safety and Health Administration. We are also subject to a variety of federal and state employment and labor laws and regulations, including the Americans with Disabilities Act, the Federal Fair Labor Standards Act, the Worker Adjustment and Restructuring Notification Act, or WARN Act, and other regulations related to working conditions, wage-hour pay, overtime pay, family leave, employee benefits, antidiscrimination, termination of employment, safety standards and other workplace regulations.

Failure to properly adhere to these and other applicable laws and regulations could result in investigations, the imposition of penalties or adverse legal judgments by public or private plaintiffs, and our business, financial condition and results of operations could be materially adversely affected.

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Similarly, our business, financial condition and results of operations could be materially adversely affected by the cost of complying with newly-implemented laws and regulations.

In addition, from time to time we have received, and expect to continue to receive, correspondence from former employees terminated by us who threaten to bring claims against us alleging that we have violated one or more labor and employment regulations. In certain instances former employees have brought claims against us and we expect that we will encounter similar actions against us in the future. An adverse outcome in any such litigation could require us to pay contractual damages, compensatory damages, punitive damages, attorneys' fees and costs.

The reserves we establish with respect to our losses covered under our insurance programs are subject to inherent uncertainties.

In connection with our insurance programs, we establish reserves for losses and related expenses, which represent estimates involving actuarial and statistical projections, at a given point in time, of our expectations of the ultimate resolution and administration costs of losses we have incurred in respect of our liability risks. Insurance reserves inherently are subject to uncertainty. Our reserves are based on historical claims, demographic factors, industry trends, severity and exposure factors and other actuarial assumptions calculated by an independent actuary firm. The independent actuary firm performs studies of projected ultimate losses on an annual basis and provides quarterly updates to those projections. We use these actuarial estimates to determine appropriate reserves. Our reserves could be significantly affected if current and future occurrences differ from historical claim trends and expectations. While we monitor claims closely when we estimate reserves, the complexity of the claims and the wide range of potential outcomes may hamper timely adjustments to the assumptions we use in these estimates. Actual losses and related expenses may deviate, individually and in the aggregate, from the reserve estimates reflected in our financial statements. If we determine that our estimated reserves are inadequate, we will be required to increase reserves at the time of the determination, which would result in a reduction in our net income in the period in which the deficiency is determined. See Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Policies Claims Liability and Professional Liability Reserves" and note 15 of the notes to our financial statements included in Item 8.

Insurance coverage for some of our losses may be inadequate and may be subject to the credit risk of commercial insurance companies.

Some of our insurance coverage, for periods prior to the initiation of our self-insurance programs as well as portions of our current insurance coverage, is through various third party insurers. To the extent we hold policies to cover certain groups of claims or rely on insurance coverage obtained by third parties to cover such claims, but either we or such third parties did not obtain sufficient insurance limits, did not buy an extended reporting period policy, where applicable, or the issuing insurance company is unable or unwilling to pay such claims, we may be responsible for those losses. Furthermore, for our losses that are insured or reinsured through commercial insurance companies, we are subject to the "credit risk" of those insurance companies. While we believe our commercial insurance company providers currently are creditworthy, there can be no assurance that such insurance companies will remain so in the future.

Volatility in current market conditions could negatively impact insurance collateral balances and result in additional funding requirements.

Our insurance collateral is comprised principally of government and investment grade securities and cash deposits with third parties. The recent volatility experienced in the market has not had a material impact to our financial position or performance. Future volatility could, however, negatively impact the insurance collateral balances and result in additional funding requirements.

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We are subject to decreases in our revenue and profit margin under our fee-for-service contracts, where we bear the risk of changes in volume, payor mix and third party reimbursement rates.

In our fee-for-service arrangements, which generated approximately 82% of our net revenue for the year ended December 31, 2009, we, or our affiliated physicians, collect the fees for transports and physician services. Under these arrangements, we assume financial risks related to changes in the mix of insured and uninsured patients and patients covered by government-sponsored healthcare programs, third party reimbursement rates and transports and patient volume. In some cases our revenue decreases if our volume or reimbursement decreases, but our expenses may not decrease proportionately. See " Risk Factors Related to Healthcare Regulation Changes in the rates or methods of third party reimbursements may adversely affect our revenue and operations." In addition, fee-for-service contracts have less favorable cash flow characteristics in the start-up phase than traditional flat-rate contracts due to longer collection periods.

We collect a smaller portion of our fees for services rendered to uninsured patients than for services rendered to insured patients. Our credit risk related to services provided to uninsured individuals is exacerbated because the law requires communities to provide 911 emergency response services and hospital emergency departments to treat all patients presenting to the emergency department seeking care for an emergency medical condition regardless of their ability to pay. We also believe uninsured patients are more likely to seek care at hospital emergency departments because they frequently do not have a primary care physician with whom to consult.

We may not be able to successfully recruit and retain physicians and other healthcare professionals with the qualifications and attributes desired by us and our customers.

Our ability to recruit and retain affiliated physicians and other healthcare professionals significantly affects our performance under our contracts. In the recent past, our customer hospitals have increasingly demanded a greater degree of specialized skills, training and experience in the healthcare professionals providing services under their contracts with us. This decreases the number of healthcare professionals who may be permitted to staff our contracts. Moreover, because of the scope of the geographic and demographic diversity of the hospitals and other facilities with which we contract, we must recruit healthcare professionals, and particularly physicians, to staff a broad spectrum of contracts. We have had difficulty in the past recruiting physicians to staff contracts in some regions of the country and at some less economically advantaged hospitals. Moreover, we compete with other entities to recruit and retain qualified physicians and other healthcare professionals to deliver clinical services. Our future success in retaining and winning new hospital contracts depends on our ability to recruit and retain healthcare professionals to maintain and expand our operations.

Our non-compete agreements and other restrictive covenants involving physicians may not be enforceable.

We have contracts with physicians and professional corporations in many states. Some of these contracts, as well as our contracts with hospitals, include provisions preventing these physicians and professional corporations from competing with us both during and after the term of our relationship with them. The law governing non-compete agreements and other forms of restrictive covenants varies from state to state. Some states are reluctant to strictly enforce non-compete agreements and restrictive covenants applicable to physicians. There can be no assurance that our non-compete agreements related to affiliated physicians and professional corporations will not be successfully challenged as unenforceable in certain states. In such event, we would be unable to prevent former affiliated physicians and professional corporations from competing with us, potentially resulting in the loss of some of our hospital contracts.

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We are required to make significant capital expenditures for our ambulance services business in order to remain competitive.

Our capital expenditure requirements primarily relate to maintaining and upgrading our vehicle fleet and medical equipment to serve our customers and remain competitive. The aging of our vehicle fleet requires us to make regular capital expenditures to maintain our current level of service. Our capital expenditures totaled \$45 million, \$32 million, and \$38 million in the years ended December 31, 2009, 2008, and 2007, respectively. In addition, changing competitive conditions or the emergence of any significant advances in medical technology could require us to invest significant capital in additional equipment or capacity in order to remain competitive. If we are unable to fund any such investment or otherwise fail to invest in new vehicles or medical equipment, our business, financial condition or results of operations could be materially and adversely affected.

We depend on our senior management and may not be able to retain those employees or recruit additional qualified personnel.

We depend on our senior management. The loss of services of any of the members of our senior management could adversely affect our business until a suitable replacement can be found. There may be a limited number of persons with the requisite skills to serve in these positions, and we cannot assure you that we would be able to identify or employ such qualified personnel on acceptable terms.

Our revenue would be adversely affected if we lose existing contracts.

A significant portion of our growth historically has resulted from increases in the number of emergency and non-emergency transports, and the number of patient encounters and fees for services we provide under existing contracts, and the addition of new contracts. Substantially all of our net revenue in the year ended December 31, 2009 was generated under contracts, including exclusive contracts that accounted for approximately 90% of our 2009 net revenue. Our contracts with hospitals generally have terms of three years and the term of our contracts with communities to provide 911 services generally ranges from three to five years. Most of our contracts are terminable by either of the parties upon notice of as little as 30 days. Any of our contracts may not be renewed or, if renewed, may contain terms that are not as favorable to us as our current contracts. We cannot assure you that we will be successful in retaining our existing contracts or that any loss of contracts would not have a material adverse effect on our business, financial condition and results of operations. Furthermore, certain of our contracts will expire during each fiscal period, and we may be required to seek renewal of these contracts through a formal bidding process that often requires written responses to a Request for Proposal, or RFP. We cannot assure you that we will be successful in retaining such contracts or that we will retain them on terms that are as favorable as present terms.

We may not accurately assess the costs we will incur under new contracts.

Our new contracts increasingly involve a competitive bidding process. When we obtain new contracts, we must accurately assess the costs we will incur in providing services in order to realize adequate profit margins and otherwise meet our financial and strategic objectives. Increasing pressures from healthcare payors to restrict or reduce reimbursement rates at a time when the costs of providing medical services continue to increase make assessing the costs associated with the pricing of new contracts, as well as maintenance of existing contracts, more difficult. In addition, integrating new contracts, particularly those in new geographic locations, could prove more costly, and could require more management time, than we anticipate. Our failure to accurately predict costs or to negotiate an adequate profit margin could have a material adverse effect on our business, financial condition and results of operations.

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The high level of competition in our segments of the market for emergency medical services could adversely affect our contract and revenue base.

AMR. The market for providing ambulance transport services to municipalities, other healthcare providers and third party payors is highly competitive. In providing ambulance transport services, we compete with governmental entities, including cities and fire districts, hospitals, local and volunteer private providers, and with several large national and regional providers, such as Rural/Metro Corporation, Southwest Ambulance and Acadian Ambulance. In many communities, our most important competitors are the local fire departments, which in many cases have acted traditionally as the first response providers during emergencies, and have been able to expand their scope of services to include emergency ambulance transport and do not wish to give up their franchises to a private competitor.

EmCare. The market for providing outsourced physician staffing and related management services to hospitals and clinics is highly competitive. Such competition could adversely affect our ability to obtain new contracts, retain existing contracts and increase or maintain profit margins. We compete with both national and regional enterprises such as Team Health, Hospital Physician Partners, Schumacher Group, California Emergency Physicians and National Emergency Services Healthcare Group, some of which may have greater financial and other resources available to them, greater access to physicians and/or greater access to potential customers. We also compete against local physician groups and self-operated facility-based physician services departments for satisfying staffing and scheduling needs.

Our business depends on numerous complex information systems, and any failure to successfully maintain these systems or implement new systems could materially harm our operations.

We depend on complex, integrated information systems and standardized procedures for operational and financial information and our billing operations. We may not have the necessary resources to enhance existing information systems or implement new systems where necessary to handle our volume and changing needs. Furthermore, we may experience unanticipated delays, complications and expenses in implementing, integrating and operating our systems, including the integration of our AMR and EmCare systems. Any interruptions in operations during periods of implementation would adversely affect our ability to properly allocate resources and process billing information in a timely manner, which could result in customer dissatisfaction and delayed cash flow. We also use the development and implementation of sophisticated and specialized technology to differentiate our services from our competitors and improve our profitability. The failure to successfully implement and maintain operational, financial and billing information systems could have an adverse effect on our ability to obtain new business, retain existing business and maintain or increase our profit margins.

If we fail to implement our business strategy, our financial performance and our growth could be materially and adversely affected.

Our future financial performance and success are dependent in large part upon our ability to implement our business strategy successfully. Our business strategy envisions several initiatives, including increasing revenue from existing customers, growing our customer base, expanding our existing service lines, pursuing select acquisitions, implementing cost rationalization initiatives, focusing on risk mitigation and utilizing technology to differentiate our services and improve profitability. We may not be able to implement our business strategy successfully or achieve the anticipated benefits of our business plan. If we are unable to do so, our long-term growth and profitability may be adversely affected. Even if we are able to implement some or all of the initiatives of our business plan successfully, our operating results may not improve to the extent we anticipate, or at all.

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Implementation of our business strategy could also be affected by a number of factors beyond our control, such as increased competition, legal developments, government regulation, general economic conditions or increased operating costs or expenses. In addition, to the extent we have misjudged the nature and extent of industry trends or our competition, we may have difficulty in achieving our strategic objectives. Any failure to implement our business strategy successfully may adversely affect our business, financial condition and results of operations and thus our ability to service our debt. In addition, we may decide to alter or discontinue certain aspects of our business strategy at any time.

A successful challenge by tax authorities to our treatment of certain physicians as independent contractors and to our tax elections could require us to pay past taxes and penalties.

As of December 31, 2009, we contracted with approximately 3,330 physicians as independent contractors to fulfill our contractual obligations to customers. Because we treat them as independent contractors rather than as employees, we do not (i) withhold federal or state income or other employment related taxes from the compensation that we pay to them, (ii) make federal or state unemployment tax or Federal Insurance Contributions Act payments (except as described below), (iii) provide workers compensation insurance with respect to such affiliated physicians (except in states that require us to do so even for independent contractors), or (iv) allow them to participate in benefits and retirement programs available to employed physicians. Our contracts with our independent contractor physicians obligate these physicians to pay these taxes and other costs. Whether these physicians are properly classified as independent contractors depends upon the facts and circumstances of our relationship with them. It is possible that the nature of our relationship with these physicians would support a challenge to our classification of them. If such a challenge by federal or state taxing authorities were successful, and the physicians at issue were instead treated as employees, we could be adversely affected and liable for past taxes and penalties to the extent that the physicians did not fulfill their contractual obligations to pay those taxes. Under current federal tax law, however, even if our treatment were successfully challenged, if our current treatment were found to be consistent with a long-standing practice of a significant segment of our industry and we meet certain other requirements, it is possible, but not certain, that our treatment of the physicians would qualify under a "safe harbor" and, consequently, we would be protected from the imposition of past taxes and penalties. In the recent past, however, there have been proposals to eliminate the safe harbor and similar proposals could be made in the future.

We have made certain elections for income tax purposes and recorded related tax deductions that while we feel are probable of being upheld, may be challenged by the taxing authorities.

We may make acquisitions which could divert the attention of management and which may not be integrated successfully into our existing business.

We may pursue acquisitions to increase our market penetration, enter new geographic markets and expand the scope of services we provide. We cannot assure you that we will identify suitable acquisition candidates, that acquisitions will be completed on acceptable terms, that our due diligence process will uncover all potential liabilities or issues affecting our integration process, or that we will be able to integrate successfully the operations of any acquired business into our existing business. Furthermore, acquisitions into new geographic markets and services may require us to comply with new and unfamiliar legal and regulatory requirements, which could impose substantial obligations on us and our management, cause us to expend additional time and resources, and increase our exposure to penalties or fines for non-compliance with such requirements. The acquisitions could be of significant size and involve operations in multiple jurisdictions. The acquisition and integration of another business would divert management attention from other business activities. This diversion, together with other difficulties we may incur in integrating an acquired business, could have a material adverse effect on our business, financial condition and results of operations. In addition, we may borrow money or issue

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capital stock to finance acquisitions. Such borrowings might not be available on terms as favorable to us as our current borrowing terms and may increase our leverage, and the issuance of capital stock could dilute the interests of our stockholders.

