

Envision Healthcare Holdings, Inc.  
Form 10-K  
March 14, 2014

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**UNITED STATES**  
**SECURITIES AND EXCHANGE COMMISSION**  
WASHINGTON, D.C. 20549  
  
**FORM 10-K**

Mark one:

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

For the fiscal year ended December 31, 2013

Or

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

For the transition period from to

| Commission<br>File Number                                                                                                                                                                                                                              | Exact Name of<br>Registrant<br>as specified in its charter | State or Other<br>Jurisdiction of<br>Incorporation or<br>Organization                                                                                                                                                                               | IRS Employer<br>Identification<br>Number |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 001-36048                                                                                                                                                                                                                                              | Envision Healthcare<br>Holdings, Inc.                      | Delaware                                                                                                                                                                                                                                            | 45-0832318                               |
| 001-32701                                                                                                                                                                                                                                              | Envision Healthcare<br>Corporation                         | Delaware                                                                                                                                                                                                                                            | 20-3738384                               |
| <b>ENVISION HEALTHCARE HOLDINGS, INC.</b><br><b>6200 S. Syracuse Way, Suite 200</b><br><b>Greenwood Village, CO 80111</b><br>(Address of principal executive offices)<br><b>(303) 495-1200</b><br>(Registrant's telephone number, including area code) |                                                            | <b>ENVISION HEALTHCARE CORPORATION</b><br><b>6200 S. Syracuse Way, Suite 200</b><br><b>Greenwood Village, CO 80111</b><br>(Address of principal executive offices)<br><b>(303) 495-1200</b><br>(Registrant's telephone number, including area code) |                                          |
| Securities registered pursuant to Section 12(b) of the Act:                                                                                                                                                                                            |                                                            |                                                                                                                                                                                                                                                     |                                          |

**Title of each class:**

Envision Healthcare Holdings, Inc.: **Common Stock, \$0.01 par value**

Envision Healthcare Corporation: **None**

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

**Name of each exchange on which registered**

New York Stock Exchange

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

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Envision Healthcare Holdings, Inc. Yes ☐ No ☒

Envision Healthcare Corporation Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act.

Envision Healthcare Holdings, Inc. Yes ☐ No ☒

Envision Healthcare Corporation Yes ☒ No ☐

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Envision Healthcare Holdings, Inc. Yes ☒ No ☐

Envision Healthcare Corporation Yes ☐ No ☒

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

Envision Healthcare Holdings, Inc. Yes ☒ No ☐

Envision Healthcare Corporation Yes ☒ No ☐

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

Envision Healthcare Holdings, Inc. ☐

Envision Healthcare Corporation ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Envision Healthcare Holdings, Inc.

Large accelerated filer ☐

Accelerated filer ☐

Non-accelerated filer ☒

Smaller reporting company ☐

(Do not check if a  
smaller reporting  
company)

Envision Healthcare Corporation

Large accelerated filer ☐

Accelerated filer ☐

Non-accelerated filer ☒

Smaller reporting company ☐

(Do not check if a  
smaller reporting  
company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Envision Healthcare Holdings, Inc. Yes ☐ No ☒

Envision Healthcare Corporation Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity of Envision Healthcare Holdings, Inc. held by non-affiliates as of the close of business on June 30, 2013 was \$0.

Indicate the number of shares outstanding of each of the issuer's classes of common stock as of the latest practicable date:

**Envision Healthcare Holdings, Inc.**

At March 1, 2014, the registrant had 181,131,273 shares of common stock, par value \$0.01 per share, outstanding.

**Envision Healthcare Corporation**

At March 1, 2014, the registrant had 1,000 shares of common stock, par value \$0.01 per share, outstanding. All of Envision Healthcare Corporation's outstanding stock was held at such date by Envision Healthcare Intermediate Corporation, its sole stockholder.

Envision Healthcare Corporation meets the conditions set forth in General Instruction I(1)(a) and (b) of Form 10-K and is therefore filing this Form with the reduced disclosure format applicable to Envision Healthcare Corporation.

### Documents incorporated by reference:

Portions of Envision Healthcare Holdings, Inc.'s proxy statement to be filed with the Securities and Exchange Commission in connection with Envision Healthcare Holdings, Inc.'s 2014 Annual Meeting of Stockholders (the "Proxy Statement") are incorporated by reference into Part III hereof. Such Proxy Statement will be filed within 120 days of Envision Healthcare Holdings, Inc.'s fiscal year ended December 31, 2013.

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ENVISION HEALTHCARE CORPORATION**

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ON FORM 10-K**

**FOR THE YEAR ENDED  
DECEMBER 31, 2013**

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**EXPLANATORY NOTE**

This Form 10-K is a combined annual report being filed separately by two registrants: Envision Healthcare Holdings, Inc. (formerly known as CDRT Holding Corporation) and Envision Healthcare Corporation (formerly known as Emergency Medical Services Corporation). Unless the context indicates otherwise, any reference in this annual report to "Holding" refers to Envision Healthcare Holdings, Inc., any reference to "Corporation" refers to Envision Healthcare Corporation, the indirect, wholly-owned subsidiary of Holding, and any references to "EVHC," the "Company," "we," "our," or "us" refer to Envision Healthcare Holdings, Inc. and its direct and indirect subsidiaries, including Corporation. Our business is conducted primarily through two operating subsidiaries, EmCare Holdings, Inc. ("EmCare") and American Medical Response, Inc. ("AMR"). Each registrant hereto is filing on its own behalf all of the information contained in this annual report that relates to such registrant. Each registrant hereto is not filing any information that does not relate to such registrant, and therefore makes no representation as to any such information.

