PROVIDER ACCOUNT MANAGEMENT INC
Form 424B3
October 07, 2011

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Table of Contents

Filed Pursuant to Rule 424(b)(3)
Registration No. 333-177015

PROSPECTUS

Emergency Medical Services Corporation

Offer to Exchange

$950,000,0000 Outstanding 8.125% Senior Notes due 2019

for

$950,000,0000 Registered 8.125% Senior Notes due 2019

Emergency Medical Services Corporation, is offering to exchange $950,000,000 aggregate principal amount of outstanding 8.125% Senior Notes due 2019 (the "Old Notes"), for a like principal amount of registered 8.125% Senior Notes due 2019 (the "New Notes").

The terms of the New Notes are identical in all material respects to the terms of the Old Notes, except that the New Notes are registered under the Securities Act of 1933, as amended (the "Securities Act"), and will not contain restrictions on transfer or provisions relating to additional interest, will bear a different CUSIP number from the Old Notes and will not entitle their holders to registration rights.

No public market currently exists for the Old Notes or the New Notes.

The exchange offer will expire at 5:00 p.m., New York City time, on November 7, 2011 (the "Expiration Date") unless we extend the Expiration Date. You should read the section called "The Exchange Offer" for further information on how to exchange your Old Notes for New Notes.

See "Risk Factors" beginning on page 21 for a discussion of risk factors that you should consider prior to tendering your Old Notes in the exchange offer and risk factors related to ownership of the Notes.

Each broker-dealer that receives New Notes for its own account pursuant to the exchange offer must acknowledge that it will deliver a prospectus in connection with any resale of such New Notes. The letter of transmittal states that by so acknowledging and by delivering a prospectus, a broker-dealer will not be deemed to admit that it is an "underwriter" within the meaning of the Securities Act. This prospectus, as it may be amended or supplemented from time to time, may be used by a broker-dealer in connection with resales of New Notes received in exchange for Old Notes where such Old Notes were acquired by such broker-dealer as a result of market-making activities or other trading

activities. We have agreed that, for a period of up to 90 days after the consummation of the exchange offer, we will make this prospectus available to any broker-dealer for use in connection with any such resale. See "Plan of Distribution."

Neither the Securities and Exchange Commission ("SEC") nor any state securities commission has approved or disapproved of these securities or passed upon the adequacy or accuracy of this prospectus. Any representation to the contrary is a criminal offense.

The date of this prospectus is October 7, 2011

Table of Contents

TABLE OF CONTENTS

You should rely only on the information contained in this prospectus or to which we have referred you. We have not authorized anyone to provide you with different information. If anyone provides you with different or inconsistent information, you should not rely on it. This prospectus does not constitute an offer to sell, or a solicitation of an offer to purchase, the securities offered by this prospectus in any jurisdiction to or from any person to whom or from whom it is unlawful to make such offer or solicitation of an offer in such jurisdiction. You should not assume that the information contained in this prospectus is accurate as of any date other than the date of this prospectus. Also, you should not assume that there has been no change in the affairs of Emergency Medical Services Corporation and its subsidiaries since the date of this prospectus.

Table of Contents

SUMMARY

This summary highlights information contained elsewhere in this prospectus. This summary does not contain all of the information that you should consider in making your investment decision. You should read the following summary together with the entire prospectus, including the more detailed information regarding our company, the New Notes being issued in the exchange offer and our consolidated financial statements and the related notes included in this prospectus. In this prospectus, unless the context requires otherwise, (i) references to "EMSC" and the "Company" mean Emergency Medical Services Corporation; (ii) references to "we," "us" and "our" mean EMSC and its consolidated subsidiaries; (iii) references to "Parent" mean CDRT Acquisition Corporation; (iv) references to "Merger Sub" mean CDRT Merger Sub, Inc.; and (v) references to "Holding" mean CDRT Holding Corporation. Financial information identified in this prospectus as "pro forma" or "on a pro forma basis" gives effect to the Transactions (as defined below).

Our Company

We are a leading provider of outsourced facility-based physician services and medical transportation services in the United States. We operate our business and market our services under the EmCare and AMR brands, which represent EmCare Holdings Inc. ("EmCare") and American Medical Response, Inc. ("AMR"). EmCare, with more than 35 years of operating history, is a leading provider of physician services 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, as well as anesthesiology, hospitalist/inpatient, radiology and teleradiology programs. AMR, with more than 50 years of operating history, is a leading provider of medical transportation services to communities, payors and hospitals in the United States based on net revenue and number of transports.

Approximately 86% of our net revenue for the year ended December 31, 2010 was generated under exclusive contracts. We had contract retention rates of 88% at EmCare and 99% at AMR as of December 31, 2010. During 2010, we provided services in approximately 14 million patient encounters in more than 2,000 communities nationwide. For the year ended December 31, 2010, we generated net revenue of approximately $2.9 billion, of which EmCare and AMR represented 52% and 48%, respectively. Our Adjusted EBITDA for the year ended December 31, 2010 was $322.1 million, an increase of $35.1 million, or 12.2%, as compared with 2009. See "Summary Historical Financial Data" for a discussion of Adjusted EBITDA and a reconciliation of Adjusted EBITDA to net income.

Table of Contents

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

	EmCare	AMR
Core Services:	Facility-based physician services Emergency department staffing and related management services Anesthesiology, hospitalist/inpatient services, radiology and teleradiology	Pre- and post-hospital medical transportation Emergency ("911") and non-emergency ambulance transports Managed transportation services Fixed-wing air ambulance services Disaster response
Customers:	Hospitals Other healthcare facilities Independent physician groups Attending medical staff	Communities Government agencies Healthcare facilities Insurers
National Market Position:	8% share of emergency department services market 12% share of outsourced emergency department services market 3% share of anesthesia services market 1% share of hospitalist services market 1% share of radiology services market	7% share of total ambulance market 16% share of outsourced ambulance market 5% share of managed transportation market 1% share of medical air transport market
Number of Contracts:	569 facility contracts	168 "911" contracts 3,375 non-emergency transport arrangements
Volume for the year ended December 31, 2010:	Approximately 11.0 million patient encounters	Approximately 3.2 million patient transports

EmCare

EmCare is a leading provider of outsourced facility-based physician services to healthcare facilities in the United States, based on number of contracts with hospitals and affiliated physician groups. EmCare has 569 contracts with hospitals and independent physician groups to provide emergency department, anesthesiology, hospitalist/inpatient, radiology and teleradiology staffing, and other management services. We have added 318 net new contracts since 2001. During 2010, EmCare had approximately 11.0 million patient encounters across 40 states and the District of Columbia. As of December 31, 2010, EmCare had an 8% share of the total emergency department ("ED") services market and a 12% share of the outsourced ED services market, the largest share among outsourced providers based on number of ED contracts. EmCare's share of the combined markets for anesthesiology, hospitalist and radiology services was approximately 2% as of such date.

EmCare focuses on providing an environment where physicians can practice quality medicine, while improving operational efficiencies and patient satisfaction and mitigating risk at its customers'

Table of Contents

hospitals and facilities. We recruit and hire or subcontract with physicians and other healthcare professionals, who then provide services to patients in the facilities with whom we contract. EmCare bills and collects from each patient or the patient's insurance provider for the medical services performed. We also have practice support agreements with independent physician groups and hospitals pursuant to which we provide management services such as billing and collection, recruiting, risk management and certain other administrative services.

American Medical Response

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, 2010, we had a 7% share of the total ambulance services market and a 16% share of the outsourced ambulance market, the largest share among outsourced providers based on number of transports and net revenue. During 2010, AMR treated and transported approximately 3.2 million patients in 38 states and the District of Columbia utilizing nearly 4,300 vehicles that operated out of more than 200 sites. AMR has more than 3,500 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 insurance companies and healthcare facilities.

During 2010, 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 28% of AMR's net revenue for the same period. The remaining balance of net revenue for 2010 was generated from managed transportation services, fixed-wing air ambulance services, and the provision of training, dispatch and other services to communities and public safety agencies.

AMR also has a national contract with the Federal Emergency Management Agency ("FEMA") 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 in the full 48 contiguous states.

Overview of Our Industry

We operate in the outsourced facility-based physician services and medical transportation markets, two large and growing segments of the healthcare market. 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. By law, most communities are required to provide emergency ambulance services and most hospitals are required to provide emergency department services. We believe 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.

Shortage of primary care physicians. We believe that a portion of the historical and expected growth of emergency department visits is driven by the shortage of primary care physicians in

Table of Contents

the United States, which causes many patients to utilize the ED as their primary source for healthcare.

For further information on the facility-based physician services and medical transportation markets in which we compete, please see "Business Description of our Business Industry Overview."

Our 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 Player in Two Large, Growing and Highly Fragmented Markets. We are a leading provider of outsourced facility-based physician services and medical transportation services in the United States. We have significant scale with approximately 14 million patient encounters annually in over 2,000 communities across the United States. The markets in which we compete are highly fragmented with minimal presence from national providers, which we believe results in significant opportunities for continued market share gains as well as strategic "tuck-in" acquisitions. We believe our track record of consistently meeting or exceeding our customers' service expectations across both of our businesses affords us the opportunity to compete effectively in the bidding process for new contracts, as well as to continue to grow complementary service offerings.

Strong, Stable Underlying Industry Volume Trends. We operate within an attractive segment of healthcare services that is supported by strong and stable underlying market volume trends. Based on available data, hospital ED visits have grown at a compound annual growth rate ("CAGR") of 2.5% from 1999 to 2009, and ambulance transports have increased at a CAGR of 3.9% from 2003 to 2009, with no year-over-year declines in market volumes over these periods. These stable, historical market volumes are primarily supported by the critical non-discretionary nature of emergency medical services, as well as aging demographics and a shortage of primary care physicians in the United States.

Broad Spread of Risk with Significant Customer, Geographic and Contract Diversification. Because of our diverse revenue base, we are not reliant on any single facility, community or market. As of December 31, 2010, EmCare had 569 individual facility contracts, with the top 10 ED contracts representing only 9% of EmCare net revenue, and no customer (including all facility contracts under a single hospital system) comprised more than 10% of total net revenue. As of December 31, 2010, AMR had 168 exclusive "911" emergency services contracts and 3,375 non-emergency transport arrangements. AMR's top ten "911" contracts accounted for approximately 24% of AMR net revenue in 2010. We believe that our other services, including anesthesia, hospitalist, radiology, managed transportation and fixed-wing air transport services, also exhibit a broad spread of risk through a diversified customer base and geographic footprint.

Attractive Business Model with Stable Cash Flows and Proven Ability to De-Lever our Balance Sheet. We believe our operating model and the contractual nature of our businesses drive a meaningful amount of recurring revenue which, combined with our relatively low capital expenditure and working capital requirements, lead to strong and predictable cash flows. During 2010, approximately 86% of our net revenue was generated under exclusive contracts. We believe these exclusive contracts and the critical care nature of our services have historically resulted in long-term, stable customer relationships. EmCare and AMR have maintained relationships with their ten largest customers for 15 and 35 years, respectively. We believe our ability to consistently deliver high levels of customer service and continue to improve our customer's key metrics are illustrated by our high contract retention rates of 88% in EmCare and 99% in AMR as of December 31, 2010. Our strong earnings growth and free cash flow generated by our stable customer base have enabled us to reduce our total leverage ratio meaningfully over the last five years.

Table of Contents

Favorable Pricing Environment with Unique Reimbursement Characteristics. Pricing and reimbursement for EmCare and AMR services have historically been favorable. We believe this trend will remain stable into the future. At EmCare, commercial payor leverage is reduced due to the emergency nature of the services, and physician reimbursement under Medicare has historically been stable. In addition, in many of our hospital contracts, we have the ability to obtain or increase subsidies to offset any reimbursement or payor mix changes. At AMR, communities and municipalities set emergency allowable rates for commercial payors and, with limited exception, do not pay for services out of the tax base. Further, we expect future Medicare reimbursement of ambulance services to be stable given that the phase-in of the Medicare national ambulance fee schedule was completed in 2010, and reimbursement for ambulance services represents a relatively small proportion of total Medicare spending. In addition, at both EmCare and AMR we have visibility into payor mix prior to entering into new contracts, and our payor mix has been stable over time, which allows us to more effectively manage exposure to each payor category.

Opportunities for Continued Cost Reduction and Productivity Improvement. We have a strong track record of profitable growth exhibited by a 16.0% CAGR in our Adjusted EBITDA and our expansion of Adjusted EBITDA margins by approximately 200 basis points from 2006 to 2010. Our consistent earnings growth and margin expansion over the last several years have been driven by our management's continuous focus on cost reductions and productivity improvements as well as benefits realized from information technology investments. We believe there are additional opportunities to continue to drive margin improvements in the future through targeted initiatives and additional technology enhancements.

Increased Outsourcing of Health Services. We believe market conditions are conducive to continued outsourcing of health services. In the EmCare segment, hospitals are increasingly outsourcing physician services due to increased cost pressures, the need to enhance operating efficiency, difficulties in physician recruiting and retention, the future possibility of pay-for-performance models and the desire to improve quality of care while reducing patient care cost. In the AMR segment, communities are increasingly outsourcing emergency medical transportation services due to cost pressures and budget constraints, the need for quality enhancement and improved clinical outcomes, the lack of risk management expertise and the pressure to meet peak demands.

Strong and Experienced Management Team with Demonstrated Track Record of Performance. We have a strong and deep management team with a historical track record of success. Many of our officers have decades of industry experience and significant tenure at EMSC. We are led by William Sanger, CEO, who has 35 years of industry experience, Randy Owen, EVP and CFO, who has 29 years of industry experience, Todd Zimmerman, EmCare President and EVP, who has 20 years of industry experience, and Mark Bruning, AMR President, who has 28 years of industry experience. Our current management team has led us through a series of initiatives focused on driving organic revenue growth and productivity and efficiency gains as well as executing several strategic acquisitions. Together these initiatives have resulted in net revenue and Adjusted EBITDA CAGRs of 10.3% and 16.0%, respectively, over the last four years.

Our Strategy

Our objective is to continue to be a leader in outsourced facility-based physician services and medical transportation services in the United States as we pursue the following strategies and initiatives:

Achieve Organic Growth through Market Share Gains and Continued Outsourcing. 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 positions provide us with new and expanded opportunities to grow our customer base through market

Table of Contents

share gains from local and regional competitors as well as through continued outsourcing of physician and medical transportation services by hospitals and communities.

Grow Complementary Service Lines by Cross-Selling to Existing Customers and Adding New Customers. We believe our track record of maintaining successful long-term relationships with customers, combined with the expanded breadth of our service offerings, creates opportunities for us to increase revenue from our existing customer base and add new customers seeking services we previously did not provide. We have entered complementary service lines at both EmCare and AMR that are designed to leverage our core competencies.

Supplement Organic Growth with Opportunistic Acquisitions. The outsourced facility-based physician services and medical transportation services industries are highly fragmented, with only a few large national providers. We believe we have a successful track record of making strategic acquisitions at attractive valuations designed to enhance our market position and improve our value proposition for customers.

Enhance Operational Efficiencies and Productivity to Drive Continued Margin Improvement. We believe there are significant opportunities to build upon our success in improving our productivity and profitability at both EmCare and AMR. At EmCare, we continue to focus on initiatives to improve physician productivity, including more efficient scheduling around peak and off-peak hours, use of mid-level providers as well as improving and realigning physician compensation programs to help accelerate productivity gains. At AMR, we expect to benefit from additional investments in technology, such as the continued roll-out of ePCR (electronic patient care records) to enhance data collection accuracy and billing system automation to reduce our billing costs and days sales outstanding ("DSO").

We describe additional elements of our strategy in "Business Business Strategy."

Emergency Medical Services Corporation is incorporated under the laws of the state of Delaware. Our corporate headquarters are located at 6200 S. Syracuse Way, Suite 200, Greenwood Village, CO 80111. Our telephone number is (303) 495-1200.

The Transactions

On February 13, 2011, EMSC entered into an Agreement and Plan of Merger (the "Merger Agreement") with Parent and Merger Sub, formerly a wholly owned subsidiary of Parent. Pursuant to the Merger Agreement, Merger Sub merged with and into EMSC, with EMSC as the surviving corporation and a wholly owned subsidiary of Parent (the "Merger"). Immediately following the Merger, all of the outstanding common stock of Parent was owned by Holding, which is owned by Clayton, Dubilier & Rice Fund VIII, L.P. ("CD&R Fund VIII"), CD&R Friends & Family Fund VIII, L.P. ("CD&R F&F Fund"), CD&R Advisor Fund VIII Co-Investor, L.P. ("CD&R Advisor Co-Investor") and CD&R EMS Co-Investor, L.P. (together with CD&R Fund VIII, CD&R F&F Fund and CD&R Advisor Co-Investor, the "CD&R Affiliates").

Table of Contents

On May 25, 2011, the following transactions occurred in connection with the Merger (collectively, the "Transactions"):

LP units of the entity formerly known as Emergency Medical Services L.P., a wholly owned subsidiary of EMSC, were exchanged for EMSC common stock;

outstanding shares of EMSC common stock were converted into the right to receive $64.00 per share in cash, without interest and less any applicable withholding taxes;

options to purchase shares of EMSC common stock (other than options that were rolled over by certain members of management as described below), vested or unvested, were cancelled and each option was converted into the right to receive a cash payment equal to the excess (if any) of $64.00 per share over the exercise price per share of the option times the number of shares subject to the option, without interest and less any applicable withholding taxes;

restricted shares, vested or unvested, were fully vested at the effective time and canceled and extinguished and each restricted share was converted into the right to receive $64.00 per share in cash, without interest and less any applicable withholding taxes;

restricted stock units, vested or unvested, were cancelled and extinguished, and each restricted stock unit was converted into the right to receive a cash payment equal to $64.00 per share times the number of shares of EMSC common stock subject to such restricted stock units, without interest and less any applicable withholding taxes;

the CD&R Affiliates invested $887.1 million in the common stock of Holding, the proceeds of which were contributed to Parent (the "CD&R Equity Investment");

certain members of our management rolled over existing options to purchase EMSC common stock with an aggregate value of $28.3 million, based on the Merger consideration price, into options to purchase common stock of Holding (the "Management Rollover Investment" and, together with the CD&R Equity Investment, the "Equity Contributions");

Merger Sub entered into new senior secured credit facilities, comprising (i) a seven-year senior secured term loan facility of up to $1,440 million (as further described in "Description of Other Indebtedness Term Loan Facility," the "Term Loan Facility") and (ii) a five-year senior secured asset-based loan facility of up to $350 million (as further described in "Description of Other Indebtedness ABL Facility," the "ABL Facility" and, together with the Term Loan Facility, the "Senior Secured Credit Facilities");

Merger Sub issued the Old Notes;

the net proceeds of the Equity Contributions, the Old Notes and the borrowings under the Term Loan Facility were used to fund the cash consideration payable to our former stockholders and other equity holders, repay outstanding borrowings under our prior senior secured credit facility and pay related transaction fees and expenses;

Merger Sub merged with and into EMSC, with EMSC as the surviving corporation; and

upon consummation of the Merger, the rights and obligations of Merger Sub under the Old Notes and the Indenture, dated as of May 25, 2011, governing the Notes (the "Indenture") and under the Senior Secured Credit Facilities were assumed by the Company.

Our Sponsor

Founded in 1978, Clayton, Dubilier & Rice, LLC is a private equity firm with an integrated operational and financial approach to investing. CD&R has 40 investment professionals with offices in New York and London. Over the firm's 33-year history, CD&R has invested over $12 billion in capital

Table of Contents

in 51 businesses and is currently investing out of its $5 billion eighth fund. CD&R has a disciplined and clearly defined investment strategy with a special focus on multi-location services and distribution businesses.

Ownership and Organizational Structure

The following chart illustrates our ownership and organizational structure:

(1) Represents options to purchase Holding common stock held by EMSC management as well as shares of Holding common stock to be issued to EMSC management in connection with a management equity offering completed in September 2011. See "Security Ownership of Certain Beneficial Owners and Management."

(2) In connection with the Transactions, we entered into the ABL Facility, which provides for a five-year senior secured revolving credit facility of up to $350 million, subject to a borrowing base of approximately $356 million and approximately $47 million of letters of credit issued under the ABL Facility as of June 30, 2011. As of June 30, 2011, we were able to borrow approximately $303 million under the ABL Facility. See "Description of Other Indebtedness ABL Facility." We have not drawn on the ABL Facility.

Table of Contents

(3) In connection with the Transactions, we entered into the Term Loan Facility which provides for a seven-year senior secured term loan facility of up to $1,440 million. See "Description of Other Indebtedness Term Loan Facility."

(4) The Old Notes are not guaranteed by any of our foreign subsidiaries or any of our subsidiaries subject to regulation as an insurance company, including our captive insurance subsidiary. The Old Notes are structurally subordinated to the indebtedness and other liabilities of our non-guarantor subsidiaries, including their insurance liabilities. As of June 30, 2011, the non-guarantor subsidiaries had no indebtedness and approximately $155.9 million of primarily insurance-related liabilities. Our non-guarantor subsidiaries generated approximately $2.1 million of our net revenue for the year ended December 31, 2010 and held approximately $162.0 million of our assets as of June 30, 2011.

(5) Due to the corporate practice of medicine restrictions of certain states, we maintain long-term management contracts with affiliated physician groups, which employ or contract with physicians to provide physician services. These entities are not subsidiaries of our company but their operations are typically consolidated in accordance with generally accepted accounting principles. See "Business EmCare Contracts Affiliated Physician Group Contracts."

Market and Industry Data

The market data and other statistical information used throughout this prospectus are based on independent industry publications, government publications, reports by market research firms or other published independent sources. Some data are also based on our good faith estimates, which are derived from our review of internal surveys, as well as the independent sources listed above. Although we believe these sources are reliable, we have not independently verified the information. None of the independent industry publications used in this prospectus were prepared on our behalf and none of the sources cited in this prospectus consented to the inclusion of any data from its reports, nor have we sought their consent.

Trademarks and Service Marks

EMSC®, AMR® and EmCare® are three of our brand names, trademarks or service marks. Information contained in this prospectus may also refer to brand names, trademarks or service marks of other companies. All such brand names, trademarks or service marks are the property of their respective owners.

Table of Contents

Summary of the Terms of the Exchange Offer

The Notes	On May 25, 2011 (the "Issuance Date"), Merger Sub issued $950 million aggregate principal amount of 8.125% Senior Notes due 2019 pursuant to exemptions from the registration requirements of the Securities Act. On such date, upon the consummation of the Merger of Merger Sub with and into the Company, the Company assumed all the rights and obligations under the Old Notes and the Indenture. The initial purchasers for the Old Notes were Barclays Capital Inc., Deutsche Bank Securities Inc., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Morgan Stanley & Co. Incorporated, RBC Capital Markets, LLC, UBS Securities LLC, Citigroup Global Markets Inc., Natixis Securities North America Inc. (the "Initial Purchasers"). When we use the term "Old Notes" in this prospectus, we mean the 8.125% Senior Notes due 2019 that were privately placed with the Initial Purchasers on May 25, 2011, and were not registered with the SEC. When we use the term "New Notes" in this prospectus, we mean the 8.125% Senior Notes due 2019 registered with the SEC and offered hereby in exchange for the Old Notes. When we use the term "Notes" in this prospectus, the related discussion applies to both the Old Notes and the New Notes. The terms of the New Notes are identical in all material respects to the terms of the Old Notes, except that the New Notes are registered under the Securities Act and will not be subject to restrictions on transfer, will bear a different CUSIP and ISIN number than the Old Notes, will not entitle their holders to registration rights and will be subject to terms relating to book-entry procedures and administrative terms relating to transfers that differ from those of the Old Notes. The CUSIP numbers for the Old Notes are 12513P AA7 (Rule 144A) and U1251T AA5 (Regulation S). The ISIN numbers for the Old Notes are US12513PAA75 (Rule 144A), and USU1251TAA52 (Regulation S). The CUSIP number for the New Notes is 29100P AB8 and the ISIN number for the New Notes is US29100PAB85.
The Exchange Offer	You may exchange Old Notes for a like principal amount of New Notes. The consummation of the exchange offer is not conditioned upon any minimum or maximum aggregate principal amount of Old Notes being tendered for exchange.
Resale of New Notes	We believe the New Notes that will be issued in the exchange offer may be resold by most investors without compliance with the registration and prospectus delivery provisions of the Securities Act, subject to certain conditions. You should read the discussion under the heading "The Exchange Offer" for further information regarding the exchange offer and resale of the New Notes.

Table of Contents

Registration Rights Agreement	We have undertaken the exchange offer pursuant to the terms of the Exchange and Registration Rights Agreement we entered into with the Initial Purchasers on May 25, 2011 (the "Registration Rights Agreement"). Pursuant to the Registration Rights Agreement, we agreed to use our commercially reasonable efforts to consummate an exchange offer for the Old Notes pursuant to an effective registration statement or to cause resales of the Old Notes to be registered. The Registration Rights Agreement provides that if a Registration Default occurs, the interest rate on the Registrable Securities will be increased by (i) 0.25% per annum for the first 90-day period beginning on the day immediately following such Registration Default and (ii) an additional 0.25% per annum with respect to each subsequent 90-day period, in each case until and including the date such Registration Default ends, up to a maximum increase of 0.50% per annum. See "Exchange Offer; Registration Rights."
Consequences of Failure to Exchange the Old Notes	You will continue to hold Old Notes that remain subject to their existing transfer restrictions if: you do not tender your Old Notes; or you tender your Old Notes and they are not accepted for exchange. We will have no obligation to register the Old Notes after we consummate the exchange offer. See "The Exchange Offer Terms of the Exchange Offer; Period for Tendering Old Notes."
Expiration Date	The exchange offer will expire at 5:00 p.m., New York City time, on November 7, 2011 (the "Expiration Date"), unless we extend it, in which case Expiration Date means the latest date and time to which the exchange offer is extended.
Interest on the New Notes	The New Notes will accrue interest from the most recent date to which interest has been paid or provided for on the Old Notes or, if no interest has been paid on the Old Notes, from the Issuance Date.

Table of Contents

Conditions to the Exchange Offer	The exchange offer is subject to several customary conditions. We will not be required to accept for exchange, or to issue New Notes in exchange for, any Old Notes, and we may terminate or amend the exchange offer if we determine in our reasonable judgment at any time before the Expiration Date that the exchange offer would violate applicable law or any applicable interpretation of the staff of the SEC. The foregoing conditions are for our sole benefit and may be waived by us at any time. In addition, we will not accept for exchange any Old Notes tendered, and no New Notes will be issued in exchange for any such Old Notes, if at any time any stop order is threatened or in effect with respect to: the registration statement of which this prospectus constitutes a part; or the qualification of the Indenture under the Trust Indenture Act of 1939, as amended (the "Trust Indenture Act"). See "The Exchange Offer Conditions to the Exchange Offer." We reserve the right to terminate or amend the exchange offer at any time prior to the Expiration Date upon the occurrence of any of the foregoing events.
Procedures for Tendering Old Notes	If you wish to accept the exchange offer, you must tender your Old Notes and do the following on or prior to the Expiration Date, unless you follow the procedures described under "The Exchange Offer Guaranteed Delivery Procedures." if Old Notes are tendered in accordance with the book-entry procedures described under "The Exchange Offer Book-Entry Transfer," transmit an Agent's Message to the Exchange Agent through the Automated Tender Offer Program ("ATOP") of The Depository Trust Company ("DTC"), or transmit a properly completed and duly executed letter of transmittal, or a facsimile copy thereof, to the Exchange Agent, including all other documents required by the letter of transmittal. See "The Exchange Offer Procedures for Tendering Old Notes."
Guaranteed Delivery Procedures	If you wish to tender your Old Notes, but cannot properly do so prior to the Expiration Date, you may tender your Old Notes according to the guaranteed delivery procedures set forth under "The Exchange Offer Guaranteed Delivery Procedures."

Table of Contents

Withdrawal Rights	Tenders of Old Notes may be withdrawn at any time prior to 5:00 p.m., New York City time, on the Expiration Date. To withdraw a tender of Old Notes, a notice of withdrawal must be actually received by the Exchange Agent at its address set forth in "The Exchange Offer Exchange Agent" prior to 5:00 p.m., New York City time, on the Expiration Date. See "The Exchange Offer Withdrawal Rights."
Acceptance of Old Notes and Delivery of New Notes	Except in some circumstances, any and all Old Notes that are validly tendered in the exchange offer prior to 5:00 p.m., New York City time, on the Expiration Date will be accepted for exchange. The New Notes issued pursuant to the exchange offer will be delivered promptly after the Expiration Date. See "The Exchange Offer Acceptance of Old Notes for Exchange; Delivery of New Notes."
Material United States Federal Income Tax Considerations	We believe that the exchange of an Old Note for a New Note pursuant to the exchange offer will not be treated as a sale or exchange for U.S. federal income tax purposes. See "Material United States Federal Income Tax Considerations."
Exchange Agent	Wilmington Trust, National Association is serving as the Exchange Agent (the "Exchange Agent").

Table of Contents

Summary of the Terms of the Notes

The terms of the New Notes offered in the exchange offer are identical in all material respects to the Old Notes, except that the New Notes:

- are registered under the Securities Act and therefore will not be subject to restrictions on transfer;
- will not be subject to provisions relating to additional interest;
- will bear a different CUSIP and ISIN number;
- will not entitle their holders to registration rights; and
- will be subject to terms relating to book-entry procedures and administrative terms relating to transfers that differ from those of the Old Notes.

The following summary contains basic information about the New Notes and the guarantees thereof and is not intended to be complete. For a more complete understanding of the New Notes and the guarantees, please refer to the section entitled "Description of Notes" in this prospectus.

Issuer	Emergency Medical Services Corporation
Notes offered	$950 million aggregate principal amount of 8.125% Senior Notes due 2019.
Maturity	The Notes will mature on June 1, 2019
Interest payment dates	June 1 and December 1, commencing on December 1, 2011.
Ranking	The Notes are our unsecured senior indebtedness and rank: equal in right of payment with all of our existing and future senior indebtedness; senior in right of payment to all of our existing and future subordinated obligations; effectively subordinated to all of our secured indebtedness, including indebtedness under our new $1,440 million senior secured term loan facility and our new senior secured asset-based loan facility of up to $350 million, to the extent of the value of the assets securing such indebtedness; and structurally subordinated to all existing and future indebtedness and other liabilities of our non-guarantor subsidiaries, including all of our foreign subsidiaries.
Guarantors	The Notes are guaranteed, on an unsecured senior basis, by each of our domestic subsidiaries that is a borrower under or that guarantees our obligations under our senior secured credit facilities. These guarantees are subject to release under specified circumstances. See "Description of Notes Subsidiary Guarantees." The guarantee of each Guarantor will be an unsecured senior obligation of that Guarantor and ranks: equal in right of payment with all existing and future senior indebtedness of that guarantor;

Table of Contents

	senior in right of payment with all existing and future guarantor subordinated obligations; effectively subordinated to all secured indebtedness of that guarantor to the extent of the value of the assets securing such indebtedness, including any such guarantor's guarantee of indebtedness under our new $1,440 million senior secured term loan facility and our new senior secured asset-based loan facility of up to $350 million; and structurally subordinated to all existing and future indebtedness and other liabilities of our non-guarantor subsidiaries, including all of our foreign subsidiaries. The Notes are not guaranteed by any of our foreign subsidiaries or any of our subsidiaries subject to regulation as an insurance company, including our captive insurance subsidiary. The Notes are structurally subordinated to the indebtedness and other liabilities of our non-guarantor subsidiaries, including their insurance liabilities. As of June 30, 2011, the non-guarantor subsidiaries had no indebtedness and approximately $155.9 million of primarily insurance-related liabilities. Our non-guarantor subsidiaries generated approximately $2.1 million of our net revenue for the year ended December 31, 2010 and held approximately $162.0 million of our assets as of June 30, 2011.
Optional redemption	We may redeem the Notes, in whole or in part, at any time (1) prior to June 1, 2014, at a price equal to 100% of the principal amount thereof, plus accrued and unpaid interest, if any, to the redemption date, plus the make-whole premium described under "Description of Notes Optional Redemption," and (2) on and after June 1, 2014, at the redemption prices described under "Description of Notes Optional Redemption."
Optional redemption after certain equity offerings	Prior to June 1, 2014, we may redeem on one or more occasions up to 35% of the original aggregate principal amount of the Notes in an amount not exceeding the net proceeds of one or more equity offerings at a redemption price equal to 108.125% of the principal amount thereof, plus accrued and unpaid interest, if any, to the redemption date, as described under "Description of Notes Optional Redemption."
Offer to repurchase	If we experience a change of control, we must offer to repurchase all of the Notes (unless otherwise redeemed) at a price equal to 101% of their principal amount, plus accrued and unpaid interest, if any, to the repurchase date. See "Description of Notes Change of Control."