If Laidlaw is unwilling or unable to satisfy any indemnification claims made by us pursuant to the purchase agreements relating to the acquisition of AMR and EmCare, we will be forced to satisfy such claims ourselves.

Laidlaw has agreed to indemnify us for certain claims or legal actions brought against us arising out of the operations of AMR and EmCare prior to the closing date of the acquisition. If we make a claim against Laidlaw, and Laidlaw is unwilling or unable to satisfy such claim, we would be required to satisfy the claim ourselves and, as a result, our financial condition may be adversely affected.

Many of our employees are represented by labor unions and any work stoppage could adversely affect our business.

Approximately 45% of AMR's employees are represented by 39 collective bargaining agreements. A total of 22 collective bargaining agreements, representing approximately 2,300 employees, are subject to renegotiation in 2010. Although we believe our relations with our employees are good, we cannot assure you that we will be able to negotiate a satisfactory renewal of these collective bargaining agreements or that our employee relations will remain stable.

Our consolidated revenue and earnings could vary significantly from period to period due to our national contract with the Federal Emergency Management Agency.

Our revenue and earnings under our national contract with FEMA are likely to vary significantly from period to period. In the first three years of the FEMA contract, our annual revenues from services rendered under this contract have varied by approximately \$104 million. In its present form, the contract generates revenue for us only in the event of a national emergency and then only if FEMA exercises its broad discretion to order a deployment. Our FEMA revenue therefore depends largely on circumstances outside of our control. We therefore cannot predict the revenue and earnings, if any, we may generate in any given period from our FEMA contract. This may lead to increased volatility in our actual revenue and earnings period to period.

We may be required to enter into large scale deployment of resources in response to a national emergency under our contract with FEMA, which may divert management attention and resources.

We do not believe that a FEMA deployment adversely affects our ability to service our local 911 contracts. However, any significant FEMA deployment requires significant management attention and could reduce our ability to pursue other local transport opportunities, such as inter-facility transports, and to pursue new business opportunities, which could have an adverse effect on our business and results of operations.

Risk Factors Related to Healthcare Regulation

We conduct business in a heavily regulated industry and if we fail to comply with these laws and government regulations, we could incur penalties or be required to make significant changes to our operations.

The healthcare industry is heavily regulated and closely scrutinized by federal, state and local governments. Comprehensive statutes and regulations govern the manner in which we provide and bill for services, our contractual relationships with our physicians, vendors and customers, our marketing activities and other aspects of our operations. Failure to comply with these laws can result in civil and criminal penalties such as fines, damages and exclusion from the Medicare and Medicaid programs. The risk of our being found in violation of these laws and regulations is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions

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are sometimes open to a variety of interpretations. Any action against us for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses and divert our management's attention from the operation of our business.

Our practitioners and our customers are also subject to ethical guidelines and operating standards of professional and trade associations and private accreditation agencies. Compliance with these guidelines and standards is often required by our contracts with our customers or to maintain our reputation.

The laws, regulations and standards governing the provision of healthcare services may change significantly in the future. We cannot assure you that any new or changed healthcare laws, regulations or standards will not materially adversely affect our business. We cannot assure you that a review of our business by judicial, law enforcement, regulatory or accreditation authorities will not result in a determination that could adversely affect our operations.

We are subject to comprehensive and complex laws and rules that govern the manner in which we bill and are paid for our services by third party payors, and the failure to comply with these rules, or allegations that we have failed to do so, can result in civil or criminal sanctions, including exclusion from federal and state healthcare programs.

Like most healthcare providers, the majority of our services are paid for by private and governmental third party payors, such as Medicare and Medicaid. These third party payors typically have differing and complex billing and documentation requirements that we must meet in order to receive payment for our services. Reimbursement to us is typically conditioned on our providing the correct procedure and diagnostic codes and properly documenting the services themselves, including the level of service provided, the medical necessity for the services, the site of service and the identity of the practitioner who provided the service.

We must also comply with numerous other laws applicable to our documentation and the claims we submit for payment, including but not limited to (1) "coordination of benefits" rules that dictate which payor we must bill first when a patient has potential coverage from multiple payors; (2) requirements that we obtain the signature of the patient or patient representative, or, in certain cases, the documentation, prior to submitting a claim; (3) requirements that we make repayment to any payor which pays us more than the amount to which we are entitled; (4) requirements that we bill a hospital or nursing home, rather than Medicare, for certain ambulance transports provided to Medicare patients of such facilities; (5) "reassignment" rules governing our ability to bill and collect professional fees on behalf of our physicians; (6) requirements that our electronic claims for payment be submitted using certain standardized transaction codes and formats; and (7) laws requiring us to handle all health and financial information of our patients in a manner that complies with specified security and privacy standards. See Item 1, "Business Regulatory Matters Medicare, Medicaid and Other Government Reimbursement Programs."

Governmental and private third party payors and other enforcement agencies carefully audit and monitor our compliance with these and other applicable rules, and in some cases in the past have found that we were not in compliance. We have received in the past, and expect to receive in the future, repayment demands from third party payors based on allegations that our services were not medically necessary, were billed at an improper level, or otherwise violated applicable billing requirements. See Item 3, "Legal Proceedings." Our failure to comply with the billing and other rules applicable to us could result in non-payment for services rendered or refunds of amounts previously paid for such services. In addition, non-compliance with these rules may cause us to incur civil and criminal penalties, including fines, imprisonment and exclusion from government healthcare programs such as Medicare and Medicaid, under a number of state and federal laws. These laws include the federal False Claims Act, the Civil Monetary Penalties Law, the Health Insurance Portability and

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Accountability Act of 1996, the federal Anti-Kickback Statute, the Balanced Budget Act of 1997, the federal Deficit Reduction Act of 2005, ARRA, and other provisions of federal, state and local law. The federal False Claims Act was recently amended in a manner which makes it easier for the government to demonstrate that a violation has occurred.

In addition, from time to time we self-identify practices that may have resulted in Medicare or Medicaid overpayments or other regulatory issues. For example, we have previously identified situations in which we may have inadvertently utilized incorrect billing codes for some of the services we have billed to government programs such as Medicare or Medicaid. In such cases, if appropriate, it is our practice to disclose the issue to the affected government programs and to refund any resulting overpayments. Although the government usually accepts such disclosures and repayments without taking further enforcement action, it is possible that such disclosures or repayments will result in allegations by the government that we have violated the False Claims Act or other laws, leading to investigations and possibly civil or criminal enforcement actions. See Item 1, "Business Regulatory Matters Corporate Compliance Program and Corporate Integrity Obligations."

If our operations are found to be in violation of these or any of the other laws which govern our activities, any resulting penalties, damages, fines or other sanctions could adversely affect our ability to operate our business and our financial results. See Item 1, "Business Regulatory Matters Federal False Claims Act" and "Business Other Healthcare Fraud and Abuse Laws."

Under recently enacted amendments to federal privacy law, we are subject to more stringent penalties in the event we improperly use or disclose protected health information regarding our patients.

The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, required the Department of Health and Human Services, or HHS, to adopt standards to protect the privacy and security of certain health-related information. The HIPAA privacy regulations contain detailed requirements concerning the use and disclosure of individually identifiable health information by "covered entities," which include AMR and EmCare.

In addition to the privacy requirements, HIPAA covered entities must implement certain administrative, physical, and technical security standards to protect the integrity, confidentiality and availability of certain electronic health information received, maintained, or transmitted. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was enacted as part of the ARRA, significantly expands the scope of the privacy and security requirements under HIPAA and increases penalties for violations. Prior to the HITECH Act, the focus of HIPAA enforcement was on resolution of alleged non-compliance through voluntary corrective action without fines or penalties in most cases. That focus changed under the HITECH Act, which now imposes mandatory penalties for violations of HIPAA that are due to "willful neglect." For violations due to willful neglect, penalties start at \$10,000 and are not to exceed \$250,000. For violations due to willful neglect that are not corrected, penalties start at \$50,000 and are not to exceed \$1.5 million. For violations based on reasonable cause, penalties start at \$1,000 per violation and are not to exceed \$100,000. For violations determined to be made without knowledge, penalties start at \$100 per violation and are not to exceed \$25,000. The HITECH Act specifically allows the Office for Civil Rights (OCR) to continue to use corrective action without a penalty, but only in situations where the violation was made without knowledge. The HITECH Act also authorizes state attorneys general to file suit on behalf of their residents. Courts will be able to award damages, costs, and attorneys' fees related to violations of HIPAA in such cases.

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The HITECH Act and implementing regulations enacted by HHS further requires that patients be notified of any unauthorized acquisition, access, use, or disclosure of their unsecured protected health information ("Unsecured PHI") that compromises the privacy or security of such information, with some exceptions related to unintentional or inadvertent use or disclosure by employees or authorized individuals within the "same facility." The HITECH Act and implementing regulations specify that such notifications must be made "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach." If a breach affects 500 patients or more, it must be reported immediately to HHS, which will post the name of the breaching entity on its public web site. Breaches affecting 500 patients or more in the same state or jurisdiction must be reported to the local media. If a breach involves fewer than 500 people, the covered entity must record it in a log and notify HHS at least annually. The security breach notification requirements apply not only to unauthorized disclosures of Unsecured PHI to outside third parties, but also to unauthorized internal access to such PHI. This means that unauthorized employee "snooping" into medical records could trigger the notification requirements. These security breach notification requirements became effective on September 23, 2009, but HHS has indicated it will not exercise its enforcement discretion and will not impose sanctions for failure to provide notifications for breaches occurring prior to February 22, 2010.

Many states in which we operate also have laws that protect the privacy and security of confidential, personal information. These laws may be similar to or even more protective than the federal provisions. Not only may some of these state laws impose fines and penalties upon violators, but some may afford private rights of action to individuals who believe their personal information has been misused. California's patient privacy laws, for example, provide for penalties of up to \$250,000 and permit injured parties to sue for damages.

Changes in the healthcare industry and in healthcare spending may adversely affect our revenue.

Almost all of our revenue is either from the healthcare industry or could be affected by changes in healthcare spending. The healthcare industry is subject to changing political, regulatory and other influences. National healthcare reform is currently a major focus at the federal level, and congressional leaders may pass reform legislation during 2010. Among other things, healthcare reform may increase governmental involvement in healthcare, lower reimbursement rates or otherwise change the environment in which healthcare industry constituents operate. Healthcare industry constituents may respond by reducing their expenditures or postponing expenditure decisions, including expenditures for our services.

If we are unable to timely enroll our providers in the Medicare program, our collections and revenue will be harmed.

In the 2009 Medicare Physician Fee Schedule, or MPFS, CMS substantially reduced the time within which providers can retrospectively bill Medicare for services provided by such providers from 27 months prior to the effective date of the enrollment to 30 days prior to the effective date of the enrollment. In addition, the new enrollment rules set forth in the 2009 MPFS also provide that the effective date of the enrollment will be the later of the date on which the enrollment was filed and approved by the Medicare contractor, or the date on which the provider began providing services. If we are unable to properly enroll physicians and midlevel providers within the 30 days after the provider begins providing services, we will be precluded from billing Medicare for any services which were provided to a Medicare beneficiary more than 30 days prior to the effective date of the enrollment. Such failure to timely enroll providers could have a material adverse effect on our business, financial condition or results of operations.

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Changes in the rates or methods of third party reimbursements may adversely affect our revenue and operations.

We derive a majority of our revenue from direct billings to patients and third party payors such as Medicare, Medicaid and private health insurance companies. As a result, any changes in the rates or methods of reimbursement for the services we provide could have a significant adverse impact on our revenue and financial results. Healthcare reform legislation currently pending in Congress could result in substantial cuts in Medicare and Medicaid coverage and/or funding, as well as reductions in coverage and/or amounts paid by private payors, which could have an adverse impact on our revenues from those sources.

Government funding for healthcare programs is subject to statutory and regulatory changes, administrative rulings, interpretations of policy and determinations by intermediaries and governmental funding restrictions, all of which could materially impact program coverage and reimbursements for both ambulance and physician services. In recent years, Congress has consistently attempted to curb spending on Medicare, Medicaid and other programs funded in whole or part by the federal government. State and local governments have also attempted to curb spending on those programs for which they are wholly or partly responsible. This has resulted in cost containment measures such as the imposition of new fee schedules that have lowered reimbursement for some of our services and restricted the rate of increase for others, and new utilization controls that limit coverage of our services. For example, we estimate that the impact of a national fee schedule promulgated in 2002, as modified by subsequent legislation, resulted in a decrease in AMR's net revenue of approximately \$7 million in 2007, an increase in AMR's net revenue of approximately \$14 million in 2008, and an increase in AMR's net revenue of approximately \$24 million in 2009. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential decrease in AMR's net revenue of approximately \$30 million in 2010. Legislation is currently pending in Congress that would mitigate approximately 30% of this decrease. As another example, the 2010 Medicare Physician Fee Schedule Rule recently released by CMS will result in a 21.2% decrease in fee schedule amounts paid by Medicare for physician services unless Congress enacts legislation blocking the reduction, as it has done in previous years. Legislation is currently pending in Congress that would again replace this reduction with a small increase and would also modify the methodology CMS currently uses to calculate annual fee updates for physicians. See Item 1, "Business Regulatory Matters Medicare, Medicaid and Other Government Reimbursement Programs."

In addition, state and local government regulations or administrative policies regulate ambulance rate structures in some jurisdictions in which we conduct transport services. We may be unable to receive ambulance service rate increases on a timely basis where rates are regulated, or to establish or maintain satisfactory rate structures where rates are not regulated.

We believe that regulatory trends in cost containment will continue. We cannot assure you that we will be able to offset reduced operating margins through cost reductions, increased volume, the introduction of additional procedures or otherwise. In addition, we cannot assure you that federal, state and local governments will not impose reductions in the fee schedules or rate regulations applicable to our services in the future. Any such reductions could have a material adverse effect on our business, financial condition and results of operations.

If current or future laws or regulations force us to restructure our arrangements with physicians, professional corporations and hospitals, we may incur additional costs, lose contracts and suffer a reduction in net revenue under existing contracts, and we may need to refinance our debt or obtain debt holder consent.

A number of laws bear on our contractual relationships with our physicians. There is a risk that state authorities in some jurisdictions may find that these contractual relationships violate laws prohibiting the corporate practice of medicine and fee-splitting prohibitions. These laws prohibit the

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practice of medicine by general business corporations and are intended to prevent unlicensed persons or entities from interfering with or inappropriately influencing the physician's professional judgment. They may also prevent the sharing of professional services income with non-professional or business interests. From time to time, including recently, we have been involved in litigation in which private litigants have raised these issues. See Item 1, "Business Regulatory Matters Fee-Splitting; Corporate Practice of Medicine."