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**ENVISION HEALTHCARE HOLDINGS, INC.  
ENVISION HEALTHCARE CORPORATION**

**ANNUAL REPORT ON FORM 10-K**

**FORWARD-LOOKING STATEMENTS AND FACTORS THAT MAY AFFECT RESULTS**

This Annual Report on Form 10-K 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:

Decreases in our revenue and profit margin under our fee-for-service contracts due to changes in volume, payor mix and third party reimbursement rates, including from political discord in the federal budgeting process;

The loss of existing contracts;

Failure to accurately assess costs under new contracts;

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

Failure to implement some or all of our business strategies, including our efforts to grow our Evolution Health, LLC ("Evolution Health") business and cross-sell our services;

Lawsuits for which we are not fully reserved;

The adequacy of our insurance coverage and insurance reserves;

Our ability to successfully integrate strategic acquisitions;

The high level of competition in the markets we serve;

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;

Our ability to maintain or implement complex information systems;

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Disruptions in disaster recovery systems or management continuity planning;

Our ability to adequately protect our intellectual property and other proprietary rights or to defend against intellectual property infringement claims;

Challenges by tax authorities on our treatment of certain physicians as independent contractors;

The impact of labor union representation;

The impact of fluctuations in results due to our national contract with the Federal Emergency Management Agency ("FEMA");

Potential penalties or changes to our operations, including our ability to collect accounts receivable, if we fail to comply with extensive and complex government regulation of our industry;

The impact of changes in the healthcare industry, including changes due to healthcare reform;

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Our ability to timely enroll our providers in the Medicare program;

Our ability to restructure our operations to comply with future changes in government regulation;

The outcome of government investigations of certain of our business practices;

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

Our ability to generate cash flow to service our substantial debt obligations;

The significant influence of investment funds sponsored by, or affiliated with, Clayton, Dubilier & Rice, LLC (the "CD&R Affiliates") over us; and

Risks related to other factors discussed in this Annual Report on Form 10-K.

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. Readers should read carefully the factors described in the "Risk Factors" section of this Annual Report on Form 10-K 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.

## **PART I.**

### **ITEM 1. BUSINESS**

#### **Company Overview**

We are a leading provider of physician-led, outsourced medical services in the United States with more than 20,000 affiliated clinicians. We offer a broad range of clinically-based and coordinated care solutions across the patient continuum, by which we mean the patient treatment cycle, from medical transportation to hospital encounters to comprehensive care alternatives in various settings. We believe that our capabilities offer a powerful value proposition to healthcare facilities, communities and payors by helping to improve the quality of care and lower overall healthcare costs. We market our services on a stand-alone, multi-service and integrated basis, primarily under our EmCare and AMR brands. EmCare, with 40 years of operating history and nearly 8,000 affiliated physicians and other clinicians, is a leading provider of integrated facility-based physician services, including emergency, anesthesiology, hospitalist/inpatient care, radiology, tele-radiology and surgery. EmCare also offers physician-led care management solutions outside the hospital. AMR, with more than 55 years of operating history and more than 12,000 paramedics and emergency medical technicians, is a leading provider and manager of community-based medical transportation services, including emergency ("911"), non-emergency, managed transportation, fixed-wing air ambulance and disaster response.



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Since May 2011, our management has implemented a number of value-enhancing initiatives to expand our service offerings, increase our market presence and position us for future growth. Some of these initiatives include:

Optimizing our contract portfolio and prioritizing markets at EmCare and AMR;

Developing further EmCare's integrated service offerings, resulting in a meaningful acceleration of new contract growth;

Re-aligning AMR's business model and strategy by improving productivity, clinical outcomes and the use of technology, leading to operating margin improvements and revenue growth opportunities; and

Leveraging the core competencies of EmCare and AMR to extend our clinical capabilities into various settings outside the hospital.

In 2012, we expanded EmCare's physician-led services outside the hospital through the formation of Evolution Health. Evolution Health provides comprehensive care management solutions through a suite of physician-led services, including transitional care teams, direct patient care and care coordination by clinicians outside the acute-care setting, as well as tele-monitoring and tele-medicine. Evolution Health serves patients who require comprehensive care across various settings, many of whom suffer from advanced illnesses and chronic diseases. Our Evolution Health solutions leverage many of the competencies of EmCare and AMR, including clinical resource management, patient flow coordination, evidence-based clinical protocols, community-based clinical and medical transportation services, patient monitoring and clinician recruitment.