Table of Contents

	If we sell assets under certain circumstances, we must use the proceeds to make an offer to purchase Notes at a price equal to 100% of their principal amount, plus accrued and unpaid interest, if any, to the date of purchase. See "Description of Notes Certain Covenants Limitation on Sales of Assets and Subsidiary Stock."
Certain covenants	The Indenture contains covenants that, among other things, limit our ability and the ability of our restricted subsidiaries to: incur more indebtedness or issue certain preferred shares; pay dividends, redeem stock or make other distributions; make investments; create restrictions on the ability of our restricted subsidiaries to pay dividends to us or make other intercompany transfers; create liens; transfer or sell assets; merge or consolidate; enter into certain transactions with our affiliates; and designate subsidiaries as unrestricted subsidiaries. Most of these covenants will cease to apply for so long as the Notes have investment grade ratings from both Moody's and S&P. These covenants are subject to important exceptions and qualifications, which are described under "Description of Notes Certain Covenants" and "Description of Notes Merger and Consolidation."
Risk factors	Investing in the Notes involves risks. For a description of risks you should consider before making your investment decision, see "Risk Factors."

Table of Contents

Ratio of Earnings to Fixed Charges

	Predecessor						Successor
	Year ended December 31,					Period from January 1 through May 24, 2011	Period from May 25, through June 30, 2011
	2006	2007	2008	2009	2010		
Ratio of earnings to fixed charges(1)	0.46	0.37	0.27	0.22	0.14	0.23	0.66

(1) For the purposes of calculating the ratio of earnings to fixed charges, earnings consist of income before taxes plus fixed charges. Fixed charges consist of interest expense, amortization of debt issuance costs and the portion of rental expense that we believe is representative of the interest component of rental expense.

Table of Contents

Summary Historical Financial Data

The following table presents summary consolidated historical financial data for EMSC and its consolidated subsidiaries.

The consolidated financial statements included in this prospectus are presented for two periods: the period prior to and including May 24, 2011 ("Predecessor") and the period including and after May 25, 2011 ("Successor"), the date of the Merger. As a result of the Transactions, our consolidated financial statements after the Merger are not comparable to our consolidated financial statements prior to the date of the Merger. The historical data presented below are not necessarily indicative of the results to be expected for any future period.

The summary historical financial data for EMSC and its consolidated subsidiaries as of December 31, 2009 and 2010 (Predecessor) and for the years ended December 31, 2008, 2009 and 2010 (Predecessor) are derived from our audited consolidated financial statements included elsewhere in this prospectus. The summary historical financial data for EMSC and its consolidated subsidiaries as of and for the six months ended June 30, 2010 (Predecessor), the period from January 1 through May 24, 2011 (Predecessor), the period from May 25 through June 30, 2011 and as of June 30, 2011 (Successor) are derived from our unaudited consolidated financial statements included elsewhere in this prospectus. The summary historical balance sheet data for EMSC and its consolidated subsidiaries as of December 31, 2008 were derived from our audited consolidated financial statements not included in this prospectus.

This information should be read in conjunction with "Risk Factors," "Unaudited Pro Forma Consolidated Financial Statements," "Selected Historical Financial Data," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and the related notes included elsewhere in this prospectus.

	Predecessor					Successor
	Year ended December 31,			Six months ended June 30,	Period from January 1 through May 24	Period from May 25 through June 30,
	2008	2009	2010	2010	2011	2011
	(in thousands of dollars)					
Statement of Operations Data:						
Net revenue	$ 2,409,864	$ 2,569,685	$ 2,859,322	$ 1,388,158	$ 1,221,790	$ 319,543
Compensation and benefits	1,637,425	1,796,779	2,023,503	976,760	874,633	221,804
Operating expenses	383,359	334,328	359,262	177,115	156,740	41,856
Insurance expense	82,221	97,610	97,330	48,012	47,229	10,089
Selling, general and administrative expenses	69,658	63,481	67,912	35,156	29,241	6,861
Depreciation and amortization expense	68,980	64,351	65,332	31,872	28,467	11,061
Income from operations	168,221	213,136	245,983	119,243	85,480	27,872
Interest income from restricted assets	6,407	4,516	3,105	1,714	1,124	162
Interest expense	(42,087)	(40,996)	(22,912)	(13,326)	(7,886)	(17,950)
Realized gain (loss) on	2,722	2,105	2,450	149	(9)	7

investments						
Interest and other (expense) income	2,055	1,816	968	471	(28,873)	(140)
Loss on early debt extinguishment	(241)		(19,091)	(19,091)	(10,069)	
Income before income taxes and equity in earnings of unconsolidated subsidiary	137,077	180,577	210,503	89,160	39,767	9,951
Income tax expense	(52,530)	(65,685)	(79,126)	(34,365)	(19,242)	(4,158)
Income before equity in earnings of unconsolidated subsidiary	84,547	114,892	131,377	54,795	20,525	5,793
Equity in earnings of unconsolidated subsidiary	300	347	347	199	143	33
Net income	$ 84,847	$ 115,239	$ 131,724	$ 54,994	$ 20,668	$ 5,826

Table of Contents

	Predecessor					Successor
	Year ended December 31,			Six months ended June 30,	Period from January 1 through May 24	Period from May 25 through June 30,
	2008	2009	2010	2010	2011	2011
	(in thousands of dollars)					
Balance Sheet Data (at end of period):						
Cash and cash equivalents	$ 146,173	$ 332,888	$ 287,361	$ 313,033		$ 186,811
Working capital(1)	495,033	516,078	531,477	524,777		385,188
Property, plant and equipment, net	124,869	125,855	133,731	121,324		135,479
Total assets	1,541,219	1,654,707	1,748,552	1,704,795		4,072,796
Total debt(2)	458,505	453,930	421,276	427,535		2,379,335
Stockholders' equity	539,039	686,087	847,205	764,775		891,301
Cash Flow Data:						
Cash flows provided by (used in):						
Operating activities	$ 211,457	$ 272,553	$ 185,544	$ 84,742	$ 67,975	$ 37,721
Investing activities	(74,945)	(116,629)	(158,865)	(60,358)	(89,459)	(2,847,446)
Financing activities	(19,253)	30,791	(72,206)	(44,239)	20,671	2,709,988
Purchases of property, plant and equipment	(32,088)	(44,728)	(49,121)	(15,168)	(18,496)	(2,892)
Other Financial Data:						
Adjusted EBITDA(3)	$ 247,084	$ 286,982	$ 322,119	$ 155,874	$ 130,582	$ 40,039
Cash interest expense	39,983	39,165	20,428	12,190	6,556	16,046

(1) Working capital is defined as current assets less current liabilities.

(2) Total debt is defined as long-term debt and capital lease obligations, including current maturities, and excludes adjustments resulting from loan fees, which are accounted for as a reduction to outstanding debt.

(3) 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 (expense) income, realized gain (loss) on investments, interest expense, depreciation and amortization expense, equity-based compensation expenses and related party management fees. Adjusted EBITDA, as reported historically, has been adjusted to reflect equity-based compensation expenses and related party management fees. See the reconciliation table below.

Adjusted EBITDA is commonly used by management and investors as a performance measure. Adjusted EBITDA is not considered a measure of financial performance under GAAP, and the items excluded from Adjusted EBITDA are significant components in understanding and assessing our financial performance. Adjusted EBITDA has limitations as an analytical tool and should not be considered in isolation or as an alternative to GAAP measures such as net income, cash flows provided by or used in operating, investing or financing activities or other financial statement data presented in our consolidated financial statements as an indicator of financial performance or liquidity. Some of these limitations are:

- Adjusted EBITDA does not reflect changes in, or cash requirements for, our working capital needs;
- Adjusted EBITDA does not reflect our interest expense, or the requirements necessary to service interest or principal payments on our debt;

Adjusted EBITDA does not reflect our income tax expenses or the cash requirements to pay our taxes;

Adjusted EBITDA does not reflect historical cash expenditures or future requirements for capital expenditures or contractual commitments; and

although depreciation and amortization charges are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and Adjusted EBITDA does not reflect any cash requirements for such replacements.

Because Adjusted EBITDA is not a measure determined in accordance with GAAP and is susceptible to varying calculations, this measure, as presented, may not be comparable to other similarly titled measures of other companies.

Table of Contents

The following tables set forth a reconciliation to net income of Adjusted EBITDA for the periods presented:

	Predecessor					Successor
	Year ended December 31,			Six Months ended June 30,	Period from January 1, through May 24,	Period from May 25 through June 30,
	2008	2009	2010	2010	2011	2011
	(in thousands of dollars)					
Consolidated/Combined						
Net income	$ 84,847	$ 115,239	$ 131,724	$ 54,994	$ 20,668	$ 5,826
Income tax expense	52,530	65,685	79,126	34,365	19,242	4,158
Equity in earnings of unconsolidated subsidiary(a)	(300)	(347)	(347)	(199)	(143)	(33)
Loss on early debt extinguishment(b)	241		19,091	19,091	10,069	
Interest and other (income) expense(c)	(2,055)	(1,816)	(968)	(471)	28,873	140
Realized (gain) loss on investments(d)	(2,722)	(2,105)	(2,450)	(149)	9	(7)
Interest expense	42,087	40,996	22,912	13,326	7,886	17,950
Interest income from restricted assets	(6,407)	(4,516)	(3,105)	(1,714)	(1,124)	(162)
Income from operations	168,221	213,136	245,983	119,243	85,480	27,872
Interest income from restricted assets	6,407	4,516	3,105	1,714	1,124	162
Depreciation and amortization expense	68,980	64,351	65,332	31,872	28,467	11,061
Equity-based compensation expense(e)	2,476	3,979	6,699	2,545	15,112	430
Related party management fees(f)	1,000	1,000	1,000	500	399	514
Adjusted EBITDA	$ 247,084	$ 286,982	$ 322,119	$ 155,874	$ 130,582	$ 40,039

(a) Represents the equity in earnings recognized in the 2008, 2009, 2010 and 2011 periods relating to the minority interest held by AMR in a joint venture in Trinidad. AMR recognizes equity in earnings of the unconsolidated subsidiary in the income statement, but not in Adjusted EBITDA.

(b) Represents a loss on early debt extinguishment of $241,000 recorded during 2008, no effect on early debt extinguishment in 2009, a loss on early debt extinguishment of $19.1 million recorded during 2010, and a loss on early debt extinguishment of $10.1 million during the Predecessor period of January 1 through May 24, 2011.

(c) Represents interest and other (income) expense. During the Predecessor period of January 1 through May 24, 2011 and the Successor period of May 25 through June 30, 2011, this included $29.5 million and $0.3 million, respectively, of expenses incurred with the Transactions.

(d) Represents realized gains or losses on investments held at EMCA Insurance Company, Ltd. ("EMCA") associated with insurance related assets. These gains or losses are recorded only upon a sale or maturity of such investments.

(e) Represents the non-cash equity based compensation expense related to equity based awards under our prior and existing equity-based incentive plans.

(f) Represents the management fees paid to our prior sponsor and payable to CD&R as part of the consulting agreement entered into at the closing of the Transactions.

Table of Contents

RISK FACTORS

Investing in the Notes involves a high degree of risk. Before you make your investment decision, you should carefully consider the risks described below and the other information contained in this prospectus, including the consolidated financial statements and the related notes. If any of the following risks actually occurs, our business, financial condition, results of operations or cash flows could be materially adversely affected.

Risk Factors Related to the Notes

Our substantial indebtedness may adversely affect our financial health and prevent us from making payments on the Notes.

We have substantial indebtedness. As of June 30, 2011, we had total indebtedness, including capital leases, of approximately $2,387 million, including $950 million of Old Notes, $1,436 million of borrowings under the Term Loan Facility and approximately $2 million of other long-term indebtedness. In addition, as of June 30, 2011, after giving effect to approximately $47 million of letters of credit issued under the ABL Facility, we were able to borrow approximately $303 million under the ABL Facility. As of December 31, 2010, we also had approximately $155 million in operating lease commitments.

The degree to which we are leveraged may have important consequences for us. For example, it may:

make it more difficult for us to make payments on our indebtedness;

increase our vulnerability to general economic and industry conditions, including recessions and periods of significant inflation and financial market volatility;

expose us to the risk of increased interest rates because any borrowings we make under the ABL Facility, and our borrowings under the Term Loan Facility under certain circumstances, will bear interest at variable rates;

require us to use a substantial portion of our cash flow from operations to service our indebtedness, thereby reducing our ability to fund working capital, capital expenditures and other expenses;

limit our flexibility in planning for, or reacting to, changes in our business and the industries in which we operate;

place us at a competitive disadvantage compared to competitors that have less indebtedness; and

limit our ability to borrow additional funds that may be needed to operate and expand our business.

The Indenture, the credit agreement governing the ABL Facility (as further described in "Description of Other Indebtedness ABL Facility," the "ABL Credit Agreement") and the credit agreement governing the Term Loan Facility (as further described in "Description of Other Indebtedness Term Loan Facility," the "Term Loan Credit Agreement") contain restrictive covenants that limit our ability to engage in activities that may be in our long-term best interests. Those covenants include restrictions on our ability to, among other things, incur more indebtedness, pay dividends, redeem stock or make other distributions, make investments, create liens, transfer or sell assets, merge or consolidate and enter into certain transactions with our affiliates. Our failure to comply with those covenants could result in an event of default, which, if not cured or waived, could result in the acceleration of all of our indebtedness. See also " The Indenture, the ABL Credit Agreement and the Term Loan Credit Agreement restrict our ability and the ability of most of our subsidiaries to engage in some business and financial transactions."

Table of Contents

Despite our indebtedness levels, we, our subsidiaries and our affiliated professional corporations may be able to incur substantially more indebtedness which may increase the risks created by our substantial indebtedness.

We, our subsidiaries and our affiliated professional corporations may be able to incur substantial additional indebtedness in the future. The terms of the Indenture do not fully prohibit us, our subsidiaries and our affiliated professional corporations from doing so. If we or our subsidiaries are in compliance with certain incurrence ratios set forth in the ABL Credit Agreement, the Term Loan Credit Agreement and the Indenture, we and our subsidiaries may be able to incur substantial additional indebtedness, which may increase the risks created by our current substantial indebtedness. See "Description of Other Indebtedness ABL Facility," "Description of Other Indebtedness Term Loan Facility" and "Description of Notes Certain Covenants Limitation on Indebtedness." Our affiliated professional corporations will not be subject to the covenants governing our indebtedness.

After giving effect to approximately $47 million of letters of credit issued under the ABL Facility, as of June 30, 2011, we were able to borrow approximately $303 million under the ABL Facility. All of these borrowings would be secured and would rank senior to the Notes and the subsidiary guarantees.

The Notes are effectively subordinated to borrowings under the ABL Facility and the Term Loan Facility to the extent of the value of the assets securing such debt and structurally subordinated to the indebtedness and other liabilities of our non-guarantor subsidiaries.

The Indenture permits us to incur certain secured indebtedness, including indebtedness under the Senior Secured Credit Facilities. All of the obligations under the Senior Secured Credit Facilities are guaranteed by the same subsidiaries that guarantee the Notes. In addition, the Senior Secured Credit Facilities are secured by substantially all of our assets and by substantially all of the assets of each subsidiary guarantor of the Senior Secured Credit Facilities, including the capital stock of each subsidiary guarantor of the Senior Secured Credit Facilities held by us or any other subsidiary guarantor and a lien on substantially all of our tangible and intangible assets and all of the tangible and intangible assets of each other subsidiary guarantor of the Senior Secured Credit Facilities, subject to certain exceptions. The Notes are not secured by any of our assets or those of our subsidiaries and therefore do not have the benefit of such collateral. Accordingly, if an event of default occurs under the Senior Secured Credit Facilities, the lenders under those facilities will have a superior right to our assets and the assets of the subsidiary guarantors, to the exclusion of the holders of the Notes, even if we are in default under the Notes. In that event, our assets and the assets of the subsidiary guarantors would first be used to repay in full all indebtedness and other obligations secured by them (including all indebtedness outstanding under the Senior Secured Credit Facilities), resulting in all or a portion of our assets being unavailable to satisfy the claims of the holders of the Notes. Further, if the lenders under the Senior Secured Credit Facilities foreclose and sell the pledged equity interests in any subsidiary guarantor of the Notes, then that subsidiary guarantor will be released from its guarantee of the Notes automatically and immediately upon the sale. If any of the foregoing events occur, we cannot assure you that there will be sufficient assets to pay amounts due on the Notes. The covenant described under "Description of Notes Certain Covenants Limitation on Liens" will not limit or establish conditions on our ability to secure indebtedness under the Senior Secured Credit Facilities.

Payments on the Notes are required to be made only by us and the note guarantors. Accordingly, claims of holders of the Notes will be structurally subordinated to the claims of creditors of our non-guarantor subsidiaries, including trade creditors. All obligations of our non-guarantor subsidiaries will have to be satisfied before any of the assets of such subsidiaries would be available for distribution, upon liquidation or otherwise, to us or a subsidiary guarantor of the Notes. Furthermore, some of the non-guarantor subsidiaries are intended to be bankruptcy remote, and the assets held by them will not be available to our general creditors in a bankruptcy unless and until they are transferred to a non-bankruptcy remote entity.

Table of Contents

As of June 30, 2011, the Notes and subsidiary guarantees were effectively subordinated to approximately $1,436 million of secured indebtedness under the Senior Secured Credit Facilities. As of June 30, 2011, we had approximately $303 million available for future borrowings under the ABL Facility. As of June 30, 2011, our non-guarantor subsidiaries had no indebtedness and approximately $156 million of primarily insurance-related liabilities.

We will require a significant amount of cash to service our indebtedness. The ability to generate cash or refinance our indebtedness as it becomes due depends on many factors, some of which are beyond our control.

EMSC is a holding company, and as such has no independent operations or material assets other than its ownership of equity interests in its subsidiaries, and its subsidiaries' contractual arrangements with physicians and professional corporations, and it depends on its subsidiaries to distribute funds to it so that it may pay its obligations and expenses, including satisfying its obligations under the Notes. The ability of the Company to make scheduled payments on, or to refinance its respective obligations under, its indebtedness, including the Notes, and to fund planned capital expenditures and other corporate expenses will depend on the ability of its subsidiaries to make distributions, dividends or advances to it, which in turn will depend on their future operating performance and on economic, financial, competitive, legislative, regulatory and other factors and any legal and regulatory restrictions on the payment of distributions and dividends to which they may be subject. Many of these factors are beyond our control. We cannot assure you that our business will generate sufficient cash flow from operations, that currently anticipated cost savings and operating improvements will be realized or that future borrowings will be available to the Company in an amount sufficient to enable it to satisfy its respective obligations under its indebtedness or to fund its other needs. In order for the Company to satisfy its obligations under its indebtedness and fund planned capital expenditures, we must continue to execute our business strategy. If we are unable to do so, we may need to reduce or delay our planned capital expenditures or refinance all or a portion of our indebtedness on or before maturity. Significant delays in our planned capital expenditures may materially and adversely affect our future revenue prospects. In addition, we cannot assure you that we will be able to refinance any of our indebtedness, including the Notes and the Senior Secured Credit Facilities, on commercially reasonable terms or at all.

The Indenture, the ABL Credit Agreement and the Term Loan Credit Agreement restrict our ability and the ability of most of our subsidiaries to engage in some business and financial transactions.

Indenture. The Indenture contains restrictive covenants that, among other things, limits our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness or issue certain preferred shares;
- pay dividends, redeem stock or make other distributions;
- make investments;
- create restrictions on the ability of our restricted subsidiaries to pay dividends to us or make other intercompany transfers;
- create liens;
- transfer or sell assets;
- merge or consolidate;
- enter into certain transactions with our affiliates; and
- designate subsidiaries as unrestricted subsidiaries.

23

Table of Contents

Senior Secured Credit Facilities. The ABL Credit Agreement and the Term Loan Credit Agreement will contain a number of covenants that limit our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness;
- declare dividends;
- repurchase, prepay or redeem junior indebtedness (including the Notes);
- redeem and repurchase capital stock;
- incur additional liens;
- sell assets;
- agree to payment restrictions affecting our restricted subsidiaries;
- make negative pledges;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;
- make investments;
- enter into transactions with affiliates; and
- designate any of our subsidiaries as unrestricted subsidiaries.

The ABL Credit Agreement also contains other covenants customary for asset-based facilities of this nature. Our ability to borrow additional amounts under the Senior Secured Credit Facilities depends upon satisfaction of these covenants. Events beyond our control can affect our ability to meet these covenants.

Our failure to comply with obligations under the Indenture, the ABL Credit Agreement and the Term Loan Credit Agreement may result in an event of default under that indenture or those credit agreements. A default, if not cured or waived, may permit acceleration of our indebtedness. We cannot be certain that we will have funds available to remedy these defaults. If our indebtedness is accelerated, we cannot be certain that we will have sufficient funds available to pay the accelerated indebtedness or that we will have the ability to refinance the accelerated indebtedness on terms favorable to us or at all.

We may not have access to the cash flow and other assets of our subsidiaries that may be needed to make payment on the Notes.

Our ability to make payments on the Notes is dependent on the earnings and the distribution of funds from our subsidiaries. All of our business is conducted through our subsidiaries. The ability of our subsidiaries to make distributions, dividends or advances to us will depend on their future operating performance and on economic, financial, competitive, legislative, regulatory and other factors and any legal and regulatory restrictions on the payment of distributions and dividends to which they may be subject. Under the terms of the Indenture, the ABL Credit Agreement and the Term Loan Credit Agreement, our subsidiaries will be permitted to incur additional indebtedness that may restrict or prohibit

distributions, dividends or loans from those subsidiaries to us. We cannot assure you that the agreements governing the current and future indebtedness of our subsidiaries will permit our subsidiaries to provide us with sufficient dividends, distributions or loans to fund payments on the Notes when due.

Furthermore, none of our existing or future foreign subsidiaries, any subsidiary subject to regulation as an insurance company, and our domestic subsidiaries that do not guarantee our indebtedness under the ABL and Term Loan Credit Facilities will guarantee the Notes. See

Table of Contents

"Description of Notes Subsidiary Guarantees." The Notes will be structurally subordinated to any future indebtedness and other liabilities of our non-guarantor subsidiaries. In the event of a bankruptcy, liquidation or reorganization of any of our non-guarantor subsidiaries, holders of their indebtedness and their trade creditors will generally be entitled to payment of claims from the assets of that subsidiary before any assets are or could be made available for distribution to us.

As of June 30, 2011, our non-guarantor subsidiaries had no indebtedness. Our non-guarantor subsidiaries generated approximately 0% of our net revenues for the years ended December 31, 2008, 2009 and 2010, and held approximately 8% and 4% of our assets as of December 31, 2010 and June 30, 2011, respectively.

Because each guarantor's liability under its guarantee of the Notes may be reduced to zero, avoided or released under certain circumstances, you may not receive any payments from some or all of the guarantors.

Each of our domestic subsidiaries that is a guarantor under the Senior Secured Credit Facilities is a guarantor of the Notes. However, the guarantees are limited to the maximum amount that the guarantors are permitted to guarantee under applicable law. As a result, a guarantor's liability under a guarantee could be reduced to zero depending on the amount of other obligations of such entity. Further, under certain circumstances, a court under applicable fraudulent conveyance and transfer statutes or other applicable laws could void the obligations under a guarantee or subordinate the guarantee to other obligations of the guarantor. See "Our being subject to certain fraudulent transfer and conveyance statutes may have adverse implications for the holders of the Notes." In addition, you will lose the benefit of a particular guarantee if it is released under the circumstances described under "Description of Notes Subsidiary Guarantee."

As a result, an entity's liability under its guarantee could be materially reduced or eliminated depending upon the amounts of its other obligations and upon applicable laws. In particular, in certain jurisdictions, a guarantee issued by a company that is not in the company's corporate interests or where the burden of that guarantee exceeds the benefit to the company may not be valid and enforceable. It is possible that a creditor of an entity or the insolvency administrator in the case of an insolvency of an entity may contest the validity and enforceability of the guarantee and the applicable court may determine that the guarantee should be limited or voided. If any guarantees are deemed invalid or unenforceable, in whole or in part, or to the extent that agreed limitations on the guarantee apply, the Notes would be effectively subordinated to all liabilities of the applicable guarantor, including trade payables of such guarantor.

If we or our subsidiaries default on our and their obligations to pay our and their indebtedness, we may not be able to make payments on the Notes.

Any default under the agreements governing our or our subsidiaries' indebtedness, including a default under the Senior Secured Credit Facilities that is not waived by the required lenders, and the remedies sought by the holders of such indebtedness could make us unable to pay principal, premium, if any, and interest on the Notes when due and substantially decrease the market value of the Notes.

If we or our subsidiaries are unable to generate sufficient cash flow and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our indebtedness, or if we or they otherwise fail to comply with the various covenants in the instruments governing our or their indebtedness (including covenants in the Senior Secured Credit Facilities and the Indenture), we or they could be in default under the terms of the agreements governing such indebtedness. In the event of such default, the holders of such indebtedness could elect to declare all the funds borrowed thereunder to be due and payable, together with accrued and unpaid interest, the lenders under the Senior Secured Credit Facilities could elect to terminate their commitments thereunder, cease making further loans and institute foreclosure proceedings against our assets, which

Table of Contents

could further result in a cross-default or cross-acceleration of our debt issued under other instruments, and we could be forced into bankruptcy or liquidation. If amounts outstanding under the Senior Secured Credit Facilities, the Notes or other debt of our subsidiaries are accelerated, all our non-guarantor subsidiaries' debt and liabilities would be payable from our subsidiaries' assets, prior to any distributions of our subsidiaries' assets to pay interest and principal on the Notes, and we might not be able to repay or make any payments on the Notes.

We may not be able to repurchase the Notes upon a change of control.

Upon the occurrence of a change of control event specified in the Indenture, the Company will be required to offer to repurchase all outstanding Notes (unless otherwise redeemed) at a price equal to 101% of the principal amount thereof, plus accrued and unpaid interest and additional interest, if any, to the date of repurchase. It is possible, however, that we will not have sufficient funds available at the time of the change of control to make the required repurchase of Notes. Furthermore, restrictions in the ABL Credit Agreement and the Term Loan Credit Agreement do not allow those repurchases unless we have repaid the indebtedness under the Senior Secured Credit Facilities or received the requisite consent of the lenders under the Senior Secured Credit Facilities. We may be unable to repay all of that indebtedness or to obtain such consent. Any requirement to offer to repurchase outstanding Notes may therefore require us to refinance our other outstanding debt, which we may not be able to do on commercially reasonable terms, if at all. A change of control may constitute an event of default under the Senior Secured Credit Facilities. In addition, our failure to repurchase the Notes after a change of control in accordance with the terms of the Indenture would constitute an event of default under such indenture, which in turn would result in a default under the ABL Credit Agreement and the Term Loan Credit Agreement, resulting in the acceleration of the indebtedness represented by the Notes and under the Senior Secured Credit Facilities.

Certain corporate events may not trigger a change of control event, in which case we will not be required to redeem the Notes.

The Indenture permits us to engage in certain important corporate events, such as leveraged recapitalizations, that would increase indebtedness but would not constitute a "Change of Control" (as defined in "Description of Notes Change of Control"). If we effected a leveraged recapitalization or other such non-change of control transaction that resulted in an increase in indebtedness, our ability to make payments on the Notes would be adversely affected. However, we would not be required to redeem the Notes, and you might be required to continue to hold your Notes, despite our decreased ability to meet our obligations under the Notes.

The definition of Change of Control includes a disposition of "all or substantially all of our assets." Although there is a limited body of case law interpreting the phrase "substantially all," there is no precise established definition of the phrase under applicable law. Accordingly, in certain circumstances there may be a degree of uncertainty as to whether a particular transaction would involve a disposition of "substantially all" of our assets. As a result, it may be unclear as to whether a Change of Control has occurred and whether we are required to make an offer to repurchase the Notes. As noted below, under certain circumstances the sale or disposition of a Minority Business shall not at any time be deemed to constitute a disposition of "all or substantially all" of our assets.

The terms of the Indenture include exceptions to certain covenants relating to a sale of a Minority Business.

The terms of the Indenture include exceptions to certain covenants that apply in the event that a future sale or disposition (whether directly or indirectly, whether by sale or transfer of any such assets, or of any capital stock or other interest in any entity holding such assets, or by merger or consolidation or of any combination thereof, and whether in one or more transactions, or otherwise, including any

Table of Contents

Minority Business Offering or any Minority Business Disposition (each as defined in the "Description of Notes")) of any business unit which represents less than 50% of our consolidated Adjusted EBITDA ("Minority Business"). Accordingly, we may sell or dispose of a Minority Business at any time subject to certain conditions. For important information regarding this exception and the applicable obligations and restrictions, see "Description of Notes Change of Control," "Description of Notes Certain Covenants Merger and Consolidation" and "Description of Notes Certain Definitions."

If we sell or dispose of any such Minority Business, we may not receive any cash proceeds depending on the structure of such sale or disposition and to the extent cash proceeds are received we may be unable to reinvest the net proceeds of such sale in businesses or assets that produce similar net sales or earnings or Adjusted EBITDA. Accordingly, a sale of a Minority Business could adversely impact our operating results and financial performance, as well as the price, liquidity and ratings of the Notes. Such risks could be significant.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

Our indebtedness under the ABL Facility will bear interest at variable rates, and, to the extent LIBOR exceeds 1.5%, our indebtedness under the Term Loan Facility bears interest at variable rates. As a result, increases in interest rates could increase the cost of servicing such debt and materially reduce our profitability and cash flows. As of June 30, 2011, assuming all ABL Facility revolving loans were fully drawn and LIBOR exceeded 1.5%, each one percentage point change in interest rates would result in approximately a $17.9 million change in annual interest expense on the Senior Secured Credit Facilities. The impact of such an increase would be more significant for us than it would be for some other companies because of our substantial debt.

Federal and state fraudulent transfer laws may permit a court to void the Notes and/or the guarantees, and if that occurs, you may not receive any payments on the Notes.

Federal and state fraudulent transfer and conveyance statutes may apply to the issuance of the Notes and the incurrence of the guarantees of the Notes. Under federal bankruptcy law and comparable provisions of state fraudulent transfer or conveyance laws, which may vary from state to state, the Notes or the guarantees thereof could be voided as a fraudulent transfer or conveyance if the Company or any of the Guarantors, as applicable, (a) issued the Notes or incurred the guarantee with the intent of hindering, delaying or defrauding creditors or (b) received less than reasonably equivalent value or fair consideration in return for either issuing the Notes or incurring the guarantee and, in the case of (b) only, one of the following is also true at the time thereof:

- the Company or any of the Guarantors, as applicable, were insolvent or rendered insolvent by reason of the issuance of the Notes or the incurrence of the guarantee;
- the issuance of the Notes or the incurrence of the guarantee left the Company or any of the Guarantors, as applicable, with an unreasonably small amount of capital or assets to carry on its business; or
- the Company or any of the Guarantors intended to, or believed that the Company or such Guarantor would, incur debts beyond the Company's or such Guarantor's ability to pay as they mature.

As a general matter, value is given for a transfer or an obligation if, in exchange for the transfer or obligation, property is transferred or a valid antecedent debt is satisfied. A court would likely find that a Guarantor did not receive reasonably equivalent value or fair consideration for its guarantee to the extent such Guarantor did not obtain a reasonably equivalent benefit from the issuance of the Notes.