Our physician contracts include contracts with individual physicians and with physicians organized as separate legal professional entities (e.g., professional medical corporations). Antitrust laws may deem each such physician/entity to be separate, both from EmCare and from each other and, accordingly, each such physician/practice is subject to a wide range of laws that prohibit anti-competitive conduct between or among separate legal entities or individuals. A review or action by regulatory authorities or the courts could force us to terminate or modify our contractual relationships with physicians and affiliated medical groups or revise them in a manner that could be materially adverse to our business. See Item 1, "Business Regulatory Matters Antitrust Laws."

Various licensing and certification laws, regulations and standards apply to us, our affiliated physicians and our relationships with our affiliated physicians. Failure to comply with these laws and regulations could result in our services being found to be non-reimbursable or prior payments being subject to recoupment, and can give rise to civil or criminal penalties. We are pursuing steps we believe we must take to retain or obtain all requisite licensure and operating authorities. While we have made reasonable efforts to substantially comply with federal, state and local licensing and certification laws and regulations and standards as we interpret them, we cannot assure you that agencies that administer these programs will not find that we have failed to comply in some material respects.

EmCare's professional liability insurance program, under which insurance is provided for most of our affiliated medical professionals and professional and corporate entities, is reinsured through our wholly-owned subsidiary, EMCA Insurance Company, Ltd. The activities associated with the business of insurance, and the companies involved in such activities, are closely regulated. Failure to comply with the laws and regulations can result in civil and criminal fines and penalties and loss of licensure. While we have made reasonable efforts to substantially comply with these laws and regulations, and utilize licensed insurance professionals where necessary or appropriate, we cannot assure you that we will not be found to have violated these laws and regulations in some material respects.

Adverse judicial or administrative interpretations could result in a finding that we are not in compliance with one or more of these laws and rules that affect our relationships with our physicians.

These laws and rules, and their interpretations, may also change in the future. Any adverse interpretations or changes could force us to restructure our relationships with physicians, professional corporations or our hospital customers, or to restructure our operations. This could cause our operating costs to increase significantly. A restructuring could also result in a loss of contracts or a reduction in revenue under existing contracts. Moreover, if we are required to modify our structure and organization to comply with these laws and rules, our financing agreements may prohibit such modifications and require us to obtain the consent of the holders of such debt or require the refinancing of such debt.

Our contracts with healthcare facilities and marketing practices are subject to the federal Anti-Kickback Statute, and we entered into a settlement in 2006 for alleged violations of that statute.

We are subject to the federal Anti-Kickback Statute, which prohibits the knowing and willful offer, payment, solicitation or receipt of any form of "remuneration" in return for, or to induce, the referral of business or ordering of services paid for by Medicare or other federal programs. "Remuneration" potentially includes discounts and in-kind goods or services, as well as cash. Certain federal courts have held that the Anti-Kickback Statute can be violated if "one purpose" of a payment is to induce referrals. Violations of the Anti-Kickback Statute can result in imprisonment, civil or criminal fines or exclusion from Medicare and other governmental programs.

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In 1999, the Office of Inspector General of the Department of Health and Human Services, or the OIG, issued an Advisory Opinion indicating that discounts provided to health facilities on the transports for which they are financially responsible potentially violate the Anti-Kickback Statute when the ambulance company also receives referrals of Medicare and other government-funded transports from the facility. The OIG has clarified that not all discounts violate the Anti-Kickback Statute, but that the statute may be violated if part of the purpose of the discount is to induce the referral of the transports paid for by Medicare or other federal programs, and the discount does not meet certain "safe harbor" conditions. In the Advisory Opinion and subsequent pronouncements, the OIG has provided guidance to ambulance companies to help them avoid unlawful discounts. See Item 1, "Business Regulatory Matters Federal Anti-Kickback Statute."

Like other ambulance companies, we have provided discounts to our healthcare facility customers (nursing home and hospital) in certain circumstances. We have attempted to comply with applicable law when such discounts are provided. However, the government alleged that certain of our hospital and nursing home contracts in effect in Texas in periods prior to 2002 contained discounts in violation of the federal Anti-Kickback Statute, and in 2006 we entered into a settlement with the government regarding these allegations. The settlement included a CIA.

There can be no assurance that other investigations or legal action related to our contracting practices will not be pursued against AMR in other jurisdictions or for different time frames. See Item 1, "Business American Medical Response Legal Matters." If we are found to have violated the Anti-Kickback Statute, we may be subject to civil or criminal penalties, including exclusion from the Medicare or Medicaid programs, or may be required to enter into settlement agreements with the government to avoid such sanctions. Typically, such settlement agreements require substantial payments to the government in exchange for the government to release its claims, and may also require us to enter into a CIA. See Item 1, "Business Regulatory Matters Corporate Compliance Program and Corporate Integrity Obligations."

In addition to AMR's contracts with healthcare facilities, other marketing practices or transactions entered into by AMR and EmCare may implicate the Anti-Kickback Statute. Although we have attempted to structure our past and current marketing initiatives and business relationships to comply with the Anti-Kickback Statute, we cannot assure you that the OIG or other authorities will not find that our marketing practices and relationships violate the statute.

Changes in our ownership structure and operations require us to comply with numerous notification and reapplication requirements in order to maintain our licensure, certification or other authority to operate, and failure to do so, or an allegation that we have failed to do so, can result in payment delays, forfeiture of payment or civil and criminal penalties.

We and our affiliated physicians are subject to various federal, state and local licensing and certification laws with which we must comply in order to maintain authorization to provide, or receive payment for, our services. For example, Medicare and Medicaid require that we complete and periodically update enrollment forms in order to obtain and maintain certification to participate in programs. Compliance with these requirements is complicated by the fact that they differ from jurisdiction to jurisdiction, and in some cases are not uniformly applied or interpreted even within the same jurisdiction. Failure to comply with these requirements can lead not only to delays in payment and refund requests, but in extreme cases can give rise to civil or criminal penalties.

In certain jurisdictions, changes in our ownership structure require pre- or post-notification to governmental licensing and certification agencies, or agencies with which we have contracts. Relevant laws in some jurisdictions may also require re-application or re-enrollment and approval to maintain or renew our licensure, certification, contracts or other operating authority. The change in corporate structure and ownership in connection with our initial public offering required us to give notice,

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re-enroll or make other applications for authority to continue operating in various jurisdictions or to continue receiving payment from their Medicaid or other payment programs.

While we have made reasonable efforts to substantially comply with these requirements, we cannot assure you that the agencies that administer these programs or have awarded us contracts will not find that we have failed to comply in some material respects. A finding of non-compliance and any resulting payment delays, refund demands or other sanctions could have a material adverse effect on our business, financial condition or results of operations.

If we fail to comply with the terms of our settlement agreements with the government, we could be subject to additional litigation or other governmental actions which could be harmful to our business.

In the last seven years, we have entered into four settlement agreements with the United States government. In February 2003, one of our subsidiaries, AMR of South Dakota, entered into a settlement agreement to resolve allegations that it incorrectly billed for transports performed by other providers when an AMR paramedic accompanied the patient during transport, and that it billed for certain non-emergency transports using emergency codes. In July 2004, another subsidiary, AMR West, entered into a settlement agreement in connection with billing matters related to emergency transports and specialized services. In August 2004, AMR entered into a settlement agreement on behalf of a subsidiary, Regional Emergency Services LP, or RES, to resolve allegations of violations of the False Claims Act by RES and a hospital system based on the absence of certificates of medical necessity and other non-compliant billing practices. In September 2006, AMR entered into a settlement agreement to resolve allegations that AMR subsidiaries provided discounts to healthcare facilities in Texas in periods prior to 2002 in violation of the Federal Anti-Kickback Statute. See Item 3, "Legal Proceedings."

As part of the settlement AMR West entered into with the government, we entered into a Corporate Integrity Agreement, or CIA, which expired in 2009. In connection with the September 2006 settlement for AMR, we also entered into a CIA which requires us to maintain a compliance program which includes the training of employees and safeguards involving our contracting process nationwide (including tracking of contractual arrangements in Texas). See Item 1, "Business Regulatory Matters Corporate Compliance Program and Corporate Integrity Obligations."

We cannot assure you that the CIAs or the compliance program we have initiated have prevented, or will prevent, any repetition of the conduct or allegations that were the subject of these settlement agreements, or that the government will not raise similar allegations in other jurisdictions or for other periods of time. If such allegations are raised, or if we fail to comply with the terms of the CIAs, we may be subject to fines and other contractual and regulatory remedies specified in the CIAs or by applicable laws, including exclusion from the Medicare program and other federal and state healthcare programs. Such actions could have a material adverse effect on the conduct of our business, our financial condition or our results of operations.

If we are unable to effectively adapt to changes in the healthcare industry, our business may be harmed.

Political, economic and regulatory influences are subjecting the healthcare industry in the United States to fundamental change. We anticipate that Congress and state legislatures may continue to review and assess alternative healthcare delivery and payment systems and may in the future propose and adopt legislation effecting fundamental changes in the healthcare delivery system.

We cannot assure you as to the ultimate content, timing or effect of changes, nor is it possible at this time to estimate the impact of potential legislation. Further, it is possible that future legislation enacted by Congress or state legislatures could adversely affect our business or could change the operating environment of our customers. It is possible that changes to the Medicare or other government reimbursement programs may serve as precedent to similar changes in other payors' reimbursement policies in a manner adverse to us. Similarly, changes in private payor reimbursement

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programs could lead to adverse changes in Medicare and other government payor programs which could have a material adverse effect on our business, financial condition or results of operations.

Changes in the rates or methods of third party reimbursements may adversely affect our revenue and operations.

We derive a majority of our revenue from direct billings to patients and third party payors such as Medicare, Medicaid and private health insurance companies. As a result, any changes in the rates or methods of reimbursement for the services we provide could have a significant adverse impact on our revenue and financial results. Healthcare reform legislation currently pending in Congress could result in substantial cuts in Medicare and Medicaid coverage and/or funding, as well as reductions in coverage and/or amounts paid by private payors, which could have an adverse impact on our revenues from those sources.

Even if healthcare reform legislation currently pending in Congress is not enacted, government funding for healthcare programs is subject to statutory and regulatory changes, administrative rulings, interpretations of policy and determinations by intermediaries and governmental funding restrictions, all of which could materially impact program coverage and reimbursements for both ambulance and physician services. In recent years, Congress has consistently attempted to curb spending on Medicare, Medicaid and other programs funded in whole or part by the federal government. State and local governments have also attempted to curb spending on those programs for which they are wholly or partly responsible. This has resulted in cost containment measures such as the imposition of new fee schedules that have lowered reimbursement for some of our services and restricted the rate of increase for others, and new utilization controls that limit coverage of our services. For example, we estimate that the impact of a national fee schedule promulgated in 2002, as modified by subsequent legislation, resulted in a decrease in AMR's net revenue of approximately \$7 million in 2007, an increase in AMR's net revenue of approximately \$14 million in 2008, and an increase in AMR's net revenue of approximately \$24 million in 2009. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential decrease in AMR's net revenue of approximately \$30 million in 2010.

In addition, state and local government regulations or administrative policies regulate ambulance rate structures in some jurisdictions in which we conduct transport services. We may be unable to receive ambulance service rate increases on a timely basis where rates are regulated, or to establish or maintain satisfactory rate structures where rates are not regulated.

We believe that regulatory trends in cost containment will continue. We cannot assure you that we will be able to offset reduced operating margins through cost reductions, increased volume, the introduction of additional procedures or otherwise. In addition, we cannot assure you that federal, state and local governments will not impose reductions in the fee schedules or rate regulations applicable to our services in the future. Any such reductions could have a material adverse effect on our business, financial condition or results of operations.

ITEM 1B. UNRESOLVED STAFF COMMENTS

Not applicable.

ITEM 2. PROPERTIES

We lease approximately 67,000 square feet in an office building at 6200 S. Syracuse Way, Greenwood Village, Colorado for the AMR and EMSC corporate headquarters and which also serves as one of AMR's billing offices. Our leases for our business segments are described below.

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AMR

Facilities. In addition to the corporate headquarters, we also lease approximately 580 administrative facilities and other facilities used principally for ambulance basing, garaging and maintenance in those areas in which we provide ambulance services. We own 15 facilities used principally for administrative services and stationing for our ambulances. We believe our present facilities are sufficient to meet our current and projected needs, and that suitable space is readily available should our need for space increase. Our leases expire at various dates through 2025.

Vehicle Fleet. We operate approximately 4,100 vehicles. Of these, 79% are ambulances, 10% are wheelchair vans and 11% are support vehicles. As of December 31, 2009, we owned approximately 90% of our vehicles and leased the balance. We replace ambulances based upon age and usage, but generally every eight to ten years. The average age of our existing ambulance fleet is approximately 5 years. We primarily use in-house maintenance services to maintain our fleet. In those operations where our fleet is small and quality external maintenance services that agree to maintain our fleet in accordance with AMR standards are available, we utilize these maintenance services. We continue to explore ways to decrease our overall capital expenditures for vehicles, including major refurbishing and overhaul of our vehicles to extend their useful life.

EmCare

Facilities. We lease approximately 49,000 square feet in an office building at 1717 Main Street, Dallas, Texas, for certain of EmCare's key support functions and regional operations. We also lease 25 facilities to house administrative, billing and other support functions for other regional operations. We believe our present facilities are sufficient to meet our current and projected needs, and that suitable space is readily available should our need for space increase. Our leases expire at various dates through 2019.

We lease approximately 117,000 square feet in a business park located at 1000 River Road, Conshohocken, Pennsylvania, for certain key billing and support functions. We believe our present facilities are sufficient to meet our current and projected needs, and that suitable space is readily available should our need for space increase. Our primary lease expires in 2019 with the right to renew for two additional terms of five years each.

ITEM 3. LEGAL PROCEEDINGS

We are subject to litigation arising in the ordinary course of our business, including litigation principally relating to professional liability, auto accident and workers compensation claims. There can be no assurance that our insurance coverage will be adequate to cover all liabilities occurring out of such claims. In the opinion of management, we are not engaged in any legal proceedings that we expect will have a material adverse effect on our business, financial condition, cash flows or results of our operations other than as set forth below.

From time to time, in the ordinary course of business and like others in the industry, we receive requests for information from government agencies in connection with their regulatory or investigational authority. Such requests can include subpoenas or demand letters for documents to assist the government in audits or investigations. We review such requests and notices and take appropriate action. We have been subject to certain requests for information and investigations in the past and could be subject to such requests for information and investigations in the future.

We are subject to the Medicare and Medicaid fraud and abuse laws, which prohibit, among other things, any false claims, or any bribe, kickback, rebate or other remuneration, in cash or in kind, in return for the referral of Medicare and Medicaid patients. Violation of these prohibitions may result in civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs.

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We have implemented policies and procedures that management believes will assure that we are in substantial compliance with these laws, but we cannot assure you that the government or a court will not find that some of our business practices violate these laws.