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The following table presents an overview of our core services, key types of customers, results of operations and contracts. References in this annual report to number of contracts, clinicians and employees are as of December 31, 2013, unless otherwise noted.

|                         | <b>EmCare</b>                                                                                                                                                                                                        | <b>AMR</b>                                                                                                                                                                                                                                  |
|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Core Services:          | Facility-based physician services<br>Emergency Department<br>Anesthesiology<br>Hospitalist/inpatient care<br>Radiology/tele-radiology<br>Surgery<br><br>Physician-led care management solutions outside the hospital | Emergency "911" medical transportation services<br><br>Non-emergency medical transportation services<br><br>Managed transportation services<br><br>Fixed-wing air ambulance services<br><br>Disaster response<br><br>Event medical services |
| Key Customers:          | Healthcare facilities<br>Payors<br>Attending medical staff<br>Independent physician groups                                                                                                                           | Communities<br>Government agencies<br>Healthcare facilities<br>Payors                                                                                                                                                                       |
| Net Revenue (2013):     | \$2.3 billion (63% of total net revenue)                                                                                                                                                                             | \$1.4 billion (37% of total net revenue)                                                                                                                                                                                                    |
| Adjusted EBITDA (2013): | \$294.0 million (66% of total Adjusted EBITDA)                                                                                                                                                                       | \$151.8 million (34% of total Adjusted EBITDA)                                                                                                                                                                                              |
| Number of Contracts:    | 706 facility contracts                                                                                                                                                                                               | 169 "911" contracts<br>3,677 non-emergency transport arrangements                                                                                                                                                                           |
| Patient Volume (2013):  | 12.1 million weighted patient encounters                                                                                                                                                                             | 2.8 million weighted transports                                                                                                                                                                                                             |

### ***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 1990s. Over its 40 years of operating history, EmCare has become a leading provider of integrated facility-based physician services to healthcare facilities in the United States. EmCare has recently further expanded the company's comprehensive care management solutions outside the hospital through Evolution Health.

AMR was founded in 1992 through the consolidation of several well-established regional ambulance companies and has grown organically and through acquisitions. In February 1997, AMR merged with another leading ambulance company and became a leading provider and manager of community-based medical transportation services.

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In January 2005, an investor group led by Onex, including members of management, purchased our operating subsidiaries, EmCare and AMR which became indirect wholly owned subsidiaries of Corporation.

Holding was formed in 2011 in connection with the acquisition of Corporation in a merger transaction (the "Merger") by the CD&R Affiliates. In May 2011, in connection with the Merger, substantially all of the outstanding shares of common stock of the Company were purchased by the CD&R Affiliates, and Corporation became an indirect wholly owned subsidiary of the Company. As a result of the Merger, information for the year ended December 31, 2011 is generally separated into two periods, the periods preceding the Merger ("Predecessor") and the period succeeding the Merger ("Successor"). Financial information for the Predecessor period is for Corporation.

In 2012, we formed Evolution Health through the combination of two acquired businesses, a provider of primary care physician healthcare services to patients at their place of residence with operations in Texas, and a post-acute care services provider with operations in Indiana, Ohio, Oklahoma and Texas. We have subsequently expanded Evolution Health's service offerings and sought to integrate its services with our other lines of business.

In June 2013, we changed our name from CDRT Holding Corporation to Envision Healthcare Holdings, Inc., and our indirect wholly owned subsidiary, Emergency Medical Services Corporation, changed its name to Envision Healthcare Corporation.

On July 29, 2013, Holding effected a 9.3 for 1.0 stock split of Holding's common stock, resulting in 132,082,885 shares of common stock issued, not including 504,197 treasury shares. The accompanying consolidated financial statements for Holding give retroactive effect to the stock split for all periods presented.

On August 13, 2013, Holding's Registration Statement was declared effective by the SEC for an initial public offering of its common stock, par value \$0.01 per share ("Common Stock"). Holding registered the offering and sale of 42,000,000 shares of Common Stock and an additional 6,300,000 shares of Common Stock, to be sold to the underwriters pursuant to their option to purchase additional shares at a price of \$23 per share. On August 19, 2013, Holding completed the offering of 48,300,000 shares of Common Stock, at a price of \$23 per share, for an aggregate offering price of \$1,110.9 million. At the closing, we received net proceeds of approximately \$1,025.9 million, after deducting the underwriters' discounts and commissions paid and offering expenses of approximately \$85.0 million, including a \$20.0 million payment to Clayton, Dubilier & Rice, LLC ("CD&R") in connection with the termination of the Consulting Agreement which was recorded to "Selling, general and administrative expenses" in Holding's Consolidated Statements of Operations.

On February 5, 2014, Holding registered the offering and sale of 27,500,000 shares of Common Stock and an additional 4,125,000 shares of Common Stock, which were sold by CD&R Affiliates to the underwriters pursuant to their option to purchase additional shares at \$30.50 per share less the underwriting discount. The CD&R Affiliates, certain executive officers and directors of Holding and certain non-executives were the selling stockholders in the offering. Holding did not receive any of the proceeds from the sale of the shares being sold by the selling stockholders, including any shares sold pursuant to any exercise of the underwriters' option to purchase additional shares. Upon completion of this offering, Holding had 181,131,273 shares of Common Stock outstanding.