Table of Contents

We cannot be certain as to the standards a court would use to determine whether or not the Company or any of the Guarantors were insolvent at the relevant time or, regardless of the standard that a court uses, whether the Notes or the guarantees would be subordinated to the Company's or any of the Guarantors' other debt. In general, however, a court would deem an entity insolvent if:

- the sum of its debts, including contingent and unliquidated liabilities, was greater than the fair saleable value of all of its assets;
- the present fair saleable value of its assets was less than the amount that would be required to pay its probable liability on its existing debts, including contingent liabilities, as they become absolute and mature; or
- it could not pay its debts as they became due.

If a court were to find that the issuance of the Notes or the incurrence of a guarantee was a fraudulent transfer or conveyance, the court could void the payment obligations under the Notes or that guarantee, could subordinate the Notes or that guarantee to presently existing and future indebtedness of the Company or of the related Guarantor or could require the holders of the Notes to repay any amounts received with respect to that guarantee. In the event of a finding that a fraudulent transfer or conveyance occurred, you may not receive any repayment on the Notes.

The indenture contains a "savings clause" intended to limit each subsidiary Guarantor's liability under its guarantee to the maximum amount that it could incur without causing the guarantee to be a fraudulent transfer under applicable law. There can be no assurance that this provision will be upheld as intended.

A downgrade, suspension or withdrawal of the rating assigned by a rating agency to our company or the Notes, if any, could cause the liquidity or market value of the Notes to decline.

The Notes have been rated by nationally recognized rating agencies and may in the future be rated by additional rating agencies. We cannot assure you that any rating assigned will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, circumstances relating to the basis of the rating, such as adverse changes in our business, so warrant. Any downgrade, suspension or withdrawal of a rating by a rating agency (or any anticipated downgrade, suspension or withdrawal) could reduce the liquidity or market value of the Notes.

Any future lowering of our ratings may make it more difficult or more expensive for us to obtain additional debt financing. If any credit rating initially assigned to the Notes is subsequently lowered or withdrawn for any reason, you may lose some or all of the value of your investment.

If the lenders under the Senior Secured Credit Facilities release the guarantors or subsidiaries that are co-borrowers under the credit agreements for those facilities, those guarantors or subsidiaries that are co-borrowers will be released from their guarantees of the Notes.

The lenders under the Senior Secured Credit Facilities have the discretion to release the guarantees or the obligations of the co-borrowers under the credit agreement for those facilities. If a subsidiary is no longer a guarantor of obligations or co-borrowers under the Senior Secured Credit Facilities or any other successor credit facilities that may be then outstanding, then the guarantee of the Notes by such subsidiary will be released automatically without action by, or consent of, any holder of the Notes or the trustee under the Indenture. See "Description of Notes Subsidiary Guarantees." You will not have a claim as a creditor against any subsidiary that is no longer a guarantor of the Notes, and the indebtedness and other liabilities, including trade payables, whether secured or unsecured, of those subsidiaries will effectively be senior to claims of holders of the Notes.

Table of Contents

Certain restrictive covenants in the Indenture will not apply during any time that the Notes achieve investment grade ratings.

Most of the restrictive covenants in the Indenture will not apply during any time that the Notes achieve investment grade ratings from Moody's Investment Service, Inc. and Standard & Poor's, and no default or event of default has occurred. If these restrictive covenants cease to apply, we may take actions, such as incurring additional debt or making certain dividends or distributions, which would otherwise be prohibited under the Indenture. Ratings are given by these rating agencies based upon analyses that include many subjective factors. The investment grade ratings, if granted, may not reflect all of the factors that would be important to holders of the Notes.

Risks Related to Not Participating in the Exchange Offer

You may have difficulty selling the Old Notes that you do not exchange.

If you do not exchange your Old Notes for the New Notes offered in the exchange offer, your Old Notes will continue to be subject to significant restrictions on transfer. Those transfer restrictions are described in the Indenture and arose because the Old Notes were originally issued under exemptions from the registration requirements of the Securities Act.

The Old Notes may not be offered, sold or otherwise transferred, except in compliance with the registration requirements of the Securities Act, pursuant to an exemption from registration under the Securities Act or in a transaction not subject to the registration requirements of the Securities Act, and in compliance with applicable state securities laws. The Company did not register the Old Notes under the Securities Act, and it does not intend to do so. If you do not exchange your Old Notes, your ability to sell those Notes will be significantly limited.

If a large number of outstanding Old Notes are exchanged for New Notes issued in the exchange offer, it may be more difficult for you to sell your unexchanged Old Notes due to the limited amounts of Old Notes that would remain outstanding following the exchange offer.

Risk Factors Related to Our Relationship with the CD&R Affiliates

We are indirectly owned and controlled by the CD&R Affiliates, and their interests as equity holders may conflict with your interests as a holder of the Notes.

We are indirectly owned and controlled by the CD&R Affiliates, who have the ability to control our policy and operations. The CD&R Affiliates control our board of directors, and thus are able to appoint new management and approve any action requiring the vote of our outstanding common stock, including amendments of our certificate of incorporation, mergers and sales of substantially all of our assets. The directors controlled by the CD&R Affiliates are also able to make decisions affecting our capital structure, including decisions to issue additional capital stock and incur additional debt. The interests of the CD&R Affiliates as stockholders may not in all cases be aligned with your interests as a holder of the Notes. For example, if we encounter financial difficulties or are unable to pay our debts as they mature, the interests of the CD&R Affiliates might conflict with your interests as a holder of the Notes. In addition, one or more of the CD&R Affiliates may have an interest in pursuing acquisitions, divestitures, financings or other transactions that, in their judgment, could enhance their equity investments, even though such a transaction might involve risks to you as a holder of the Notes. Furthermore, one or more of the CD&R Affiliates may in the future own businesses that directly or indirectly compete with us. One or more of the CD&R Affiliates may also pursue acquisition opportunities that may be complementary to our business, and as a result, those acquisition opportunities may not be available to us. We are party to a consulting agreement with CD&R and an indemnification agreement with CD&R and the CD&R Affiliates. See "Certain Relationships and Related Party Transaction Post-Merger Relationships and Related Party Transactions."

Table of Contents

Risk 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. 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 EmCare and AMR, 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 American International Group, Inc. ("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. For further information, see "Business Legal Proceedings" and note 7 to our unaudited consolidated financial statements included elsewhere in this prospectus. 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 "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 the Employee Retirement Income Security Act of 1974 ("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, 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

Table of Contents

our business, financial condition and results of operations could be materially adversely affected. 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 "Management's Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Policies Claims Liability and Professional Liability Reserves" and note 15 to our audited financial statements included in this prospectus.

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 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 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 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.

Table of Contents

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 81% of our net revenue for the year ended December 31, 2010, we, or our affiliated physicians, collect the fees for transports and physician services provided. 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.

Table of Contents

We are required to make 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 $32 million, $45 million, and $49 million in the years ended December 31, 2008, 2009, and 2010, 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, 2010 was generated under contracts, including exclusive contracts that accounted for approximately 86% of our 2010 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 ("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.

Table of Contents

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

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, The Schumacher Group, Sheridan Healthcare, 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 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.

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, Paramedics Plus 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.

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. 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.

Disruptions in our disaster recovery systems or management continuity planning could limit our ability to operate our business effectively.

Our information technology systems facilitate our ability to conduct our business. While we have disaster recovery systems and business continuity plans in place, any disruptions in our disaster recovery systems or the failure of these systems to operate as expected could, depending on the magnitude of the problem, adversely affect our operating results by limiting our capacity to effectively monitor and control our operations. Despite our implementation of a variety of security measures, our technology systems could be subject to physical or electronic break-ins, and similar disruptions from unauthorized tampering. In addition, in the event that a significant number of our management personnel were unavailable in the event of a disaster, our ability to effectively conduct business could be adversely affected.

Table of Contents

We may not be able to adequately protect our intellectual property and other proprietary rights that are material to our business.

Our ability to compete effectively depends in part upon our rights in trademarks, copyrights, other intellectual property and proprietary technology. Our use of contractual provisions, confidentiality procedures and agreements, and trademark, copyright, unfair competition, trade secret and other laws to protect our intellectual property and other proprietary rights may not be adequate. Litigation may be necessary to enforce our intellectual property rights and protect our proprietary technology, or to defend against claims by third parties that the conduct of our businesses or our use of intellectual property infringe their intellectual property rights. Any litigation or claims brought by or against us could result in substantial costs and diversion of our resources. A successful claim of trademark, copyright or other intellectual property infringement or misappropriation against us could prevent us from providing services, which could have a material adverse effect on our business, financial condition or results of operations.

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 and other productivity 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.

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.

The pro forma financial information in this prospectus may not be reflective of our operating results and financial conditions following the Transactions.

The pro forma financial information included in this prospectus is derived from our historical consolidated financial statements. The preparation of this pro forma information is based upon certain assumptions and estimates. This pro forma information may not reflect what our results of operations, financial position and cash flows would have been had the Transactions and specified adjustments occurred during the periods presented or what our results of operations, financial position and cash flows will be in the future. The pro forma information contained in this prospectus is based on adjustments that our management believes are reasonable. Our estimate of these adjustments may differ from actual amounts.

Table of Contents

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, 2010, we contracted with approximately 3,460 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 was 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 have evaluated and expect to continue to evaluate possible acquisitions on an ongoing basis. We cannot assure you that we will identify suitable acquisition candidates, acquisitions will be completed on acceptable terms, our due diligence process will uncover all potential liabilities or issues affecting our integration process, we will not incur break-up, termination or similar fees and expenses, or 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 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.

Table of Contents

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

Approximately 48% of AMR's employees are represented by 39 active collective bargaining agreements. A total of 12 active and 3 new collective bargaining agreements, representing approximately 4,200 employees, are in the negotiation process in 2011. 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 four years of the FEMA contract, our annual revenues from services rendered under this contract have varied by approximately $107 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 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.

Table of Contents

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, 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 "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. 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 Accountability Act of 1996, the federal Anti-Kickback Statute and other provisions of federal, state and local law. The federal False Claims Act and the Anti-Kickback Statute were both 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

Table of Contents

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 "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 "Business Regulatory Matters Federal False Claims Act" and "Business Other Federal 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 ("HIPAA") required the Department of Health and Human Services ("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 EmCare and AMR.

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 (the "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 HHS Office for Civil Rights ("HHS-OCR") to continue to use corrective action without a penalty, but only in situations where the violation was made without knowledge. In February 2011, HHS-OCR for the first time exercised its authority to impose civil monetary penalties, imposing significant fines on two different covered entities for HIPAA violations, signaling an increase in HIPAA enforcement action and a departure from the prior model of voluntary corrective action. The HITECH Act also authorized 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.

The HITECH Act and implementing regulations enacted by HHS further require 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

Table of Contents

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.

The recent healthcare reform legislation and other 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 and policy. The healthcare industry is subject to changing political, regulatory and other influences. In March 2010, the President signed into law the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the "PPACA"), commonly referred to as "the healthcare reform legislation," which made major changes in how health care is delivered and reimbursed. The PPACA, among other things, increases the number of individuals with Medicaid coverage, implements reimbursement policies that tie payment to quality, facilitates the creation of "accountable care organizations" that may use capitation and other alternative payment methodologies, increases enforcement of fraud and abuse laws, and encourages the use of information technology. Many of these changes will not go into effect until future years and many require implementing regulations which have not yet been drafted. In addition, a number of states have challenged the constitutionality of certain provisions of PPACA, and many of these challenges are still pending final adjudication in several jurisdictions. Congress has also proposed a number of legislative initiatives, including possible repeal of PPACA. At this time, it remains unclear whether there will be any changes made to PPACA, whether to certain provisions or its entirety. Further, as to implementation of PPACA, while it is too soon to accurately predict the full impact of these and other health reform measures on our business, they could potentially have major impacts, both positive and negative.

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

The 2009 Medicare Physician Fee Schedule rule 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 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.

Table of Contents

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 relationships with our physicians. There is a risk that state authorities in some jurisdictions may find that our contractual relationships with our physicians violate laws prohibiting the corporate practice of medicine and fee-splitting. These laws generally prohibit the practice of medicine by lay entities or persons 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 "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 "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. 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.

Table of Contents

Our relationships with healthcare providers, facilities and marketing practices are subject to the federal Anti-Kickback Statute and similar state laws, and we entered into a settlement in 2006 for alleged violations of the Anti-Kickback 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" has been broadly interpreted to mean anything of value, including, for example, gifts, discounts, credit arrangements, 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. The Anti-Kickback Statute is broad and prohibits many arrangements and practices that are lawful in businesses outside of the healthcare industry. Violations of the Anti-Kickback Statute can result in imprisonment, civil or criminal fines or exclusion from Medicare and other governmental programs. Recognizing that the federal Anti-Kickback Statute is broad, Congress authorized the Office of Inspector General of the Department of Health and Human Services (the "OIG") to issue a series of regulations, known as "safe harbors." These safe harbors set forth requirements that, if met in their entirety, will assure healthcare providers and other parties that they will not be prosecuted under the Anti-Kickback Statute. The failure of a transaction or arrangement to fit precisely within one or more safe harbors does not necessarily mean that it is illegal, or that prosecution will be pursued. However, conduct and business arrangements that do not fully satisfy each applicable safe harbor may result in increased scrutiny by government enforcement authorities, such as the OIG.

In 1999, 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 "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 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 Corporate Integrity Agreement ("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 "Business Legal Proceedings." Many states have adopted laws similar to the federal Anti-Kickback Statute. Some of these state prohibitions apply to referral of patients for healthcare items or services reimbursed by any payor, not only the Medicare and Medicaid programs, and do not contain identical safe harbors. Additionally, we could be subject to private actions brought pursuant to the False Claims Act's "whistleblower" or "qui tam" provisions which, among other things, allege that our practices or relationships violate the Anti-Kickback Statute. The False Claims Act imposes liability on any person or entity who, among other things, knowingly presents, or causes to be presented, a false or fraudulent claim for payment by a federal healthcare program. The qui tam provisions of the False Claims Act allow a private individual to bring actions on behalf of the federal government alleging that the defendant has submitted a false claim to the federal government, and to share in any monetary recovery. In recent years, the number of suits brought by private individuals has increased dramatically. In addition, various states have enacted false claim laws analogous to the False Claims Act. Many of

Table of Contents

these state laws apply where a claim is submitted to any third party payor and not merely a federal healthcare program. There are many potential bases for liability under these false claim statutes. Liability arises, primarily, when an entity knowingly submits, or causes another to submit, a false claim for reimbursement. Pursuant to changes in the PPACA, a claim resulting from a violation of the Anti-Kickback Statute can constitute a false or fraudulent claim for purposes of the federal False Claims Act.

If we are found to have violated the Anti-Kickback Statute or a similar state statute, we may be subject to civil and 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 "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 EmCare and AMR 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 we will not have to defend against alleged violations from private or public entities or 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, 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. The extent of such notices and filings may vary in each jurisdiction in which we operate, although those regulatory entities requiring notification generally request factual information regarding the new corporate structure and new ownership composition of the operating entities that hold the applicable licensing and certification.

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.

Table of Contents

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 five years, we have entered into two settlement agreement with the United States government. 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. In May 2011, AMR entered into a settlement agreement with the DOJ and a corporate integrity agreement with the OIG to resolve allegations that AMR subsidiaries submitted claims for reimbursement in periods dating back to 2000. The government believed such claims lacked support for the level billed in violation of the False Claims Act.

In connection with the September 2006 settlement for AMR, we 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 "Business Regulatory Matters Corporate Compliance Program and Corporate Integrity Obligations."

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 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 reviewed the information provided by the government and provided our response. On May 20, 2011, AMR entered into a settlement agreement with the DOJ and a corporate integrity agreement with the OIG in connection with this matter. Under the terms of the settlement, AMR paid $2.7 million to the federal government. We entered into the settlement in order to avoid the uncertainties of litigation, and have not admitted any wrongdoing.

In connection with the May 2011 settlement for AMR, we entered into a CIA with the OIG which requires us to maintain a compliance program. This program includes, among other elements, the appointment of a compliance officer and committee, training of employees nationwide, safeguards for our billing operations as they relate to services provided in New York, including specific training for operations and billing personnel providing services in New York, review by an independent review organization and reporting of certain reportable events.

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. Sweeping healthcare reform legislation was signed into law last year and is currently in the early implementation stages. See "Risk Factors Related to Healthcare Regulation The recent healthcare reform legislation and other changes in the healthcare industry and in healthcare spending may adversely affect our revenue." 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.

Table of Contents

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 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 enacted last year by Congress resulted in substantial changes in Medicare and Medicaid coverage and reimbursement, as well as changes in coverage or amounts paid by private payors, which could have an adverse impact on our revenues from those sources.

In addition to changes from healthcare reform legislation, 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 an increase in AMR's net revenue of approximately $14 million in 2008, an increase in AMR's net revenue of approximately $24 million in 2009, and a decrease in AMR's net revenue of approximately $18 million in 2010. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential increase in AMR's net revenue of less than $1 million for 2011.

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.

Legislative provisions at the national level impact payments received by EmCare physicians under the Medicare program. Under the statutory formula, physician payments under the Medicare Physician Fee Schedule, is updated on an annual basis according to a statutory formula. Because application of the statutory formula for the update factor, which is based on a flawed Sustainable Growth Rate ("SGR"), would result in a decrease in total physician payments for the past several years, Congress has intervened with interim legislation to prevent the reductions. For 2010, the Center for Medicare and Medicaid Services ("CMS"), the agency responsible for administering the Medicare program, projected a rate reduction of 21.2% from 2009 to 2010 levels (and projected to be a 24.9% reduction for 2011). Therefore, a number of interim measures were passed to avoid a decrease for 2010, and from June through December 2010, the update factor was increased by 2.2%. For 2011, the Medicare and Medicaid Extenders Act of 2010, which was signed into law on December 15, 2010, froze the 2010 updates through 2011. President Obama's budget for fiscal year 2012 includes measures that would

Table of Contents

freeze the update factor for an additional two years. If Congress fails to intervene to prevent the negative update factor in the future through either another temporary measure or a permanent revision to the statutory formula, the resulting decrease in payment may adversely impact physician revenues, as well as EmCare revenues.

The freezing of the update factor does not translate to 2011 payment rates at the 2010 level for all physician procedures. Rather, from year-to-year some physician specialties, including EmCare's physicians (who are emergency medicine physicians, anesthesiologists, hospitalists and radiologists), may see higher or lowered payments. Each physician service is given a weight that measures its costliness relative to other physician services. CMS is required to make periodic assessments regarding the weighting of procedures, impacting the payment amounts. For 2011, CMS published estimates of changes by specialty based on a number of factors, such as changes to practice expense relative value units, rescaling of relative values to match the revised and rebased Medicare Economic Index, equipment utilization rate changes, multiple procedure payment reductions for contiguous body parts and recalculations of misvalued codes. The full impact of these changes on any given practice is scheduled to go into effect 2012. CMS estimates that the impact for 2011 is a 3% reduction for emergency medicine, 1% reduction in anesthesiology, a 1% increase for internal medicine, and a 10% reduction in radiology. The changes are calculated prior to the application of what is known as the "conversion factor," which translates the relative value units to dollar amounts. For 2011, because CMS was required to make all its other changes to the Medicare Physician Fee Schedule (discussed above) budget neutral, CMS made a downward adjustment to the conversion factor to $33.9764 for 2011 (from $36.8729 at the end of 2010). At this time, we cannot predict the impact, if any, these regulatory changes will have on EmCare's future revenues.

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.

Table of Contents

FORWARD-LOOKING STATEMENTS

This prospectus contains statements about future events and expectations that constitute forward-looking statements. Forward-looking statements are based on our beliefs, assumptions and expectations of our future financial and operating performance and growth plans, taking into account the information currently available to us. These statements are not statements of historical fact. Forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations of future results we express or imply in any forward-looking statements and you should not place undue reliance on such statements. Factors that could contribute to these differences include, but are not limited to, the following:

- the impact on our revenue of changes in transport volume, mix of insured and uninsured patients, and third party reimbursement rates and methods;
- 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 changes in the healthcare industry;
- 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 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;
- our ability to maintain or implement complex information systems;
- our ability to implement our business strategy;

our ability to successfully integrate strategic acquisitions;

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

the risk that the benefits from the Transactions may not be fully realized or may take longer to realize than expected; and

risks related to other factors discussed in the prospectus.

Words such as "anticipates," "believes," "continues," "estimates," "expects," "goal," "objectives," "intends," "may," "opportunity," "plans," "potential," "near-term," "long-term," "projections," "assumptions," "projects," "guidance," "forecasts," "outlook," "target," "trends," "should," "could," "would," "will" and similar expressions are intended to identify such forward-looking statements. We qualify any forward-looking statements entirely by these cautionary factors.

Other risks, uncertainties and factors, including those discussed under "Risk Factors," could cause our actual results to differ materially from those projected in any forward-looking statements we make.

Table of Contents

You should read carefully the factors described in the "Risk Factors" section of this prospectus to better understand the risks and uncertainties inherent in our business and underlying any forward-looking statements.

We assume no obligation to update or revise these forward-looking statements for any reason, or to update the reasons actual results could differ materially from those anticipated in these forward-looking statements, even if new information becomes available in the future. Comparisons of results for current and any prior periods are not intended to express any future trends or indications of future performance, unless expressed as such, and should only be viewed as historical data.

Table of Contents

THE EXCHANGE OFFER

Pursuant to the Registration Rights Agreement, we agreed to prepare and file with the SEC a registration statement on an appropriate form under the Securities Act with respect to a proposed offer to the holders of the Old Notes to issue and deliver to such holders of Old Notes, in exchange for their Old Notes, a like aggregate principal amount of New Notes that are identical in all material respects to the Old Notes, except for provisions relating to registration rights and the transfer restrictions relating to the Old Notes, and except for certain related differences described below. See "Exchange Offer; Registration Rights."

Terms of the Exchange Offer; Period for Tendering Old Notes

This prospectus and the accompanying letter of transmittal contain the terms and conditions of the exchange offer. Upon the terms and subject to the conditions included in this prospectus and in the accompanying letter of transmittal, which together constitute the exchange offer, we will accept for exchange Old Notes which are properly tendered on or prior to the Expiration Date, unless you have previously withdrawn them.

When you tender Old Notes as provided below, our acceptance of the Old Notes will constitute a binding agreement between you and us upon the terms and subject to the conditions in this prospectus and in the accompanying letter of transmittal. In tendering Old Notes, you should also note the following important information:

You may only tender Old Notes in minimum denominations of $2,000 and any integral multiple of $1,000 in excess thereof.

We will keep the exchange offer open for not less than 20 business days after the date on which notice of the exchange offer is mailed to holders of the Old Notes. We are sending this prospectus, together with the letter of transmittal, on or about the date of this prospectus, to all of the registered holders of Old Notes at their addresses listed in the Trustee's security register with respect to the Old Notes.

The exchange offer expires at 5:00 p.m., New York City time, on Monday, November 7, 2011; provided, however, that we, in our sole discretion, may extend the period of time for which the exchange offer is open.

As of the date of this prospectus, $950.0 million aggregate principal amount of Old Notes was outstanding. The exchange offer is not conditioned upon any minimum principal amount of Old Notes being tendered.

Our obligation to accept Old Notes for exchange in the exchange offer is subject to the conditions described under " Conditions to the Exchange Offer."

We expressly reserve the right, at any time, to extend the period of time during which the exchange offer is open, and thereby delay acceptance of any Old Notes, by giving oral or written notice of an extension to the Exchange Agent and notice of that extension to the holders of Notes as described below. During any extension, all Old Notes previously tendered will remain subject to the exchange offer unless withdrawal rights are exercised as described under " Withdrawal Rights." Any Old Notes not accepted for exchange for any reason will be returned without expense to the tendering holder of Notes promptly after the expiration or termination of the exchange offer.

We expressly reserve the right to amend or terminate the exchange offer, and not to accept for exchange any Old Notes that we have not yet accepted for exchange, at any time prior to the Expiration Date. If we make a material change to the terms of the exchange offer, including the waiver of a material condition, we will, to the extent required by law, disseminate additional

Table of Contents

offer materials and extend the period of time for which the exchange offer is open so that at least five business days remain in the exchange offer following notice of a material change.

We will give oral or written notice of any extension, amendment, termination or non-acceptance described above to holders of the Old Notes as promptly as practicable. If we extend the Expiration Date, we will give notice by means of a press release or other public announcement no later than 9:00 a.m., New York City time, on the business day after the previously scheduled Expiration Date. Without limiting the manner in which we may choose to make any public announcement and subject to applicable law, we will have no obligation to publish, advertise or otherwise communicate any public announcement other than by issuing a release to an appropriate news agency. Such announcement may state that we are extending the exchange offer for a specified period of time.

Holders of Old Notes do not have any appraisal or dissenters' rights in connection with the exchange offer.

Old Notes which are not tendered for exchange, or are tendered but not accepted, in connection with the exchange offer will remain outstanding and be entitled to the benefits of the Indenture, but will not be entitled to any further registration rights under the Registration Rights Agreement.

We intend to conduct the exchange offer in accordance with the applicable requirements of the Exchange Act and the rules and regulations of the SEC thereunder.

By executing, or otherwise becoming bound by, the letter of transmittal, you will be making to us the representations described under " Resale of the New Notes."

Important rules concerning the exchange offer

You should note the following important rules concerning the exchange offer:

All questions as to the validity, form, eligibility, time of receipt and acceptance of Old Notes tendered for exchange will be determined by us in our sole discretion, which determination shall be final and binding.

We reserve the absolute right to reject any and all tenders of any particular Old Notes not properly tendered or to not accept any particular Old Notes if such acceptance might, in our judgment or the judgment of our counsel, be unlawful.

We also reserve the absolute right to waive any defects or irregularities or conditions of the exchange offer as to any particular Old Notes either before or after the Expiration Date, including the right to waive the ineligibility of any holder who seeks to tender Old Notes in the exchange offer. Unless we agree to waive any defect or irregularity in connection with the tender of Old Notes for exchange, you must cure any defect or irregularity within any reasonable period of time as we shall determine.

Our interpretation of the terms and conditions of the exchange offer as to any particular Old Notes either before or after the Expiration Date shall be final and binding on all parties. Neither we, the Exchange Agent nor any other person shall be under any duty to notify you of any defect or irregularity with respect to any tender of Old Notes for exchange, nor shall any of them incur any liability for failing to so notify you.

Table of Contents

Procedures for Tendering Old Notes

What to submit and how

If you, as a holder of any Old Notes, wish to tender your Old Notes for exchange in the exchange offer, you must, except as described under " Guaranteed Delivery Procedures," transmit the following on or prior to the Expiration Date to the Exchange Agent:

(1) if Old Notes are tendered in accordance with the book-entry procedures described under " Book-Entry Transfer," an Agent's Message, as defined below, transmitted through DTC's ATOP, or (2) a properly completed and duly executed letter of transmittal, or a facsimile copy thereof, to the Exchange Agent at the address set forth below under " Exchange Agent," including all other documents required by the letter of transmittal.

In addition,

(1) a timely confirmation of a book-entry transfer of Old Notes into the Exchange Agent's account at DTC using the procedure for book-entry transfer described under " Book-Entry Transfer" (a "Book- Entry Confirmation"), along with an Agent's Message, must be actually received by the Exchange Agent prior to the Expiration Date, or

(2) certificates for Old Notes must be actually received by the Exchange Agent along with the letter of transmittal on or prior to the Expiration Date, or

(3) you must comply with the guaranteed delivery procedures described below.

The term "Agent's Message" means a message, transmitted through ATOP by DTC to, and received by, the Exchange Agent and forming a part of a Book-Entry Confirmation, that states that DTC has received an express acknowledgement that the tendering holder has received and agrees to be bound by the letter of transmittal or, in the case of an Agent's Message relating to guaranteed delivery, that such holder has received and further agrees to be bound by the notice of guaranteed delivery, and that we may enforce the letter of transmittal, and the notice of guaranteed delivery, as the case may be, against such holder.

The method of delivery of Old Notes, letters of transmittal, notices of guaranteed delivery and all other required documentation, including delivery of Old Notes through DTC and transmission of Agent's Messages through DTC's ATOP, is at your election and risk. Delivery will be deemed made only when all required documentation is actually received by the Exchange Agent. Delivery of documents or instructions to DTC does not constitute delivery to the Exchange Agent. If delivery is by mail, we recommend that registered mail, properly insured, with return receipt requested, be used. In all cases, sufficient time should be allowed to assure timely delivery to the Exchange Agent. Holders tendering Old Notes or transmitting Agent's Messages through DTC's ATOP must allow sufficient time for completion of ATOP procedures during DTC's normal business hours. No Old Notes, Agent's Messages, letters of transmittal, notices of guaranteed delivery or any other required documentation should be sent to us.

How to sign your letter of transmittal and other documents

Signatures on a letter of transmittal or a notice of withdrawal, as the case may be, must be guaranteed unless the Old Notes being surrendered for exchange are tendered:

(1) by a registered holder of the Old Notes who has not completed the box entitled "Special Issuance Instructions" or "Special Delivery Instructions" on the letter of transmittal, or

(2) for the account of an "eligible guarantor" institution within the meaning of Rule 17Ad-15 under the Exchange Act, or a commercial bank or trust company having an office or correspondent in the United States that is a member in good standing of a medallion program

Table of Contents

recognized by the Securities Transfer Association Inc., including the Securities Transfer Agents Medallion Program ("STAMP"), the Stock Exchanges Medallion Program ("SEMP") and the New York Stock Exchange Medallion Signature Program ("MSP") (each, an "Eligible Institution").

If signatures on a letter of transmittal or a notice of withdrawal, as the case may be, are required to be guaranteed, the guarantees must be by an Eligible Institution.

If the letter of transmittal is signed by a person or persons other than the registered holder or holders of Old Notes, the Old Notes must be endorsed or accompanied by appropriate powers of attorney, in either case signed exactly as the name or names of the registered holder or holders appear on the Old Notes and with the signatures guaranteed.

If the letter of transmittal or any Old Notes or powers of attorney are signed by trustees, executors, administrators, guardians, attorneys-in-fact, officers or corporations or others acting in a fiduciary or representative capacity, the person should so indicate when signing and, unless waived by us, proper evidence satisfactory to us of such person's authority to so act must be submitted.

Acceptance of Old Notes for Exchange; Delivery of New Notes

Once all of the conditions to the exchange offer are satisfied or waived, we will accept all Old Notes properly tendered and not properly withdrawn, and will issue the New Notes promptly after The Expiration Date. See " Conditions to the Exchange Offer" below. For purposes of the exchange offer, our giving of oral or written notice of acceptance to the Exchange Agent will be considered our acceptance of the tendered Old Notes.

In all cases, we will issue New Notes in exchange for Old Notes that are accepted for exchange only after timely receipt by the Exchange Agent of:

a Book-Entry Confirmation or Old Notes in proper form for transfer,

a properly transmitted Agent's Message or a properly completed and duly executed letter of transmittal, and

all other required documentation.

If we do not accept any tendered Old Notes for any reason included in the terms and conditions of the exchange offer, if you submit certificates representing Old Notes in a greater principal amount than you wish to exchange or if you properly withdraw tendered Old Notes in accordance with the procedures described under " Withdrawal Rights," we will return any unaccepted, non-exchanged or properly withdrawn Old Notes, as the case may be, without expense to the tendering holder. In the case of Old Notes tendered by book-entry transfer into the Exchange Agent's account at DTC using the book-entry transfer procedures described below, unaccepted, non-exchanged or properly withdrawn Old Notes will be credited to an account maintained with DTC. We will return the Old Notes or have them credited to the DTC account, as applicable, promptly after the expiration or termination of the exchange offer.