During the first quarter of fiscal 2004 we were advised by the United States Department of Justice, or DOJ, that it was investigating certain business practices at AMR including whether discounts in violation of the federal Anti-Kickback Statute were provided by AMR in exchange for referrals involving Medicare eligible patients. Specifically, the government alleged that certain of our hospital and nursing home contracts in effect in Texas in periods prior to 2002 contained discounts in violation of the federal Anti-Kickback Statute. We negotiated a settlement with the government pursuant to which we paid \$9 million and obtained a release from the U.S. Government of all claims related to such conduct alleged to have occurred in Texas in periods prior to 2002. In connection with the settlement, we entered into a Corporate Integrity Agreement, or CIA, which is effective for a period of five years beginning September 12, 2006. Pursuant to the CIA, we are required to maintain a compliance program which includes, among other elements, the appointment of a compliance officer and committee; training of employees nationwide; safeguards for our contracting processes nationwide, including tracking of contractual arrangements in Texas; review by an independent review organization and reporting of certain reportable events. Under the provisions of our purchase agreement for the acquisition of AMR, we and Laidlaw shared responsibility for the settlement amount and certain of the costs associated with the CIA. There can be no assurance that other investigations or legal action related to our contracting practices will not be pursued against AMR in other jurisdictions or for different time frames.

On December 13, 2005, a lawsuit purporting to be a class action was commenced against AMR in Spokane, Washington, in Washington State Court, Spokane County. The complaint alleges that AMR billed patients and third party payors for transports it conducted between 1998 and 2005 at a higher level than contractually permitted. The court has certified a class in this case, but the size and membership of the class has not yet been determined. At this time, AMR does not believe that any incorrect billings are material in amount.

In December 2006, AMR received a subpoena from the DOJ. The subpoena requested copies of documents for the period from January 2000 through the present. The subpoena required us to produce a broad range of documents relating to the operations of certain AMR affiliates in New York. We produced documents responsive to the subpoena. The government has identified claims for reimbursement that the government believes lack support for the level billed, and invited us to respond to the identified areas of concern. We are reviewing the information provided by the government and intend to provide a response. We do not believe the identified claims will result in a material adverse effect on the financial condition of EMSC.

Three different lawsuits purporting to be class actions have been filed against AMR and certain subsidiaries in California alleging violations of California wage and hour laws. On April 16, 2008, Lori Bartoni commenced a suit in the Superior Court for the State of California, County of Alameda, which has since been removed to the United States District Court, Northern District of California; on July 8, 2008, Vaughn Banta filed suit in the Superior Court of the State of California, County of Los Angeles; and on January 22, 2009, Laura Karapetian filed suit in the Superior Court of the State of California, County of Los Angeles. At the present time, courts have not certified classes in any of these cases. Plaintiffs allege principally that the AMR entities failed to pay daily overtime charges pursuant to California law, and failed to provide required meal breaks or pay premium compensation for missed meal breaks. Plaintiffs are seeking to certify the classes and are seeking lost wages, punitive damages, attorneys' fees and other sanctions permitted under California law for violations of wage hour laws. We are unable at this time to estimate the amount of potential damages, if any.

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We are involved in other litigation arising in the ordinary course of business. Management believes the outcome of these legal proceedings will not have a material adverse effect on our financial condition, results of operations or liquidity.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

There were no matters submitted to a vote of security holders during the fourth quarter of the year ended December 31, 2009.

PART II.

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Shares of our class A common stock have been trading on the New York Stock Exchange ("NYSE"), under the symbol "EMS", since our initial public offering of such stock on December 16, 2005. There is no established market for our class B common stock or our LP exchangeable units. The following table details the high and low sales prices of our class A common stock during the years ended December 31, 2009 and 2008.

	HIGH	LOW
Year ended December 31, 2009:		
Fourth Quarter	\$ 55.50	\$ 41.50
Third Quarter	49.54	36.31
Second Quarter	37.38	28.90
First Quarter	39.11	26.64
Year ended December 31, 2008:		
Fourth Quarter	\$ 38.63	\$ 26.29
Third Quarter	34.83	20.75
Second Quarter	26.45	20.56
First Quarter	33.03	21.17

On February 16, 2010, the last sale price of our class A common stock as reported by the NYSE was \$53.82 and there were approximately 74 holders of record of our class A common stock, 3 holders of record of our class B common stock and 5 holders of record of our LP exchangeable units.

We refer you to our Registration Statement filed on Form S-1 under the Securities Act of 1933 with the Securities and Exchange Commission on December 15, 2005 under the caption "Description of Capital Stock" for a further description of our capital stock.

Dividend Policy

We currently intend to retain any future earnings to support our operations and to fund the development and growth of our business. In addition, the payment of dividends by us to holders of our common stock is limited by our senior secured credit facility. See Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations" and Item 8, "Financial Statements and Supplementary Data." Our future dividend policy will depend on the requirements of financing agreements to which we may be a party. We did not pay dividends in 2009, 2008 or 2007 and do not intend to pay cash dividends on our common stock in the foreseeable future. Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions.

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Recent Sales of Unregistered Securities

We did not have any sales of unregistered securities during the year ended December 31, 2009.

Issuer Purchases of Equity Securities

We did not repurchase any shares of our common stock during the year ended December 31, 2009.

Summary of Equity Compensation Plans

We adopted our equity option plan approved by security holders in 2005 in connection with the acquisition of AMR and EmCare. In 2007 we adopted our Long-Term Incentive Plan, which was approved by our shareholders in 2007, and we ceased to issue options under the previous equity option plan. The compensation committee of our board of directors, or the board itself if there is no committee, administers the equity option plans.

These plans provide for the issuance of up to 4,857,907 shares of our class A common stock at December 31, 2009, including 2,010,510 shares that may be issued upon the exercise of outstanding stock options at a weighted average price of \$12.92, and 228,292 shares that may vest pursuant to outstanding restricted stock grants. At December 31, 2009, 308,567 shares remain available under the Long-Term Incentive Plan for future grants.

Management Investment and Equity Purchase Plan

In connection with our acquisition of AMR and EmCare, our named executive officers, other members of management and certain employees and affiliated physicians, physician assistants and nurse practitioners purchased shares of class A common stock pursuant to our equity purchase plan. Certain of these shares held by these investors, including our named executive officers, are governed by equityholder agreements. These agreements contain restrictions on transfer of the equity. See "Description of Capital Stock Equityholder Agreements" in our Registration Statement under the Securities Act of 1933 filed on Form S-1 with the Securities and Exchange Commission on December 15, 2005 for a description of the transfer restrictions and "piggyback" registration rights.

Non-Employee Director Compensation Program

Under the terms of our Non-Employee Director Compensation Program, in addition to an annual cash retainer of \$50,000, each continuing non-employee director (other than Robert M. Le Blanc, our Lead Director), effective immediately following each annual meeting of stockholders, will receive a grant of a number of restricted stock units, or RSUs, having a fair market value of \$100,000, based on the closing price of our class A common stock on the business day immediately preceding the grant date. The RSUs will vest on the date of the following annual meeting of stockholders, immediately prior to the vote for directors, and will be paid in shares of our class A common stock (one share for each RSU). The number of RSUs granted to a non-employee director joining the board other than at an annual meeting of stockholders will be pro-rated based on the amount of time remaining until the next annual meeting of stockholders. This equity component of the non-employee director compensation program became effective as of June 1, 2006, and was approved by the stockholders at the 2007 annual meeting of stockholders. The number of RSUs issued and outstanding at December 31, 2009 was 76,864 and due to the nature of the plan, the number of shares remaining for future issuance is indeterminable.

Generally, a non-employee director will forfeit his annual compensation (both the cash and the equity components) if he does not attend at least 75% of the meetings held in that year by the board of directors and the board committees on which he serves. The board of directors may waive this requirement if it determines that extenuating circumstances precluded such attendance. There will be

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no compensation paid to directors for attendance at individual meetings, for service on committees of the board of directors or for serving as Chair of any such committee.

Employee Stock Purchase Plan and Stock Purchase Plan

Under our Employee Stock Purchase Plan, or ESPP, 500,000 shares of class A common stock are authorized for purchase during specific offering periods. The Compensation Committee of our Board of Directors administers the ESPP, and has sole discretion in determining when offerings will be made and the terms of each, and to designate which subsidiary corporations of EMSC will be eligible to participate. It also has the authority to construe the ESPP and any purchase rights granted thereunder, and establish, amend and revoke rules and regulations for the administration of the ESPP.

Under the Long-Term Incentive Plan, we may also offer and sell up to 500,000 shares of our class A common stock to employees of professional associations or professional corporations, for which we or our subsidiaries provide management services pursuant to a physician services agreement, as well as to independent contractors that provide clinical services for such professional associations or professional corporations, for us or for any of our subsidiaries. The purchase price associated with the class A common stock sold to such individuals will be determined from time to time pursuant to the Long-Term Incentive Plan by our Compensation Committee. We refer to this framework pursuant to the Long-Term Incentive Plan as the Stock Purchase Plan, or SPP.

We offered our class A common stock to eligible employees and independent contractors associated with EMSC and our subsidiaries pursuant to the ESPP and SPP during 2009 and 2008. The purchases of stock under these plans occurred in October 2009 and September 2008 at a 5% discount to the closing price of our class A common stock on predetermined dates established pursuant to the ESPP and SPP, and as such no compensation charge was recorded for these plans during 2009 or 2008. Employee contributions to these plans were used to purchase shares of class A common stock totaling 8,644 and 20,627 during 2009 and 2008, respectively.

Performance Graph

The performance graph comparing cumulative total return among EMSC and certain indexes will be filed in EMSC's annual report for the year ended December 31, 2009, which will be filed with the Securities and Exchange Commission within 120 days after December 31, 2009; the performance graph is incorporated herein by reference.

Offer to Provide Form 10-K

Stockholders may request a complimentary copy of our Annual Report on Form 10-K by mail addressed to our Investor Relations Department at the following address: Emergency Medical Services Corporation, 6200 South Syracuse Way, Suite 200, Greenwood Village, CO 80111.

ITEM 6. SELECTED FINANCIAL DATA

The following table sets forth our selected financial data derived from our consolidated financial statements for each of the periods indicated. The selected financial data presented below should be read in conjunction with Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our audited consolidated financial statements and notes thereto appearing in Item 8 of this Report.

Effective as of January 31, 2005, we acquired AMR and EmCare from Laidlaw and, as such, the 2005 period reflects the period as of and for the eleven months ended December 31, 2005.

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Financial data as of and for the eleven months ended December 31, 2005 and the years ended December 31, 2006, 2007, 2008 and 2009 are derived from our audited consolidated financial statements.

	As of and for the					Eleven months ended
	Year ended					
	December 31,					
	2009	2008	2007	2006	2005	
	(dollars in thousands, except per share amounts)					
Statement of Operations Data:						
Net revenue	\$ 2,569,685	\$ 2,409,864	\$ 2,106,993	\$ 1,934,205	\$ 1,655,485	
Compensation and benefits	1,796,779	1,637,425	1,455,970	1,333,648	1,146,055	
Operating expenses	334,328	383,359	317,518	294,806	233,087	
Insurance expense	97,610	82,221	66,308	74,258	86,814	
Selling, general and administrative expenses	63,481	69,658	61,893	57,403	54,262	
Depreciation and amortization expense	64,351	68,980	70,483	66,005	54,143	
Restructuring charges			2,242	6,369	1,781	
Income from operations	213,136	168,221	132,579	101,716	79,343	
Interest income from restricted assets	4,516	6,407	7,143	5,987	4,014	
Interest expense	(40,996)	(42,087)	(46,948)	(45,605)	(47,813)	
Realized gain (loss) on investments	2,105	2,722	245	(467)	(164)	
Interest and other income	1,816	2,055	2,055	2,346	1,040	
Loss on early debt extinguishment		(241)		(377)	(2,040)	
Income before income taxes and equity in earnings of unconsolidated subsidiary	180,577	137,077	95,074	63,600	34,380	
Income tax expense	(65,685)	(52,530)	(36,104)	(24,961)	(14,372)	
Income before equity in earnings of unconsolidated subsidiary	114,892	84,547	58,970	38,639	20,008	
Equity in earnings of unconsolidated subsidiary	347	300	848	432	59	
Net income	\$ 115,239	\$ 84,847	\$ 59,818	\$ 39,071	\$ 20,067	
Net income per share:						
Basic	\$ 2.71	\$ 2.04	\$ 1.44	\$ 0.94	\$ 0.56	
Diluted	\$ 2.64	\$ 1.97	\$ 1.39	\$ 0.92	\$ 0.55	

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Weighted average number of common shares outstanding:					
Basic	42,552,716	41,652,783	41,551,207	41,502,632	33,621,542
Diluted	43,623,800	43,130,782	43,146,881	42,528,885	34,282,176

Other Financial

Data:

Cash flows provided by (used in):					
Operating activities	\$ 272,553	\$ 211,457	\$ 97,818	\$ 165,742	\$ 109,963
Investing activities	(116,629)	(74,945)	(100,226)	(113,127)	(909,629)
Financing activities	30,791	(19,253)	(8,014)	(31,327)	803,083
Cash and cash equivalents					
	332,888	146,173	28,914	39,336	18,048
Total assets	1,654,707	1,541,219	1,479,563	1,318,217	1,267,028
Long-term debt and capital lease obligations, including current maturities					
	453,930	458,505	482,883	479,775	502,184
Shareholders' Equity	686,087	539,039	449,496	386,040	344,984

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The following table summarizes our unaudited results for each quarter in the years ended December 31, 2009 and 2008 (in thousands, except per share amounts).

2009				
For the quarter ended				
	March 31,	June 30,	September 30,	December 31,
Net revenue	\$ 613,022	\$ 637,291	\$ 665,056	\$ 654,316
Income from operations	47,508	55,697	55,472	54,459
Net income	24,071	29,019	28,878	33,271
Basic net income per common share	0.57	0.69	0.67	0.77
Diluted net income per common share	0.56	0.67	0.66	0.75

2008				
For the quarter ended				
	March 31,	June 30,	September 30,	December 31,
Net revenue	\$ 565,786	\$ 571,079	\$ 679,328	\$ 593,671
Income from operations	34,940	36,340	54,875	42,066
Net income	17,019	18,335	28,617	20,876
Basic net income per common share	0.41	0.44	0.69	0.50
Diluted net income per common share	0.40	0.43	0.66	0.48

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion of our financial condition and results of operations should be read in conjunction with the audited consolidated financial statements and the notes to the audited consolidated financial statements included in Item 8 of this Report and the "Selected Financial Data" included in Item 6 of this Report. The following discussion contains forward-looking statements and involves numerous risks and uncertainties, including, but not limited to, those described in the "Risk Factors" section in Item 1A of this Report. Our results may differ materially from those anticipated in any forward-looking statements.

Our financial statements referred to in this Item 7 are included in Item 8 of this Annual Report.