## ***Description of our Business***

### ***Industry Overview***

We operate in the facility-based physician services and community-based medical transportation markets, two large and growing segments of the healthcare market that are supported by favorable

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demographics, including the growth and aging of the population. Our services are offered on a stand-alone basis or as part of an integrated services program combining two or more services.

***Emergency Department ("ED")***

We provide outsourced ED physician services to hospitals and other facilities. Facility-based ED physician services providers such as EmCare are primarily focused on improving the patient experience and enhancing 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. In addition, we believe leading facility-based outsourced physician services providers are well-positioned to improve operational efficiency, reducing wait times and increasing the productivity in a hospital ED.

We believe the physician reimbursement component of the ED services market represents annual expenditures of nearly \$20 billion. The market for outsourced ED staffing and related management services is highly fragmented, with more than 1,000 national, regional and local providers handling an estimated 130 million patient visits in 2013. There are nearly 5,000 hospitals in the United States that operate EDs, of which approximately 67% outsource their ED physician staffing and management. We believe we are one of only six national providers and the largest provider based on number of ED contracts.

Between 2000 and 2010, the total number of patient visits to hospital EDs increased from approximately 108 million to approximately 130 million per annum, an increase of 20%. We believe that a portion of the historical and expected growth of ED 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. This trend, combined with a decline in the number of hospital EDs, has resulted in a substantial increase in the average number of patient visits per hospital ED during this period. In addition, the Patient Protection and Affordable Care Act ("PPACA") is designed to provide healthcare coverage to previously uninsured individuals through the expansion of state Medicaid programs and the creation of federal and state healthcare exchanges, which we anticipate will increase overall utilization and reimbursement for ED services. We believe increased volumes through EDs and cost pressures facing hospitals have resulted and will result in an increased focus by facilities on improving the operating efficiency of their EDs, a core competency of EmCare.

***Anesthesiology Services***

We provide anesthesiology services to hospitals, free-standing ambulatory 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 surgeon satisfaction, which is crucial to the financial viability of the surgery department in hospitals and free-standing ambulatory surgery centers. The anesthesiology market is estimated to have annual expenditures of approximately \$19 billion and is currently serviced primarily by hospitals, which self-operate their programs, and by local outsourced providers.

***Hospitalist Services***

We provide inpatient service physicians, or hospitalists, for patients who are admitted to hospitals and either have no primary care physician or the attending physician requests that our hospitalist manage the patient. This program benefits hospitals by optimizing the average length of stay for patients and can improve patient flow and care coordination through effective working relationships with EDs. Inpatient service physicians are also an integral part of the post-discharge coordination of patient care by directing how care outside the hospital setting should be established and coordinated.

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Certain studies indicate better patient outcomes and lower costs with these hospitalist programs. The market for 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.

***Physician-Led Care Management Solutions Outside the Hospital***

In 2012, we expanded EmCare's physician-led services outside the hospital through the formation of Evolution Health. Evolution Health provides comprehensive care management solutions through a suite of physician-led services, including transitional care teams, direct patient care and care coordination by clinicians outside the acute-care setting, as well as tele-monitoring and tele-medicine. Evolution Health serves patients who require comprehensive care across various settings, many of whom suffer from advanced illnesses and chronic diseases. We believe that leading providers of care management solutions outside the hospital can offer an attractive value proposition through our business model which helps payors reduce their cost of care, promote the most appropriate care in the most appropriate setting, identify member health risks, enable self-care and independence at home, and reduce hospital lengths of stay and readmissions. For hospitals, we believe leading providers can improve patient flow coordination, decrease lengths of stay and reduce readmission rates. We believe the addressable market for care management solutions outside the hospital represents annual expenditures of approximately \$64 billion.

***Radiology/Tele-radiology Services***

We provide radiology, including tele-radiology, services to hospitals. The industry for these services comprises a number of smaller local and regional groups, which are at a disadvantage compared to national providers having the ability to recruit, train and leverage existing capital and infrastructure support. Tele-radiology, the process whereby digital radiologic images are sent from one point to another, has become a fast-growing healthcare service. This technology allows hospitals to have access to full-time radiology support, even when access to full-time radiologists on-site may be limited. The market for radiology and tele-radiology service has estimated annual expenditures of approximately \$11 billion and is currently serviced primarily by hospitals, which self-operate their programs, and by local outsourced providers.

***Surgery Services***

We offer management, oversight and surgeon staffing for trauma surgery services. This service gives hospitals the opportunity to raise their trauma designation by providing expanded coverage and management for surgery services. While the market for this service is still emerging, we estimate annual expenditures of approximately \$2 billion.

***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 emergency medical technicians ("EMTs") to provide immediate medical care to injured or ill patients. Non-emergency services utilize paramedics, EMTs and/or nurses to transport patients between healthcare facilities or between facilities and patient residences.

"911" emergency response services are provided primarily under exclusive long-term contracts with communities and government agencies which by law are generally required to provide such services. These contracts typically specify maximum fees a provider may charge and set forth minimum

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requirements, such as response times, staffing levels, types of vehicles and equipment, quality assurance and insurance coverage. The rates that 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, the payor mix and the performance requirements.