Book-Entry Transfer

The Exchange Agent will make a request to establish an account with respect to the Old Notes at DTC for purposes of the exchange offer promptly after the date of this prospectus. Any financial institution that is a participant in DTC's systems, including Euroclear Bank, S.A./N.V., as operator of the Euroclear System ("Euroclear"), or Clearstream Banking, société anonyme ("Clearstream") may make book-entry delivery of Old Notes by causing DTC to transfer Old Notes into the Exchange Agent's account at DTC in accordance with DTC's ATOP procedures for transfer. However, the exchange for the Old Notes so tendered will only be made after timely confirmation of book-entry transfer of Old Notes into the Exchange Agent's account, and timely receipt by the Exchange Agent of

Table of Contents

an Agent's Message and all other documents required by the letter of transmittal. Only participants in DTC may deliver Old Notes by book-entry transfer.

Although delivery of Old Notes may be effected through book-entry transfer into the Exchange Agent's account at DTC, the letter of transmittal, or a facsimile copy thereof, properly completed and duly executed, with any required signature guarantees, or an Agent's Message, with all other required documentation, must in any case be transmitted to and received by the Exchange Agent at its address listed under " Exchange Agent" on or prior to the Expiration Date, or you must comply with the guaranteed delivery procedures described below under " Guaranteed Delivery Procedures."

If your Old Notes are held through DTC, you must complete the accompanying form called "Instructions to Registered Holder and/or Book-Entry Participant," which will instruct the DTC participant through whom you hold your Old Notes of your intention to tender your Old Notes or not tender your Old Notes. Please note that delivery of documents or instructions to DTC does not constitute delivery to the Exchange Agent and we will not be able to accept your tender of Old Notes until the Exchange Agent actually receives from DTC the information and documentation described under " Acceptance of Old Notes for Exchange; Delivery of New Notes."

Guaranteed Delivery Procedures

If you are a registered holder of Old Notes and you want to tender your Old Notes but the procedure for book-entry transfer cannot be completed prior to the Expiration Date, your Old Notes are not immediately available or time will not permit your Old Notes to reach the Exchange Agent before the Expiration Date, a tender may be effected if:

the tender is made through an Eligible Institution, as defined above,

prior to the Expiration Date, the Exchange Agent receives from such Eligible Institution, by facsimile transmission, mail or hand delivery, a properly completed and duly executed notice of guaranteed delivery, substantially in the form provided by us, or an Agent's Message with respect to guaranteed delivery in lieu thereof, in either case stating:

the name and address of the holder of Old Notes,

the amount of Old Notes tendered,

that the tender is being made by delivering such notice and guaranteeing that, within three New York Stock Exchange trading days after the Expiration Date, a Book-Entry Confirmation or the certificates for all physically tendered Old Notes, in proper form for transfer, together with either an appropriate Agent's Message or a properly completed and duly executed letter of transmittal in lieu thereof, and all other required documentation, will be deposited by that Eligible Institution with the Exchange Agent, and

a Book-Entry Confirmation or the certificates for all physically tendered Old Notes, in proper form for transfer, together with either an appropriate Agent's Message or a properly completed and duly executed letter of transmittal in lieu thereof, and all other required documentation, are received by the Exchange Agent within three New York Stock Exchange trading days after the Expiration Date.

Withdrawal Rights

You can withdraw your tender of Old Notes at any time on or prior to 5:00 p.m., New York City time, on the Expiration Date.

For a withdrawal to be effective, a written notice of withdrawal must be actually received by the Exchange Agent prior to such time, properly transmitted either through DTC's ATOP or to the

53

Table of Contents

Exchange Agent at the address listed below under " Exchange Agent." Any notice of withdrawal must:

- specify the name of the person having tendered the Old Notes to be withdrawn;
- identify the Old Notes to be withdrawn;
- specify the principal amount of the Old Notes to be withdrawn;
- contain a statement that the tendering holder is withdrawing its election to have such Notes exchanged for New Notes;
- except in the case of a notice of withdrawal transmitted through DTC's ATOP system, be signed by the holder in the same manner as the original signature on the letter of transmittal by which the Old Notes were tendered, including any required signature guarantees, or be accompanied by documents of transfer to have the Trustee with respect to the Old Notes register the transfer of the Old Notes in the name of the person withdrawing the tender;
- if certificates for Old Notes have been delivered to the Exchange Agent, specify the name in which the Old Notes are registered, if different from that of the withdrawing holder;
- if certificates for Old Notes have been delivered or otherwise identified to the Exchange Agent, then, prior to the release of those certificates, specify the serial numbers of the particular certificates to be withdrawn, and, except in the case of a notice of withdrawal transmitted through DTC's ATOP system, include a notice of withdrawal signed in the same manner as the letter of transmittal by which the Old Notes were tendered, including any required signature guarantees; and
- if Old Notes have been tendered using the procedure for book-entry transfer described above, specify the name and number of the account at DTC from which the Old Notes were tendered and the name and number of the account at DTC to be credited with the withdrawn Old Notes, and otherwise comply with the procedures of DTC.

Please note that all questions as to the validity, form, eligibility and time of receipt of notices of withdrawal will be determined by us, and our determination shall be final and binding on all parties. Any Old Notes so withdrawn will be considered not to have been validly tendered for exchange for purposes of the exchange offer. New Notes will not be issued in exchange for such withdrawn Old Notes unless the Old Notes so withdrawn are validly re-tendered.

If you have properly withdrawn Old Notes and wish to re-tender them, you may do so by following one of the procedures described under " Procedures for Tendering Old Notes" above at any time on or prior to the Expiration Date.

Conditions to the Exchange Offer

Notwithstanding any other provisions of the exchange offer, we will not be required to accept for exchange, or to issue New Notes in exchange for, any Old Notes and may terminate or amend the exchange offer, if we determine in our reasonable judgment at any time before the Expiration Date that the exchange offer would violate applicable law or any applicable interpretation of the staff of the SEC.

The foregoing conditions are for our sole benefit and may be waived by us regardless of the circumstances giving rise to that condition. Our failure at any time to exercise the foregoing rights shall not be considered a waiver by us of that right. The rights described in the prior paragraph are ongoing rights which we may assert at any time and from time to time.

Table of Contents

In addition, we will not accept for exchange any Old Notes tendered, and no New Notes will be issued in exchange for any such Old Notes, if at any time any stop order is threatened or in effect with respect to the registration statement of which this prospectus constitutes a part or the qualification of the Indenture under the Trust Indenture Act.

We reserve the right to terminate or amend the exchange offer at any time prior to the Expiration Date upon the occurrence of any of the foregoing events.

Exchange Agent

Wilmington Trust, National Association has been appointed as the Exchange Agent for the exchange offer. All executed letters of transmittal, notices of guaranteed delivery, notices of withdrawal and any other required documentation should be directed to the Exchange Agent at the address set forth below. Requests for additional copies of this prospectus or of the letter of transmittal and requests for notices of guaranteed delivery should be directed to the Exchange Agent, addressed as follows:

Deliver To:

By mail, hand or overnight courier:	*By facsimile:*	*For information or confirmation by telephone:*
Wilmington Trust, National Association c/o Wilmington Trust Company Corporate Capital Markets Rodney Square North 1100 North Market Street Wilmington, Delaware 19890-1626	(302) 636-4139	Sam Hamed (302) 636-6181

Delivery to an address other than the address of the Exchange Agent as listed above or transmission of instructions via facsimile other than as listed above does not constitute a valid delivery.

Fees and Expenses

The principal solicitation is being made by mail; however, additional solicitation may be made by telephone or in person by our officers, regular employees and affiliates. We will not pay any additional compensation to any of our officers and employees who engage in soliciting tenders. We will not make any payment to brokers, dealers or others soliciting acceptances of the exchange offer. However, we will pay the Exchange Agent reasonable and customary fees (including attorney fees and expenses) for its services and will reimburse it for its reasonable out-of-pocket expenses in connection with the exchange offer.

The estimated cash expenses to be incurred in connection with the exchange offer, including legal, accounting, SEC filing, printing and Exchange Agent expenses, will be paid by us and are estimated in the aggregate to be approximately $750,000.

Transfer Taxes

Holders who tender their Old Notes for exchange will not be obligated to pay any transfer taxes in connection therewith, except that holders who instruct us to register New Notes in the name of, or request that Old Notes not tendered or not accepted in the exchange offer be returned to, a person other than the registered tendering holder will be responsible for the payment of any applicable transfer tax.

Table of Contents

Resale of the New Notes

Under existing interpretations of the staff of the SEC contained in several no-action letters to third parties, the New Notes would in general be freely transferable by holders thereof (other than affiliates of us) after the exchange offer without further registration under the Securities Act (subject to certain representations required to be made by each holder of Old Notes participating in the exchange offer, as set forth below). The relevant no-action letters include the Exxon Capital Holdings Corporation letter, which was made available by the SEC on May 13, 1988, the Morgan Stanley & Co. Incorporated letter, which was made available by the SEC on June 5, 1991, the K-111 Communications Corporation letter, which was made available by the SEC on May 14, 1993, and the Shearman & Sterling letter, which was made available by the SEC on July 2, 1993.

However, any purchaser of Old Notes who is an "affiliate" of ours or who intends to participate in the exchange offer for the purpose of distributing the New Notes:

- will not be able to rely on such SEC interpretation;
- will not be able to tender its Old Notes in the exchange offer; and
- must comply with the registration and prospectus delivery requirements of the Securities Act in connection with any sale or transfer of Old Notes unless such sale or transfer is made pursuant to an exemption from those requirements.

By executing, or otherwise becoming bound by, the letter of transmittal, you will represent to us that:

- any New Notes to be received by you will be acquired in the ordinary course of business;
- you have no arrangements or understandings with any person to participate in the distribution of the Old Notes or New Notes within the meaning of the Securities Act; and
- you are not our "affiliate" within the meaning of Rule 405 under the Securities Act;
- if you are a broker-dealer, you will receive the New Notes for your own account in exchange for the Old Notes acquired as a result of market-making activities or other trading activities and that you will deliver a prospectus in connection with any resale of New Notes (see "Plan of Distribution");
- if you are not a broker-dealer, you are not engaged in and do not intend to engage in the distribution of the New Notes; and
- you are not acting on behalf of any person that could not truthfully make any of the foregoing representations contained in this paragraph.

We have not sought, and do not intend to seek, a no-action letter from the SEC with respect to the effects of the exchange offer, and there can be no assurance that the SEC staff would make a similar determination with respect to the New Notes as it has made in previous no-action letters.

In addition, in connection with any resales of those Old Notes, each participating broker-dealer receiving New Notes for its own account in exchange for Old Notes, where such Old Notes were acquired by such exchanging dealer as a result of market-making activities or other trading activities, must represent that it will deliver a prospectus meeting the requirements of the Securities Act in connection with any resale of such New Notes. We have agreed that for a period of up to 90 days after the exchange offer is consummated, we will make this prospectus, as amended or supplemented, available to any broker-dealer for use in connection with any such resale. See "Plan of Distribution."

The SEC has taken the position in the Shearman & Sterling no-action letter, which it made available on July 2, 1993, that broker-dealers may fulfill their prospectus delivery requirements with respect to the New Notes, other than a resale of an unsold allotment from the original sale of the Old Notes, by delivery of the prospectus contained in the exchange offer registration statement.

Table of Contents

USE OF PROCEEDS

The exchange offer is intended to satisfy our obligations under the Registration Rights Agreements we entered into in connection with the private offering of the Old Notes. We will not receive any cash proceeds from the issuance of the New Notes under the exchange offer. In consideration for issuing the New Notes as contemplated by this prospectus, we will receive Old Notes in like principal amounts, the terms of which are identical in all material respects to the New Notes, subject to limited exceptions. Old Notes surrendered in exchange for New Notes will be retired and canceled and cannot be reissued. Accordingly, the issuance of the New Notes will not result in any increase in our indebtedness.

We used the net proceeds from the offering of the Old Notes, together with the Equity Contributions and the borrowings under the Term Loan Facility, to fund the Transactions.

Table of Contents

UNAUDITED PRO FORMA CONSOLIDATED FINANCIAL STATEMENTS

The following unaudited pro forma consolidated financial statements present our results of operations resulting from the Transactions as described under "Summary The Transactions." The unaudited pro forma consolidated financial statements are based on our consolidated financial statements included elsewhere in this prospectus, adjusted to give pro forma effect to the Transactions.

The unaudited pro forma consolidated financial statements include the pro forma consolidated statements of operations for the year ended December 31, 2010 and the six months ended June 30, 2010 and 2011 which give effect to the Transactions as if they occurred on January 1, 2010. The combined results for the six months ended June 30, 2011 represent the combination of our Predecessor results for the period from January 1 through May 24, 2011, plus our Successor results for the period from May 25 through June 30, 2011.

The unaudited pro forma consolidated financial statements are presented for informational purposes only and do not purport to represent our results of operations had the Transactions occurred on the date noted above or to project the results for any future date or period. In the opinion of management, all adjustments have been made that are necessary to present fairly the unaudited pro forma consolidated financial information.

The unaudited pro forma consolidated financial statements are based on the estimates and assumptions set forth in the notes to these statements that management believes are reasonable. These estimates include an allocation of fair value to identifiable intangible assets other than goodwill, and the resulting excess of the purchase price over the carrying value of the net assets acquired is recorded as goodwill. The value assigned at June 30, 2011 to intangible assets is based on preliminary valuation data and may change once an external valuation is completed during the third quarter of 2011. The result of the final purchase price allocation could be materially different from the preliminary allocation set forth in this prospectus.

The unaudited pro forma consolidated statements of operations eliminate non-recurring charges that were incurred in connection with the Transactions, including (i) equity-based compensation expense of $12.4 million related to the accelerated vesting of restricted stock, restricted stock units, and stock options awarded to management and members of our board of directors that vested upon the change in control; (ii) the expense to write-off existing deferred financing fees of approximately $10.1 million; and (iii) certain non-recurring expenses related to the Transactions of $29.8 million.

The unaudited pro forma consolidated financial statements should be read in conjunction with "Risk Factors," "Selected Historical Financial Data," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and related notes included elsewhere in this prospectus.

Table of Contents

Emergency Medical Services Corporation
Consolidated Statement of Operations

	Year Ended December 31, 2010		
	Actual	Adjustments	Pro forma
	(in thousands of dollars)		
Net revenue	$ 2,859,322	$	$ 2,859,322
Compensation and benefits	2,023,503		2,023,503
Operating expenses	359,262		359,262
Insurance expense	97,330		97,330
Selling, general and administrative expenses	67,912	4,000(1)	71,912
Depreciation and amortization expense	65,332	55,261(2)	120,593
Income from operations	245,983	(59,261)	186,722
Interest income from restricted assets	3,105		3,105
Interest expense	(22,912)	22,689(3)	
		(170,660)(4)	(170,883)
Realized gain on investments	2,450		2,450
Interest and other income	968		968
Loss on early debt extinguishment	(19,091)	19,091(5)	
Income before income taxes and equity in earnings of unconsolidated subsidiary	210,503	(188,141)	22,362
Income tax expense	(79,126)	70,517(7)	(8,609)
Income before equity in earnings of unconsolidated subsidiary	131,377	(117,624)	13,753
Equity in earnings of unconsolidated subsidiary	347		347
Net income	$ 131,724	$ (117,624)	$ 14,100

	Six months ended June 30, 2010		
	Actual	Adjustments	Pro forma
	(in thousands of dollars)		
Net revenue	$ 1,388,158	$	$ 1,388,158
Compensation and benefits	976,760		976,760
Operating expenses	177,115		177,115
Insurance expense	48,012		48,012
Selling, general and administrative expenses	35,156	2,000(1)	37,156
Depreciation and amortization expense	31,872	28,496(2)	60,368
Income from operations	119,243	(30,496)	88,747
Interest income from restricted assets	1,714		1,714
Interest expense	(13,326)	13,215(3)	
		(85,472)(4)	(85,583)
Realized gain on investments	149		149
Interest and other income	471		471
Loss on early debt extinguishment	(19,091)	19,091(5)	
Income before income taxes and equity in earnings of unconsolidated subsidiary	89,160	(83,662)	5,498
Income tax expense	(34,365)	32,248(7)	(2,117)
Income before equity in earnings of unconsolidated subsidiary	54,795	(51,414)	3,381
Equity in earnings of unconsolidated subsidiary	199		199

Net income	54,994	$ (51,414)	$ 3,580

Table of Contents

	Predecessor January 1 through May 24, 2011	Successor May 25 through June 30, 2011	Combined Six months ended June 30, 2011		Six months ended June 30, 2011
	Actual	Actual	Actual	Adjustments	Pro forma
	(in thousands of dollars)				
Net revenue	$ 1,221,790	$ 319,543	$ 1,541,333	$	1,541,333
Compensation and benefits	874,633	221,804	1,096,437	(12,431)(6)	1,084,006
Operating expenses	156,740	41,856	198,596		198,596
Insurance expense	47,229	10,089	57,318		57,318
Selling, general and administrative expenses	29,241	6,861	36,102	1,587(1)	37,689
Depreciation and amortization expense	28,467	11,061	39,528	20,242(2)	59,770
Income from operations	85,480	27,872	113,352	(9,398)	103,954
Interest income from restricted assets	1,124	162	1,286		1,286
Interest expense	(7,886)	(17,950)	(25,836)	7,781(3)	
				(66,275)(4)	(84,330)
Realized gain (loss) on investments	(9)	7	(2)		(2)
Interest and other income (expense)	(28,873)	(140)	(29,013)	29,654(6)	641
Loss on early debt extinguishment	(10,069)		(10,069)	10,069(5)	
Income before income taxes and equity in earnings of unconsolidated subsidiary	39,767	9,951	49,718	(28,169)	21,549
Income tax expense	(19,242)	(4,158)	(23,400)	15,104(7)	(8,296)
Income before equity in earnings of unconsolidated subsidiary	20,525	5,793	26,318	(13,065)	13,253
Equity in earnings of unconsolidated subsidiary	143	33	176		176
Net income	20,668	$ 5,826	$ 26,494	$ (13,065)	$ 13,429

Table of Contents

Notes to Unaudited Pro Forma Consolidated Statement of Operations
(dollars in thousands)

(1)

Represents an adjustment to reflect the incremental management fee payable to CD&R as compared to the management fee paid to our prior owner based on the terms of the new consulting agreement entered into at the closing of the Transactions and an annual fee paid to one of our new directors as compensation for his services. For more information, see "Management Director Compensation" and "Certain Relationships and Related Party Transactions."

(2)

Represents additional amortization due to an increase in the estimated fair market values of identifiable intangible assets associated with the Transactions. Intangible assets subject to amortization include the fair market value of our contracts amortized on a straight-line basis with an estimated weighted average useful life of 10 years. These estimates are preliminary in nature and could change as a result of adjustments to the estimates of the fair market value of these assets and their useful lives resulting from independent appraisal and our valuation review.

	Year ended December 31, 2010	Six months ended June 30, 2010	Predecessor January 1 through May 24, 2011	Successor May 25 through June 30, 2011	Combined Six months ended June 30, 2011
Estimated amortization on existing preliminary intangibles	$ 76,440	$ 38,220	$ 31,850	$	$ 31,850
Less: Amortization on prior intangibles	(21,179)	(9,724)	(11,608)		(11,608)
Pro forma adjustment to amortization expense	$ 55,261	$ 28,496	$ 20,242	$	$ 20,242

(3)

Represents a pro forma adjustment to eliminate interest expense associated with our prior senior secured credit facility, including amortization of prior deferred financing fees.

(4)

Represents interest expense on our borrowings under the Term Loan Facility and the Notes, and the amortization of deferred financing costs. Pro forma interest expense reflects a weighted average annual interest rate of 6.4% on indebtedness incurred to fund the Transactions and amortization expense on the $118.8 million of deferred financing costs associated with our new borrowings, utilizing a weighted average maturity of 7 years.

	Year ended December 31, 2010	Six months ended June 30, 2010	Predecessor January 1 through May 24, 2011	Successor May 25 through June 30, 2011	Combined Six months ended June 30, 2011
Interest on Term Loan	$ 76,736	$ 38,510	$ 29,149	$	$ 29,149
Interest on the Notes	77,188	38,594	30,661		30,661
Amortization on deferred financing fees	16,736	8,368	6,465		6,465
Pro forma adjustment to interest expense	$ 170,660	$ 85,472	$ 66,275	$	$ 66,275

If LIBOR increases above 1.50%, a 0.125% increase in the floating rate applicable to the $1,436 million indebtedness under our Senior Secured Credit Facilities outstanding at June 30, 2011 would result in an approximate $1.8 million increase in cash interest expense annually.

Table of Contents

(5)

To eliminate the loss on early debt extinguishment recorded as part of our prior debt restructuring, which occurred in April 2010, and incurred in connection with the Transactions.

(6)

Reflects an adjustment to reduce expenses recorded in the first six months of 2011 related to legal and accounting fees and accelerated equity-based compensation expense incurred in connection with the Transactions.

(7)

To adjust income tax expense to reflect the items noted in (1) through (6), principally as a result of increased interest and amortization expenses, at an effective tax rate of 38.5%.

Table of Contents

SELECTED HISTORICAL FINANCIAL DATA

The following table sets forth our selected historical financial data derived from our consolidated financial statements for each of the periods indicated. The selected historical financial data presented below should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and related notes included elsewhere in this prospectus. The selected historical data as of December 31, 2009 and 2010 (Predecessor) and for the years ended December 31, 2008, 2009 and 2010 (Predecessor) are derived from our audited consolidated financial statements included elsewhere in this prospectus. The selected historical financial data as of December 31, 2006, 2007 and 2008 (Predecessor) and for the years ended December 31, 2006 and 2007 (Predecessor) are derived from our audited consolidated financial statements not included in this prospectus. The selected historical financial data as of and for the six months ended June 30, 2010 (Predecessor), the period from January 1 through May 24, 2011 (Predecessor) and the period from May 25 through June 30, 2011 and as of June 30, 2011 (Successor) are derived from our unaudited consolidated financial statements included elsewhere in this prospectus. As a result of the Transactions, our financial statements after the Merger are not comparable to our

Table of Contents

financial statements prior to such date. Our historical financial data may not be a reliable indicator of future results of operations of our business.

	Predecessor							Successor
	As of and for the year ended December 31,					Six months ended June 30, 2010	Period from January 1 through May 24, 2011	Period from May 25 through June 30, 2011
	2006	2007	2008	2009	2010			
	(in thousands of dollars)							
Statement of Operations Data:								
Net revenue	$ 1,934,205	$ 2,106,993	$ 2,409,864	$ 2,569,685	$ 2,859,322	$ 1,388,158	$ 1,221,790	$ 319,543
Compensation and benefits	1,333,648	1,455,970	1,637,425	1,796,779	2,023,503	976,760	874,633	221,804
Operating expenses	294,806	317,518	383,359	334,328	359,262	177,115	156,740	41,856
Insurance expense	74,258	66,308	82,221	97,610	97,330	48,012	47,229	10,089
Selling, general and administrative expenses	57,403	61,893	69,658	63,481	67,912	35,156	29,241	6,861
Depreciation and amortization expense	66,005	70,483	68,980	64,351	65,332	31,872	28,467	11,061
Restructuring charges	6,369	2,242						
Income from operations	101,716	132,579	168,221	213,136	245,983	119,243	85,480	27,872
Interest income from restricted assets	5,987	7,143	6,407	4,516	3,105	1,714	1,124	162
Interest expense	(45,605)	(46,948)	(42,087)	(40,996)	(22,912)	(13,326)	(7,886)	(17,950)
Realized (loss) gain on investments	(467)	245	2,722	2,105	2,450	149	(9)	7
Interest and other (expense) income	2,346	2,055	2,055	1,816	968	471	(28,873)	(140)
Loss on early debt extinguishment	(377)		(241)		(19,091)	(19,091)	(10,069)	
Income before income taxes and equity in earnings of unconsolidated subsidiary	63,600	95,074	137,077	180,577	210,503	89,160	39,767	9,951
Income tax expense	(24,961)	(36,104)	(52,530)	(65,685)	(79,126)	(34,365)	(19,242)	(4,158)
Income before equity in earnings of unconsolidated subsidiary	38,639	58,970	84,547	114,892	131,377	54,795	20,525	5,793
	432	848	300	347	347	199	143	33

Equity in earnings of unconsolidated subsidiary								
Net income	$ 39,071	$ 59,818	$ 84,847	$ 115,239	$ 131,724	$ 54,994	$ 20,668	$ 5,826
Balance Sheet Data (at end of period):								
Cash and cash equivalents	39,336	28,914	146,173	332,888	287,361	313,033		186,811
Total assets	1,318,217	1,479,563	1,541,219	1,654,707	1,748,552	1,704,795		4,072,796
Long-term debt and capital lease obligations, including current maturities	479,775	482,883	458,505	453,930	421,276	427,535		2,379,335
Stockholders' Equity	386,040	449,496	539,039	686,087	847,205	764,775		891,301
Cash Flow Data:								
Cash flows provided by (used in):								
Operating activities	$ 165,742	$ 97,818	$ 211,457	$ 272,553	$ 185,544	$ 84,742	$ 67,975	$ 37,721
Investing activities	(113,127)	(100,226)	(74,945)	(116,629)	(158,865)	(60,358)	(89,459)	(2,847,446)
Financing activities	(31,327)	(8,014)	(19,253)	30,791	(72,206)	(44,239)	20,671	2,709,988
Purchases of property, plant and equipment	(60,415)	(38,335)	(32,088)	(44,728)	(49,121)	(15,168)	(18,496)	(2,892)

Table of Contents

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following information should be read in conjunction with "Selected Historical Financial Data" and our consolidated financial statements and related notes included elsewhere in this prospectus. The following discussion may contain forward-looking statements that reflect our plans, estimates and beliefs. Our actual results could differ materially from those discussed in these forward-looking statements. Factors that could cause or contribute to these differences include those factors discussed below and elsewhere in this prospectus, particularly in "Risk Factors" and "Forward-Looking Statements."

Company Overview

We are a leading provider of outsourced facility-based physician services and medical transportation services in the United States. We operate our business and market our services under the EmCare and AMR brands. EmCare is a leading provider of physician services in the United States, based on number of contracts with hospitals and affiliated physician groups. Through EmCare, we provide facility-based physician services for emergency departments, as well as anesthesiology, hospitalist/inpatient, radiology and teleradiology programs. AMR is a leading provider of medical transportation services to communities, payors and hospitals in the United States based on net revenue and number of transports. Approximately 86% of our net revenue for the year ended December 31, 2010 was generated under exclusive contracts. We had contract retention rates of 88% at EmCare and 99% at AMR as of December 31, 2010. During 2010, we provided services in approximately 14 million patient encounters in more than 2,000 communities nationwide.

EmCare

Over its more than 35 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. During 2010, EmCare had approximately 11.0 million patient encounters across 40 states and the District of Columbia. As of December 31, 2010, EmCare had an 8% share of the total ED services market and a 12% share of the outsourced ED services market, the largest share among outsourced providers based on number of ED contracts. EmCare's share of the combined markets for anesthesiology, hospitalist and radiology services was approximately 2% as of such date.

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 569 contracts with hospitals and independent physician groups to provide emergency department, anesthesiology, hospitalist/inpatient, radiology and teleradiology staffing and other administrative services.

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. As of December 31, 2010, AMR had a 7% share of the total ambulance services market and a 16% share of the outsourced ambulance market, the largest share among outsourced providers based on number of transports and net revenue. During 2010, AMR treated and transported approximately 3.2 million patients in 38 states and the District of Columbia by utilizing its fleet of nearly 4,300 vehicles that operated out of more than 200 sites. As of December 31, 2010, AMR had more than 3,500 contracts with communities, government agencies, healthcare providers and insurers to provide ambulance transport services. During 2010, approximately 58% of

Table of Contents

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 inter-facility transports accounted for 28% of AMR's net revenue for the same period. The remaining balance of net revenue for 2010 was generated from managed transportation services, fixed-wing air ambulance services, and the provision of training, dispatch and other services to communities and public safety agencies.

Effects of the Transactions

In accordance with GAAP, we accounted for the Merger using the acquisition method of accounting for business combinations. Under this method of accounting, we recorded the acquisition based on the fair value of the merger consideration, which includes cash consideration paid and the Notes.

We have allocated the purchase price to the identifiable tangible and intangible assets acquired and liabilities assumed based on their respective fair values at the date of completion of the Merger. Any excess of the value of consideration paid over the aggregate fair value of those net assets is recorded as goodwill. Our consolidated financial statements for periods after the Merger reflect such fair values and have not been restated retroactively to reflect our historical financial position or our results of operations.

The unaudited pro forma consolidated financial statements included in this prospectus are based on the estimates and assumptions set forth in the notes to such statements that management believes are reasonable. These estimates include an allocation of fair value to identifiable intangible assets other than goodwill, and the resulting excess of the purchase price over the carrying value of the net assets acquired is recorded as goodwill. The value assigned at June 30, 2011 to intangible assets is based on preliminary valuation data and may change once an external valuation is completed during the third quarter of 2011. The result of the final purchase price allocation could be materially different from the preliminary allocation set forth in this prospectus.

For further discussion of the accounting treatment related to the Transactions and of the pro forma effects of the Transactions, see "Unaudited Pro Forma Consolidated Financial Statements."

Presentation

The consolidated financial statements included in this prospectus are presented for two periods: Predecessor and Successor results, which relate to the periods preceding the Merger and the period succeeding the Merger, respectively. The discussion in this Management's Discussion and Analysis of Financial Condition and Results of Operations is presented on a combined basis of the Predecessor and Successor periods for the six months ended June 30, 2011. The 2011 Predecessor and Successor results are presented but are not discussed separately. Management believes that the discussion on a combined basis is more meaningful as it allows the results of operations to be analyzed to the comparable period in 2010. Exceptions to this include depreciation and amortization expense, interest expense, and interest and other (expense) income, which had significant impacts as a result of the Merger, but are addressed separately in the discussion below. See Note 1 to the unaudited consolidated financial statements included elsewhere in this prospectus.

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

Table of Contents

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 payor mix as a percentage of both net revenue and total transports and patient encounters for the years ended December 31, 2008, 2009 and 2010 and the six months ended June 30, 2010 and 2011. In determining the net revenue payor mix, we use cash collections in the period as an approximation of net revenue recorded.

	Percentage of Cash Collections (Net Revenue)					Percentage of Total Volume				
	Year ended December 31,			Six months ended June 30,		Year ended December 31,			Six months ended June 30,	
	2008	2009	2010	2010	2011	2008	2009	2010	2010	2011
Medicare	23.1%	23.3%	22.0%	21.9%	22.0%	25.7%	24.0%	25.2%	24.9%	26.3%
Medicaid	4.4	4.8	5.6	5.1	6.1	10.7	11.5	12.9	12.5	13.1
Commercial insurance and managed care	47.4	50.2	48.7	49.8	48.7	42.0	43.1	42.2	43.0	42.6
Self-pay	4.3	3.9	4.3	4.2	4.9	21.6	21.4	19.7	19.6	18.0
Other revenue and subsidies	20.8	17.8	19.4	19.0	18.3					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Our 2011 volume mix has been positively impacted compared to our 2010 volume mix primarily by the continued expansion of our anesthesia business, which has a lower percentage of self-pay volume than our emergency department, radiology and inpatient services businesses.

Our 2010 volume mix has been positively impacted compared to our 2009 volume mix due primarily to the recent expansion of our anesthesia business, which has a lower percentage of self-pay mix than our emergency department, radiology and inpatient services businesses, and due to a decreased percentage of self-pay patients treated in 2010. Our payor mix was negatively impacted in 2009 due to an increased level of self-pay patients treated in response to the H1N1 virus, which did not recur in 2010.

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

EmCare

Of EmCare's net revenue for the six months ended June 30, 2011 and for the year ended December 31, 2010, approximately 74% and 78%, respectively, was derived from our hospital contracts for emergency department staffing and approximately 26% and 22%, respectively, was derived from anesthesiology, hospitalist, radiology, teleradiology and other hospital management services. Of this revenue for the six months ended June 30, 2011 and for the year ended December 31, 2010, approximately 78% and 77%, respectively, was generated from billings to third party payors and patients for patient encounters and approximately 22% and 23%, respectively, was generated from

Table of Contents

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, anesthesiology and hospitalist encounters, and radiology reads 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, anesthesiology, hospitalist, radiology, teleradiology, 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.