Company Overview

We are a leading provider of emergency medical services and facility-based outsourced physician services in the United States. We operate our business and market our services under the AMR and EmCare brands. AMR is a leading provider of ground and fixed-wing air ambulance services in the United States based on net revenue and number of transports. EmCare is a leading provider of outsourced physician services to healthcare facilities in the United States, based on number of contracts with hospitals and affiliated physician groups. Through EmCare, we provide outsourced facility-based physician services for emergency departments and hospitalist/inpatient, anesthesiology, radiology and teleradiology programs. Approximately 90% of our net revenue for the year ended December 31, 2009 was generated under exclusive contracts. During 2009, we provided emergency medical and outsourced physician services in approximately 13 million patient encounters in more than 2,200 communities nationwide.

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American Medical Response

Over its more than 50 years of operating history, AMR has developed the largest network of ambulance services in the United States based on net revenue and number of transports. AMR has a 9% share of the total ambulance services market and a 25% share of the private provider ambulance market. During 2009, AMR treated and transported approximately 3.2 million patients in 38 states by utilizing its fleet of more than 4,100 vehicles. As of December 31, 2009, AMR had approximately 3,600 contracts with communities, government agencies, healthcare providers and insurers to provide ambulance transport services. For the year ended December 31, 2009, approximately 58% of AMR's net revenue was generated from emergency 911 ambulance transport services. Non-emergency ambulance transport services, including critical care transfer, wheelchair transports and other interfacility transports, or IFTs, accounted for 29% of AMR's net revenue for the same period. The balance of net revenue for 2009 was generated from fixed-wing air ambulance services, Medicare and Medicaid managed transportation services, and the provision of training, dispatch and other services to communities and public safety agencies.

EmCare

Over its more than 30 years of operating history, EmCare has become the largest provider of outsourced emergency department services to healthcare facilities in the United States based on number of contracts with hospitals and affiliated physician groups. EmCare has an 8% share of the total emergency department services market and a 12% share of the outsourced emergency department services market. During 2009, EmCare had approximately 9.8 million patient encounters in 39 states.

EmCare provides facility-based physician services and related management services to healthcare facilities. EmCare recruits and hires or subcontracts with physicians and other healthcare professionals, who then provide professional services within the healthcare facilities with which we contract. We also provide billing and collection, risk management and other administrative services to our healthcare professionals and to independent physicians. EmCare has 527 contracts with hospitals and independent physician groups to provide emergency department, hospitalist/inpatient, anesthesiology, radiology and teleradiology staffing and other administrative services.

Key Factors and Measures We Use to Evaluate Our Business

The key factors and measures we use to evaluate our business focus on the number of patients we treat and transport and the costs we incur to provide the necessary care and transportation for each of our patients.

We evaluate our revenue net of provisions for contractual payor discounts and provisions for uncompensated care. Medicaid, Medicare and certain other payors receive discounts from our standard charges, which we refer to as contractual discounts. In addition, individuals we treat and transport may be personally responsible for a deductible or co-pay under their third party payor coverage, and most of our contracts require us to treat and transport patients who have no insurance or other third party payor coverage. Due to the uncertainty regarding collectability of charges associated with services we provide to these patients, which we refer to as uncompensated care, our net revenue recognition is based on expected cash collections. Our net revenue represents gross billings after provisions for contractual discounts and estimated uncompensated care. Provisions for contractual discounts and uncompensated care have increased historically primarily as a result of increases in gross billing rates without corresponding increases in payor reimbursement. The table below summarizes our approximate

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payor mix as a percentage of both net revenue and total transports and patient encounters for the years ended December 31, 2009, 2008 and 2007.

	Percentage of Net Revenue			Percentage of Total Volume		
	Year ended December 31,			Year ended December 31,		
	2009	2008	2007	2009	2008	2007
Medicare	23.3%	23.1%	24.8%	24.0%	25.7%	26.2%
Medicaid	4.8	4.4	4.6	11.5	10.7	10.9
Commercial insurance and managed care	50.2	47.4	48.5	43.1	42.0	40.6
Self-pay	3.9	4.3	4.6	21.4	21.6	22.3
Fees and subsidies	17.8	20.8	17.5			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

In addition to continually monitoring our payor mix, we also analyze the following measures in each of our business segments:

AMR

Approximately 88% of AMR's net revenue for the year ended December 31, 2009 was transport revenue derived from the treatment and transportation of patients, including fixed-wing air ambulance services, based on billings to third party payors, healthcare facilities and patients. The balance of AMR's net revenue is derived from direct billings to communities and government agencies for the provision of training, dispatch center and other services. AMR's measures for transport net revenue include:

Transports. We utilize transport data, including the number and types of transports, to evaluate net revenue and as the basis by which we measure certain costs of the business. We segregate transports into two main categories: ambulance transports (including emergency, as well as non-emergency, critical care and other interfacility transports) and wheelchair transports due to the significant differences in reimbursement and the associated costs of providing ambulance and wheelchair transports. As a result of these differences, in certain analyses we weight our transport numbers according to category in an effort to better measure net revenue and costs.

Net revenue per transport. Net revenue per transport reflects the expected net revenue for each transport based on gross billings less provisions for contractual discounts and estimated uncompensated care. In order to better understand the trends across service lines and in our transport rates, we analyze our net revenue per transport based on weighted transports to reflect the differences in our transportation mix.

The change from period to period in the number of transports is influenced by changes in transports in existing markets from both new and existing facilities we serve for non-emergency transports, and the effects of general community conditions for emergency transports. The general community conditions may include (1) the timing, location and severity of influenza, allergens and other annually recurring viruses, (2) severe weather that affects a region's health status and/or infrastructure and (3) community-specific demographic changes.

The costs we incur in our AMR business segment consist primarily of compensation and benefits for ambulance crews and support personnel, direct and indirect operating costs to provide transportation services, and costs related to accident and insurance claims. AMR's key cost measures include:

Unit hours and cost per unit hour. Our measurement of a unit hour is based on a fully staffed ambulance or wheelchair van for one operating hour. We use unit hours and cost per unit hour

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to measure compensation-related costs and the efficiency of our deployed resources. We monitor unit hours and cost per unit hour on a combined basis, as well as on a segregated basis between ambulance and wheelchair transports.

Operating costs per transport. Operating costs per transport is comprised of certain direct operating costs, including vehicle operating costs, medical supplies and other transport-related costs, but excluding compensation-related costs. Monitoring operating costs per transport allows us to better evaluate cost trends and operating practices of our regional and local management teams.

Accident and insurance claims. We monitor the number and magnitude of all accident and insurance claims in order to measure the effectiveness of our risk management programs. Depending on the type of claim (workers compensation, auto, general or professional liability), we monitor our performance by utilizing various bases of measurement, such as net revenue, miles driven, number of vehicles operated, compensation dollars, and number of transports.

We have focused our risk mitigation efforts on employee training for proper patient handling techniques, development of clinical and medical equipment protocols, driving safety, implementation of technology to reduce auto incidents and other risk mitigation processes which we believe has resulted in a reduction in the frequency, severity and development of claims.

AMR's business requires various investments in long-term assets and depreciation expense relates primarily to charges for usage of these assets, including vehicles, computer hardware and software, equipment and other technologies. Amortization expense relates primarily to intangibles recorded for customer relationships.

EmCare

Of EmCare's net revenue for the year ended December 31, 2009, approximately 85% was derived from our hospital contracts for emergency department staffing and approximately 15% was derived from hospitalist, anesthesiology, radiology, teleradiology and other hospital management services. Of this revenue, approximately 80% was generated from billings to third party payors and patients for patient encounters and approximately 20% was generated from billings to hospitals and affiliated physician groups for professional services. EmCare's key net revenue measures are:

Patient encounters. We utilize patient encounters to evaluate net revenue and as the basis by which we measure certain costs of the business. We segregate patient encounters into four main categories - emergency department visits, radiology reads, and anesthesiology and hospitalist encounters - due to the significant differences in reimbursement and the associated costs of providing the various services. As a result of these differences, in certain analyses we weight our patient encounter numbers according to category in an effort to better measure net revenue and costs.

Number of contracts. This reflects the number of contractual relationships we have for outsourced emergency department staffing, hospitalist, radiology, teleradiology, and anesthesiology services and other hospital management services. We analyze the change in our number of contracts from period to period based on "net new contracts," which is the difference between total new contracts and contracts that have terminated.

Revenue per patient encounter. This reflects the expected net revenue for each patient encounter based on gross billings less all estimated provisions for contractual discounts and uncompensated care. Net revenue per patient encounter also includes net revenue from billings to third party payors and hospitals.

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The change from period to period in the number of patient encounters under our "same store" contracts is influenced by general community conditions as well as hospital-specific elements, many of which are beyond our direct control. The general community conditions include: (1) the timing, location and severity of influenza, allergens and other annually recurring viruses and (2) severe weather that affects a region's health status and/or infrastructure. Hospital-specific elements include the timing and extent of facility renovations, hospital staffing issues and regulations that affect patient flow through the hospital.

The costs incurred in our EmCare business segment consist primarily of compensation and benefits for physicians and other professional providers, professional liability costs, and contract and other support costs. EmCare's key cost measures include:

Provider compensation per patient encounter. Provider compensation per patient encounter includes all compensation and benefit costs for all professional providers, including physicians, physician assistants and nurse practitioners, during each patient encounter. Providers include all full-time, part-time and independently contracted providers. Analyzing provider compensation per patient encounter enables us to monitor our most significant cost in performing services under our contracts.

Professional liability costs. These costs include provisions for estimated losses for actual claims, and claims likely to be incurred in the period, within our self-insurance limits based on our past loss experience, as well as actual direct costs, including investigation and defense costs, claims payments, reinsurance costs and other costs related to provider professional liability.

EmCare's business is not as capital intensive as AMR's and EmCare's depreciation expense relates primarily to charges for usage of computer hardware and software, and other technologies. Amortization expense relates primarily to intangibles recorded for customer relationships.

Non-GAAP Measures

Adjusted Earnings Before Interest, Taxes, Depreciation and Amortization ("Adjusted EBITDA")

Adjusted EBITDA is defined as net income before equity in earnings of unconsolidated subsidiary, income tax expense, loss on early debt extinguishment, interest and other income, realized gain on investments, interest expense, and depreciation and amortization. Adjusted EBITDA is commonly used by management and investors as a performance measure and liquidity indicator. Adjusted EBITDA is not considered a measure of financial performance under U.S. generally accepted accounting principles, or GAAP, and the items excluded from Adjusted EBITDA are significant components in understanding and assessing our financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to such GAAP measures as net income, cash flows provided by or used in operating, investing or financing activities or other financial statement data presented in our financial statements as an indicator of financial performance or liquidity. Since Adjusted EBITDA is not a measure determined in accordance with GAAP and is susceptible to varying calculations, Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

The following tables set forth a reconciliation of Adjusted EBITDA to net income for our company, and reconciliations of Adjusted EBITDA to income from operations for our two operating

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segments and a reconciliation of Adjusted EBITDA to cash flows from operating activities, using data derived from our financial statements for the periods indicated (amounts in thousands):

	Year ended December 31,		
	2009	2008	2007
Consolidated/Combined			
Adjusted EBITDA	\$ 282,003	\$ 243,608	\$ 210,205
Depreciation and amortization expense	(64,351)	(68,980)	(70,483)
Interest income from restricted assets	(4,516)	(6,407)	(7,143)
Income from operations	213,136	168,221	132,579
Interest income from restricted assets	4,516	6,407	7,143
Interest expense	(40,996)	(42,087)	(46,948)
Realized gain on investments	2,105	2,722	245
Interest and other income	1,816	2,055	2,055
Loss on debt extinguishment		(241)	
Equity in earnings of unconsolidated subsidiary	347	300	848
Income tax expense	(65,685)	(52,530)	(36,104)
Net income	\$ 115,239	\$ 84,847	\$ 59,818

AMR

Adjusted EBITDA	\$ 124,709	\$ 129,933	\$ 92,725
Depreciation and amortization expense	(49,190)	(55,082)	(56,560)
Interest income from restricted assets	(1,980)	(2,590)	(2,881)
Income from operations	\$ 73,539	\$ 72,261	\$ 33,284

EmCare

Adjusted EBITDA	\$ 157,294	\$ 113,675	\$ 117,480
Depreciation and amortization expense	(15,161)	(13,898)	(13,923)
Interest income from restricted assets	(2,536)	(3,817)	(4,262)
Income from operations	\$ 139,597	\$ 95,960	\$ 99,295

	Year ended December 31,		
	2009	2008	2007
Adjusted EBITDA	\$ 282,003	\$ 243,608	\$ 210,205
Interest paid	(39,165)	(39,983)	(44,874)
Change in accounts receivable	18,742	27,618	(74,991)
Change in other operating assets/liabilities	42,675	(15,353)	5,868
Equity based compensation	3,979	2,476	1,727
Excess tax benefits from stock-based compensation	(17,448)		
Other	(18,233)	(6,909)	(117)
Cash flows provided by operating activities	\$ 272,553	\$ 211,457	\$ 97,818

Factors Affecting Operating Results

Federal Emergency Management Agency Contract

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In 2007, FEMA awarded AMR with a national contract to provide ambulance, para-transit, and rotary and fixed-wing air ambulance transportation services to supplement federal and military responses to disasters, acts of terrorism and other public health emergencies. The contract covered the 21 states along the Gulf and Atlantic coasts and was expanded by FEMA to the full 48 contiguous

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states on October 1, 2009. FEMA has the option to renew the contract for different zones in the contract at various points during 2010 and 2011. In August 2008, AMR was deployed under this contract to provide patient evacuations and disaster relief efforts in three Gulf Coast states for hurricanes Gustav and Ike and recorded approximately \$107 million in net revenue during the year ended December 31, 2008. For the year ended December 31, 2007, net revenue for the FEMA contract was approximately \$11 million associated with AMR's deployment for hurricane Dean. There were no material FEMA deployments during the year ended December 31, 2009.

Rate Changes by Government Sponsored Programs

In February 2002, CMS issued the Final Rule that revised Medicare policy on the coverage of ambulance transport services, effective April 1, 2002. The Final Rule was the result of a mandate under the BBA to establish a national fee schedule for payment of ambulance transport services that would control increases in expenditures under Part B of the Medicare program, establish definitions for ambulance transport services that link payments to the type of services furnished, consider appropriate regional and operational differences and consider adjustments to account for inflation, among other provisions. The Final Rule provided for a five-year phase-in of a national fee schedule, beginning April 1, 2002. We estimate that the impact of a national fee schedule promulgated in 2002, as modified by subsequent legislation, resulted in a decrease in AMR's net revenue of approximately \$7 million in 2007, an increase in AMR's net revenue of approximately \$14 million in 2008, and an increase in AMR's net revenue of approximately \$24 million in 2009. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential decrease in AMR's net revenue totaling approximately \$30 million for 2010. Although we have been able to substantially mitigate the phased-in reductions of the BBA through additional fee and subsidy increases, we may not be able to continue to do so.

Medicare pays for all EmCare physicians' services based upon a national fee schedule. The rate formula may result in significant yearly fluctuations which may be unrelated to changes in the actual cost of providing physician services.