Non-emergency services generally are provided pursuant to non-exclusive contracts with healthcare facilities and payors. 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.

We believe that the ambulance services market, including both emergency and non-emergency transports, represents annual expenditures of approximately \$18 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 43 million ambulance transports in 2013. There are a limited number of regional ambulance providers, and we are the largest national ambulance provider based on net revenue.

***Managed Transportation***

We provide managed transportation administration services to insurers, government entities and healthcare providers. Through partnerships with external transportation providers, our services include managing ambulance, wheelchair 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 \$2 billion.

***Fixed-Wing Air Transport Services***

We also provide fixed-wing air ambulance transport services, including the specialized medical care required by patients during the transports. Our services focus on patients who require longer travel distances to retain the appropriate care, both in emergency and non-emergency situations. Additionally, we offer international repatriation services for emergency medical needs. We believe the medical air transportation market represents annual expenditures of approximately \$3 billion.

**Business Segments and Services**

We operate our business and market our services under our two business segments: EmCare and AMR. We provide integrated facility-based physician services in 45 states and the District of Columbia and provide and manage medical transportation services in 40 states and the District of Columbia.

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

**EmCare**

EmCare is a leading provider of integrated facility-based physician services to healthcare facilities in the United States. EmCare has contracts covering 706 clinical departments with hospitals and independent physician groups to provide emergency, anesthesiology, hospitalist/inpatient care, radiology, tele-radiology and surgery services as well as other administrative services. During 2013, EmCare had approximately 12.1 million weighted patient encounters in 45 states and the District of Columbia. As of December 31, 2013, EmCare had a 9% share of the total ED services market and a 13% share of the outsourced ED services market, the largest share among outsourced providers based on number of contracts. EmCare's share of the combined markets for anesthesiology, hospitalist, radiology and surgery services was approximately 1% as of such date.

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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, |              |              |
|---------------------------|-------------------------------------------|--------------|--------------|
|                           | 2013                                      | 2012         | 2011         |
| Net revenue               | \$ 2,358,787                              | \$ 1,915,148 | \$ 1,667,062 |
| Income from operations    | 219,842                                   | 199,300      | 164,242      |
| Total identifiable assets | 2,624,161                                 | 2,468,605    | 2,459,724    |

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

***Hospital-Based Services***

We provide a full range of hospital-based physician staffing and related management services for EDs, anesthesiology, hospitalist/inpatient care, radiology, tele-radiology and surgery 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 relationship, 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, operational improvement and physician utilization patterns. The regional-based management staff provides support for these efforts and ensures that each customer's expectations are identified, that service plans are developed and executed to meet those expectations, and that our and the customer's financial objectives are achieved.

***Staffing.*** We provide a full range of staffing services to meet the unique needs of each healthcare facility. Our dedicated clinical teams include qualified 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 appropriate mix of qualified physicians and other medical professionals 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 and expertise necessary to identify and attract specialized physicians. We have committed significant resources to the development of proprietary recruiting support systems, such as EmSource, a proprietary national physician database, and EmForce, a recruiting management and tracking program 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

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physician retention rates. We actively recruit physicians through various media options including social media, 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 situations such as physician illness and personal emergencies do not result in a disruption of coverage.

**Operational Improvement Assessments.** We implement process improvement programs for our hospital customers that are directed toward enhancement of operating and triage systems, and improvement of critical operational metrics, including turnaround times, "left without being treated", and throughput times. Through an initial assessment, we establish baseline values, which are used to develop and implement process improvement programs, and then we monitor the success of the initiatives. We also design and implement customized patient satisfaction programs for our hospital customers. These programs are delivered to the clinical and non-clinical members of the hospital ED 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. During 2013, we had 11 practice support agreements which generated \$42 million in net revenue.

**Practice Improvement.** We provide ongoing support to our affiliated physicians through targeted leadership development programs, risk management review and support and comprehensive documentation review and training for our affiliated physicians. We review certain statistical indicators that allow us to provide specific training to individual physicians, and we tailor training for broader groups of physicians as we see trends developing in these areas.

**Non-Hospital Based Services**

**Physician-Led Care Management Solutions.** We provide physician-led care management solutions to patients outside the hospital. We provide comprehensive care management solutions through a suite of physician-led techniques and services, including transitional care teams, direct patient care and care coordination by clinicians outside the acute-care setting, tele-monitoring and tele-medicine. We market these services to payors and healthcare systems.

**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 ED setting to identify claim trends and risk factors so that we can better target our risk management initiatives. Periodically, we target the medical conditions associated with our most

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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 have developed "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;

hospitals in the form of subsidies;

fees for management services provided; and

individual patients.

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

|                                   | Percentage of EmCare<br>cash collections |               |               |
|-----------------------------------|------------------------------------------|---------------|---------------|
|                                   | Year ended December 31,                  |               |               |
|                                   | 2013                                     | 2012          | 2011          |
| Medicare                          | 16.6%                                    | 14.0%         | 14.3%         |
| Medicaid                          | 3.5                                      | 3.7           | 4.4           |
| Commercial insurance/managed care | 59.4                                     | 60.3          | 57.1          |
| Self-pay                          | 3.0                                      | 3.3           | 2.8           |
| Fees/other                        | 2.4                                      | 2.7           | 3.1           |
| Subsidies                         | 15.1                                     | 16.0          | 18.3          |
| <b>Total net revenue</b>          | <b>100.0%</b>                            | <b>100.0%</b> | <b>100.0%</b> |

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 most of our ED 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. Certain ED services are also billed by 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 800 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 15 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.