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 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 hour of coverage. Provider compensation per hour of coverage 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 hour of coverage 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, based on our past loss experience, as well as actual direct costs, including investigation and defense costs, claims payments, 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.

AMR

Approximately 87% of AMR's net revenue for the six months ended June 30, 2011 and for the year ended December 31, 2010 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 was derived from direct billings to

Table of Contents

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 and net revenue per transport is influenced by the mix of emergency versus non-emergency transports, 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 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 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,

Table of Contents

equipment and other technologies. Amortization expense relates primarily to intangibles recorded for customer relationships.

Factors Affecting Operating Results

Federal Emergency Management Agency Contract

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 original contract covered the 21 states along the Gulf and Atlantic coasts and was expanded by FEMA to the full 48 contiguous states on October 1, 2009. This expanded coverage extends through October 31, 2011 and FEMA has the option to renew the contract for different zones in the contract at various points during the remainder of 2011 and 2012. 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. There were no material FEMA deployments during the years ended December 31, 2010 or 2009.

Rate Changes by Government Sponsored Programs

In February 2002, the 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 Balanced Budget Act of 1997 ("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 an increase in AMR's net revenue of approximately $14 million in 2008, an increase in AMR's net revenue of approximately $24 million in 2009, and a decrease in AMR's net revenue of approximately $18 million in 2010. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential increase in AMR's net revenue of less than $1 million for 2011. 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 and related volume 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 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. For the year ended December 31, 2010, AMR and EmCare's contract retention rates were 99% and 88%, respectively.

Table of Contents

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. Fuel expense represented 11.2% and 9.8% of AMR's operating expenses for the six months ended June 30, 2011 and 2010, respectively. Excluding the impact of the 2008 hurricane deployment, fuel expense represented 10.2%, 9.1% and 14.1% of AMR's operating expenses for the years ended December 31, 2010, 2009, and 2008, 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.

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 elsewhere in this prospectus.

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 the six months ended June 30, 2011 and 2010 we recorded increases in our provisions for insurance liabilities of $8.2 million and $0.1 million, respectively, related to reserves for losses in prior years. During 2010 we recorded an increase in our provisions for insurance liabilities of $0.4 million, an increase of $4.5 million during 2009, and a decrease of $4.1 million during 2008 related to reserves for losses in prior years. 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.

Table of Contents

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. EmCare and AMR 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 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 14 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.

Business Combinations

Effective January 1, 2009, we adopted ASC 805, *Business Combinations*, which revised the accounting guidance that we were required to apply for our acquisitions in comparison to prior fiscal years. In accordance with this guidance, the assets and liabilities of an acquired business are recorded at their fair values at the date of acquisition. The excess of the purchase price over the estimated fair values is recorded as goodwill. All acquisition costs are expensed as incurred. While we use our best estimates and assumptions as a part of the purchase price allocation process to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period we may record adjustments to the assets acquired and liabilities assumed, with the corresponding offset to goodwill. Upon the conclusion of the measurement period any subsequent adjustments are recorded as expense.

Revenue Recognition

Revenue is recognized at the time of service and is recorded net of provisions for contractual discounts and estimated uncompensated care. We estimate our provision for contractual discounts and uncompensated care based on payor reimbursement schedules, historical collections and write-off experience and other economic data. As a result of the estimates used in recording the provisions and the nature of healthcare collections, which may involve lengthy delays, there is a reasonable possibility that recorded estimates will change materially in the short-term.

Table of Contents

The changes in the provisions for contractual discounts and estimated uncompensated care are primarily a result of changes in our gross fee-for-service rate schedules and gross accounts receivable balances. These gross fee schedules, including any changes to existing fee schedules, generally are negotiated with various contracting entities, including municipalities and facilities. Fee schedule increases are billed for all revenue sources and to all payors under that specific contract; however, reimbursement in the case of certain state and federal payors, including Medicare and Medicaid, will not change as a result of the change in gross fee schedules. In certain cases, this results in a higher level of contractual and uncompensated care provisions and allowances, requiring a higher percentage of contractual discount and uncompensated care provisions compared to gross charges.

In addition, management analyzes the ultimate collectability of revenue and accounts receivable after certain stages of the collection cycle using a look-back analysis to determine the amount of receivables subsequently collected. Adjustments related to this analysis are recorded as a reduction or increase to net revenue each month, and were less than 1% of net revenue for each of the six month periods ending June 30, 2011 and 2010 and for the years ended December 31, 2010, 2009 and 2008.

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. We have recorded reserves based upon management's best estimate of final outcomes, but such estimates may differ from the tax authorities ultimate outcomes.

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 that is significant to our financial statements.

Table of Contents

Results of Operations

Basis of Presentation

The following tables present, for the periods indicated, a comparison of financial data from our audited consolidated statements of operations for the years ended December 31, 2008, 2009 and 2010 and from our unaudited consolidated statements of operations for the six months ended June 30, 2010, the period from January 1 through May 24, 2011 and the period from May 25 through June 30, 2011, as well as for the combined six months ended June 30, 2011 for EMSC and our two operating segments. The results of operations will be discussed on a combined basis for the six months ended June 30, 2011. Management believes that the discussion on a combined basis is more meaningful as it allows the results of operations to be analyzed to the comparable period in 2010. Exceptions to this include depreciation and amortization expense, interest expense, and interest and other (expense) income, which had significant impacts as a result of the Merger, but are addressed separately in the discussion below.

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

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30, 2010	Period from January 1 through May 24, 2011	Period from May 25 through June 30, 2011	Six Months Ended June 30, 2011
	2008	2009	2010	(unaudited)	(unaudited)	(unaudited)	(unaudited)
Net revenue	$ 2,409,864	$ 2,569,685	$ 2,859,322	$ 1,388,158	$ 1,221,790	$ 319,543	$ 1,541,333
Compensation and benefits	1,637,425	1,796,779	2,023,503	976,760	874,633	221,804	1,096,437
Operating expenses	383,359	334,328	359,262	177,115	156,740	41,856	198,596
Insurance expense	82,221	97,610	97,330	48,012	47,229	10,089	57,318
Selling, general and administrative expenses	69,658	63,481	67,912	35,156	29,241	6,861	36,102
Depreciation and amortization expense	68,980	64,351	65,332	31,872	28,467	11,061	39,528
Income from operations	168,221	213,136	245,983	119,243	85,480	27,872	113,352
Interest income from restricted assets	6,407	4,516	3,105	1,714	1,124	162	1,286
Interest expense	(42,087)	(40,996)	(22,912)	(13,326)	(7,886)	(17,950)	(25,836)
Realized gain (loss) on investments	2,722	2,105	2,450	149	(9)	7	(2)
Interest and other income (expense)	2,055	1,816	968	471	(28,873)	(140)	(29,013)
Loss on early debt extinguishment	(241)		(19,091)	(19,091)	(10,069)		(10,069)
Equity in earnings of unconsolidated subsidiary	300	347	347	199	143	33	176
Income tax expense	(52,530)	(65,685)	(79,126)	(34,365)	(19,242)	(4,158)	(23,400)
Net income	$ 84,847	$ 115,239	$ 131,724	$ 54,994	$ 20,668	$ 5,826	26,494

Table of Contents

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30, 2010	Period from January 1 through May 24, 2011	Period from May 25 through June 30, 2011	Six Months ended June 30, 2011
	2008	2009	2010	(unaudited)	(unaudited)	(unaudited)	(unaudited)
Net revenue	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Compensation and benefits	67.9	69.9	70.8	70.4	71.6	69.4	71.1
Operating expenses	15.9	13.0	12.6	12.8	12.8	13.1	12.9
Insurance expenses	3.4	3.8	3.4	3.5	3.9	3.2	3.7
Selling, general and administrative expenses	2.9	2.5	2.4	2.5	2.4	2.1	2.3
Depreciation and amortization expense	2.9	2.5	2.3	2.3	2.3	3.5	2.6
Income from operations	7.0%	8.3%	8.6%	8.6%	7.0%	8.7%	7.4%

Segment Results of Operations and as a Percentage of Net Revenue
(in thousands of dollars)

EmCare

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30, 2010	Period from January 1 through May 24, 2011	Period from May 25 through June 30, 2011	Six Months ended June 30, 2011
	2008	2009	2010	(unaudited)	(unaudited)	(unaudited)	(unaudited)
Net revenue	$ 1,008,063	$ 1,225,828	$ 1,478,462	$ 707,037	$ 642,059	$ 171,714	$ 813,773
Compensation and benefits	795,777	956,306	1,164,389	557,107	513,639	133,192	646,831
Operating expenses	36,355	39,872	45,745	23,037	21,038	6,040	27,078
Insurance expense	42,326	49,619	52,540	24,052	24,361	5,631	29,992
Selling, general and administrative expenses	23,747	25,273	28,479	15,200	12,900	2,907	15,807
Depreciation and amortization expense	13,898	15,161	20,384	9,568	9,411	4,687	14,098
Income from operations	$ 95,960	$ 139,597	$ 166,925	$ 78,073	$ 60,710	$ 19,257	$ 79,967

Table of Contents

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30, 2010	Period from January 1 through May 24, 2011	Period from May 25 through June 30, 2011	Six Months ended June 30, 2011
	2008	2009	2010	(unaudited)	(unaudited)	(unaudited)	(unaudited)
Net revenue	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Compensation and benefits	78.9	78.0	78.8	78.8	80.0	77.6	79.5
Operating expenses	3.6	3.3	3.1	3.3	3.3	3.5	3.3
Insurance expense	4.2	4.0	3.6	3.4	3.8	3.3	3.7
Selling, general and administrative expenses	2.4	2.1	1.9	2.1	2.0	1.7	1.9
Depreciation and amortization expense	1.4	1.2	1.4	1.4	1.5	2.7	1.7
Income from operations	9.5%	11.4%	11.3%	11.0%	9.5%	11.2%	9.8%

AMR

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30, 2010	Period from January 1 through May 24, 2011	Period from May 25 through June 30, 2011	Six Months ended June 30, 2011
	2008	2009	2010	(unaudited)	(unaudited)	(unaudited)	(unaudited)
Net revenue	$ 1,401,801	$ 1,343,857	$ 1,380,860	$ 681,121	$ 579,731	$ 147,829	$ 727,560
Compensation and benefits	841,648	840,473	859,114	419,653	360,994	88,612	449,606
Operating expenses	347,004	294,456	313,517	154,078	135,702	35,816	171,518
Insurance expense	39,895	47,991	44,790	23,960	22,868	4,458	27,326
Selling, general and administrative expenses	45,911	38,208	39,433	19,956	16,341	3,954	20,295
Depreciation and amortization expense	55,082	49,190	44,948	22,304	19,056	6,374	25,430
Income from operations	$ 72,261	$ 73,539	$ 79,058	$ 41,170	$ 24,770	$ 8,615	$ 33,385

Table of Contents

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30, 2010	Period from January 1 through May 24, 2011	Period from May 25 through June 30, 2011	Six Months ended June 30, 2011
	2008	2009	2010	(unaudited)	(unaudited)	(unaudited)	(unaudited)
Net revenue	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Compensation and benefits	60.0	62.5	62.2	61.6	62.3	59.9	61.8
Operating expenses	24.8	21.9	22.7	22.6	23.4	24.2	23.6
Insurance expense	2.8	3.6	3.2	3.5	3.9	3.0	3.8
Selling, general and administrative expenses	3.3	2.8	2.9	2.9	2.8	2.7	2.8
Depreciation and amortization expense	3.9	3.7	3.3	3.3	3.3	4.3	3.5
Income from operations	5.2%	5.5%	5.7%	6.0%	4.3%	5.8%	4.6%

Non-GAAP Measures

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 (expense) income, realized gain (loss) on investments, interest expense, depreciation and amortization expense, equity-based compensation expenses and related party management fees. Adjusted EBITDA, as reported historically, has been adjusted to reflect equity-based compensation expenses and related party management fees. See the reconciliation table below.

Adjusted EBITDA is commonly used by management and investors as a performance measure. Adjusted EBITDA is not considered a measure of financial performance under GAAP, and the items excluded from Adjusted EBITDA are significant components in understanding and assessing our financial performance. Adjusted EBITDA has limitations as an analytical tool and should not be considered in isolation or as an alternative to GAAP measures such as net income, cash flows provided by or used in operating, investing or financing activities or other financial statement data presented in our consolidated financial statements as an indicator of financial performance or liquidity. Because Adjusted EBITDA is not a measure determined in accordance with GAAP and is susceptible to varying calculations, this measure, as presented, may not be comparable to other similarly titled measures of other companies.

Table of Contents

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 segments for the periods indicated (amounts in thousands of dollars):

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30,	Period from January 1 through May 24,	Period from May 25 through June 30,	Six Months ended June 30,
	2008	2009	2010	2010	2011	2011	2011
Consolidated/Combined							
Adjusted EBITDA	$ 247,084	$ 286,982	$ 322,119	$ 155,874	$ 130,582	$ 40,039	$ 170,621
Related party management fees	(1,000)	(1,000)	(1,000)	(500)	(399)	(514)	(913)
Equity-based compensation expense	(2,476)	(3,979)	(6,699)	(2,545)	(15,112)	(430)	(15,542)
Depreciation and amortization expense	(68,980)	(64,351)	(65,332)	(31,872)	(28,467)	(11,061)	(39,528)
Interest income from restricted assets	(6,407)	(4,516)	(3,105)	(1,714)	(1,124)	(162)	(1,286)
Income from operations	168,221	213,136	245,983	119,243	85,480	27,872	113,352
Interest income from restricted assets	6,407	4,516	3,105	1,714	1,124	162	1,286
Interest expense	(42,087)	(40,996)	(22,912)	(13,326)	(7,886)	(17,950)	(25,836)
Realized gain (loss) on investments	2,722	2,105	2,450	149	(9)	7	(2)
Interest and other income (expense)	2,055	1,816	968	471	(28,873)	(140)	(29,013)
Loss on early debt extinguishment	(241)		(19,091)	(19,091)	(10,069)		(10,069)
Income tax expense	(52,530)	(65,685)	(79,126)	(34,365)	(19,242)	(4,158)	(23,400)
Equity in earnings of unconsolidated subsidiary	300	347	347	199	143	33	176
Net income	$ 84,847	$ 115,239	$ 131,724	$ 54,994	$ 20,668	$ 5,826	26,494
EmCare							
Adjusted EBITDA	$ 115,239	$ 159,535	$ 192,503	$ 90,037	$ 77,686	$ 24,434	$ 102,120
Related party management fees	(450)	(450)	(450)	(225)	(180)	(231)	(411)
Equity-based compensation expense	(1,114)	(1,791)	(3,015)	(1,145)	(6,801)	(193)	(6,994)
Depreciation and amortization expense	(13,898)	(15,161)	(20,384)	(9,568)	(9,411)	(4,687)	(14,098)
Interest income from restricted assets	(3,817)	(2,536)	(1,729)	(1,026)	(584)	(66)	(650)
Income from operations	$ 95,960	$ 139,597	$ 166,925	$ 78,073	$ 60,710	$ 19,257	$ 79,967
AMR							
Adjusted EBITDA	$ 131,845	$ 127,447	$ 129,616	$ 65,837	$ 52,896	$ 15,605	$ 68,501
Related party management fees	(550)	(550)	(550)	(275)	(219)	(283)	(502)
Equity-based compensation expense	(1,362)	(2,188)	(3,684)	(1,400)	(8,311)	(237)	(8,548)
Depreciation and amortization expense	(55,082)	(49,190)	(44,948)	(22,304)	(19,056)	(6,374)	(25,430)

Interest income from restricted assets	(2,590)	(1,980)	(1,376)	(688)	(540)	(96)	(636)
Income from operations	$ 72,261	$ 73,539	$ 79,058	$ 41,170	$ 24,770	$ 8,615	$ 33,385

Combined six months ended June 30, 2011 compared to the six months ended June 30, 2010

Consolidated

Our results for the combined six months ended June 30, 2011 reflect an increase in net revenue of $153.2 million and a decrease in net income of $28.5 million compared to the six months ended June 30, 2010. The decrease in net income is attributable primarily to an increase in interest expense and other fees associated with the Merger, partially offset by a decrease in income tax expense. During the combined six months ended June 30, 2011, we recorded $29.8 million for fees associated with the Merger, which are included in interest and other (expense) income. An additional $12.4 million in stock compensation expense was recorded for stock options and restricted stock which automatically

Table of Contents

vested with the Merger and the associated payroll taxes; see Note 1 to the accompanying unaudited consolidated financial statements.

Net revenue. For the six months ended June 30, 2011, we generated net revenue of $1,541.3 million compared to net revenue of $1,388.2 million for the six months ended June 30, 2010, representing an increase of 11.0%. The increase is attributable primarily to increases in rates and volumes on existing contracts combined with increased volume from net new contracts and acquisitions.

Adjusted EBITDA. Adjusted EBITDA was $170.6 million, or 11.1% of net revenue, for the six months ended June 30, 2011 compared to $155.9 million, or 11.2% of net revenue, for the six months ended June 30, 2010.

Interest expense. Interest expense for the six months ended June 30, 2011 was $25.8 million compared to $13.3 million for the six months ended June 30, 2010. The change was due to the increase in our outstanding debt and effective interest rate associated with the issuance of our new senior subordinated unsecured notes and borrowings under our new credit facilities in May 2011. In conjunction with entering into our new credit facility, we increased our total outstanding debt by $2.0 billion.

Interest and other (expense) income. During the six months ended June 30, 2011, $29.0 million was expensed compared to $0.5 million of income recognized during the six months ended June 30, 2010. The increase in expense was due to $29.8 million expensed during the second quarter of 2011 for investment banking, legal, accounting and other advisory services related to the Merger.

Loss on early debt extinguishment. During the six months ended June 30, 2011, we recorded a loss on early debt extinguishment of $10.1 million which included unamortized debt issuance associated with our credit facility in place prior to the Merger. During the six months ended June 30, 2010, we recorded a loss on early debt extinguishment of $19.1 million as we entered into a new credit facility and redeemed our senior subordinated notes.

Income tax expense. Income tax expense decreased by $11.0 million for the six months ended June 30, 2011 compared to the same period in 2010. Our effective tax rate was 41.8% for the Successor period from May 25, 2011 through June 30, 2011 and 48.4% for the Predecessor period from January 1, 2011 through May 24, 2011. Our effective tax rate for the six months ended June 30, 2010 was 38.5%. The increase in our effective tax rate was a result of certain Merger related costs that are not deductible for tax purposes.

EmCare

Net revenue. Net revenue for the combined six months ended June 30, 2011 was $813.8 million, an increase of $106.7 million, or 15.1%, from $707.0 million for the six months ended June 30, 2010. The increase was due primarily to an increase in patient encounters from net new hospital contracts and net revenue increases in existing contracts. Net new contracts since December 31, 2009 accounted for a net revenue increase of $81.5 million for the six months ended June 30, 2011, of which $69.6 million came from net new contracts added in 2010 with the remaining increase in net revenue from those added in 2011. Net revenue under our "same store" contracts (contracts in existence for the entirety of both periods) increased $25.2 million, or 4.3%, for the six months ended June 30, 2011. The change was due primarily to a 5.5% increase in same store weighted patient encounters, partially offset by a 1.2% decrease in revenue per weighted patient encounter. The increase in same store net revenue was due primarily to additional volume, partially offset by a lower average charge per patient, related to a stronger flu season in the first quarter of 2011 compared to the same period in 2010.

Compensation and benefits. Compensation and benefits costs for the six months ended June 30, 2011 were $646.8 million, or 79.5% of net revenue, compared to $557.1 million, or 78.8% of net

Table of Contents

revenue, for the same period in 2010. Stock-based compensation expense was $7.0 million during the six months ended June 30, 2011 compared to $1.1 million during the same quarter last year. The increase was due primarily to accelerated stock-based compensation expense associated with the Merger. Provider compensation costs increased $62.3 million from net new contract additions. Same store provider compensation costs were $15.5 million higher than the prior period due primarily to a 5.5% increase in same store weighted patient encounters, partially offset by a 1.5% decrease in provider compensation per weighted patient encounter. Non-provider compensation and total benefits costs, excluding stock-based compensation expense, increased by $6.0 million during the six months ended June 30, 2011 compared to the same period in 2010. The increase is due to our recent acquisitions and organic growth. Payroll taxes related to Merger of $0.3 million were also expensed during the six months ended June 30, 2011.

Operating expenses. Operating expenses for the six months ended June 30, 2011 were $27.1 million, or 3.3% of net revenue, compared to $23.0 million, or 3.3% of net revenue, for the same period in 2010. Operating expenses increased $4.1 million due primarily to our recent acquisitions and organic growth.

Insurance expense. Professional liability insurance expense for the six months ended June 30, 2011 was $30.0 million, or 3.7% of net revenue, compared to $24.1 million, or 3.4% of net revenue, for the six months ended June 30, 2010. We recorded an increase of prior year insurance provisions of $3.3 million during the six months ended June 30, 2011 compared to a decrease of less than $0.1 million during the six months ended June 30, 2010.

Selling, general and administrative. Selling, general and administrative expense for the six months ended June 30, 2011 was $15.8 million, or 1.9% of net revenue, compared to $15.2 million, or 2.1% of net revenue, for the six months ended June 30, 2010.

Depreciation and amortization. Depreciation and amortization expense for the six months ended June 30, 2011 was $14.1 million, or 1.7% of net revenue, compared to $9.6 million, or 1.4% of net revenue, for the six months ended June 30, 2010. The $4.5 million increase is due primarily to additional amortization expense associated with intangible assets recorded as a result of the Merger transaction during the second quarter of 2011 as well as amortization expense associated with contract intangible assets recorded on acquisitions completed since December 31, 2009.

AMR

Net revenue. Net revenue for the combined six months ended June 30, 2011 was $727.6 million, an increase of $46.4 million, or 6.8%, from $681.1 million for the same period in 2010. The increase in net revenue was due primarily to an increase of 3.5%, or $23.7 million, in weighted transport volume and an increase in net revenue per weighted transport of 3.3%, or $22.7 million. The increase in net revenue per weighted transport of 3.3% was due to a 1.7% increase in net revenue per transport resulting primarily from a higher mix of emergency versus non-emergency transports and rate increases in several markets, with the remaining increase coming from growth in our managed transportation business. AMR's managed transportation business represented 6.1% of AMR's net revenue for the six months ended June 30, 2011 compared to 4.6% for the six months ended June 30, 2010. Weighted transports increased 50,100 from the same period last year. The change was due to an increase in weighted transport volume in existing markets of 1.5%, or 21,700 weighted transports, an increase of 21,500 weighted transports from acquisitions, and an increase of 9,500 weighted transports from our entry into new markets, which increases were partially offset by a decrease of 2,600 weighted transports from the exit of certain markets.

Compensation and benefits. Compensation and benefit costs for the six months ended June 30, 2011 were $449.6 million, or 61.8% of net revenue, compared to $419.7 million, or 61.6% of net

Table of Contents

revenue, for the same period last year. Stock-based compensation expense was $8.5 million during the six months ended June 30, 2011 compared to $1.4 million during the same quarter last year. The increase was due primarily to accelerated stock-based compensation expense associated with the Merger. Ambulance crew wages per ambulance unit hour increased by approximately 2.7%, or $6.4 million, attributable primarily to annual wage rate increases. Ambulance unit hours increased period over period by 2.9%, or $6.7 million, due primarily to our recent acquisitions and our entry into new markets. Non-crew compensation, excluding stock-based compensation expense, increased period over period by $1.8 million due primarily to increased costs of $1.5 million in our managed transportation business. Total benefits related costs increased $8.1 million due primarily to increases in payroll taxes, of which $0.3 million were related to the Merger, and higher costs for our health insurance plans.

Operating expenses. Operating expenses for the six months ended June 30, 2011 were $171.5 million, or 23.6% of net revenue, compared to $154.1 million, or 22.6% of net revenue, for the six months ended June 30, 2010. The change is due primarily to increased costs associated with our managed transportation business of $12.9 million and an increase in fuel costs of $4.1 million.

Insurance expense. Insurance expense for the six months ended June 30, 2011 was $27.3 million, or 3.8% of net revenue, compared to $24.0 million, or 3.5% of net revenue, for the same period in 2010. We recorded an increase of prior year insurance provisions of $4.8 million during the six months ended June 30, 2011 compared to an increase of $0.1 million during the six months ended June 30, 2010.

Selling, general and administrative. Selling, general and administrative expense for the six months ended June 30, 2011 was $20.3 million, or 2.8% of net revenue, compared to $20.0 million, or 2.9% of net revenue, for the six months ended June 30, 2010.

Depreciation and amortization. Depreciation and amortization expense for the six months ended June 30, 2011 was $25.4 million, or 3.5% of net revenue, compared to $22.3 million, or 3.3% of net revenue, for the same period in 2010. The $3.1 million increase is due primarily to additional amortization expense associated with intangible assets recorded as a result of the Merger transaction during the second quarter of 2011 as well as amortization expense associated with contract intangible assets recorded on acquisitions completed since December 31, 2009.

Year ended December 31, 2010 compared to year ended December 31, 2009

Consolidated

Our results for the year ended December 31, 2010 reflect an increase in net revenue of $289.6 million and an increase in net income of $16.5 million compared to the year ended December 31, 2009. The increase in net income was attributable primarily to growth in income from operations and a decrease in interest expense, partially offset by the loss on early debt extinguishment. Basic and diluted earnings per share were $3.00 and $2.95, respectively, for the year ended December 31, 2010. Basic and diluted earnings per share were $2.71 and $2.64, respectively, for the same period in 2009. The basic and diluted earnings per share for the year ended December 31, 2010 include the impact from the loss on early debt extinguishment and a reserve recorded in connection with a tentative legal settlement relating to certain AMR affiliates in New York (the "DOJ Accrual"). These items were recorded in the second quarter of 2010 and account for basic and diluted earnings per share of $0.31 and $0.30, respectively, for the year ended December 31, 2010.

Net revenue

For the year ended December 31, 2010, we generated net revenue of $2,859.3 million compared to net revenue of $2,569.7 million for the year ended December 31, 2009, representing an increase of

Table of Contents

11.3%. The increase is attributable to increases in revenues on existing contracts and increased volume from net new contracts and acquisitions.

Adjusted EBITDA

Adjusted EBITDA was $322.1 million, or 11.3% of net revenue, for the year ended December 31, 2010 compared to $287.0 million, or 11.1% of net revenue, for the same period in 2009. The year ended December 31, 2010 includes the impact from the DOJ Accrual described previously.

Interest expense

Interest expense for the year ended December 31, 2010 was $22.9 million compared to $41.0 million for the same period in 2009. The decrease was due to entering into our previous credit facility in April 2010 and the redemption of our prior senior subordinated notes which resulted in a decrease to our effective interest rate compared to our previous debt structure. In conjunction with entering our previous credit facility, we reduced our total outstanding debt by $25.0 million.

Income tax expense

Income tax expense increased by $13.4 million for the year ended December 31, 2010, compared to the same period in 2009. Our effective tax rate for the year ended December 31, 2010 was 37.6% compared with 36.4% for the same period in 2009. The effective tax rate in 2009 was impacted by the reversal of reserves associated with previous tax positions recognized in prior periods, partially offset by additional valuation allowances recognized during 2009. The effective tax rate in 2010 was favorably impacted by the reduction of certain valuation allowances recognized in prior periods.

EmCare

Net revenue

Net revenue for the year ended December 31, 2010 was $1,478.5 million, an increase of $252.6 million, or 20.6%, from $1,225.8 million for the year ended December 31, 2009. 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, 2008, we added 95 net new contracts which accounted for a net revenue increase of $191.3 million in 2010. Of the 95 net new contracts added since December 31, 2008, 53 were added in 2009 resulting in an incremental increase in 2010 net revenue of $143.6 million. During the year ended December 31, 2010, EmCare added 107 new contracts and terminated 65 contracts resulting in an increase in net revenue of $47.7 million. Net revenue under our "same store" contracts (contracts in existence for the entirety of both years) increased $46.5 million, or 5.0%, for the year ended December 31, 2010. The change is due to a 4.5% increase in revenue per weighted patient encounter and an increase in same store weighted patient encounters of 0.5% over the prior period. 2009 weighted encounters were positively impacted by additional volume from patients treated in response to the H1N1 virus.

Compensation and benefits

Compensation and benefits costs for the year ended December 31, 2010 were $1,164.4 million, or 78.8% of net revenue, compared to $956.3 million, or 78.0% of net revenue, for the same period in 2009. Provider compensation costs increased $160.1 million from net new contract additions. "Same store" provider compensation and benefits costs were $30.0 million over the prior period due to a 4.3% increase in provider compensation per weighted patient encounter and a 0.5% increase in weighted patient encounters. Non-provider compensation and total benefits costs increased by $17.0 million due primarily to our recent acquisitions.

Table of Contents

Operating expenses

Operating expenses for the year ended December 31, 2010 were $45.7 million, or 3.1% of net revenue, compared to $39.9 million, or 3.3% of net revenue, for the same period in 2009. Operating expenses increased $5.9 million due primarily to higher collection agency and billing fees incurred in connection with our net new contracts added since December 31, 2008 and the expansion of our anesthesiology and radiology businesses.

Insurance expense

Professional liability insurance expense for the year ended December 31, 2010 was $52.5 million, or 3.6% of net revenue, compared to $49.6 million, or 4.0% of net revenue, for the same period in 2009. An increase of prior year insurance provisions of $3.6 million was recorded during the year ended December 31, 2010 compared to an increase of $3.4 million during the same period in 2009.

Selling, general and administrative

Selling, general and administrative expense for the year ended December 31, 2010 was $28.5 million, or 1.9% of net revenue, compared to $25.3 million, or 2.1% of net revenue, for the same period in 2009. The $3.2 million increase is due primarily to growth in the number of net new contracts since December 31, 2008, including costs relating to our acquisitions.

Depreciation and amortization

Depreciation and amortization expense for the year ended December 31, 2010 was $20.4 million, or 1.4% of net revenue, compared to $15.2 million, or 1.2% of net revenue, for the same period in 2009. The $5.2 million increase is due primarily to additional amortization expense associated with contract intangible assets recorded on acquisitions completed subsequent to December 31, 2008.

AMR

Net revenue

Net revenue for the year ended December 31, 2010 was $1,380.9 million, an increase of $37.0 million, or 2.8%, from $1,343.9 million for the same period in 2009. The increase in net revenue was due primarily to an increase in net revenue per weighted transport of 2.8%, or $37.3 million. The increase in net revenue per weighted transport of 2.8% was due to a 2.1% increase in rates with the remaining increase coming from growth in our managed transportation business combined with other non-transport related revenue increases. Weighted transports decreased 700 from the same period last year. This change was due to a decrease in weighted transport volume in existing markets of 0.6%, or 17,800 weighted transports, due to the exit of certain contracts in existing markets, and a decrease of 14,600 weighted transports from the exit of certain markets, which decreases were offset by an increase of 31,700 weighted transports from our entry into new markets.

Compensation and benefits

Compensation and benefit costs for the year ended December 31, 2010 were $859.1 million, or 62.2% of net revenue, compared to $840.5 million, or 62.5% of net revenue, for the year ended December 31, 2009. Ambulance crew wages per ambulance unit hour increased by approximately 4.3%, or $19.7 million attributable primarily to annual wage rate increases. Ambulance unit hours decreased period over period by 1.4%, or $6.8 million, due primarily to the reduction in volume in existing markets and increased efficiency in our ambulance unit hour deployment.

Table of Contents

Operating expenses

Operating expenses for the year ended December 31, 2010 were $313.5 million, or 22.7% of net revenue, compared to $294.5 million, or 21.9% of net revenue, for the year ended December 31, 2009. The change is due primarily to increased fuel costs of $5.1 million, increased costs associated with growth in our managed transportation business of $9.2 million, and a $3.1 million reserve recorded in connection with the DOJ Accrual.