Changes in Net New Contracts

Our operating results are affected directly by the number of net new contracts we have in a period, reflecting the effects of both new contracts and contract expirations. We regularly bid for new contracts, frequently in a formal competitive bidding process that often requires written responses to a Request for Proposal, or RFP, and, in any fiscal period, certain of our contracts will expire. We may elect not to seek extension or renewal of a contract if we determine that we cannot do so on favorable terms. With respect to expiring contracts we would like to renew, we may be required to seek renewal through an RFP, and we may not be successful in retaining any such contracts, or retaining them on terms that are as favorable as present terms.

Inflation and Fuel Costs

Certain of our expenses, such as wages and benefits, insurance, fuel and equipment repair and maintenance costs, are subject to normal inflationary pressures. Excluding the impact of the 2008 hurricane deployment, fuel expense represented 9.1%, 14.1% and 12.2% of AMR's operating expenses for the years ended December 31, 2009, 2008 and 2007, respectively. Although we have generally been able to offset inflationary cost increases through increased operating efficiencies and successful negotiation of fees and subsidies, we can provide no assurance that we will be able to offset any future inflationary cost increases through similar efficiencies and fee changes.

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Critical Accounting Policies

The preparation of financial statements requires management to make estimates and assumptions relating to the reporting of results of operations, financial condition and related disclosure of contingent assets and liabilities at the date of the financial statements. Actual results may differ from those estimates under different assumptions or conditions. The following are our most critical accounting policies, which are those that require management's most difficult, subjective and complex judgments, requiring the need to make estimates about the effect of matters that are inherently uncertain and may change in subsequent periods.

The following discussion is not intended to represent a comprehensive list of our accounting policies. For a detailed discussion of the application of these and other accounting policies, see note 2 to our audited consolidated financial statements included in Item 8 of this Report.

Claims Liability and Professional Liability Reserves

We are self-insured up to certain limits for costs associated with workers compensation claims, automobile, professional liability claims and general business liabilities. Reserves are established for estimates of the loss that we will ultimately incur on claims that have been reported but not paid and claims that have been incurred but not reported. These reserves are based upon independent actuarial valuations, which are updated quarterly. Reserves other than general liability reserves are discounted at a rate commensurate with the interest rate on monetary assets that essentially are risk free and have a maturity comparable to the underlying liabilities. The actuarial valuations consider a number of factors, including historical claim payment patterns and changes in case reserves, the assumed rate of increase in healthcare costs and property damage repairs. Historical experience and recent trends in the historical experience are the most significant factors in the determination of these reserves. We believe the use of actuarial methods to account for these reserves provides a consistent and effective way to measure these subjective accruals. However, given the magnitude of the claims involved and the length of time until the ultimate cost is known, the use of any estimation technique in this area is inherently sensitive. Accordingly, our recorded reserves could differ from our ultimate costs related to these claims due to changes in our accident reporting, claims payment and settlement practices or claims reserve practices, as well as differences between assumed and future cost increases. Due to the complexity and uncertainty associated with these factors, we do not believe it is practical or meaningful to quantify the sensitivity of any particular assumption in isolation. During 2009 we recorded an increase in our provisions for insurance liabilities of \$4.5 million related to reserves for losses in prior years, and recorded reductions of \$4.1 million and \$21.5 million in 2008 and 2007, respectively, related to reserves for prior year losses. Accrued unpaid claims and expenses that are expected to be paid within the next twelve months are classified as current liabilities. All other accrued unpaid claims and expenses are classified as non-current liabilities.

Trade and Other Accounts Receivable

Our internal billing operations have primary responsibility for billing and collecting our accounts receivable. We utilize various processes and procedures in our collection efforts depending on the payor classification; these efforts include monthly statements, written collection notices and telephonic follow-up procedures for certain accounts. AMR and EmCare write off amounts not collected through our internal collection efforts to our uncompensated care allowance, and send these receivables to third party collection agencies for further follow-up collection efforts. We record any subsequent collections through third party collection efforts as a recovery.

As we discuss further in our "Revenue Recognition" policy below, we determine our allowances for contractual discounts and uncompensated care based on sophisticated information systems and financial models, including payor reimbursement schedules, historical write-off experience and other

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economic data. We record our patient-related accounts receivable net of estimated allowances for contractual discounts and uncompensated care in the period in which we perform services. We record gross fee-for-service revenue and related receivables based upon established fee schedule prices. We reduce our recorded revenue and receivables for estimated discounts to patients covered by contractual insurance arrangements, and reduce these further by our estimate of uncollectible accounts. Due to the complexity and uncertainty associated with these factors, we do not believe it is practical or meaningful to quantify the sensitivity of any particular assumption in isolation.

Our provision and allowance for uncompensated care is based primarily on the historical collection and write-off activity of our approximately 13 million annual patient encounters. We extract this data from our billing systems regularly and use it to compare our accounts receivable balances to estimated ultimate collections. Our allowance for uncompensated care is related principally to receivables we record for self-pay patients and is not recorded on specific accounts due to the volume of individual patient receivables and the thousands of commercial and managed care contracts.

We also have other receivables related to facility and community subsidies and contractual receivables for providing staffing to communities for special events. We review these other receivables periodically to determine our expected collections and whether any allowances may be necessary. We write the balance off after we have exhausted all collection efforts.

Revenue Recognition

A significant portion of our revenue is derived from Medicare, Medicaid and private insurance payors that receive discounts from our standard charges, which are referred to as contractual provisions. Additionally, we are also subject to collection risk for services provided to uninsured patients or for the deductible or co-pay portion of services for insured patients, which are referred to as uncompensated care. We record our healthcare services revenue net of estimated provisions for contractual allowances and uncompensated care.

Healthcare reimbursement is complex and may involve lengthy delays. Third party payors are continuing their efforts to control expenditures for healthcare and may disallow, in whole or in part, claims for reimbursement based on determinations that certain amounts are not reimbursable under plan coverage, were for services provided that were not determined medically necessary, or insufficient supporting information was provided. In addition, multiple payors with different requirements can be involved with each claim.

Management utilizes sophisticated information systems and financial models to estimate the provisions for contractual allowances and uncompensated care. The estimate for contractual allowances is determined on a payor-specific basis and is predominantly based on prior collection experience, adjusted as needed for known changes in reimbursement rates and recent changes in payor mix and patient acuity factors. The estimate for uncompensated care is based principally on historical collection rates, write-off percentages and accounts receivable agings. These estimates are analyzed continually and updated by management by monitoring reimbursement rate trends from governmental and private insurance payors, recent trends in collections from self-pay patients, the ultimate cash collection patterns from all payors, accounts receivable aging trends, operating statistics and ratios, and the overall trends in accounts receivable write-offs. Due to the complexity and uncertainty associated with these factors, we do not believe it is practical or meaningful to quantify the sensitivity of any particular assumption in isolation.

Management also regularly analyzes the ultimate collectability of accounts receivable after certain stages of the collection cycle using a look-back analysis to determine the amount of receivables subsequently collected. The analysis resulted in revenue adjustments which were less than 1% of net revenue for the years ended December 31, 2009 and 2008, and 1.6% of net revenue for the year ended December 31, 2007.

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The evaluation of these factors, as well as the interpretation of governmental regulations and private insurance contract provisions, involves complex, subjective judgments. As a result of the inherent complexity of these calculations, our actual revenues and net income, and our accounts receivable, could vary significantly from the amounts reported.

Income Taxes

Deferred income taxes reflect the impact of temporary differences between the reported amounts of assets and liabilities for financial reporting purposes and such amounts as measured by tax laws and regulations. The deferred tax assets and liabilities represent the future tax return consequences of those differences, which will either be taxable or deductible when the assets and liabilities are recovered or settled. A valuation allowance is provided for deferred tax assets when management concludes it is more likely than not that some portion of the deferred tax assets will not be recognized. The respective tax authorities, in the normal course, audit previous tax filings. It is not possible at this time to predict the final outcome of these audits or establish a reasonable estimate of possible additional taxes owing, if any.

Goodwill and Other Intangible Assets

Goodwill is not amortized and is required to be tested annually for impairment, or more frequently if changes in circumstances, such as an adverse change to our business environment, cause us to believe that goodwill may be impaired. Goodwill is allocated at the reporting unit level. If the fair value of the reporting unit falls below the book value of the reporting unit at an impairment assessment date, an impairment charge would be recorded.

Should our business environment or other factors change, our goodwill may become impaired and may result in material charges to our income statement.

Definite life intangible assets are subject to impairment reviews when evidence or triggering events suggest that an impairment may have occurred. Should such triggering events occur that cause us to review our definite life intangibles, management evaluates the carrying value in relation to the projection of future cash flows of the underlying assets. If deemed necessary, we would take a charge to earnings for the difference between the carrying value and the estimated fair value. Should factors affecting the value of our definite life intangibles change significantly, such as declining contract retention rates or reduced contractual cash flows, we may need to record an impairment charge in amounts that are significant to our financial statements.

Results of Operations

Basis of Presentation

The following tables present, for the periods indicated, consolidated results of operations and amounts expressed as a percentage of net revenue. This information has been derived from our audited statements of operations for the years ended December 31, 2009, 2008 and 2007.

Table of Contents**Consolidated Results of Operations and as a Percentage of Net Revenue**
(dollars in thousands)

	Year ended December 31,		
	2009	2008	2007
Net revenue	\$ 2,569,685	\$ 2,409,864	\$ 2,106,993
Compensation and benefits	1,796,779	1,637,425	1,455,970
Operating expenses	334,328	383,359	317,518
Insurance expense	97,610	82,221	66,308
Selling, general and administrative expenses	63,481	69,658	61,893
Depreciation and amortization expenses	64,351	68,980	70,483
Restructuring charges			2,242
Income from operations	213,136	168,221	132,579
Interest income from restricted assets	4,516	6,407	7,143
Interest expense	(40,996)	(42,087)	(46,948)
Realized gain on investments	2,105	2,722	245
Interest and other income	1,816	2,055	2,055
Loss on early debt extinguishment		(241)	
Equity in earnings of unconsolidated subsidiary	347	300	848
Income tax expense	(65,685)	(52,530)	(36,104)
Net income	\$ 115,239	\$ 84,847	\$ 59,818

	Year ended December 31,		
	2009	2008	2007
Net revenue	100.0%	100.0%	100.0%
Compensation and benefits	69.9	67.9	69.1
Operating expenses	13.0	15.9	15.1
Insurance expenses	3.8	3.4	3.1
Selling, general and administrative expenses	2.5	2.9	2.9
Depreciation and amortization expenses	2.5	2.9	3.3
Restructuring charges			0.1
Income from operations	8.3%	7.0%	6.3%

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AMR

(dollars in thousands)

	Year ended December 31,					
	2009	% of net revenue	2008	% of net revenue	2007	% of net revenue
Net revenue	\$ 1,343,857	100.0%	\$ 1,401,801	100.0%	\$ 1,219,212	100.0%
Compensation and benefits	840,473	62.5	841,648	60.0	772,677	63.4
Operating expenses	294,456	21.9	347,004	24.8	275,603	22.6
Insurance expense	47,991	3.6	39,895	2.8	36,513	3.0
Selling, general and administrative expenses	38,208	2.8	45,911	3.3	42,333	3.5
Depreciation and amortization expense	49,190	3.7	55,082	3.9	56,560	4.6
Restructuring charges					2,242	0.2
Income from operations	\$ 73,539	5.5%	\$ 72,261	5.2%	\$ 33,284	2.7%

EmCare

(dollars in thousands)

	Year ended December 31,					
	2009	% of net revenue	2008	% of net revenue	2007	% of net revenue
Net revenue	\$ 1,225,828	100.0%	\$ 1,008,063	100.0%	\$ 887,781	100.0%
Compensation and benefits	956,306	78.0	795,777	78.9	683,293	77.0
Operating expenses	39,872	3.3	36,355	3.6	41,915	4.7
Insurance expense	49,619	4.0	42,326	4.2	29,795	3.4
Selling, general and administrative expenses	25,273	2.1	23,747	2.4	19,560	2.2
Depreciation and amortization expense	15,161	1.2	13,898	1.4	13,923	1.6
Income from operations	\$ 139,597	11.4%	\$ 95,960	9.5%	\$ 99,295	11.2%

Year ended December 31, 2009 compared to year ended December 31, 2008

Consolidated

Our results for the year ended December 31, 2009 reflect an increase in net revenue of \$159.8 million and an increase in net income of \$30.4 million compared to the year ended December 31, 2008. We recorded approximately \$107 million of revenue related to our FEMA deployment during the year ended December 31, 2008. Excluding the impact of FEMA deployment revenue and related income from operations, we experienced growth in income from operations, partially offset by increased income tax expense. Basic and diluted earnings per share were \$2.71 and \$2.64, respectively, for the year ended December 31, 2009. Basic and diluted earnings per share were \$2.04 and \$1.97, respectively, for the same period in 2008.

Net revenue

For the year ended December 31, 2009, we generated net revenue of \$2,569.7 million compared to net revenue of \$2,409.9 million for the year ended December 31, 2008, representing an increase of

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6.6%, or 11.6% excluding the impact of the 2008 FEMA deployment. The increase is attributable to increases in rates and volumes on existing contracts combined with increased volume from net new contracts and acquisitions, partially offset by a decrease in FEMA revenues recorded in the year ended December 31, 2009 compared to the same period in 2008.

Adjusted EBITDA

Adjusted EBITDA was \$282.0 million, or 11.0% of net revenue, for the year ended December 31, 2009 compared to \$243.6 million, or 10.1% of net revenue, for the same period in 2008. The 2008 period includes the positive impact to Adjusted EBITDA related to our hurricane deployment under the FEMA contract.

Interest expense

Interest expense for the year ended December 31, 2009 was \$41.0 million compared to \$42.1 million for the same period in 2008. The decrease is due to an unscheduled principal payment of \$20 million made in December 2008.

Income tax expense

Income tax expense increased by \$13.2 million for the year ended December 31, 2009, compared to the same period in 2008, which resulted primarily from increased operating income and was partially offset by the reversal of reserves associated with previous tax positions. Our effective tax rate for the year ended December 31, 2009 was 36.4% compared with 38.2% for the same period in 2008. The decrease to the effective tax rate is due primarily to the reversal of reserves associated with previous tax positions, partially offset by additional valuation allowances recognized during 2009.

AMR

Net revenue

Net revenue for the year ended December 31, 2009 was \$1,343.9 million, a decrease of \$57.9 million, or 4.1%, from \$1,401.8 million for the same period in 2008. The change in net revenue was due primarily to \$107.3 million of FEMA hurricane deployment revenue recorded in 2008. Excluding the impact of the 2008 FEMA deployment, net revenue per weighted transport increased 6.5%, or \$82.0 million, and was offset by a decrease of 2.5%, or \$32.7 million, in weighted transport volume. Of the increase in net revenue per weighted transport, 4.9% is attributable primarily to various rate increases, including a Medicare fee increase effective January 1, 2009, and the remainder is due primarily to growth in our managed transportation business. Weighted transports decreased 75,300 from the same period last year. The change was due to a decrease in weighted transports of 55,400 from the exit of markets, a decrease in weighted transport volume in existing markets of 36,700, or 1.3%, offset by 16,800 weighted transports from entry into new markets.