Reimbursement for our EmCare physician services has historically been stable. In addition, in many of our hospital contracts, we have had the ability to obtain or increase subsidies to offset any reimbursement or payor mix changes. Further, we typically 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.

## 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

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

**Hospital and Practice Support 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. As of December 31, 2013, EmCare had contracts covering 706 clinical departments, with the top 10 contracts representing only 7% of EmCare net revenue. One customer, Hospital Corporation of America, comprised 9.4% of EmCare's total net revenue. No customer (including all facility contracts under a single hospital system) comprised more than 10% of consolidated total net revenue. We have maintained our relationships with these customers for an average of 12.5 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.

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

***Management Information Systems***

We have invested in scalable information systems and proprietary software packages designed to allow us to grow efficiently and to deliver and implement our "best practice" procedures nationally, 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 trademark 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 EVHC and EmCare trademarks 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 facility-based services are obtained through strategic marketing programs and responses to requests for proposal ("RFPs"). 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.

A healthcare facility RFP 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 an RFP, 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 ED staffing and related management services is highly fragmented, with more than 1,000 national, regional and local providers handling an estimated 130 million patient visits in 2013. There are nearly 5,000 hospitals in the United States that operate EDs, of which approximately 67% outsource their ED physician staffing and management. Of these hospitals that

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outsource, we believe approximately 48% contract with a local provider, 18% contract with a regional provider and 34% contract with a national provider based on estimated net revenue.

Team Health is our largest competitor and has the second largest share of the ED services market with an approximately 6% share based on number of contracts. Other national providers of outsourced ED services are Hospital Physician Partners, Schumacher Group and California Emergency Physicians.

The markets for anesthesiology, inpatient and radiology services are also highly fragmented. For anesthesiology services, we have a 1% - 2% share of the market with an additional 2% market share split between Team Health, Sheridan Healthcare, Premier Anesthesia, North American Partners in Anesthesia and NorthStar Anesthesia. For inpatient services, Cogent HMG, Apogee and MEDNAX, Inc. are the market leaders, each with a 3% share. Other national providers are Team Health and IPC. For radiology services, four other national providers each have a market share similar to ours at 1%.

### **Insurance**

**Professional Liability Program.** From January 1, 2002 through the present, our professional liability insurance program provides "claims-made" insurance coverage with a limit of \$1 million per loss event and a \$3 million annual per provider aggregate, for all medical professionals whom we have agreed to cover under our professional liability insurance program. In addition, from time to time, we contract with insurance providers outside of our insurance program, customarily when the third party provider can provide economically more favorable terms to our insurance program for a specific specialist practice, or if it is a legacy provider from acquisitions. Our subsidiaries and affiliated corporate entities are provided with coverage of \$1 million per loss event and share a \$10 million annual corporate aggregate.

From 2002 through the present, most of our professional liability insurance coverage was provided by affiliates of Columbia Casualty Company and Continental Casualty Company (collectively, "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 following 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 and through letters of credit.

### **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, 2013.

| Job Classification     | Full-time | Part-time | Total  |
|------------------------|-----------|-----------|--------|
| Physicians             | 3,021     | 4,088     | 7,109  |
| Physician assistants   | 659       | 534       | 1,193  |
| Nurse practitioners    | 840       | 705       | 1,545  |
| Non-clinical employees | 2,056     | 659       | 2,715  |
| Total                  | 6,576     | 5,986     | 12,562 |

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

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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.

**AMR**

AMR has developed the largest network of ambulance services and a leading position in other medical transportation 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, 2013, we had a 6% share of the total ambulance services market and a 16% share of the outsourced ambulance market. During 2013, AMR treated and transported approximately 2.8 million patients in 40 states and the District of Columbia utilizing nearly 4,300 vehicles that operated out of nearly 200 sites. AMR has more than 3,800 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, healthcare facilities and government agencies.

During 2013, approximately 61% 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 transfers, wheelchair transports and other interfacility transports, accounted for 24% of AMR's net revenue for the same period. The remaining balance of net revenue for 2013 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 including services provided to FEMA.

AMR has a national contract with FEMA to provide ambulance and para-transit services, as well as 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 audited consolidated financial statements, AMR's net revenue, income from operations and total identifiable assets were as follows for each of the periods indicated (in thousands).

|                           | As of and for the year ended<br>December 31, |              |              |
|---------------------------|----------------------------------------------|--------------|--------------|
|                           | 2013                                         | 2012         | 2011         |
| Net revenue               | \$ 1,369,525                                 | \$ 1,384,973 | \$ 1,440,539 |
| Income from operations    | 56,986                                       | 57,641       | 49,170       |
| Total identifiable assets | 1,515,162                                    | 1,544,908    | 1,318,772    |

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

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

**Services**

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

**"911" Response Services.** 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

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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 11% of AMR's net revenue for 2013.