Insurance expense

Insurance expense for the year ended December 31, 2010 was $44.8 million, or 3.2% of net revenue, compared to $48.0 million, or 3.6% of net revenue, for the year ended December 31, 2009. We recorded a decrease of prior year insurance provisions of $3.2 million during the year ended December 31, 2010 compared to an increase of $1.1 million for the same period in 2009.

Selling, general and administrative

Selling, general and administrative expense for the year ended December 31, 2010 was $39.4 million, or 2.9% of net revenue, compared to $38.2 million, or 2.8% of net revenue, for the year ended December 31, 2009.

Depreciation and amortization

Depreciation and amortization expense for the year ended December 31, 2010 was $44.9 million, or 3.3% of net revenue, compared to $49.2 million, or 3.7% of net revenue, for the same period in 2009. The decrease is due primarily to a $3.0 million reduction in depreciation expense related to AMR's ability to utilize fewer ambulances to service its existing contracts and the timing of replacing fully depreciated assets. Amortization expense also decreased by $1.3 million as certain contract-related intangible assets became fully amortized in 2009.

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 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.

Table of Contents

Adjusted EBITDA

Adjusted EBITDA was $287.0 million, or 11.1% of net revenue, for the year ended December 31, 2009 compared to $247.1 million, or 10.3% 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 to the reversal of reserves associated with previous tax positions, partially offset by additional valuation allowances recognized during 2009.

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 Consultants Mid-Atlantic and the management services company of Pinnacle Anesthesia Consultants, P.A., collectively referred to as 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. 2009 weighted encounters were positively impacted by additional volume from patients treated in response to the H1N1 virus.

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.

Table of Contents

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.

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

Table of Contents

2008. The change is primarily attributable to increased health insurance costs. Excluding the impact of 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.

Liquidity and Capital Resources

Our primary source of liquidity is cash flows provided by our operating activities. We are now able to use the ABL Facility 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.

Post-Transactions Liquidity

In connection with the Transactions, we entered into the ABL Facility, which provides for up to $350 million of senior secured first priority borrowings, subject to a borrowing base of $356 million as of June 30, 2011. The ABL Facility is available to fund working capital and for general corporate purposes. As of June 30, 2011, we had available borrowing capacity under the ABL Facility of approximately $303 million. We did not borrow under the ABL Facility to fund the Transactions. As of June 30, 2011, we had approximately $47 million of letters of credit issued under the ABL Facility. For a description of the ABL Facility, see "Description of Other Indebtedness ABL Facility."

Table of Contents

We believe that our cash and cash equivalents, cash flow provided by our operating activities and amounts available under the ABL Facility will be adequate to meet the liquidity needs of our business through at least the next twelve months. While the ABL Facility generally does not contain financial maintenance covenants, a springing fixed charge coverage ratio of not less than 1.0 to 1.0 will be tested if our excess availability (as defined in the ABL Credit Agreement) falls below specified thresholds at any time. If we require additional financing to meet cyclical increases in working capital needs, to fund acquisitions or unanticipated capital expenditures, we may need to access the financial markets. See "Risk Factors Risk Factors Relating to the Offering, the Notes and the Transactions Our substantial indebtedness may adversely affect our financial health and prevent us from making payments on the Notes."

The Indenture, the ABL Credit Agreement and the Term Loan Credit Agreement contain significant covenants, including prohibitions on our ability to incur certain additional indebtedness and to make certain investments and to pay dividends. See "Description of Other Indebtedness" and "Risk Factors Risk Factors Relating to the Offering, the Notes and the Transactions The Indenture, the ABL Credit Agreement and the Term Loan Credit Agreement restrict our ability and the ability of most of our subsidiaries to engage in some business and financial transactions."

We may from time to time repurchase or otherwise retire or extend our debt and/or take other steps to reduce our debt or otherwise improve our financial position. These actions may include open market debt repurchases, negotiated repurchases, other retirements of outstanding debt and/or opportunistic refinancing of debt. The amount of debt that may be repurchased or otherwise retired or refinanced, if any, will depend on market conditions, trading levels of our debt, our cash position, compliance with debt covenants and other considerations. Our affiliates may also purchase our debt from time to time, through open market purchases or other transactions. In such cases, our debt may not be retired, in which case we would continue to pay interest in accordance with the terms of the debt, and we would continue to reflect the debt as outstanding in our condensed consolidated statements of financial position.

Cash Flow

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

	Predecessor					Successor	Combined
	Year ended December 31,			Six Months ended June 30, 2010	Period from January 1, through May 24, 2011	Period from May 25 through June 30, 2011	Six Months ended June 30, 2011
	2008	2009	2010	(unaudited)	(unaudited)	(unaudited)	(unaudited)
Net cash provided by (used in)							
Operating activities	$ 211,457	$ 272,553	$ 185,544	$ 84,742	$ 67,975	$ 37,721	$ 105,696
Investing activities	(74,945)	(116,629)	(158,865)	(60,358)	(89,459)	(2,847,446)	(2,936,905)
Financing activities	(19,253)	30,791	(72,206)	(44,239)	20,671	2,709,988	2,730,659

Operating Activities

Net cash provided by operating activities was $105.7 million for the combined six months ended June 30, 2011 compared to $84.7 million for the same period in 2010. The increase in operating cash flows was affected primarily by increases in cash flows from operating assets and liabilities, offset by a decrease in net income. Accounts payable and accrued liabilities increased cash flows from operations $27.0 million during the six months ended June 30, 2011 compared to $13.1 million during the six

Table of Contents

months ended June 30, 2010. The change is due primarily to the timing of income tax related payments, and lower incentive compensation payments during the six months ended June 30, 2011 compared to the same period in 2010. Accounts receivable increased $3.0 million and days sales outstanding, or DSO, decreased 2 days during the six months ended June 30, 2011.

Net cash provided by operating activities was $185.5 million for the year ended December 31, 2010 compared to $272.6 million for the same period last year. Cash tax payments increased $78.0 million due to increased utilization of our net operating loss carryforwards in 2009 compared to 2010. Trade and other accounts receivable decreased cash flows from operations $22.2 million during the year ended December 31, 2010 primarily due to revenue growth, offset by a decrease in DSO. Operating cash flow in 2009 was positively impacted by a reduction in accounts receivable of $18.7 million from a reduction in DSO. Operating cash flow associated with the change in prepaids and other current assets decreased by $18.5 million for the year ended December 31, 2010 compared to the same period in 2009. The positive impact in 2009 is primarily attributable to the timing of payments for income taxes and insurance premiums. Accounts payable and accrued liabilities decreased operating cash flow by $3.1 million during 2010 compared to an increase of $18.0 million in 2009. The change is attributable primarily to the timing of payroll related payments.

We regularly analyze DSO, which is calculated by taking our net revenue for the quarter divided 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 December 31, 2007 shown below are due to additional collections on accounts receivable from continued billing and collection process enhancements at both EmCare and AMR. The following table outlines our DSO by segment and in total excluding the impact of acquisitions completed within the specific quarter:

	Q4 2007	Q4 2008	Q4 2009	Q1 2010	Q2 2010	Q3 2010	Q4 2010	Q1 2011	Q2 2011
EmCare	79	68	60	56	55	54	54	54	52
AMR	89	79	68	66	68	70	69	66	68
EMSC	85	74	64	61	62	61	61	60	59

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 in 2008. 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. 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.

Investing Activities

Net cash used in investing activities was $2,936.9 million for the combined six months ended June 30, 2011 compared to $60.4 million for the same period in 2010. The increase is primarily due to the purchase of EMSC by CD&R for $2.8 billion combined with increases in acquisition activity.

Table of Contents

Acquisitions of businesses totaled $99.5 million during the six months ended June 30, 2011 compared to $51.0 million during the same period in 2010.

Net cash used in investing activities was $158.9 million for the year ended December 31, 2010 compared to $116.6 million for the same period in 2009. The change relates primarily to increases in acquisition activity. Acquisitions of businesses totaled $119.9 million during the year ended December 31, 2010 compared to $75.6 million during the same period in 2009. This change in cash used in investing activities was offset by an increase in cash provided by other investing activities of $11.3 million during the year ended December 31, 2010 compared to the same period in 2009 due primarily to the return of performance bond collateral.

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.

Financing Activities

Net cash provided by financing activities was $2,730.7 million for the combined six months ended June 30, 2011 compared to net cash used in financing activities of $44.2 million for the same period in 2010. We entered into the Senior Secured Credit Facilities in connection with CD&R's acquisition of EMSC which resulted in new borrowings of $2,390.0 million during the six months ended June 30, 2011 compared to the same period in 2010. During the six months ended June 30, 2011, we also received $887.1 million in proceeds from CD&R's equity investment in EMSC. These sources of cash from financing activities were partially offset by $114.0 million in debt issuance costs and $26.2 million in equity issuance costs, and repayment of our previous credit facility of $415.0 million related to the Merger. At June 30, 2011, there were no amounts outstanding under our ABL Facility.

Net cash used in financing activities was $72.2 million for the year ended December 31, 2010 compared to net cash provided by financing activities of $30.8 million for the same period in 2009. In connection with our previous credit facilities entered into in April 2010, we incurred $12.1 million in debt issuance costs related to our previous credit facility and used $25.0 million to reduce our total outstanding debt. We also incurred $14.5 million in cash payments related to the redemption of our prior senior subordinated notes during the year ended December 31, 2010. Additionally, the change in bank overdrafts increased the cash used in financing activities by $32.6 million in 2010 as we transferred funds between bank accounts to take advantage of attractive depository terms. These items are partially offset by the cash flow benefit related to tax deductions for stock-based compensation during the year ended December 31, 2010. At December 31, 2010 and 2009, there were no amounts outstanding under our previous revolving credit facility.

Net cash provided by financing activities was $30.8 million for the year ended December 31, 2009 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 inflow from excess tax benefits associated with stock-based compensation during the year ended December 31, 2009. At December 31, 2009 and 2008, there were no amounts outstanding under our previous revolving credit facility.

Table of Contents

Pre-Transactions Liquidity

In April 2010, we entered into our prior senior secured credit facilities, consisting of a $425 million term loan and a $150 million revolving credit facility. All outstanding borrowings under the prior senior secured credit facilities were repaid in connection with the Transactions.

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.

Tabular Disclosure of Pro Forma Contractual Obligations and other Commitments

The following table reflects a summary of obligations and commitments outstanding as of December 31, 2010, on a pro forma basis after giving effect to the Transactions as if they had occurred on December 31, 2010, including our borrowings under the Term Loan Facility and the Notes.

	Less than 1 Year	1 - 3 Years	3 - 5 Years	More than 5 Years	Total
			(in thousands)		
Contractual obligations (Payments Due by Period):					
Notes	$	$	$	$ 950,000	$ 950,000
Term Loan Facility(1)	14,400	28,800	28,800	1,368,000	1,440,000
ABL Facility(2)					
Interest on debt(3)	154,254	306,240	303,216	377,380	1,141,090
Capital lease obligations	158	232	167	199	756
Operating lease obligations	34,472	52,759	29,567	38,565	155,363
Other contractual obligations(4)	48,723	34,129	20,983	55,628	159,463
Subtotal	252,007	422,160	382,733	2,789,772	3,846,672
Other commitments (Amount of Commitment Expiration Per Period):					
Guarantees of surety bonds				39,112	39,112
Letters of credit(5)				27,842	27,842
Subtotal				66,954	66,954
Total obligations and commitments	$ 252,007	$ 422,160	$ 382,733	$ 2,856,726	$ 3,913,626

(1) The Term Loan Facility provides for a seven-year senior secured term loan facility of up to $1,440 million, which was drawn at the closing of the Transactions. Borrowings under the Term Loan Facility bear interest at the rates specified in "Description of Other Indebtedness Term Loan Facility."

(2) The ABL Facility provides for a five-year senior secured asset-based loan facility of up to $350 million, subject to a borrowing base of $356 million as of June 30, 2011. We have not made any draws under the ABL Facility. Borrowings under the ABL Facility will bear interest at the rates specified in "Description of Other Indebtedness ABL Facility."

Table of Contents

(3) Represents estimated interest payments on the Notes and under the Term Loan Facility, and costs relating to letters of credit and commitment fees under the ABL Facility. See "Unaudited Pro Forma Consolidated Financial Statements."

(4) Includes CD&R management fee, dispatch and responder fees, contingent consideration related to acquisitions and other purchase obligations of goods and services.

(5) Includes letters of credit relating to our insurance program issued by EMCA, which are deemed to have expiration dates in excess of 5 years. Does not include letters of credit that will be outstanding and undrawn under the ABL Facility.

Quantitative and Qualitative Disclosures About Market Risk

Our primary exposure to market risk consists of changes in interest rates on certain of our borrowings and changes in fuel prices. While we have from time to time entered into transactions to mitigate our exposure to both changes in interest rates and fuel prices, we do not use these instruments for speculative or trading purposes.

We manage our exposure to changes in fuel prices and, as appropriate, use highly effective derivative instruments to manage well-defined risk exposures. At June 30, 2011, we were party to a series of fuel hedge transactions with a major financial institution under one master agreement. Each of the transactions effectively fixes the cost of diesel fuel at prices ranging from $3.12 to $3.29 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. These fuel hedge transactions fix the price for a total of 3.0 million gallons and are spread over periods from July 2011 through June 2012.

As of June 30, 2011, we had $2,388 million of total indebtedness, including capital leases. Based on the assumed interest rates on the $1,436 million in borrowings made under the Term Loan Facility, an increase or decrease in interest rates of 0.25% above a LIBOR floor of 1.50% applicable to the Term Loan Facility would impact our interest costs by $3.6 million annually.

Table of Contents

BUSINESS

Company Overview

We are a leading provider of outsourced facility-based physician services and medical transportation services in the United States. We operate our business and market our services under the EmCare and AMR brands, which represent EmCare Holdings Inc. and American Medical Response, Inc. EmCare, with more than 35 years of operating history, is a leading provider of physician services 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, as well as anesthesiology, hospitalist/inpatient, radiology and teleradiology programs. AMR, with more than 50 years of operating history, is a leading provider of medical transportation services to communities, payors and hospitals in the United States based on net revenue and number of transports.

Approximately 86% of our net revenue for the year ended December 31, 2010 was generated under exclusive contracts. We had contract retention rates of 88% at EmCare and 99% at AMR as of December 31, 2010. During 2010, we provided services in approximately 14 million patient encounters in more than 2,000 communities nationwide. For the year ended December 31, 2010, we generated net revenue of approximately $2.9 billion, of which EmCare and AMR represented 52% and 48%, respectively in 2010. Our Adjusted EBITDA for the year ended December 31, 2010 was $322.1 million, an increase of $35.1 million, or 12.2%, as compared with 2009.

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

	EmCare	AMR
Core Services:	Facility-based physician services Emergency department staffing and related management services Anesthesiology, hospitalist/inpatient services, radiology and teleradiology	Pre- and post-hospital medical transportation Emergency ("911") and non-emergency ambulance transports Managed transportation services Fixed-wing air ambulance services Disaster response
Customers:	Hospitals Other healthcare facilities Independent physician groups Attending medical staff	Communities Government agencies Healthcare facilities Insurers
National Market Position:	8% share of emergency department services market 12% share of outsourced emergency department services market 3% share of anesthesia services market 1% share of hospitalist services market 1% share of radiology services market	7% share of total ambulance market 16% share of outsourced ambulance market 5% share of managed transportation market 1% share of medical air transport market
Number of Contracts:	569 facility contracts	168 "911" contracts 3,375 non-emergency transport arrangements
Volume for the year ended December 31, 2010:	Approximately 11.0 million patient encounters	Approximately 3.2 million patient transports

Table of Contents

General Development of our Business

Company History

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 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 and AMR were acquired by Laidlaw International, Inc., previously Laidlaw Inc. ("Laidlaw"), in 1997 and became wholly owned subsidiaries.

Effective January 31, 2005, an investor group led by Onex Partners LP and Onex Corporation ("Onex"), and including members of management, purchased our operating subsidiaries EmCare and AMR from Laidlaw through a holding company, Emergency Medical Services L.P., a limited partnership formed at the time of this acquisition. We operated through the holding company, Emergency Medical Services L.P. (now known as Emergency Medical Services LP Corporation), until the formation of EMSC, a Delaware corporation. A reorganization was effected concurrently with our initial public offering of common stock on December 21, 2005, which resulted in AMR, EmCare and Emergency Medical Services LP Corporation becoming subsidiaries of EMSC, and EMSC controlling 100% of the voting power of the company formerly known as Emergency Medical Services LP.

On February 13, 2011, EMSC entered into the Merger Agreement with Parent and Merger Sub. On May 25, 2011, pursuant to the Merger Agreement, Merger Sub merged with and into EMSC, with EMSC as the surviving corporation and a wholly owned subsidiary of Parent. All of the outstanding common stock of Parent is owned by Holding, which is owned by the CD&R Affiliates and EMSC management. See "Summary The Transactions" and "Security Ownership of Certain Beneficial Owners and Management."

Description of our Business

Industry Overview

We operate in the facility-based physician services and medical transportation markets, two large and growing segments of the healthcare market. 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. By law, most communities are required to provide emergency ambulance services and most hospitals are required to provide emergency department services. We believe 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.

Shortage of primary care physicians. We believe that a portion of the historical and expected growth of emergency department visits is driven by the shortage of primary care physicians in the United States, which causes many patients to utilize the ED as their primary source for healthcare.

Table of Contents

Emergency Department

We provide outsourced facility-based physician services to hospitals and other healthcare facilities. Outsourced physician services providers such as EmCare are primarily focused on improving operational efficiency, reducing wait times and increasing the productivity in a hospital ED, which drives approximately 50% of a hospital's patient admissions, on average. In addition to improving ED operating performance metrics, we believe leading outsourced providers can improve patient satisfaction and enhance the quality of care at their customers' healthcare facilities through broader physician access, physician retention and training programs, better management tools and risk mitigation expertise.

We believe the physician reimbursement component of the emergency department services market represents annual expenditures of nearly $15 billion. There are nearly 4,900 hospitals in the United States that operate emergency departments, of which approximately 66% 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 900 national, regional and local providers. We believe we are one of only six national providers and the largest provider based on number of ED contracts.

Between 1999 and 2009, the total number of patient visits to hospital emergency departments increased from approximately 100 million to approximately 128 million per annum, or a CAGR of 2.5%. This trend, combined with a decline in the number of hospital emergency departments, has resulted in a substantial increase in the average number of patient visits per hospital emergency department during this period. We believe increased volumes through emergency departments and cost pressures facing hospitals have resulted in an increased focus by facilities on improving the operating efficiency of their emergency departments, a core competency of EmCare.

Anesthesiology, Hospitalist and Radiology/Teleradiology Services

We provide anesthesiology services to hospitals, free-standing surgery centers and physician offices. These services are performed by anesthesiologists and certified registered nurse anesthetists. Anesthesiologists are a key part of the effective management and productivity of surgery departments and free-standing ambulatory surgery centers. These clinicians can have a significant impact on patient throughput and the financial viability of the department of surgery in hospitals and ambulatory surgery centers. The anesthesiology market is estimated to have annual expenditures of approximately $17 billion and is currently serviced primarily by hospitals, which self-operate their programs, and by local outsourced providers.

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 costs with these hospitalist programs. This healthcare specialty, with estimated annual expenditures of approximately $18 billion, is expected to continue to grow as hospitals face additional cost pressures and added focus on improving patient outcomes. This market is currently serviced primarily by regional and local outsourced providers.

We also provide radiology, including teleradiology, services to hospitals. The industry for these service lines is comprised 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 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

Table of Contents

approximately $10 billion and is currently serviced primarily by hospitals, which self-operate their programs, and by local outsourced providers.

Ambulance Services

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 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. These contracts typically specify maximum fees a provider may charge and set forth minimum requirements such as response times, staffing levels, types of vehicles and equipment, quality assurance and insurance coverage. The rates a provider is permitted to charge for services under a contract for 911 emergency ambulance services and the amount of the subsidy, if any, the provider receives from a community or government agency depend in large part on the nature of the services it provides, payor mix and performance requirements.

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.

We believe the ambulance services market, including both emergent and non-emergent transports, represents annual expenditures of approximately $16 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 2010. There are a limited number of regional ambulance providers and we are the larger of only two national ambulance providers based on number of transports and net revenue.

Managed Transportation and Fixed-Wing Air Transport Services

We provide managed transportation administration services to insurers, government entities, and health care providers. Through partnerships with external transportation providers, which result in a non-asset intensive business model, our services include managing ambulance, wheelchair car, and other types of transportation to provide a cost effective solution for those we serve. We believe the managed transportation market represents annual expenditures of approximately $1 billion.

We also provide fixed-wing air ambulance transport services including the specialized medical care required by patients during the transports. We believe the medical air transportation market represents annual expenditures of approximately $4 billion.

Our 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 Player in Two Large, Growing and Highly Fragmented Markets. We are a leading provider of outsourced facility-based physician services and medical transportation services in the United States. We have significant scale with approximately 14 million patient encounters annually in over 2,000 communities across the United States. The markets in which we compete are highly fragmented with minimal presence from national providers, which we believe results in significant opportunities for

Table of Contents

continued market share gains as well as strategic "tuck-in" acquisitions. We believe our track record of consistently meeting or exceeding our customers' service expectations across both of our businesses affords us the opportunity to compete effectively in the bidding process for new contracts, as well as to continue to grow complementary service offerings.

Strong, Stable Underlying Industry Volume Trends. We operate within an attractive segment of healthcare services that is supported by strong and stable underlying market volume trends. Based on available data, hospital ED visits have grown at a CAGR of 2.5% from 1999 to 2009, and ambulance transports have increased at a CAGR of 3.9% from 2003 to 2009, with no year-over-year declines in market volumes over these periods. These stable, historical market volumes are primarily supported by the critical non-discretionary nature of emergency medical services, as well as aging demographics and a shortage of primary care physicians in the United States.

Broad Spread of Risk with Significant Customer, Geographic and Contract Diversification. Because of our diverse revenue base, we are not reliant on any single facility, community or market. As of December 31, 2010, EmCare had 569 individual facility contracts, with the top 10 ED contracts representing only 9% of EmCare net revenue, and no customer (including all facility contracts under a single hospital system) comprised more than 10% of total net revenue. As of December 31, 2010, AMR had 168 exclusive "911" emergency services contracts and 3,375 non-emergency transport arrangements. AMR's top ten "911" contracts accounted for approximately 24% of AMR net revenue in 2010. We believe that our other services, including anesthesia, hospitalist, radiology, managed transportation and fixed-wing air transport services, also exhibit a broad spread of risk through a diversified customer base and geographic footprint.

Attractive Business Model with Stable Cash Flows and Proven Ability to De-Lever our Balance Sheet. We believe our operating model and the contractual nature of our businesses drive a meaningful amount of recurring revenue which, combined with our relatively low capital expenditure and working capital requirements, lead to strong and predictable cash flows. During 2010, approximately 86% of our net revenue was generated under exclusive contracts. We believe these exclusive contracts and the critical care nature of our services have historically resulted in long-term, stable customer relationships. EmCare and AMR have maintained relationships with their ten largest customers for 15 and 35 years, respectively. We believe our ability to consistently deliver high levels of customer service and continue to improve our customer's key metrics are illustrated by our high contract retention rates of 88% in EmCare and 99% in AMR as of December 31, 2010. Our strong earnings growth and free cash flow generated by our stable customer base have enabled us to reduce our total leverage ratio meaningfully over the last five years.

Favorable Pricing Environment with Unique Reimbursement Characteristics. Pricing and reimbursement for EmCare and AMR services have historically been favorable. We believe this trend will remain stable into the future. At EmCare, commercial payor leverage is reduced due to the emergency nature of the services, and physician reimbursement under Medicare has historically been stable. In addition, in many of our hospital contracts, we have the ability to obtain or increase subsidies to offset any reimbursement or payor mix changes. At AMR, communities and municipalities set emergency allowable rates for commercial payors and, with limited exception, do not pay for services out of the tax base. Further, we expect future Medicare reimbursement of ambulance services to be stable given that the phase-in of the Medicare national ambulance fee schedule was completed in 2010, and reimbursement for ambulance services represents a relatively small proportion of total Medicare spending. In addition, at both EmCare and AMR we have visibility into payor mix prior to entering into new contracts, and our payor mix has been stable over time, which allows us to more effectively manage exposure to each payor category.

Opportunities for Continued Cost Reduction and Productivity Improvement. We have a strong track record of profitable growth exhibited by a 16.3% CAGR in our Adjusted EBITDA and our expansion

Table of Contents

of Adjusted EBITDA margins by approximately 200 basis points from 2006 to 2010. Our consistent earnings growth and margin expansion over the last several years have been driven by our management's continuous focus on cost reductions and productivity improvements as well as benefits realized from information technology investments. We believe there are additional opportunities to continue to drive margin improvements in the future through targeted initiatives and additional technology enhancements.

Increased Outsourcing of Health Services. We believe market conditions are conducive to continued outsourcing of health services. In the EmCare segment, hospitals are increasingly outsourcing physician services due to increased cost pressures, the need to enhance operating efficiency, difficulties in physician recruiting and retention, the future possibility of pay-for-performance models and the desire to improve quality of care while reducing patient care cost. In the AMR segment, communities are increasingly outsourcing emergency medical transportation services due to cost pressures and budget constraints, the need for quality enhancement and improved clinical outcomes, the lack of risk management expertise and the pressure to meet peak demands.

Strong and Experienced Management Team with Demonstrated Track Record of Performance. We have a strong and deep management team with a historical track record of success. Many of our officers have decades of industry experience and significant tenure at EMSC. We are led by William Sanger, CEO, who has 35 years of industry experience, Randy Owen, EVP and CFO, who has 29 years of industry experience, Todd Zimmerman, EmCare President and EVP, who has 20 years of industry experience, and Mark Bruning, AMR President, who has 28 years of industry experience. Our current management team has led us through a series of initiatives focused on driving organic revenue growth and productivity and efficiency gains as well as executing several strategic acquisitions. Together these initiatives have resulted in net revenue and Adjusted EBITDA CAGRs of 10.3% and 16.3%, respectively, over the last four years.

Business Strategy

Our objective is to continue to be a leader in outsourced facility-based physician services and medical transportation services in the United States as we pursue the following strategies and initiatives:

Achieve Organic Growth through Market Share Gains and Continued Outsourcing. 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 positions provide us with new and expanded opportunities to grow our customer base through market share gains from local and regional competitors as well as through continued outsourcing of physician and medical transportation services by hospitals and communities. Specifically, we believe EmCare has a competitive advantage over local and regional outsourced physician groups due to its more advanced patient flow processes, better management tools, core competencies in coding and billing, and broader physician access, which we believe has driven EmCare's strong track record in improving performance metrics for its customers. We believe that market share gains at AMR will be driven by AMR's strong brand recognition, economies of scale in purchasing, high quality service levels, strong clinical expertise and information technology capabilities. Given AMR's scale, we also believe we are well-positioned to compete for potential new outsourcing contracts from municipalities that are currently faced with budget constraints, including rising public safety pension liabilities. For both EmCare and AMR, we have been successful in using our scale to obtain regional and national contracts with healthcare systems, free-standing facilities and insurance providers for single and multiple service lines.

Grow Complementary Service Lines by Cross-Selling to Existing Customers and Adding New Customers. We believe our track record of maintaining successful long-term relationships with customers, combined with the expanded breadth of our service offerings, creates opportunities for us to

Table of Contents

increase revenue from our existing customer base and add new customers seeking services we previously did not provide. We have entered complementary service lines at both EmCare and AMR that are designed to leverage our core competencies. At EmCare, we continue to expand our anesthesiology, hospitalist, radiology and teleradiology services through acquisitions and cross-selling to existing facilities. As of December 31, 2010, only 10% of EmCare's 569 contracts were with facilities contracting for more than one of our service lines. We believe this provides significant future opportunities for cross-selling to our existing customers. In addition, our cross-selling potential is enhanced by our national and regional contracts, which provide preferred access to a number of healthcare facilities throughout the United States. At AMR, we have also expanded our service lines over the last several years to complement our emergency ("911") and non-emergency response services. For example, we continue to expand our managed transportation services by contracting with new payors, including governmental agencies, and providers. In addition, we believe we have opportunities to cross-sell our fixed-wing air transportation services to our existing ground ambulance customers.

Supplement Organic Growth with Opportunistic Acquisitions. The outsourced facility-based physician services and medical transportation services industries are highly fragmented, with only a few large national providers. We believe we have a successful track record of making strategic acquisitions at attractive valuations designed to enhance our market position and improve our value proposition for customers. Recent acquisitions include Affilion, an ED physician services business that expands our growth opportunities in the Arizona and New Mexico markets; Milford Anesthesia Associates, an anesthesia provider located in the Northeast that offers a strong platform for our continued regional expansion in the anesthesia services market; BestPractices, a nationally recognized ED physician services business in the Mid-Atlantic market; and Doctor's Ambulance, a provider of emergency and non-emergency ambulance services in California that provides opportunities for expansion into contiguous markets. We expect to continue pursuing select acquisitions within both EmCare and AMR, including acquisitions to enhance our presence in existing markets as well as to facilitate our entry into new geographies. We will also continue to explore the acquisition of complementary businesses and seek opportunities to expand the scope of services we provide. While we believe there are substantial opportunities for additional "tuck-in" acquisitions, we intend to continue to follow a disciplined strategy by analyzing each opportunity with careful consideration of the strategic rationale and the impact on our financial flexibility and liquidity.

Enhance Operational Efficiencies and Productivity to Drive Continued Margin Improvement. We believe there are significant opportunities to build upon our success in improving our productivity and profitability at both EmCare and AMR. At EmCare, we continue to focus on initiatives to improve physician productivity, including more efficient scheduling around peak and off-peak hours, use of mid-level providers as well as improving and realigning physician compensation programs to help accelerate productivity gains. EmCare also has opportunities for continued process efficiencies to improve billing/collection cycle times and reduce costs with the implementation of electronic medical record systems at our client facilities. At AMR, we expect to benefit from additional investments in technology, such as the continued roll-out of ePCR (electronic patient care records) to enhance data collection accuracy and billing system automation to reduce our billing costs and DSO. We also expect to continue to benefit from increased productivity through scheduling and deployment optimization software. In addition, we believe there are opportunities for operating expense efficiencies in areas such as fleet management and resource utilization. Furthermore, 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 and equipment in ambulances to reduce vehicular incidents and lifting injuries.

Business Segments and Services

We operate our business and market our services under our two business segments: EmCare and AMR. We provide facility-based physician services in 40 states and the District of Columbia and

Table of Contents

medical transportation services in 38 states and the District of Columbia. The following is a detailed business description of our two business segments.

EMCARE

EmCare is a leading provider of outsourced facility-based physician services to healthcare facilities in the United States, based on number of contracts with hospitals and affiliated physician groups. EmCare has 569 contracts with hospitals and independent physician groups to provide emergency department, anesthesiology, hospitalist/inpatient, radiology and teleradiology staffing, and other management services. We have added 318 net new contracts since 2001. During 2010, EmCare had approximately 11.0 million patient encounters across 40 states and the District of Columbia. As of December 31, 2010, EmCare had an 8% share of the total emergency department services market and a 12% share of the outsourced emergency department services market, the largest share among outsourced providers based on number of ED contracts. EmCare's share of the combined markets for anesthesiology, hospitalist and radiology services was approximately 2% as of such date.

EmCare focuses on providing an environment where physicians can practice quality medicine, while improving operational efficiencies and patient satisfaction and mitigating risk at its customers' hospitals and facilities. We recruit and hire or subcontract with physicians and other healthcare professionals, who then provide services to patients in the facilities with whom we contract. EmCare bills and collects from each patient or the patient's insurance provider for the medical services performed. We also have practice support agreements with independent physician groups and hospitals pursuant to which we provide management services such as billing and collection, recruiting, risk management and certain other administrative services.

As derived from our annual audited consolidated financial statements, EmCare's net revenue, 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,		
	2008	**2009**	**2010**
Net revenue	$ 1,008,063	$ 1,225,828	$ 1,478,462
Income from operations	95,960	139,597	166,925
Total identifiable assets	576,211	583,806	678,901

See "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 facility-based physician staffing and related management services for emergency department, anesthesiology, hospitalist/inpatient services, 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.