Compensation and benefits

Compensation and benefit costs for the year ended December 31, 2009 were \$840.5 million, or 62.5% of net revenue, compared to \$841.6 million, or 60.0% of net revenue, for the year ended December 31, 2008. The decrease of \$1.2 million was due primarily to compensation costs incurred during 2008 as a result of the FEMA deployment. Excluding the impact of the 2008 FEMA deployment, ambulance crew wages per ambulance unit hour increased by approximately 4.1%, or \$18.6 million, attributable primarily to wage rate increases. Ambulance unit hours decreased period over period by 2.7%, or \$12.4 million, due primarily to the reduction in volume in existing markets and increased efficiency in our deployments. Benefit costs increased by \$8.6 million excluding the impact of the 2008 FEMA deployment for the year ended December 31, 2009 compared to the same period in 2008. The change is primarily attributable to increased health insurance costs. Excluding the impact of

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the 2008 FEMA deployment, compensation and benefits decreased as a percentage of net revenue due to the growth in our managed transportation business; our managed transportation costs are reflected primarily in operating expenses.

Operating expenses

Operating expenses for the year ended December 31, 2009 were \$294.5 million, or 21.9% of net revenue, compared to \$347.0 million, or 24.8% of net revenue, for the year ended December 31, 2008. The change is due primarily to a decrease of \$46.9 million related to our FEMA deployment in 2008 and decreased fuel costs of \$15.2 million in the year ended December 31, 2009, including approximately \$12.8 million related to lower fuel rates. These decreases were partially offset by an increase of \$14.7 million in operating expenses associated with growth in our managed transportation business.

Insurance expense

Insurance expense for the year ended December 31, 2009 was \$48.0 million, or 3.6% of net revenue, compared to \$39.9 million, or 2.8% of net revenue, for the year ended December 31, 2008. We recorded an increase of prior year insurance provisions of \$1.1 million during the year ended December 31, 2009 compared to a reduction of \$4.4 million for the same period in 2008.

Selling, general and administrative

Selling, general and administrative expense for the year ended December 31, 2009 was \$38.2 million, or 2.8% of net revenue, compared to \$45.9 million, or 3.3% of net revenue, for the year ended December 31, 2008. The change is due primarily to travel and other administrative costs recorded during 2008 associated with the FEMA deployment.

Depreciation and amortization

Depreciation and amortization expense for the year ended December 31, 2009 was \$49.2 million, or 3.7% of net revenue, compared to \$55.1 million, or 3.9% of net revenue, for the same period in 2008. The decrease is due primarily to AMR's ability to utilize fewer ambulances to service its existing contracts and the timing of replacing fully depreciated assets.

EmCare

Net revenue

Net revenue for the year ended December 31, 2009 was \$1,225.8 million, an increase of \$217.8 million, or 21.6%, from \$1,008.1 million for the year ended December 31, 2008. The increase was due primarily to an increase in patient encounters from net new hospital contracts and net revenue increases in existing contracts. Following December 31, 2007, we added 132 net new contracts which accounted for a net revenue increase of \$146.7 million in 2009. Of the 132 net new contracts added since December 31, 2007, 79 were added in 2008 resulting in an incremental increase in 2009 net revenue of \$72.3 million. Of the 79 net new contracts added in 2008, 45 were from our acquisition of Clinical Partners in August 2008 with related management fee revenue totaling \$8.3 million during the year ended December 31, 2009. For the year ended December 31, 2009, EmCare added 106 new contracts and terminated 53 contracts resulting in an increase in net revenue of \$74.5 million. Of the 106 new contracts added in 2009, 23 were from our acquisition of Pinnacle, which was effective December 19, 2009, with related net revenue of \$2.6 million recorded in 2009. Net revenue under our "same store" contracts (contracts in existence for the entirety of both years) increased \$62.7 million, or 8.1%, for the year ended December 31, 2009. The change is due to a 1.9% increase in revenue per weighted patient encounter and an increase in same store weighted patient encounters of 6.2% over the prior period.

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Compensation and benefits

Compensation and benefits costs for the year ended December 31, 2009 were \$956.3 million, or 78.0% of net revenue, compared to \$795.8 million, or 78.9% of net revenue, for the same period in 2008. Provider compensation costs increased \$104.1 million from net new contract additions. "Same store" provider compensation and benefits costs were \$34.8 million over the prior period due primarily to a 6.2% increase in same store weighted patient encounters. Non-provider compensation and total benefits costs increased by \$21.6 million due primarily to our recent acquisitions, organic growth, and additional incentive related accruals.

Operating expenses

Operating expenses for the year ended December 31, 2009 were \$39.9 million, or 3.3% of net revenue, compared to \$36.4 million, or 3.6% of net revenue, for the same period in 2008. Operating expenses increased \$3.5 million due primarily to higher collection agency and billing fees incurred in connection with the expansion of our anesthesiology and radiology businesses.

Insurance expense

Professional liability insurance expense for the year ended December 31, 2009 was \$49.6 million, or 4.0% of net revenue, compared to \$42.3 million, or 4.2% of net revenue, for the same period in 2008. An increase of prior year insurance provisions of \$3.4 million was recorded during the year ended December 31, 2009 compared to an increase of \$0.3 million during the same period in 2008.

Selling, general and administrative

Selling, general and administrative expense for the year ended December 31, 2009 was \$25.3 million, or 2.1% of net revenue, compared to \$23.7 million, or 2.4% of net revenue, for the same period in 2008. The increase is due primarily to growth from net new contracts and acquisitions.

Depreciation and amortization

Depreciation and amortization expense for the year ended December 31, 2009 was \$15.2 million, or 1.2% of net revenue, compared to \$13.9 million, or 1.4% of net revenue, for the same period in 2008. The increase is due primarily to amortization of intangible assets associated with our recent acquisitions.

Year ended December 31, 2008 compared to year ended December 31, 2007

Consolidated

Our results for the year ended December 31, 2008 reflect an increase in net revenue of \$302.9 million and an increase in net income of \$25.0 million compared to the year ended December 31, 2007. The increase in net income is attributable primarily to an increase of \$35.6 million in operating income and a decrease in interest expense of \$4.9 million, offset by an increase in income tax expense. Basic and diluted earnings per share were \$2.04 and \$1.97, respectively, for the year ended December 31, 2008. Basic and diluted earnings per share were \$1.44 and \$1.39, respectively, for the same period in 2007.

Net revenue

For the year ended December 31, 2008, we generated net revenue of \$2,409.9 million compared to net revenue of \$2,107.0 million for the year ended December 31, 2007, representing an increase of 14.4%. The increase is attributable to increases in rates and volumes on existing contracts, increased volume from net new contracts and acquisitions, and increased FEMA deployment revenue at AMR.

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Adjusted EBITDA

Adjusted EBITDA was \$243.6 million, or 10.1% of net revenue, for the year ended December 31, 2008 compared to \$210.2 million, or 10.0% of net revenue, for the same period in 2007. The increase is attributable primarily to the net impact of revenue growth during the period.

Interest expense

Interest expense for the year ended December 31, 2008 was \$42.1 million compared to \$46.9 million for the same period in 2007. The decrease is attributable primarily to the lower rate under our interest rate swap agreement, which became effective in the fourth quarter of 2007. The swap agreement converts \$200.0 million of variable rate debt to fixed rate debt with an effective rate of 6.3%.

Income tax expense

Income tax expense increased by \$16.4 million for the year ended December 31, 2008, compared to the same period in 2007, which resulted primarily from increased operating income. Our effective tax rate for the year ended December 31, 2008 was 38.2% compared with 38.0% for the same period in 2007.

AMR

Net revenue

Net revenue for the year ended December 31, 2008 was \$1,401.8 million, an increase of \$182.6 million, or 15%, from \$1,219.2 million for the same period in 2007. The increase in net revenue was due primarily to \$97.2 million of additional FEMA deployment revenue, rate increases and higher weighted transport volume. Excluding the impact of the FEMA deployments, net revenue per weighted transport increased 5.7%, or \$70.5 million and 1.2%, or \$14.9 million as a result of higher weighted transport volume. The increase in net revenue per transport is attributable primarily to rate increases in several markets. Weighted transports increased approximately 36,400 in 2008 from the same period last year. The change was due to an increase in weighted transports of 98,700 from acquisitions and an increase in transport volume in existing markets of 0.6%, offset by a decrease in weighted transports of 79,500 from the restructuring and exit of certain of our operations.

Compensation and benefits

Compensation and benefit costs for the year ended December 31, 2008 were \$841.6 million, or 60.0% of net revenue, compared to \$772.7 million, or 63.4% of net revenue, for the year ended December 31, 2007. The increase was due primarily to compensation costs incurred as a result of increased hurricane deployments under our national FEMA contract, expenses from our acquisitions, annual salary increases and additional ambulance unit hour deployment. Excluding the impact of FEMA deployments, ambulance crew wages per ambulance unit hour increased by approximately 4.4%, or \$19.6 million, principally from wage rate increases. Ambulance unit hours increased period over period by 1.9%, or \$8.2 million. The increase is due to our acquisitions and increased transport volume in existing markets partially offset by the restructuring of certain of our operations and exit of other markets in 2007. Non-crew wages increased \$14.9 million excluding the impact of FEMA deployments due primarily to additional compensation expenses from acquisitions of \$5.3 million and annual salary increases of 4.5%. Benefit costs increased by \$11.3 million excluding FEMA deployment benefit costs for the year ended December 31, 2008 compared to the same period in 2007. The change is attributable to increased health insurance costs and additional benefit costs related to our acquisitions.

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Operating expenses

Operating expenses for the year ended December 31, 2008 were \$347.0 million, or 24.8% of net revenue, compared to \$275.6 million, or 22.6% of net revenue, for the year ended December 31, 2007. The change is due primarily to the combined impact of increased external provider expenses from our national FEMA deployment and our managed transportation business of \$54.2 million. Additionally, increased fuel costs of \$8.0 million and increased operating expenses of \$5.0 million from our acquisitions also contributed to the change.

Insurance expense

Insurance expense for the year ended December 31, 2008 was \$39.9 million, or 2.8% of net revenue, compared to \$36.5 million, or 3.0% of net revenue, for the year ended December 31, 2007. We recorded a reduction of prior year insurance provisions of \$4.4 million during the year ended December 31, 2008 compared to \$11.3 million for the same period in 2007.

Selling, general and administrative

Selling, general and administrative expense for the year ended December 31, 2008 was \$45.9 million, or 3.3% of net revenue, compared to \$42.3 million, or 3.5% of net revenue, for the year ended December 31, 2007. The increase is due primarily to travel and other administrative expenses for our national FEMA deployment.

Restructuring charges

Restructuring charges of \$2.2 million were recorded during the year ended December 31, 2007, related to the closure of one of our billing offices and restructuring our operations in Los Angeles and Orange Counties in California. There were no restructuring charges during the year ended December 31, 2008.

Depreciation and amortization

Depreciation and amortization expense for the year ended December 31, 2008 was \$55.1 million, or 3.9% of net revenue, compared to \$56.6 million, or 4.6% of net revenue, for the same period in 2007.

EmCare

Net revenue

Net revenue for the year ended December 31, 2008 was \$1,008.1 million, an increase of \$120.3 million, or 13.5%, from \$887.8 million for the year ended December 31, 2007. Following December 31, 2006, we added 96 net new contracts which accounted for a net revenue increase of \$88.8 million in 2008. Of the 96 net new contracts added since December 31, 2006, 17 were added in 2007 resulting in an increase in 2008 net revenue of \$23.9 million. For the year ended December 31, 2008, EmCare added 132 new contracts and terminated 53 contracts resulting in an increase in net revenue of \$64.9 million. Net revenue under our "same store" contracts (contracts in existence for the entirety of both years) increased \$31.5 million, or 4.4%, for the year ended December 31, 2008 due to a 0.9% increase, 4.5% increase excluding retroactive revenue adjustments discussed below, in revenue per encounter and an increase in same store patient encounters of 3.5%. Retroactive adjustments, which increased revenue for the year ended December 31, 2008 and 2007, were 0.9% and 3.7% of EmCare's net revenue, respectively.

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Compensation and benefits

Compensation and benefits costs for the year ended December 31, 2008 were \$795.8 million, or 78.9% of net revenue, compared to \$683.3 million, or 77.0% of net revenue, for the same period in 2007. Provider compensation costs increased \$67.4 million from net new contract additions. "Same store" provider compensation and benefits costs were \$34.6 million over the prior period due to a 4.1% increase in provider compensation per patient encounter. The increase is due primarily to higher net revenue per patient encounter and additional staffing due to growth in patient volumes.

Operating expenses

Operating expenses for the year ended December 31, 2008 were \$36.4 million, or 3.6% of net revenue, compared to \$41.9 million, or 4.7% of net revenue, for the same period in 2007. The decrease is due primarily to lower collection agency and billing fees.

Insurance expense

Professional liability insurance expense for the year ended December 31, 2008 was \$42.3 million, or 4.2% of net revenue, compared to \$29.8 million, or 3.4% of net revenue, for the same period in 2007. An increase of prior year insurance provisions of \$0.3 million was recorded during the year ended December 31, 2008 compared to a reduction of \$10.2 million recorded for the year ended December 31, 2007.

Selling, general and administrative

Selling, general and administrative expense for the year ended December 31, 2008 was \$23.7 million, or 2.4% of net revenue, compared to \$19.6 million, or 2.2% of net revenue, for the same period in 2007. The increase is due primarily to an increase in regional travel expense associated with the increase in contracts during the period.

Depreciation and amortization

Depreciation and amortization expense for the year ended December 31, 2008 was \$13.9 million, or 1.4% of net revenue, compared to \$13.9 million, or 1.6% of net revenue, for the same period in 2007.

Liquidity and Capital Resources

Our primary source of liquidity is cash flow provided by our operating activities. We can also use our revolving senior secured credit facility, described below, to supplement cash flows provided by our operating activities if we decide to do so for strategic or operating reasons. Our liquidity needs are primarily to service long-term debt and to fund working capital requirements, capital expenditures related to the acquisition of vehicles and medical equipment, technology-related assets and insurance-related deposits. See the discussion in Item 1A, "Risk Factors" for circumstances that could affect our sources of liquidity.

We have available to us, upon compliance with customary conditions, \$100.0 million under the revolving credit facility, less any letters of credit outstanding. Outstanding letters of credit at December 31, 2009 were \$43.6 million. Further, we have a conditional right under our senior secured credit facility to request new or existing lenders to provide up to an additional \$100.0 million of term debt (in \$20.0 million increments).

As of the date of this report, we are evaluating options to refinance all or part of our senior subordinated unsecured notes and our senior secured credit facility. Should we enter into a refinancing

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agreement, and depending on the terms of any agreement, interest and early debt extinguishment expenses would be impacted and new debt issuance costs would be incurred.