***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 critical care nurses, respiratory therapists, or specially trained critical care paramedics, 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.

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 MRI testing, CAT scans, dialysis or radiation therapy, available at another facility. We use ALS or BLS ambulance units to provide general ambulance services depending on the patient's needs.

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**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 nearly 1,200 graduates in 2013.

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

*Community Paramedic, OnSite and Offshore EMS Services.* We provide mobile healthcare and patient monitoring at home for high "911" user patients and for post discharge patients in readmission prevention programs. Our health/safety solutions, telemedicine and risk avoidance programs are specifically developed for site based activity within the oil and gas industry.

**Medical Personnel and Quality Assurance**

Approximately 76% of our 17,777 employees have daily contact with patients, including approximately 6,014 paramedics, 7,328 EMTs and 236 nurses. Paramedics and EMTs must be state-certified and locally credentialed 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 U.S. Department of Transportation, such as those offered at our training institute, NCTI. Paramedic training involves over 1,000 hours of didactic and clinical education focused on advanced levels of care. In addition, specialized courses may be completed to target specific patient populations (such as pediatrics, geriatrics, trauma, burns, etc).

In most communities, the local physician medical director (often in conjunction with a physician advisory board) develops medical protocols to be followed by paramedics and EMTs in a service area. In addition, real-time instructions are conveyed on a case-by-case basis through direct communications between the ambulance crew and hospital emergency physicians. This consultation allows for more comprehensive evaluation and treatment of difficult cases. Like physicians, both paramedics and EMTs must complete continuing education programs and, in some cases, state supervised refresher training and/or examinations to maintain their certifications.

AMR has a strong commitment to provide high-quality pre- and post-hospital emergency medical care. Our focus on patient care is based on the published medical literature, participation with leading academic medical centers throughout the country, affiliation with international efforts to improve clinical care in emergency medical services ("EMS"), and our innovative approach known as AMR Medicine. In each individual 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

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provided. In addition, we hold retrospective care audits with our employees to evaluate compliance with medical and performance standards. Our participation and leadership in national EMS organizations underscores the importance of our philosophy on patient care.

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

### ***Billing and Collections***

Our internal patient billing services 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;

fees for stand-by and event driven coverage, including from our national contract with 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:

|                                   | <b>Percentage of AMR<br/>cash collections for<br/>the year ended<br/>December 31,</b> |               |               |
|-----------------------------------|---------------------------------------------------------------------------------------|---------------|---------------|
|                                   | <b>2013</b>                                                                           | <b>2012</b>   | <b>2011</b>   |
| Medicare                          | 32.1%                                                                                 | 28.6%         | 27.8%         |
| Medicaid                          | 7.4                                                                                   | 6.3           | 6.5           |
| Commercial insurance/managed care | 39.2                                                                                  | 41.4          | 43.0          |
| Self-pay                          | 6.2                                                                                   | 6.9           | 6.9           |
| Fees                              | 12.5                                                                                  | 14.3          | 13.5          |
| Subsidies                         | 2.6                                                                                   | 2.5           | 2.3           |
| <b>Total net revenue</b>          | <b>100.0%</b>                                                                         | <b>100.0%</b> | <b>100.0%</b> |

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.



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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 Item 1A, "Risk Factors Risk Factors Related to Healthcare Regulation Changes in the rates or methods of third party reimbursements, including due to political discord in the budgeting process outside our control, may adversely affect our revenue and operations."

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 billing rates under contracts with a community or government agency.

As a "911" emergency response provider, we are uniquely positioned for stable pricing as changes in reimbursement from Medicare or other payors can typically be offset by requesting increases in the rates we are permitted to charge for "911" services from the communities we serve. Communities and municipalities set these emergency allowable rates for commercial payors and, with limited exceptions, do not pay for services out of the tax base. 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, 2013, we had 169 contracts with communities and government agencies to provide "911" emergency response services. Contracts with communities to provide emergency transport services are typically exclusive, three to five years in length and generally 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, 2013, our top ten "911" contracts accounted for approximately \$332 million, or 24% of AMR's net revenue. We have served these ten customers on a continual basis for an average of 32 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.

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**Non-Emergency Transport.** We have more than 3,600 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 48 communities where we are not an ambulance service provider. Our dispatch centers are staffed by EMTs and other experienced personnel who use local medical protocols to analyze and triage a medical situation and determine the best mode of transport.

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

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***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 electronic patient care record ("ePCR") 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 medical transportation services are likely to be required.

***Intellectual Property***

We have registered the trademarks 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 American Medical Response and AMR trademarks 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 RFPs that generally include demographic information of the community or facilities, response time parameters, vehicle and equipment requirements, the length of the contract, the minimum qualifications of bidders, billing information, selection criteria and the format to be followed in the bid. Prior to responding to an RFP, 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.

Over the last several years, AMR has developed a proprietary clinical database of patient transports, including detailed tracking of mortality rates and resuscitation metrics, which provides analytical support to AMR's differentiated clinical results. The inclusion of this data as part of our RFP submissions to support our clinical outcomes, as well as a recent initiative to improve and centralize our RFP writing process, has resulted in an increase in AMR's win rate for new "911" emergency services outsourcing contracts from municipalities.