Table of Contents

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 more than 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.

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.

Operational Assessments. We undertake operational assessments for our hospital customers that include comprehensive reviews of critical operational metrics, including turnaround times, triage systems, "left without being seen," throughput times and operating systems. These assessments establish baseline values, which are used to develop and implement process improvement programs, and then we monitor the success of the initiatives. We believe the operational and process improvements that we are often able to implement are a key differentiator between us and many of our competitors.

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 as well as other areas of a healthcare facility where outsourced services are being provided.

Practice Support Services. We provide a substantial portion of our services to healthcare facilities through our affiliate physician groups. However, in some situations 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 these needs. 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.

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

Table of Contents

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 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.

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. 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).

Professional Liability Claims Committee. 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 ("HMOs"), preferred provider organizations and private insurers,

Table of Contents

hospitals in the form of subsidies or fees for management services provided,

other management services arrangements, and

individual patients.

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,		
	2008	**2009**	**2010**
Medicare	15.6%	14.6%	15.5%
Medicaid	3.1	3.8	5.0
Commercial insurance/managed care	55.5	56.5	52.5
Self-pay	3.2	2.5	2.6
Other revenue/subsidies	22.6	22.6	24.4
Total net revenue	100.0%	100.0%	100.0%

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

We code and bill for our emergency department and hospitalist 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. Coding and billing for our anesthesiology and radiology services is provided by a combination of internal and external billing companies.

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 740 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 preferred 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

Table of Contents

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.

Hospital and Practice Support Contracts. As of December 31, 2010, EmCare provided services under 569 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 as well as for providing the capital for medical equipment and supplies associated with the services we provide.

We have established long-term relationships with some of the largest healthcare service providers in the country. None of these large customers, which have numerous individual contracts, represent revenue in aggregate that amounts to 10% of our total net revenue for the years ended December 31, 2010, 2009, or 2008. Our top ten hospital emergency department contracts represent $128.9 million, or 9%, of EmCare's net revenue for the year ended December 31, 2010. We have maintained our relationships with these top ten customers for an average of 15 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,

Table of Contents

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, 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.

Intellectual Property

We have registered the mark EmCare and the EmCare logo in the United States. Generally, registered trademarks have perpetual life, provided that they are renewed on a timely basis and continue to be used properly as trademarks. We have also developed proprietary technology that we protect through contractual provisions and confidentiality procedures and agreements. Other than the EMSC and EmCare marks and the EmTrac, EmComp, and EmBillz software, we do not believe our business is dependent to a material degree on patents, copyrights, trademarks or trade secrets. Other than licenses to commercially available software, we do not believe that any of our licenses to third-party intellectual property are material to our business taken as a whole.

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 900 national, regional and local providers handling an estimated 128 million patient visits in 2009. There are nearly 4,900 hospitals in the United States with emergency departments, of which approximately 66% currently outsource physician services. Of these hospitals that outsource, we believe approximately 49% contract with a local provider, 16% contract with regional provider and 35% 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

Table of Contents

national providers of outsourced emergency department services are Hospital Physician Partners, National Emergency Services Healthcare Group, Schumacher Group and California Emergency Physicians.

The markets for anesthesiology, inpatient and radiology services are also highly fragmented. For anesthesiology services, we have a 3% share of the market with an additional 4% market share split evenly between Sheridan Healthcare and MEDNAX National Medical Group. For inpatient services, IPC is the market leader with a 5% share. Other national providers are Team Health and Apogee. For radiology services, market share for Sheridan Healthcare is similar to ours at 1%.

Insurance

Professional Liability Program. For the period January 1, 2002 through December 31, 2010, 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 2010 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 2010 calendar years.

Captive Insurance Arrangement. Our captive insurance company, 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 breakdown of our active affiliated physicians, independent contractors and employees by job classification as of December 31, 2010.

Job Classification	Full-time	Part-time	Total
Physicians	2,088	3,133	5,221
Physician assistants	394	319	713
Nurse practitioners	549	366	915
Non-clinical employees	1,528	353	1,881
Total	4,559	4,171	8,730

Table of Contents

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.

AMERICAN MEDICAL RESPONSE

American Medical Response, Inc. 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, 2010, we had a 7% share of the total ambulance services market and a 16% share of the outsourced ambulance market, the largest share among outsourced providers based on number of transports and net revenue. During 2010, AMR treated and transported approximately 3.2 million patients in 38 states and the District of Columbia utilizing nearly 4,300 vehicles that operated out of more than 200 sites. AMR has more than 3,500 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 insurance companies and healthcare facilities.

During 2010, 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 28% of AMR's net revenue for the same period. The remaining balance of net revenue for 2010 was generated from managed transportation services, fixed-wing air ambulance services, and the provision of training, dispatch and other services to communities and public safety agencies.

AMR also has a national contract with FEMA 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 in the full 48 contiguous states.

As derived from our annual consolidated financial statements, AMR's net revenue, 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, (in thousands)		
	2008	**2009**	**2010**
Net revenue	$ 1,401,801	$ 1,343,857	$ 1,380,860
Income from operations	72,261	73,539	79,058
Total identifiable assets	789,180	730,956	784,454

See "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 medical transportation services under our AMR brand name. We operate under other names when required to do so by local statute or contractual agreement.

Table of Contents

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 ("ALS") units and Basic Life Support ("BLS") units. ALS units, which are staffed by two paramedics or one paramedic and an 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 16% of AMR's net revenue for 2010.

Non-Emergency Medical Transportation 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 medical transportation 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.

Table of Contents

Other inter-facility transports, requiring 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 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:

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.

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, air 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.

Paramedic Training. We own and operate National College of Technical Instruction ("NCTI"), the largest paramedic training college in the United States, operating more accredited programs than any other school, with approximately 1,400 graduates in 2010.

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

Medical Personnel and Quality Assurance

Approximately 73% of our 17,500 employees have daily contact with patients, including approximately 5,700 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 typically requires completion of approximately 150 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.

Table of Contents

Our commitment to quality is reflected in the fact that 17 of our operations across the country are accredited by the Commission on Accreditation of Ambulance Services ("CAAS"), representing 12% 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 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,
- HMOs and private insurers,
- individual patients, and
- fees for stand-by and event driven coverage, including from our national contract with the FEMA and community subsidies.

The table below presents AMR's payor mix as a percentage of cash collections in the period as an approximation of net revenue recorded:

	Percentage of AMR cash collections for the year ended December 31,		
	2008	**2009**	**2010**
Medicare	28.5%	30.6%	28.6%
Medicaid	5.3	5.7	6.3
Commercial insurance/managed care	41.5	44.9	44.8
Self-pay	5.1	5.2	6.0
Other revenue/subsidies	19.6	13.6	14.3
Total net revenue	100.0%	100.0%	100.0%

See "Business Regulatory Matters Medicare, Medicaid and Other Government Reimbursement Programs" 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 medical transportation services. Our provision for uncompensated care generally is higher for transports resulting from emergency ambulance calls than for non-emergency ambulance requests. See "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."

Table of Contents

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 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 such regions, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (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, 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 and was subsequently extended to December 31, 2010 pursuant to the Patient Protection and Affordable Care Act. Furthermore, the Medicare and Medicaid Extenders Act of 2010 extended this funding through December 31, 2011. 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 an increase in AMR's net revenue of approximately $14 million in 2008, an increase in AMR's net revenue of approximately $24 million in 2009, and a decrease in AMR's net revenue of approximately $18 million in 2010. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential increase in AMR's net revenue of less than $1 million during 2011. 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 Reimbursement Programs" for additional information on reimbursement from Medicare, Medicaid and other government-sponsored programs.

Contracts

Emergency Transport. As of December 31, 2010, we had 168 contracts with communities and government agencies to provide 911 emergency response services. Contracts with communities to

Table of Contents

provide emergency medical transportation services are typically exclusive, three to five years in length and generally 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, 2010, our top ten 911 contracts accounted for approximately $335 million, or 24% of AMR's net revenue. We have served these ten customers on a continual basis for an average of 35 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 3,375 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 ("SSM") technology to help determine optimal ambulance deployment and selection. In addition to dispatching our own ambulances, we also provide dispatching service for 49 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

Table of Contents

and type of medical emergency to our control center which, in turn, dispatches ambulances to the 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 medical transportation services are likely to be required.

Intellectual Property

We have registered the marks American Medical Response and the AMR logo and certain other trademarks and service marks in the United States. Generally, registered trademarks have perpetual life, provided that they are renewed on a timely basis and continue to be used properly as trademarks. We have registered the copyrights in our ePCR software and certain other copyrightable works. Copyright protection begins upon the creation of the copyrightable work and endures for the life of the author plus 70 years or, for a work made for hire that is unpublished, 120 years. We have also developed proprietary technology that we protect through contractual provisions and confidentiality procedures and agreements. Other than the EMSC, American Medical Response and AMR marks and the ePCR, Millennium and SSM systems, we do not believe our business is dependent to a material degree on patents, copyrights, trademarks or trade secrets. Other than licenses to commercially available software, we do not believe that any of our licenses to third-party intellectual property are material to our business taken as a whole.

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

Table of Contents

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.

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 a significant number of our vehicles in emergency response markets. We have also started equipping our vehicles with power stretchers, which we expect will reduce the number of lifting injuries to our employees.

Competition

Our predominant competitors are fire departments and other local governmental providers, with approximately 56% 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 Acadian Ambulance Service in Louisiana, Paramedics Plus in Texas, Oklahoma, Indiana and Florida, and small, locally owned operators that principally serve the inter-facility transport market.

Table of Contents

Insurance

Workers Compensation, Auto and General Liability. We have retained liability for the first $1 million to $3 million of the loss under these programs since September 1, 2001, managed either through ACE American Insurance Co., through an insurance subsidiary of AIG, or through our Cayman-based captive insurance subsidiary, EMCA. 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, covers the first $5 to $5.5 million for policy periods from April 15, 2002 through April 1, 2010, and covers the first $3 million after April 1, 2010. We have umbrella policies with third party insurers covering claims exceeding these retention levels with an aggregate cap of $10 million $20 million for each separate policy period.

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. Noncompliance with these requirements may result in significant fines or penalties or limitations on our operations or claims for remediation costs, as well as alleged personal injury or property damages. We believe our current operations are in substantial compliance with all applicable environmental, health and safety 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 our facilities as a result of historical practices. 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 breakdown of our employees by job classification as of December 31, 2010.

Job Classification	Full-time	Part-time	Total
Paramedics	3,871	1,817	5,688
Emergency medical technicians	4,605	2,356	6,961
Nurses	119	86	205
Support personnel	4,079	587	4,666
Total	12,674	4,846	17,520

Approximately 45% of our employees are represented by 39 collective bargaining agreements. A total of 18 collective bargaining agreements, representing approximately 4,800 employees, are subject to renegotiation in 2011. While we believe we maintain a good working relationship with our employees, we have experienced some union work actions historically; however, these actions did not have a

Table of Contents

material adverse effect on our operations. We do not expect that any future actions would have a material adverse effect on our ability to provide service to our patients and communities.

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 2010, we received approximately 22% of our net revenue from Medicare and 6% 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 determination 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, 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.

Table of Contents

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.

Medicare Physician Fee Schedule. Medicare pays for all physician services based upon a national fee schedule ("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 ("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 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. For 2010, CMS projected a rate reduction of 21.2% under the statutory formula and a number of legislative measures were passed to prevent any reduction. For June through December 2010, the update factor was increased by 2.2%. For 2011, the Medicare and Medicaid Extenders Act of 2010, which was signed into law on December 15, 2010, froze the 2010 update through 2011. President Obama's budget for fiscal year 2012 includes measures that would freeze the update factor for an additional two years. Medicare reimbursement to physicians could be reduced approximately 30% in 2012 unless Congress takes further action.

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

Table of Contents

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.

The SNF Prospective Payment System. Under the Medicare prospective payment system, applicable to skilled nursing facilities ("SNFs"), the SNFs are financially responsible for some ancillary services, including certain ambulance transports ("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 which transports are PPS transports and which ones may be billed to Medicare. 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

Table of Contents

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 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.

Ambulance Services Fee Schedule. In February 2002, the Health Care Financing Administration, now renamed the CMS, issued the Medicare Ambulance Fee Schedule Final Rule ("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.

Table of Contents

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 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 was blended with the national fee schedule on a temporary basis, until January 1, 2010. 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 and was subsequently extended to December 31, 2010 pursuant to the Patient Protection and Affordable Care Act. Furthermore, the Medicare and Medicaid Extenders Act of 2010 extended this funding through December 31, 2011. Finally, PPACA amended the annual inflation factor to add a productivity adjustment for ambulance services, beginning January 1, 2011, which may result in the annual percentage increase being less than zero for a year and may result in payment rates that are less than such payment rates for the preceding year. For 2011 the inflation factor is -0.1%.

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 an increase in AMR's net revenue of approximately $14 million in 2008, an increase in AMR's net revenue of approximately $24 million in 2009, and a decrease in AMR's net revenue of approximately $18 million in 2010. Based upon the current Medicare transport mix and barring further legislative action, we expect a potential increase in AMR's net revenue of less than $1 million for 2011. 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.

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.

Table of Contents

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. As part of the PPACA, which is also known as the healthcare reform legislation, statutory provisions were added which allow improper retention of an overpayment for sixty days or more to be a basis for a false claim act allegation, even if the claim was originally submitted appropriately. 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. In addition, PPACA provides that the government may assert that a claim including items or services resulting from a violation of the federal anti-kickback statute constitutes a false or fraudulent claim for purposes of the false claims statutes.

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. Last year, as part of PPACA, Congress amended the intent requirement of the federal anti-kickback and criminal health care fraud statutes; a person or entity no longer needs to have actual knowledge of this statute or specific intent to violate it, making it easier for the government to prove that a defendant had the requisite state of mind or "scienter" required for a violation. Violations of the Anti-Kickback Statute can result in exclusion from Medicare, Medicaid or other governmental

Table of Contents

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 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. We expect our obligations under this CIA to be released by the end of 2011.

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.

Table of Contents

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 lay entities or persons and are intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. In addition, various state laws also generally prohibit 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 the federal self-referral prohibitions, 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 HIPAA, there are two additional federal crimes that could have an 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 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

Table of Contents

result in fines 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 HIPAA

The Administrative Simplification Provisions of HIPAA required the 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 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. See "Risk Factors Risk Factors Related to Healthcare Regulation Under recently enacted amendments to federal privacy law made as part of the HITECH Act, 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 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

Table of Contents

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. Some state fraud and abuse laws apply to items or services reimbursed by any third-party payor, including commercial insurers, not just those reimbursed by 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 "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 ("EMTALA"), 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 states in which we operate have similar state law provisions concerning patient dumping. Violations of EMTALA can result in civil penalties and exclusion of the offending physician from the Medicare and Medicaid programs.

In addition to EMTALA 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.

Table of Contents

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. 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 our 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.

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

Table of Contents

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. A provision passed as part of last year's healthcare reform legislation requires that any overpayments be refunded within sixty days of discovery. Failure to refund overpayments on a timely basis could result in civil monetary penalties or provide a basis for a false claims act allegation.

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. The first CIA relates to the settlement of an investigation into alleged violations of the Anti-Kickback Statute in Texas and covers the period of September 2005 through September 2011. We expect our obligations under this CIA to be released by the end of 2011. The second CIA relates to the settlement of an investigation into alleged AMR conduct arising in its New York City operations and covers the period of May 2011 through May 2016. 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 "Risk Factors Risk Factors Related to Healthcare Regulation" for additional information related to regulatory matters.

Management Information Systems

EMSC provides information technology services that are shared by our businesses such as network engineering, data center operations, application hosting, security administration and technical support. EMSC also supports corporate applications such as the e-mail, human resources, enterprise resource planning, financial and data management systems.

Table of Contents

Intellectual Property

We have registered the mark EMSC and the EMSC logo in the United States. Generally, registered trademarks have perpetual life, provided that they are renewed on a timely basis and continue to be used properly as trademarks. We have also developed proprietary technology that we protect through contractual provisions and confidentiality procedures and agreements. Other than the EMSC, American Medical Response, AMR and EmCare marks, the ePCR, Millennium and SSM systems and the EmTrac, EmComp, and EmBillz software, we do not believe our business is dependent to a material degree on patents, copyrights, trademarks or trade secrets. Other than licenses to commercially available software, we do not believe that any of our licenses to third-party intellectual property are material to our business taken as a whole.

Properties

We lease approximately 73,000 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.

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 27 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.

AMR

Facilities. In addition to the corporate headquarters, we also lease approximately 570 administrative facilities and other facilities used principally for ambulance basing, garaging and maintenance in those areas in which we provide ambulance services. We own 19 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 own and operate approximately 4,300 vehicles. Of these, 78% are ambulances, 9% are wheelchair vans and 13% are support vehicles. Approximately 250 ambulances are part of our reserve fleet used to respond to FEMA deployments and during peak transport activity in several of our markets. We replace ambulances based upon age and usage, but generally every eight to ten years. The average age of our existing active 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.

Table of Contents

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. 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 ("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 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. We expect our obligations under this CIA to be released by the end of 2011. 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.

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 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 reviewed the information provided by the government and provided our response. On May 20, 2011, AMR entered into a settlement agreement with the DOJ and a corporate integrity agreement with the OIG in connection with this matter. Under the terms of the settlement, AMR paid $2,746,816 to the federal government. In connection with the settlement, we entered into a CIA with a five-year period beginning May 20, 2011. Pursuant to this 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 billing

Table of Contents

operations as they relate to services provided in New York, including specific training for operations and billing personnel providing services in New York, review by an independent review organization and reporting of certain reportable events. We entered into the settlement in order to avoid the uncertainties of litigation, and have not admitted any wrongdoing.

Four 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; on July 8, 2008, Vaughn Banta filed suit in the Superior Court of the State of California, County of Los Angeles; on January 22, 2009, Laura Karapetian filed suit in the Superior Court of the State of California, County of Los Angeles; and on March 11, 2010, Melanie Aguilar filed suit in Superior Court of the State of California, County of Los Angeles. The Banta and Karapetian cases have been coordinated with the Bartoni case in the Superior Court for the State of California, County of Alameda. At the present time, courts have not certified classes in any of these cases. Plaintiffs allege principally that the AMR entities failed to pay 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.

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.

Litigation Related to the Merger

Eleven purported shareholder class actions relating to the transactions contemplated by the Merger Agreement have been filed in state court in Delaware and federal and state courts in Colorado against various combinations of EMSC, the members of our board of directors, and other parties. Seven actions were filed in the Delaware Court of Chancery beginning on February 22, 2011, which were consolidated into one action entitled *In re Emergency Medical Services Corporation Shareholder Litigation*, Consolidated C.A. No. 6248-VCS. On April 4, 2011, the Delaware plaintiffs filed their consolidated class action complaint. Two actions, entitled *Scott A. Halliday v. Emergency Medical Services Corporation, et al.*, Case No. 2011CV316 (filed on February 15, 2011), and *Alma C. Howell v. William Sanger, et. al.*, Case No. 2011CV488 (filed on March 1, 2011), were filed in the District Court, Arapahoe County, Colorado. Two other actions, entitled *Michael Wooten v. Emergency Medical Services Corporation, et al.*, Case No. 11-CV-00412 (filed on February 17, 2011), and *Neal Greenberg v. Emergency Medical Services Corporation, et. al.*, Case No. 11-CV-00496 (filed on February 28, 2011), were filed in the U.S. District Court for the District of Colorado and have been consolidated. These actions generally allege that the directors of EMSC, Onex and/or the Onex subsidiaries breached their fiduciary duties by, among other things: approving the transactions contemplated by the Merger Agreement, which allegedly were financially unfair to EMSC and its public stockholders; agreeing to provisions in the Merger Agreement that would allegedly prevent the board of directors of EMSC from considering other offers; permitting the unitholders agreement (which secured the majority votes in favor of the Merger), and failing to require a provision in the Merger Agreement requiring that a majority of the public stockholders approve the transactions contemplated by the Merger Agreement; and/or making allegedly materially inadequate disclosures. The actions further allege that certain other defendants aided and abetted these breaches. In addition, the two actions filed in the U.S. District Court for the District of Colorado contain individual claims brought under Section 14(a) and Section 20(a) of the Exchange Act pertaining to the purported dissemination of allegedly misleading proxy materials. The actions seek unspecified damages and equitable relief. We believe that all of the allegations in these actions are without merit and intend to vigorously defend these matters.

Table of Contents

In addition to the foregoing shareholder class actions, Merion Capital, L.P., a former stockholder of EMSC, has filed an action in the Delaware Court of Chancery seeking to exercise its right to appraisal of its holdings in EMSC prior to the Merger. Merion Capital was the holder of 599,000 shares of class A common stock in EMSC prior to the Merger. We have not paid any merger consideration for these shares and have recorded a reserve in the amount of $38.3 million for such unpaid merger consideration pending conclusion of the appraisal action.

In July 2011, AMR received a request from the Civil Division of the U.S. Attorney's Office for the Central District of California ("USAO") asking AMR to preserve certain documents concerning AMR's provision of ambulance services within the City of Riverside, California. The USAO indicated that it, together with the Department of Health and Human Services, Office of the Inspector General, are investigating whether AMR violated the federal False Claims Act and/or the federal Anti-Kickback Statute in connection with AMR's provision of ambulance transport services within the City of Riverside. The California Attorney General's Office is conducting a parallel state investigation for possible violations of the California False Claims Act. We have complied with the USAO's request to preserve documents.

Table of Contents

MANAGEMENT

Executive Officers and Directors

Set forth below are the name, age, position and description of the business experience of our executive officers and directors:

Name	Age	Title(s)
William A. Sanger	60	Director, President and Chief Executive Officer
Randel G. Owen	52	Director, Executive Vice President and Chief Financial Officer
Todd G. Zimmerman	45	President of EmCare and Executive Vice President of EMSC
Mark E. Bruning	53	President of AMR
Steve W. Ratton, Jr.	48	Treasurer and Senior Vice President of Mergers and Acquisitions of EMSC
Steve G. Murphy	56	Senior Vice President of Government and National Services of EMSC
Kimberly Norman	46	Senior Vice President of Human Resources of EMSC
Dighton C. Packard, M.D.	63	Chief Medical Officer of EmCare
R. Jason Standifird	38	Senior Vice President, Chief Accounting Officer and Controller
Craig A. Wilson	43	Senior Vice President, General Counsel and Secretary
Ronald A. Williams	61	Director and Chairman
Richard J. Schnall	41	Director
Kenneth A. Giuriceo	37	Director
Carol J. Burt	53	Director
Leonard M. Riggs, Jr., M.D.	68	Director
Michael L. Smith	62	Director

William A. Sanger has been a director and Chief Executive Officer of EMSC and its predecessor since February 2005, and the President of EMSC since 2008. Mr. Sanger was appointed President of EmCare in 2001 and Chief Executive Officer of EmCare and AMR in June 2002. Mr. Sanger served as President and Chief Executive Officer of Cancer Treatment Centers of America, Inc. from 1997 to 2001. Mr. Sanger is also a co-founder of BIDON Companies where he has been a Managing Partner since 1999. From 1994 to 1997, Mr. Sanger was co-founder and Executive Vice President of PhyMatrix Corp., then a publicly traded diversified health services company. In addition, Mr. Sanger was President and Chief Executive Officer of various other healthcare entities, including JFK Health Care System. Mr. Sanger serves as the Chairman of the Board of Directors of Vidacare Corporation, a medical device company. Mr. Sanger is also a director of Carestream Health, Inc. Mr. Sanger has more than 30 years of experience in the healthcare industry, and we believe his experience both as an entrepreneur and a seasoned public company executive, including eight years of experience in different capacities with EmCare and AMR, make him uniquely qualified to serve in his role. Mr. Sanger has an MBA from the Kellogg School of Management at Northwestern University.

Randel G. Owen has been a Director of EMSC since August 2011, Chief Financial Officer of EMSC and its predecessor since February 10, 2005 and was appointed Executive Vice President as of December 1, 2005. Mr. Owen was appointed Executive Vice President and Chief Financial Officer of AMR in March 2003. He joined EmCare in July 1999 and served as Executive Vice President and Chief Financial Officer from June 2001 to March 2003. Mr. Owen is also a director of First Cash

Table of Contents

Financial Services, Inc. Before joining EmCare, Mr. Owen was Vice President of Group Financial Operations for PhyCor, Inc., a medical clinic operator, in Nashville, Tennessee from 1995 to 1999. Mr. Owen has more than 25 years of financial experience in the healthcare industry, and we believe his extensive financial background, financial reporting expertise, and his extensive knowledge of operations, to be valuable contributions to the board of directors. Mr. Owen received an accounting degree from Abilene Christian University.

Todd G. Zimmerman has been President of EmCare since April 2010. Prior to this role, he served as General Counsel of EMSC and its predecessor from February 10, 2005 through March 2010. Mr. Zimmerman was appointed Executive Vice President of EMSC effective December 1, 2005. Mr. Zimmerman was appointed General Counsel and Executive Vice President of EmCare in July 2002 and of AMR in May 2004. Mr. Zimmerman joined EmCare in October 1997 in connection with EmCare's acquisition of Spectrum Emergency Care, Inc., an emergency department and outsourced physician services company, where he served as Corporate Counsel. Prior to joining Spectrum in 1997, Mr. Zimmerman worked in the private practice of law for seven years, providing legal advice and support to various large corporations. Mr. Zimmerman received his B.S. in Business Administration from St. Louis University and his J.D. from the University of Virginia School of Law.

Mark E. Bruning was appointed President of AMR in May 2009, after having served as Executive Vice President since January 2008. Mr. Bruning has spent over 25 years of his career with AMR in numerous positions, and over 15 years in leadership roles with AMR. Prior to his current appointment, Mr. Bruning was a divisional Chief Operating Officer for AMR in AMR's Central Division. Mr. Bruning holds an MBA from the Kellogg Graduate School of Management at Northwestern University.

Steve W. Ratton, Jr. has been Treasurer of EMSC and its predecessor since February 2005 and was appointed Senior Vice President of Mergers and Acquisitions effective December 1, 2005. Mr. Ratton joined EmCare in April 2003 as Executive Vice President and Chief Financial Officer. Prior to joining EmCare, Mr. Ratton served as Treasurer for Radiologix, Inc. from September 2001 to April 2003. Mr. Ratton was Vice President of Finance for Matrix Rehabilitation, Inc. from August 2000 to September 2001, and Director of Finance for PhyCor, Inc. from April 1998 to August 2000. Mr. Ratton has more than 20 years of experience in the healthcare industry, in both hospital and physician settings. Mr. Ratton has an accounting degree from the University of Texas at El Paso.

Steve G. Murphy was appointed Senior Vice President of Government and National Services of EMSC effective December 1, 2005. He has served in that role with AMR since 2003. Prior to joining AMR in 1989, Mr. Murphy was National Vice President of Government Relations for CareLine Inc. and MedTrans, Inc., President and Chief Operating Officer of Pruner Health Services, Inc. and Chief Administrative Officer for Pruner's Napa Ambulance Service, Inc. Mr. Murphy has been active in emergency medical services and the ambulance industry for more than 30 years. He holds a Registered Nursing Degree and has been certified as a Certified Emergency Nurse and Mobile Intensive Care Nurse.

Kimberly Norman was appointed Senior Vice President of Human Resources of EMSC effective December 1, 2005. Ms. Norman joined MedTrans, Inc. in June 1991 and joined AMR in 1997, when it merged with MedTrans. She has held various human resource positions for AMR, including Benefits Specialist, Manager of Human Resources and Employee Development, and Regional and National Vice President of Human Resources. Ms. Norman received her B.B.M. from the University of Phoenix and a Human Resource Management Certification from San Diego State University.

Dighton C. Packard, M.D. has been Chief Medical Officer of EmCare since 1990 and became Chief Medical Officer of the predecessor of EMSC in April 2005. Dr. Packard is also the Chairman of the Department of Emergency Medicine at Baylor University Medical Center in Dallas, Texas and a member of the Board of Trustees for Baylor University Medical Center and for Baylor Heart and

Table of Contents

Vascular Hospital. Dr. Packard has practiced emergency medicine for more than 30 years. He received his B.S. from Baylor University at Waco and his M.D. from the University of Texas Medical School at San Antonio.

R. Jason Standifird has been Vice President and Controller of EMSC and its predecessor since February 2005, and was appointed Chief Accounting Officer in February 2009. Mr. Standifird joined AMR in 2004 as its Controller, and is a Certified Public Accountant. Prior to joining AMR, Mr. Standifird was a manager with PricewaterhouseCoopers in their Assurance and Business Advisory Services division. Mr. Standifird has a B.S. degree from Boston College in Accounting and Finance.

Craig A. Wilson has been General Counsel of EMSC since April 1, 2010 and Secretary of EMSC since August 10, 2011. Prior to this role, he served as Assistant Secretary from April 1, 2010 to August 10, 2011 and Corporate Counsel of EMSC from February 2005 through March 2010. Mr. Wilson was Corporate Counsel of EmCare from March 2000 through February 2005. Prior to joining EmCare in 2000, Mr. Wilson worked in the private practice of law for seven years. Mr. Wilson received his B.S. in Business Administration and Political Science from William Jewell College and his J.D. from Northwestern University School of Law.

Ronald A. Williams has been an operating advisor to Clayton, Dubilier & Rice Fund VIII, L.P. since April 2011. Previously, Mr. Williams was most recently Chairman of Aetna Inc. After joining Aetna in 2001, he became President in 2002. He served as CEO from February 2006 to November 2010 and Chairman of the Board from October 2006 to April 2011. Mr. Williams is a member of the President's Management Advisory Board, assembled by President Obama to help bring the best of business practices to the management and operation of the federal government. Mr. Williams serves on the Board of Directors of American Express Company, The Boeing Company and Johnson & Johnson, as well as the Boards of the Peterson Institute for International Economics and Save the Children. Prior to joining Aetna, Mr. Williams was Group President of the Large Group Division at WellPoint Health Networks Inc. and President of the company's Blue Cross of California subsidiary. Mr. Williams is a graduate of Roosevelt University and holds an M.S. in Management from the Sloan School of Management at the Massachusetts Institute of Technology. As Chairman, Mr. Williams brings to our board of directors his extensive management, operations, and business experience leading in a rapidly changing and highly regulated industry and his focus on innovation through information technology, as well as his leadership, financial and core business skills.

Richard J. Schnall has been a financial partner at Clayton, Dubilier & Rice since 2001 and has been with the firm since 1996. Prior to joining Clayton, Dubilier & Rice, he worked in the Investment Banking division of Donaldson, Lufkin & Jenrette, Inc. and Smith Barney & Co. Mr. Schnall is a limited partner of CD&R Associates VI Limited Partnership, a director and stockholder of CD&R Investment Associates VI, Inc., a director at Sally Beauty Holdings, Inc., Diversey, Inc., U.S. Foodservice and HGI Holding, Inc. Mr. Schnall is a graduate of the Wharton School of Business at the University of Pennsylvania and holds a Masters of Business Administration from Harvard Business School. We believe that Mr. Schnall's executive and financial experience well qualifies him to serve on our board of directors.

Kenneth A. Giuriceo has been a financial partner at Clayton, Dubilier & Rice since 2007. Prior to joining Clayton, Dubilier & Rice in 2003, Mr. Giuriceo worked in the principal investment area of Goldman, Sachs & Co., an investment and banking firm, from 2002 to December 2003. Mr. Giuriceo is currently a member of the Board of Directors of Sally Beauty Holdings, Inc., and is currently a member of the Board of Directors at The ServiceMaster Company, a private outsourcing services company, where he serves as chair of its audit committee and as a member of its compensation committee. We believe that Mr. Giuriceo's executive and financial experience well qualifies him to serve on our board of directors.