Cash Flow

The table below summarizes cash flow information derived from our statements of cash flows for the periods indicated (amounts in thousands):

	Year ended December 31,		
	2009	2008	2007
Net cash provided by (used in)			
Operating activities	\$ 272,553	\$ 211,457	\$ 97,818
Investing activities	(116,629)	(74,945)	(100,226)
Financing activities	\$ 30,791	\$ (19,253)	\$ (8,014)

Operating Activities

Net cash provided by operating activities was \$272.6 million for the year ended December 31, 2009 compared to \$211.5 million for the same period last year. Operating cash flows were affected primarily by changes in net income combined with changes in operating assets and liabilities. Operating cash flow associated with the change in prepaids and other current assets increased by \$27.8 million for the year ended December 31, 2009 compared to the same period in 2008. The change is primarily attributable to the timing of payments for income taxes and insurance premiums. Accounts payable and accrued liabilities increased operating cash flow by \$18.0 million during 2009 compared to a decrease of \$1.4 million in 2008. The change is attributable primarily to the timing of payroll related payments. Operating cash flow associated with the change in insurance accruals increased by \$10.8 million during 2009 compared to 2008. The increase relates primarily to the timing of claim payments. These changes were partially offset by a decrease in operating cash flow related to the change in accounts receivable. We continue to focus on implementing process improvements to further reduce our days sales outstanding, or DSO. Decreases in accounts receivable increased operating cash flows by \$18.7 million for the year ended December 31, 2009 compared to \$27.6 million for the same period in 2008. The reduction to accounts receivable during 2008 is also due to collection of the increased receivables outstanding as of December 31, 2007.

Net cash provided by operating activities was \$211.5 million for the year ended December 31, 2008 compared to \$97.8 million for the same period in 2007. Operating cash flows were affected primarily by changes in net income, accounts receivable and accounts payable and accrued liabilities. Decreases in accounts receivable increased operating cash flows by \$27.6 million for the year ended December 31, 2008 compared to increases in accounts receivable of \$75.0 million which decreased operating cash flows for the same period in 2007. The 2007 period was negatively impacted by increases in accounts receivable at both of our segments as described below. The reduction to accounts receivable during 2008 is due in large part to collection of the increased receivables outstanding as of December 31, 2007. The change in accounts payable and accrued liabilities is attributable primarily to the timing of payroll related liability payments.

We regularly analyze DSO, which is calculated by dividing our net revenue for the quarter by the number of days in the quarter. The result is divided into net accounts receivable at the end of the period. DSO provides us with a gauge to measure receivables, revenue and collection activities. The reductions since September 30, 2008 shown below are due to additional collections on accounts receivable as a result of continued billing and collection process enhancements at both AMR and EmCare. The following table outlines our DSO by segment and in total excluding the impact of AMR's

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2008 deployments under its contract with FEMA and EmCare's acquisition of Pinnacle in December 2009:

	Q4 2009	Q3 2009	Q2 2009	Q1 2009	Q4 2008	Q3 2008
AMR	68	70	73	74	79	83
EmCare	60	58	61	65	68	72
EMSC	64	64	67	70	74	78

Investing Activities

Net cash used in investing activities was \$116.6 million for the year ended December 31, 2009 compared to \$74.9 million for the same period in 2008. The change relates primarily to increases in acquisition activity and net capital expenditures. Acquisitions of businesses totaled \$75.6 million during the year ended December 31, 2009 compared to \$55.8 million during the same period in 2008. Net capital expenditures for the year ended December 31, 2009 were \$12.9 million higher than the same period in 2008.

Net cash used in investing activities was \$74.9 million for the year ended December 31, 2008 compared to \$100.2 million for the same period in 2007. The decrease related primarily to reduced acquisition and net capital expenditures. Acquisitions of businesses totaled \$55.8 million during the year ended December 31, 2008 compared to \$75.6 million during the same period in 2007. Net capital expenditures for the year ended December 31, 2008 were \$6.3 million less than the same period in 2007.

Financing Activities

For the year ended December 31, 2009, net cash provided by financing activities was \$30.8 million compared to net cash used in financing activities of \$19.3 million for the same period in 2008. The variance relates primarily to unscheduled payments of approximately \$20.0 million on our senior secured credit facility in 2008 combined with increased cash flows from the exercise of stock options and the cash flow benefit related to tax deductions for stock-based compensation during the year ended December 31, 2009. At December 31, 2009 and 2008, there were no amounts outstanding under our revolving credit facility.

For the year ended December 31, 2008, net cash used in financing activities was \$19.3 million compared to \$8.0 million for the same period in 2007. The variance related primarily to unscheduled payments of approximately \$20.0 million on our senior secured credit facility in 2008. Included in net cash used in financing activities for the year ended December 31, 2008 and 2007, are borrowings and repayments under our revolving credit facility. At December 31, 2008 and 2007, there were no amounts outstanding under our revolving credit facility.

Debt Facilities

We have a \$450.0 million senior secured credit facility bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or its LIBOR rate. The senior secured credit facility consists of a \$100.0 million, six-year revolving credit facility due in 2011 and a \$350.0 million, seven-year term loan due in 2012. We also have 10% senior subordinated notes with a principal balance of \$250.0 million due 2015. We prepaid \$20.0 million of the term loan in 2008.

Our \$350.0 million term loan carries interest at the alternate base rate, plus a margin of 1.00%, or the LIBOR rate, plus a margin of 2.00%. The term loan is subject to quarterly amortization of principal (in quarterly installments), with 1% of the aggregate principal payable in each of the first six years, with the remaining balance due in the final year. Our \$100.0 million revolving credit facility initially bears interest at the alternate base rate, plus a margin of 1.00%, or the LIBOR rate, plus a

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margin of 2.00%. We had no outstanding borrowings under the revolving credit facility at December 31, 2009 and 2008. Under the terms of our senior secured credit facility, our letters of credit outstanding reduce our available borrowings under the revolving credit facility. At December 31, 2009, our outstanding letters of credit totaled \$43.6 million, including \$26.7 million to support our self-insurance program and \$16.9 million, primarily related to secure our performance under certain 911 emergency response contracts, and our availability under the revolving credit facility was \$56.4 million.

All amounts borrowed under our senior secured credit facility are collateralized by, among other things:

substantially all present and future shares of the capital stock of AMR HoldCo, Inc., and EmCare HoldCo, Inc., our wholly-owned subsidiaries which are the co-borrowers, and each of their present and future domestic subsidiaries and 65% of the capital stock of controlled foreign corporations;

substantially all present and future intercompany debt of the co-borrowers and each guarantor; and

substantially all of the present and future property and assets, real and personal, of the co-borrowers and each guarantor.

The agreements governing our senior secured credit facility contain customary affirmative and negative covenants, including, among other things, restrictions on indebtedness, liens, mergers and consolidations, sales of assets, loans, acquisitions, joint ventures, restricted payments, transactions with affiliates, dividends and other payment restrictions affecting subsidiaries, a change in control of the company and other matters customarily restricted in such agreements. The agreement governing our senior secured credit facility also contains financial covenants, including a maximum total leverage ratio (3.75 to 1.00 as of December 31, 2009), maximum senior leverage ratio (2.00 to 1.00 as of December 31, 2009), a minimum fixed charge coverage ratio (1.20 to 1.00 as of December 31, 2009) and a maximum annual capital expenditure amount (\$70 million as of December 31, 2009). The financial covenant ratios are based on adjusted EBITDA, which is the amount of our income (loss) from operations before depreciation and amortization expenses and other specifically identified exclusions. These ratios are to be calculated each quarter based on the financial data for the four fiscal quarters then ending. Each financial covenant ratio and capital expenditure amount adjusts over time as set forth in our senior secured credit facility. Our failure to meet any of these financial covenants could be an event of default under our senior secured credit facility.

On March 7, 2007, we entered into Waiver and Amendment No. 2, or the Second Amendment, to our senior secured credit facility. The Second Amendment increased the threshold consideration requiring us to provide financial information to the lenders prior to an acquisition, eliminated the annual and aggregate maximum amounts we are permitted to spend on acquisitions, and extended our deadlines to provide lenders with financial forecasts of EMS LP and its subsidiaries for the immediately following fiscal year. In addition, the Second Amendment waived any potential technical non-compliance with the senior secured credit facility arising from a name change related to AMR HoldCo, Inc.

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The calculated ratios and amounts for the year ended December 31, 2009 were as follows (dollars in thousands):

Total Leverage Ratio:	1.58
Consolidated Indebtedness/	\$ 453,930
Adjusted LTM EBITDA ⁽¹⁾	\$ 286,982
Senior Leverage Ratio:	0.71
Senior Indebtedness/	\$ 203,930
Adjusted LTM EBITDA ⁽¹⁾	\$ 286,982
Fixed Charge Coverage Ratio:	6.51
Fixed Charge Numerator ⁽²⁾	\$ 242,374
Fixed Charge Denominator ⁽³⁾	\$ 37,203
Capital Expenditures:	\$ 44,608

- (1) "Adjusted LTM EBITDA" is calculated as set forth in our senior secured credit facility: our consolidated Adjusted EBITDA for the four fiscal quarters ended December 31, 2009, adding back all management fees, and other specifically identified exclusions.
- (2) The numerator for the fixed charge ratio is calculated as set forth in our senior secured credit facility: Adjusted EBITDA, less capital expenditures, for the four fiscal quarters ended December 31, 2009.
- (3) The denominator for the fixed charge ratio is calculated as set forth in our senior secured credit facility: the sum of our consolidated interest expense, cash income taxes and principal amount of all scheduled amortization payments on all Indebtedness (as defined), including pro forma annual principal payments on our senior secured credit facility, for the four fiscal quarters ended December 31, 2009.

The indenture governing our senior subordinated notes contains a number of covenants that, among other things, restrict our ability and the ability of our subsidiaries, subject to certain exceptions, to sell assets, incur additional debt or issue preferred stock, repay other debt, pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, loans or advances, make certain acquisitions, engage in mergers or consolidations and engage in certain transactions with affiliates. We do not expect to be in violation of our debt covenants in 2010.

Off-Balance Sheet Arrangements

We do not have any relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. Accordingly, we are not materially exposed to any financing, liquidity, market or credit risk that could arise if we had engaged in such relationships.

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Tabular Disclosure of Contractual Obligations and other Commitments

The following table reflects a summary of obligations and commitments outstanding as of December 31, 2009, including our borrowings under our senior secured credit facility and our senior subordinated notes.

	Less than 1 Year	1-3 Years	3-5 Years (in thousands)	More than 5 Years	Total
Contractual obligations					
(Payments Due by Period):					
Senior secured credit facility ⁽¹⁾	\$ 2,097	\$ 197,668	\$	\$	\$ 199,765
Senior subordinated notes ⁽¹⁾				250,000	250,000
Capital lease obligations	2,232	419	226	334	3,211
Other long-term debt	418	269	82	479	1,248
Interest on debt ⁽²⁾	29,513	30,708	72,292	2,778	135,291
Operating lease obligations	34,959	57,730	33,222	49,664	175,575
Other contractual obligations ⁽³⁾	26,727	19,454	9,389	4,336	59,906
Subtotal	95,946	306,248	115,211	307,591	824,996
Other commitments					
(Amount of Commitment Expiration Per Period):					
Guarantees of surety bonds				33,504	33,504
Letters of credit ⁽⁴⁾		43,637			43,637
Subtotal		43,637		33,504	77,141
Total obligations and commitments	\$ 95,946	\$ 349,885	\$ 115,211	\$ 341,095	\$ 902,137

(1) Excludes interest on our senior secured credit facility and senior subordinated notes.

(2) Interest on our floating rate debt was calculated for all years using the effective rate as of December 31, 2009 of 2.24%. See the discussion in Item 7A, "Quantitative and Qualitative Disclosures of Market Risk", for situations that could result in changes to interest costs on our variable interest rate debt.

(3)

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Includes Onex management fees, dispatch fees and responder fees, and other purchase obligations of goods and services.

- (4) Letters of credit are collateralized by our revolving credit facility and are, thus, considered to be due in 2011.

We have capital leases relating to approximately 410 ambulances and certain leasehold improvements. The terms of the leases expire at various dates through March 2018.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

As of December 31, 2009, we had \$451.0 million of outstanding debt, excluding capital leases, of which \$199.8 million was variable rate debt under our senior secured credit facility and the balance was fixed rate debt, including the \$250 million aggregate principal amount of our senior subordinated notes. An increase or decrease in interest rates of 0.125% will impact our interest costs by \$0.3 million.

We manage our exposure to changes in market interest rates and fuel prices and, as appropriate, use highly effective derivative instruments to manage well-defined risk exposures. At December 31, 2009, we were party to a series of fuel hedge transactions with a major financial institution under one master agreement. Each of the nine transactions effectively fixes the cost of diesel fuel at prices ranging

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from \$2.91 to \$3.15 per gallon. We purchase the diesel fuel at the market rate and periodically settle with our counterparty for the difference between the national average price for the period published by the Department of Energy and the agreed upon fixed price. The transactions fix the price for a total of 2.7 million gallons and are spread over periods from January 2010 through December 2010.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

See index to financial information on page F-1.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

As required by Rule 13a-15(b) of the Securities Exchange Act of 1934, as amended, management carried out an evaluation under the supervision and with the participation of the Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures that were in effect as of the end of the period covered by this report. Our Chief Executive Officer and Chief Financial Officer each concluded that our disclosure controls and procedures are effective at a reasonable assurance level as of December 31, 2009, the end of the period covered by this report.

Changes in Internal Control over Financial Reporting

There have been no changes in our internal controls over financial reporting during our most recent fiscal quarter that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal controls over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, the Company conducted an assessment of the effectiveness of its internal control over financial reporting as of December 31, 2009. The assessment was based on criteria established in the framework *Internal Control Integrated Framework*, issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this assessment, management concluded that our internal control over financial reporting was effective as of December 31, 2009.

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The effectiveness of our internal control over financial reporting as of December 31, 2009, has been audited by Ernst & Young LLP, an independent registered public accounting firm. Their report appears with the Consolidated Financial Statements included in Part II, Item 8 of this Form 10-K.

ITEM 9B. OTHER INFORMATION

On February 18, 2010, Amendment No. 3 to the Investor Equityholders' Agreement, or the Investor Equityholders' Agreement, dated February 10, 2005, among EMS LP, Onex Partners, LP and the employee equityholders signatory thereto, became effective. The Investor Equityholders' Agreement previously restricted certain employees from selling their holdings of class A common stock of EMSC, or options exercisable therefor, predating EMSC's initial public offering in December 2005 in an amount exceeding the greater of the percentage of their original investment sold by the Onex-affiliated investors in our Company or 50% of such individuals' original holdings. Amendment No. 3 provides that the employee equityholders signatory to the agreement will be obligated to maintain aggregate holdings of stock and options received prior to EMSC's initial public offering in an amount equal to, or greater than, the aggregate percentage ownership of the Onex entities in EMSC.