Table of Contents

Carol J. Burt became a director of EMSC in August 2011. She has been a principal of Burt-Hilliard Investments, a private investment and consulting service to the health care industry, since January 2008. Ms. Burt currently serves as a director of WellCare Health Plans, Inc. Ms. Burt was formerly an executive officer of WellPoint, Inc., where she served from 1997 to 2007. Most recently, Ms. Burt served as WellPoint's Senior Vice President, Corporate Finance and Development, from 2005 until 2007. From 1999 to 2004, Ms. Burt was WellPoint's Senior Vice President, Finance and Strategic Development, and from 1997 to 1998, WellPoint's Senior Vice President, Finance and Treasury. In her time with WellPoint, Ms. Burt was responsible for, among other things, mergers and acquisitions, strategy, strategic investments, treasury and capital, investment and real estate management. She also oversaw financial planning and analysis, forecasting and budgeting and related matters. In addition, WellPoint's financial services and worldwide businesses reported to her. We believe that Ms. Burt's strategic, operational and financial experience in the managed care industry are valuable assets to our board of directors.

Leonard M. Riggs, Jr., M.D. became a director of EMSC in August 2011 and was previously a director of EMSC from July 2010 to May 2011. He is a private investor and serves as an Operating Partner of CIC Partners, a private equity firm based in Dallas, Texas. Dr. Riggs was a founder of EmCare, Inc., and also served as its Chairman and Chief Executive Officer until 2002. Dr. Riggs has served on numerous boards and is a former president of the American College of Emergency Physicians. We believe Dr. Riggs's experience as a prominent physician with executive experience in outsourced healthcare services enables him to provide a unique and valuable perspective as a member of our board of directors.

Michael L. Smith became a director of EMSC in August 2011 and previously was a director of EMSC and its predecessor company from July 2005 to May 2011. Mr. Smith is a private investor who continues to serve on the boards of leading healthcare companies. He is a founding partner of Cardinal Equity Fund and Cardinal Equity Partners. From 2001 until his retirement in January 2005, Mr. Smith served as Executive Vice President and Chief Financial and Accounting Officer of Anthem, Inc. and its subsidiaries, Anthem Blue Cross and Blue Shield, which together form one of the leading health insurance groups in the United States. Mr. Smith brings a deep knowledge of public companies in the healthcare industry from his past experience as an executive and his continuing experience as a director. From 1996 to 1998 he served as Chief Operating Officer and Chief Financial Officer of American Health Network Inc., then a subsidiary of Anthem. Mr. Smith was Chairman, President and Chief Executive Officer of Mayflower Group, Inc., a transportation company, from 1989 to 1995, and held various other management positions with that company from 1974 to 1989. Mr. Smith also serves as a director of Kite Realty Group Trust, a retail property REIT, Vectren Corporation, a gas and electric power utility, and HH Gregg, Inc., a national home appliance and electronics retailer. Mr. Smith previously served as a director of Calumet Specialty Products, LP (a refiner of specialty petroleum products) from 2006 to 2009 and Intermune Inc. (a biopharmaceutical company). Mr. Smith also serves as a member of the Board of Trustees of DePauw University, a director of the Central Indiana Community Foundation and the Lumina Foundation, and the Chairman of the Indiana Commission for Higher Education. We believe that Mr. Smith's healthcare industry and public company experience well qualifies him to serve on our board of directors.

Corporate Governance

Board Composition

The board of directors of EMSC is currently composed of eight members, all of whom were elected as directors in accordance with our second amended and restated certificate of incorporation.

Under our second amended and restated by-laws, our board of directors will consist of such number of directors as may be determined from time to time by resolution of the board of directors,

Table of Contents

but in no event may the number of directors be less than one. Any vacancies or newly created directorships may be filled only by a vote of our stockholders. Each director will hold office until his or her successor has been duly elected and qualified, or until his or her earlier death, resignation or removal.

Committees of the Board of Directors

Our board of directors maintains an audit committee, a compensation committee, a compliance committee, an executive committee and a finance committee.

The audit committee has responsibility for, among other things, assisting our board of directors in reviewing our financial reporting and other internal control processes, our financial statements, the independent auditors' qualifications and independence, and the performance of our internal audit function and independent auditors. The members of our audit committee are Ms. Burt and Messrs. Giuriceo and Smith, of whom Ms. Burt and Mr. Smith are "independent" as such term is defined by The New York Stock Exchange corporate governance standards.

The compensation committee has responsibility for reviewing and approving the compensation and benefits of our employees, directors and consultants; administering our employee benefits plans; authorizing and ratifying stock option grants and other incentive arrangements; and authorizing employment and related agreements. The members of our compensation committee are Dr. Riggs and Messrs. Giuriceo, Schnall and Williams, of whom Dr. Riggs is "independent" as such term is defined by The New York Stock Exchange corporate governance standards.

The compliance committee has responsibility for ensuring proper communication of compliance issues to the board of directors and its committees; reviewing significant compliance risk areas and management's efforts to monitor, control and report such risk exposures; monitoring the effectiveness of our ethics and compliance department; and reviewing and approving compliance related policies and proceedings. The members of our compliance committee are Dr. Riggs and Messrs. Owen, Sanger, Smith and Williams.

The executive committee has responsibility for assisting the board of directors with its responsibility and, except as may be limited by law, our certificate of incorporation or bylaws, to exercise the powers and authority of the board of directors with the board of directors is not in session. The members of our executive committee are Messrs. Williams, Sanger and Schnall.

The finance committee has responsibility for assisting the board of directors in satisfying its responsibilities relating to our financing strategy, financial policies and financial condition. The members of our finance committee are Ms. Burt and Messrs. Owen, Giuriceo, Sanger and Schnall.

Director Independence

Though not formally considered by our board of directors because our common stock is not listed on a national securities exchange, our board of directors has determined that Ms. Burt, Dr. Riggs and Mr. Smith are "independent" as such term is defined by The New York Stock Exchange corporate governance standards.

Compensation Committee Interlocks and Insider Participation

During fiscal year 2010, the Compensation Committee was comprised of the following four non-employee directors for the entirety of the year: James T. Kelly, Chair, Kevin E. Benson, Robert M. LeBlanc and Michael L. Smith. Leonard M. Riggs, Jr. was elected to the Compensation Committee upon his election to the board of directors of the Company on July 10, 2010. There were no members of the Compensation Committee who served as an officer or employee of the Company or any of its subsidiaries during 2010. In addition, during 2010, no executive officer of the Company served as a

Table of Contents

director or as a member of the compensation committee of a company (i) whose executive officer served as a director or as a member of the Compensation Committee of the Company and (ii) which employs a director of the Company.

On August 10, 2011, Dr. Riggs and Messrs. Giuriceo, Schnall and Williams were appointed as members of our Compensation Committee. There are no members of the Compensation Committee who serve as an officer or employee of the Company or any of its subsidiaries. In addition, no executive officer of the Company serves as a director or as a member of the compensation committee of a company (i) whose executive officer served as a director or as a member of the Compensation Committee of the Company and (ii) which employs a director of the Company.

Table of Contents

EXECUTIVE COMPENSATION

Compensation Discussion and Analysis

Overview

This compensation discussion and analysis provides information about the material elements of compensation that are paid, awarded to, or earned by, our "named executive officers," who consist of our principal executive officer, principal financial officer, and our three other most highly compensated executive officers, for fiscal year 2010 as follows:

- William A. Sanger, President and Chief Executive Officer
- Randel G. Owen, Executive Vice President and Chief Financial Officer
- Todd G. Zimmerman, President of EmCare and Executive Vice President of the Company
- Mark Bruning, President of AMR
- Steve W. Ratton, Senior Vice President of the Company and Treasurer

Subsequent to the end of fiscal year 2010, we were acquired by the CD&R Affiliates pursuant to the Merger Agreement. Following the Merger, we became an indirect subsidiary of Holding, a company controlled by the CD&R Affiliates. This compensation discussion and analysis describes our executive compensation for fiscal year 2010, as well as certain important compensation decisions made subsequent to the end of fiscal year 2010 in connection with the Merger. The principal changes made subsequent to the end of fiscal year 2010 were the following:

- The employment agreements for each of our named executive officers were amended which, among other changes, modifies the "good reason" events for termination of employment by the executive; and
- Holding adopted a new equity incentive plan which provides for the granting of time-vested stock options to our executive officers, key employees, and directors, and each of the named executive officers received new option grants.

The information below with respect to compensation paid to the named executives in 2010 and prior fiscal years relates to compensation paid before the Merger and is therefore not necessarily indicative of the compensation amounts, philosophy or benefits that these individuals, or other executives and key employees, will receive going forward.

Compensation Overview and Philosophy

The executive compensation programs in place before the Merger were designed with the objectives of (1) attracting and retaining highly motivated, qualified and experienced executives; (2) focusing the attention of the named executive officers on the operational and financial performance of the Company; and (3) encouraging the named executive officers to meet long-term performance objectives and increase stockholder value.

Role of the Compensation Committee

The role of our Compensation Committee is to assist our board of directors in the discharge of its responsibilities relating to our executive compensation program. Our Compensation Committee is responsible for establishing, administering and monitoring our policies governing the compensation for our executive officers, including determining base salaries and cash incentive awards.

During fiscal year 2010, our board of directors consisted of Robert M. LeBlanc, William A. Sanger, Kevin E. Benson, Steven B. Epstein, Paul B. Iannini, James T. Kelly, Leonard M. Riggs, Jr. and

Table of Contents

Michael L. Smith. During 2010, the Compensation Committee was comprised of the following four non-employee directors for the entirety of the year: Mr. Kelly, Chair, Mr. Benson, Mr. LeBlanc, and Mr. Smith. Dr. Riggs was elected to the Committee upon his election to the Board on July 10, 2010. There were no members of the Compensation Committee who served as an officer or employee of the Company or any of its subsidiaries during 2010. This membership was made up of four independent, non-employee directors and one non-employee director who was not deemed independent, as permitted under NYSE rules due to the "controlled company" exception, which applied to the Company at the time. Effective upon the Merger, the members of our board of directors became Richard J. Schnall, Kenneth A. Giuriceo, Ronald A. Williams and William A. Sanger. On August 10, 2011, Carol J. Burt, Randel G. Owen, Dr. Leonard M. Riggs, Jr. and Michael L. Smith were appointed to the board of directors of EMSC, and Dr. Riggs and Messrs. Giuriceo, Schnall and Williams were appointed as members of the Compensation Committee.

The Compensation Committee developed, in consultation with management and outside consultants, an Executive Officer Evaluation and Compensation Plan which historically provided the Compensation Committee with a tool for gauging the compensation of the named executive officers. Through the Executive Officer Evaluation and Compensation Plan, the executive compensation programs in place prior to the Merger were designed to effectively attract, retain, and motivate top quality executives who have the ability to significantly influence our long-term financial success, and who are responsible for effectively managing our operations in a way that maximizes stockholder value. The compensation programs for named executive officers seek to achieve a balance between compensation levels and our annual and long-term budgets, strategic plans, business objectives, and stockholder expectations. The Executive Officer Evaluation and Compensation Plan set forth core practices that defined the overriding objectives for the 2010 and prior fiscal years executive compensation programs and the role of the various compensation elements in meeting those objectives. These core practices were as follows:

To ensure that all elements of executive compensation and benefits, and of the compensation process, were controlled by the Compensation Committee;

To ensure that total executive compensation levels were reasonably linked to our performance, which may require the Compensation Committee to look beyond financial performance measures to the executives' achievement of our other strategic goals;

To provide for compensation arrangements that were comparable to similar organizations and jobs, with realization of compensation linked to the executives' contributions toward achieving our goals;

To require that all elements of the compensation program were reviewed and approved annually by the Compensation Committee, and to require that processes and programs were reviewed regularly for compliance with relevant laws and regulations;

To design compensation arrangements so that they could be easily explained to, and understood by, individuals with a basic business background; and

To consider various programs and vehicles available for compensation, including cash and equity.

Three officers of the Company and its subsidiaries were compensated under the Executive Officer Evaluation and Compensation Plan in fiscal year 2010: William A. Sanger, who at the time was Chairman, President and Chief Executive Officer, Randel G. Owen, the Executive Vice President and Chief Financial Officer, and Todd G. Zimmerman, the Executive Vice President and President of EmCare. All aspects of compensation for these executive officers in fiscal year 2010 were determined by the Compensation Committee.

Table of Contents

Senior level employees and officers other than Messrs. Sanger, Owen and Zimmerman participated in incentive plans that were available to a significant number of employees of the Company and its subsidiaries. Although some of those individuals were "named executive officers" of the Company under the SEC rules based on their position and level of compensation in some fiscal years, in which case their compensation was disclosed in our proxy materials for those years, their individual targets and performance measures were set by Mr. Sanger, to whom they typically reported, rather than directly by the Compensation Committee.

Elements of Our Executive Compensation Program

During 2010, the compensation program for our named executive officers consisted of base salary, short-term cash incentives in the form of annual bonuses, and equity awards pursuant to the Amended and Restated Long-Term Incentive Plan. We granted equity awards in the form of stock options and shares of restricted stock to all of our named executive officers in May 2010. During 2010, our named executive officers also participated in various benefit plans made available to most of our employees, and received certain other perquisites and benefits as detailed below.

Base Salary

We pay each of our named executive officers a base salary in cash on a bi-weekly basis. The amount of the salary is reviewed annually and does not necessarily vary with our performance. We seek to provide base salary in an amount sufficient to attract and retain individuals with the qualities necessary to ensure the short-term and long-term financial success of the Company. Base salary for each named executive officer is based upon appropriate competitive reference points, job responsibilities and such executive's ability to contribute to our success. We targeted salaries between the 50th and 75th percentiles of peer companies identified by the Compensation Committee, while recognizing individual differences in scope of responsibilities, qualifications, experience and leadership abilities. We also recognize the value of adjusting salaries as needed to maintain competitiveness vis-à-vis our peers without overemphasizing the use of automatic formulas. In connection with the Merger, we increased Mr. Owen's base salary to $505,000 and we increased Mr. Bruning's salary to $515,000. See " Key Changes in Expected Compensation Following the Merger Employment Agreements."

Short-Term Incentives

A portion of the named executive officers' targeted annual cash compensation was at risk, in the form of an annual cash incentive program contingent, in the case of each of Messrs. Sanger, Owen and Zimmerman, upon meeting Adjusted EBITDA targets set by the Compensation Committee. Mr. Bruning's annual cash incentive was contingent upon meeting annual objectives pursuant to the Management and Exempt Incentive Plan ("MEIP") and Mr. Ratton received his cash compensation, in addition to base salary, based upon metrics associated with our mergers and acquisitions, as described in further detail in " Determination of 2010 Compensation of Named Executive Officers Short-Term Incentives for the Other Named Executive Officers." The primary purpose of the annual cash incentive plans was to focus the attention of the named executive officers on the operational and financial performance of the Company, as applied particularly to their areas of expertise and influence.

Long-term Incentives

The Amended and Restated Long-Term Incentive Plan was intended to assure that the key individuals who impact our long-term success had a meaningful portion of their potential total compensation linked to their success in helping meet long-term performance objectives and increasing stockholder value.

Table of Contents

The Amended and Restated Long-Term Incentive Plan provided, among other things, for the issuance of stock options, restricted shares, restricted share units ("RSUs"), stock appreciation rights, stock awards and performance shares to employees and independent contractors of the Company and its subsidiaries, including our named executive officers.

Upon completion of the Merger, each restricted share and RSU became fully vested and was cancelled and extinguished with the holder entitled to receive $64.00 for each such restricted share or share of Company common stock subject to a RSU. With respect to options to purchase shares of Company common stock, the named executive officers and other key employees had the following alternatives: each option was either (1) cancelled, with the holder thereof entitled to receive a cash payment of the excess of $64.00 over the exercise price per share subject to the option or (2) converted into a fully vested and exercisable option to purchase shares of Holding common stock on the same terms and conditions as were then applicable under such option and such other terms and conditions as may be mutually agreed by the holder of the option and Holding. See " Treatment of Outstanding Options, Restricted Shares and RSUs in the Merger" and " Key Changes in Expected Compensation Following the Merger CDRT Holding Corporation Stock Incentive Plan."

Other Compensation Elements

We offer perquisites to our named executive officers in the form of auto allowances, certain automotive maintenance and operation expenses, as well as reimbursement of certain supplemental insurance expenses. We believe that our perquisites further motivate our senior employees and fall within an expense range that is reasonable in light of such executives' position and tenure. In addition, we lease a corporate apartment in Dallas, Texas for Mr. Zimmerman and a corporate car which is primarily for his use in Dallas as we have requested Mr. Zimmerman to work at EmCare's offices in Dallas several days per week. Other than those perquisites, we do not have any other compensation elements, other than standard benefits that are available to most employees of the Company, such as 401(k) matching, subsidized medical, dental and vision insurance and life and disability insurance. From time to time, our board of directors and Compensation Committee may consider offering additional programs.

Determination of 2010 Compensation of Named Executive Officers

The following sections describe the determination of the various elements of our compensation program for the named executive officers, including objectives, market positioning, structure, operation and other information specific to 2010 payments, awards and compensation adjustments.

Base Salary

Base salary for each named executive officer in 2010 was established at a level that we believed to be sufficient to attract and retain individuals with the qualities necessary for the long-term financial success of the Company. Salaries were generally positioned between the 50^{th} and 75^{th} percentiles of the defined peer group.

The Compensation Committee reviews the base salaries of Messrs. Sanger, Owen and Zimmerman annually in accordance with the provisions of the executive officers' employment agreements. Salary adjustments take into account market data in the context of an executive's role, responsibilities, experience tenure, individual performance and contribution to our financial results. The Compensation Committee worked with management to develop an evaluation tool to periodically assess overall managerial and leadership skill by eliciting feedback from the applicable officer's direct reports, along with at least seventy-five percent of a larger group of "peer" management employees. This tool was used as one factor in the Compensation Committee's assessment of base salary for the named executive officers when considering salary adjustments.

Table of Contents

From time to time, the Compensation Committee has engaged Towers Watson for compensation review purposes and taken Towers Watson's advice into consideration when making compensation decisions for Messrs. Sanger, Owen and Zimmerman.

On April 1, 2010, we increased Mr. Zimmerman's annual base salary to $550,000 in connection with his new role as President of EmCare. This increase was implemented by Mr. Sanger, as the officer to whom Mr. Zimmerman reported, in consultation with the Chairperson of the Compensation Committee, rather than by action of the Compensation Committee.

At the Board's meeting on May 18, 2010, the Board also approved an amendment to Mr. Owen's employment agreement, dated February 10, 2005, as amended January 1, 2009 and March 12, 2009, pursuant to which his annual base compensation was increased from $382,875 to $450,000. On July 30, 2010, the Compensation Committee approved annual base salary increases to each of Messrs. Sanger, Owen, and Zimmerman in the amount of 3.0% of their respective base salaries, at approximately the same time that a large number of management employees received an annual base salary merit increase up to approximately 3.0% of the previous year's salary.

In 2008, Mark Bruning received a salary increase in connection with his promotion to Executive Vice President of AMR. Subsequently, Mr. Bruning was promoted to President of AMR on May 4, 2009, and we approved an increase in Mr. Bruning's annual base salary from $350,000 to $400,000. The Compensation Committee did not formally review these compensation packages as Mr. Bruning was not subject to the Executive Officer Evaluation and Compensation Plan. Mr. Sanger, as the officer to whom Mr. Bruning reports, constructed the compensation packages following an internal survey of the prevailing market standard for salaries at their respective positions. Mr. Sanger apprised the Compensation Committee of the proposed packages at that time. Mr. Ratton's annual salary was set and reviewed by Mr. Sanger and is currently at $315,275.

Mr. Bruning and Mr. Ratton also each received a salary increase of 3.0%, although their salary increases were determined by the Company pursuant to its standard management merit increase process rather than by the Compensation Committee.

Effective with respect to the period beginning on the closing date of the Merger, the base salaries of Mr. Owen and Mr. Bruning under their employment agreements were increased to $505,000 and $515,000, respectively. See " Key Changes in Expected Compensation Following the Merger Employment Agreements."

Short-Term Incentives for the Chief Executive Officer, Chief Financial Officer and President of EmCare

The named executive officers' employment agreements provide that each executive will be able to participate in a short-term incentive plan, under which payment is based upon performance targets to be established each year by the board of directors or the Compensation Committee.

In March 2010, the Compensation Committee established our fiscal year 2010 performance targets. These targets were based on the Compensation Committee's requirement that our 2010 Adjusted EBITDA achieve a specified percentage increase over the 2009 Adjusted EBITDA target before bonuses were awarded to the applicable named executive officers. We defined Adjusted EBITDA consistently with the Adjusted EBITDA measure used in our prior periodic filings with the SEC, which is net income before equity in earnings of unconsolidated subsidiary, income tax expense, loss on early debt extinguishment, interest and other income, realized gain (loss) on investments, interest expense, and depreciation and amortization. Under the terms of the Executive Officer Evaluation and Compensation Plan, awards are based on an incentive "pool" created by the difference between our current year Adjusted EBITDA and our Adjusted EBITDA for the prior year, provided that our current year Adjusted EBITDA reached a pre-determined threshold.

Table of Contents

In March 2011, following the audit and release of our year-end financial statements for 2010, the Compensation Committee determined that the threshold level of Adjusted EBITDA had not been achieved for 2010, and therefore no cash awards were paid to officers under the Executive Officer Evaluation and Compensation Plan.

Under the terms of the Executive Officer Evaluation and Compensation Plan, the performance measures are not individualized for each of Messrs. Sanger and Owen, but rather align the annual bonus compensation of these named executive officers as a group with the performance of the Company as a whole. There was no individualized performance review process for Messrs. Sanger and Owen in the granting of bonus awards for services provided in the previous fiscal years; however, the Compensation Committee had the discretion to consider individual performance when determining bonus awards and targets, including individual percentages for 2010. Because the bonuses were based on meeting Company financial targets and did not provide for upward or downward adjustment based on individual performance, there was no guarantee that any of these named executive officers would receive a bonus, and there was also no minimum, target or maximum predetermined aggregate dollar amount that these named executive officers could receive. Bonus awards for Messrs. Zimmerman and Bruning are partially determined pursuant to the Executive Officer Evaluation and Compensation Plan and partially based on individualized performance measures.

The Compensation Committee has historically believed that Adjusted EBITDA is the appropriate measure to align the interests of management with the interests of the Company, in part because the Compensation Committee recognizes the prevalence of Adjusted EBITDA as a measure of our financial performance among outside financial analysts and investors and in part because it represents what we have historically believed to be the best measure of our profitability. The current Compensation Committee has not reviewed measures for fiscal year 2011 or 2012.

Short-Term Incentives for the Other Named Executive Officers

Under the MEIP, which is currently available to approximately 1,700 employees of the Company and its subsidiaries, participants are eligible to receive a percentage of their target bonus if we and, as applicable, the participant's business segment or operations unit, meets a predetermined Adjusted EBITDA threshold for the fiscal year established by the Compensation Committee. The Compensation Committee typically approves the MEIP threshold in an amount approximately commensurate with our earnings targets for the applicable fiscal year. Accordingly, each participant's potential bonus is adjusted up or down on a sliding percentage scale depending on whether the Adjusted EBITDA meets or exceeds the MEIP threshold, in addition to certain other factors based on the participants' department targets and fulfillment of individual and strategic goals. Historically, in order to achieve 100% or more of an executive's target bonus, we would need to exceed the fiscal year Adjusted EBITDA targets.

Mr. Bruning participates in the MEIP and Mr. Sanger, as the executive officer to whom Mr. Bruning reports, sets Mr. Bruning's target objectives on an annual basis in accordance with the MEIP. These target objectives are generally linked to our strategic plan. Awards under the MEIP are generally paid in cash in a lump sum during the fiscal year following the year in which performance was measured, although the MEIP allows the Company to pay smaller portions in quarterly amounts during the fiscal year in which performance was measured (provided that the Adjusted EBITDA for the quarter was on the budgeted target to meet the annual MEIP threshold). We determined that the annual MEIP threshold level of Adjusted EBITDA had not been achieved for 2010 and, accordingly, Mr. Bruning did not receive any cash award under the MEIP for 2010 other than $26,250 in quarterly bonus payments that had been paid over the course of 2010.

As the Senior Vice President of Mergers and Acquisitions, Mr. Ratton participates in our Mergers and Acquisitions Incentive Plan (the "M&A Plan"). The M&A Plan is designed to compensate members of our M&A Department based on the successful completion of our acquisitions. Under the

Table of Contents

terms of the M&A Plan, Mr. Ratton receives a bonus payment on a sliding scale based on the projected profitability of each acquired company. The bonus payment is equal to (i) 0.75% of Mr. Ratton's base salary for each $1 million of projected year one revenue of the acquired company if the projected margin is below 10%, (ii) 1% of Mr. Ratton's base salary for each $1 million of projected year one revenue of the acquired company if the projected margin is between 10% and 15%, and (iii) 1.25% of Mr. Ratton's base salary for each $1 million of projected year one revenue of the acquired company if the projected margin is above 15%. 75% of Mr. Ratton's bonus amount for any given transaction is paid following the closing based upon the projected results, with an amount up to the remaining 25% paid after one year if the acquired company's financial results met or exceeded initial projections. No adjustment is made if the acquired company's financial results were below projections.

Long-Term Incentives

We granted options to officers and other employees in fiscal 2010 under the Amended and Restated Long-Term Incentive Plan in order to align the interests of our officers and employees with the interests of shareholders and thereby provide an incentive to the officers and employees to increase shareholder value. None of the options granted under the Amended and Restated Long-Term Incentive Plan remain outstanding following the Merger.

Other Compensation Elements

We provide officers and other employees with certain benefits to protect an employee and his or her immediate family in the event of illness, disability or death. The named executive officers are eligible for health and welfare benefits available to all our eligible employees during active employment on the same terms and conditions, as well as basic life insurance and accidental death coverage. Mr. Sanger also receives full reimbursement from the Company for his health plan.

We do not have a pension plan for employees or executives. Substantially all salaried employees, including the named executive officers, are eligible to participate in our 401(k) savings plans. We maintain four defined contribution plans for eligible employees. Employees were allowed to contribute to these plans a maximum of 40% of their compensation up to a maximum of $16,500 ($22,000 for employees aged 50 and over) in 2010. In general, we match the contribution up to a maximum of 3% on the first 6% of the employee's salary per year, depending on the plan.

In addition to the health and welfare benefits generally available to all salaried, full-time employees, we also provide each of Messrs. Sanger, Owen and Zimmerman with an annual auto allowance of $14,400, and certain related operating and auto insurance expenses. In addition, we provide Mr. Bruning with an annual auto allowance of $9,000, all as further described in the footnotes to the Summary Compensation Table. In addition, we provide Messrs. Sanger and Owen with supplemental life insurance beyond the level of coverage offered generally to employees. These auto expenses and supplemental life insurance provisions are pursuant to contractual negotiations between the Company and these named executive officers.

We allow named executive officers to use our corporate aircraft for personal travel, provided that such use would not conflict with a corporate objective at that time. In 2010, all personal use of the Company aircraft was reimbursed by the named executive officers following use and no incremental expense was incurred by the Company. Effective with respect to the period beginning on the closing date of the Merger, Mr. Sanger's employment agreement was modified to provide that the Company will bear the cost of up to 25 hours of personal use of a corporate aircraft by Mr. Sanger per calendar year.

Table of Contents

Summary Compensation Table for Fiscal Years 2008, 2009 and 2010

The following table sets forth the compensation of the Chief Executive Officer, Chief Financial Officer and the three other most highly compensated executive officers during fiscal year 2010 who were serving as executive officers of the Company at the end of fiscal year 2010.

Name and Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards ($)(1)	Option Awards ($)(2)	All Other Compensation ($)(3)	Total ($)
(a)	(b)	(c)	(d)	(e)	(f)	(i)	(j)
William A. Sanger	2008	937,421	1,402,610			58,440	2,398,471
President and Chief Executive Officer	2009	983,664	2,654,716	1,111,875	453,750	64,466	5,268,471
	2010	958,706		2,535,300	806,544	58,017	4,358,567
Randel G. Owen							
	2008	406,473	397,163			25,535	829,171
Executive Vice President and	2009	426,536	644,618	555,938	226,875	27,690	1,881,657
Chief Financial Officer	2010	440,356		1,056,375	336,060	24,863	1,857,654
Todd G. Zimmerman							
	2008	378,901	371,587			21,337	771,825
President of EmCare and Executive	2009	397,591	600,906	555,938	226,875	24,494	1,805,803
Vice President of the Company(4)	2010	512,953		1,408,500	448,080	57,566	2,427,099
Mark Bruning							
	2008	296,155	319,352		589,950	14,404	1,219,861
President of AMR	2009	396,158	297,526	370,625	151,250	19,177	1,234,736
	2010	406,377	26,250	704,250	224,040	17,577	1,378,494
Steve W. Ratton,	2008						
Senior Vice President of the	2009						
Company and Treasurer(5)	2010	312,877	465,525	394,380	125,462	7,350	1,305,594

(1) Represents aggregate grant date fair value under ASC Section 718 of all restricted stock awards granted during a specified year. See Note 11 to our audited consolidated financial statements included elsewhere in this prospectus, for the assumptions made in determining these values. There were no forfeitures of restricted stock awards by our named executive officers in 2010.

(2) Represents aggregate grant date fair value under ASC Section 718 of all option awards granted during a specified year. See Note 11 to our audited consolidated financial statements included elsewhere in this prospectus, for the assumptions made in determining these values. There were no forfeitures of options by our named executive officers in 2010. Further information regarding these awards is disclosed in the "Grants of Plan-Based Awards Table" in the Proxy Statements for the specified years. We no longer have performance vesting of our options, and the value therefore does not reflect any performance assumptions.

(3) For Mr. Sanger, amount includes (a) an annual auto allowance, (b) the Company 401(k) match, (c) supplemental individual insurance expenses of $22,687 for 2008, $40,977 for 2009 and $33,692 for 2010, (d) expenses attributed in 2008 to Mr. Sanger for non-employees accompanying him on business travel on an aircraft in which we own a fractional interest (such costs are estimated by reviewing the cost of commercial alternatives for such flights) and (e) other expenses including auto maintenance and fuel expenses permitted pursuant to the terms of Mr. Sanger's employment agreement.

For Mr. Owen, amount includes (a) an annual auto allowance, (b) Company 401(k) match , (c) supplemental individual insurance expenses and (d) other expenses, including auto maintenance and fuel expenses permitted pursuant to the terms of Mr. Owen's employment agreement.

For Mr. Zimmerman, amount includes (a) an annual auto allowance, (b) Company 401(k) match, (c) insurance expenses of as permitted pursuant to the terms of Mr. Zimmerman's employment agreement, (d) auto maintenance and fuel expenses permitted pursuant to the terms of Mr. Zimmerman's employment agreement, (e) for 2010, cost of a lease of a corporate car in Dallas, Texas that Mr. Zimmerman uses and (f) for 2010, $30,845 for a lease of an apartment in Dallas, Texas that Mr. Zimmerman uses when working at EmCare's Dallas office.

Table of Contents

For Mr. Bruning, amount includes (a) an annual auto allowance, (b) Company 401(k) match, (c) insurance expenses, as permitted pursuant to the terms of Mr. Bruning's employment agreement and (d) for 2008 in ancillary hotel expenses incurred during business travel.

For Mr. Ratton, amount includes (a) Company 401(k) match.

(4) Mr. Zimmerman served as our General Counsel for the entirety of 2009 and until he was appointed President of EmCare effective April 1, 2010.

(5) Mr. Ratton's compensation information is provided only with respect to 2010, since Mr. Ratton was not a named executive officer in 2008 or 2009.

Grant of Plan-Based Awards at End of Fiscal Year 2010

The following table summarizes cash-based and equity-based awards for each of the named executive officers that were granted during fiscal year 2010 by the Company and its affiliates, none of which are outstanding following the Merger other than the options rolled over as described in "Treatment of Outstanding Options, Restricted Shares and RSUs in the Merger Treatment of Options." For a description of how these and other outstanding awards were treated in the Merger, see "Treatment of Outstanding Options, Restricted Shares and RSUs in the Merger" below.