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***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. During 2011 we equipped our vehicles with power stretchers, which we believe reduced the number of lifting injuries to our employees in 2012 and going forward.

***Competition***

Our predominant competitors are fire departments and other local government providers. Based on the population of the top 200 cities, we estimate fire departments and other local government providers are approximately 52% 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. Based on the population of the top 200 cities, we estimate approximately 48% of communities currently outsource ambulance services. Of these communities that outsource, we believe approximately 69% contract with a local or regional provider, 10% contract with a hospital-based provider and 21% contract with a national provider.

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 provide comprehensive clinical care;

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, generates ambulance transport revenue less than half of AMR's net revenue. Other larger private provider competitors include Falck, a Danish corporation which has increased its U.S. presence in the Northeast and Florida, Acadian Ambulance Service in Louisiana, Paramedics Plus in Texas, Oklahoma, Indiana, Florida and California, 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 American International Group, Inc., through CNA 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 and through the present. We have umbrella policies with third party insurers covering claims exceeding these retention levels with an aggregate cap of \$10 million to \$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. Non-compliance 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 the facilities we lease as a result of historical practices of the owners or former operators. Based on available information, we do not believe that any known compliance obligations, releases or investigations under environmental laws or regulations will have a material adverse effect on our business, financial position and results of operations. However, there can be no guarantee that these releases or newly discovered information, more stringent enforcement of or changes in environmental requirements, or our inability to enforce available indemnification agreements will not result in significant costs.

**Employees**

The following is the breakdown of our employees by job classification as of December 31, 2013.

| Job Classification            | Full-time | Part-time | Total  |
|-------------------------------|-----------|-----------|--------|
| Paramedics                    | 3,951     | 2,063     | 6,014  |
| Emergency medical technicians | 4,415     | 2,913     | 7,328  |
| Nurses                        | 110       | 126       | 236    |
| Support personnel             | 3,608     | 591       | 4,199  |
| Total                         | 12,084    | 5,693     | 17,777 |

Approximately 44% of AMR employees are represented by 37 active collective bargaining agreements. There are 25 operational locations representing approximately 4,795 employees currently in

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the process of negotiations or will be subject to negotiation in 2014. In addition, six collective bargaining agreements, representing 600 employees will be subject to negotiations in 2015. 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.

**Competitive Strengths**

We believe the following competitive strengths position us to capitalize on the favorable healthcare services industry trends:

***Leading Player in Large and Highly Fragmented Markets.*** In 2013, we had a total of 14.9 million weighted patient encounters and weighted transports across approximately 2,100 communities. We are one of the largest outsourced providers in our markets, though we estimate that EmCare has only a 9% share of the total ED services market, AMR has only a 6% share of the total ambulance market, and our other services have no more than a 4% share of their respective total markets. Due to our scale and scope, we are able to offer our customers integrated services and national contracting capabilities, while demonstrating differentiated clinical outcomes across our businesses. We have developed strong brand recognition and competitive advantages in clinician recruitment as a result of our market position, clinical best practices and clinician leadership development programs. We believe that our scale and scope, when combined with our capabilities and comprehensive service offerings across the patient continuum, enable us to enter strategic business partnerships with multi-state hospital systems and communities, differentiating us from local and regional competitors. In addition, we believe that our track record of consistently meeting or exceeding our customers' service expectations allows us to continue to compete effectively in the bidding process for new contracts. Given our market positions and the highly fragmented markets in which we provide our services, we believe there continue to be significant opportunities to grow market share by obtaining new contracts and through targeted acquisitions.

***Strong and Consistent Revenue Growth from Diversified Sources.*** We have a history of delivering strong revenue growth through a combination of new contracts, same-contract revenue growth and acquisitions. We believe that our significant new contract revenue growth has been driven by our differentiated service offerings and ability to deliver efficient, high-quality care. Further, new contract growth has been accelerating since 2011 as a result of our integrated service offerings and the success of each of EmCare and AMR in cross-selling services to their respective customers. Our new contract pipeline remains robust across each of our businesses. In 2013, 61% of EmCare new contracts were signed with facilities not previously utilizing its services. We believe that same-contract revenue growth is supported by consistent underlying market volume trends and stable pricing due to the emergency nature of many of our services. Market volumes have been driven primarily by the non-discretionary nature of our services, aging demographics and primary care physician shortages that drive additional patients to emergency rooms. Furthermore, we expect that the PPACA will increase patient volumes and provide reimbursement opportunities with respect to previously uninsured patients. To supplement our same-contract and new contract organic growth, we have a proven track record of executing strategic acquisitions to expand our service lines and market presence.

***Differentiated Service Model Well-Positioned for Growth.*** We provide a broad set of clinically-based solutions designed to enable healthcare providers, hospital systems, communities and payors to realize economic and clinical benefits. EmCare is differentiated by providing integrated physician and clinician resource management across multiple service lines, utilizing comprehensive evidence-based clinical protocols and employing a data-driven process to more effectively recruit and retain physicians. AMR is differentiated by its clinical expertise, logistics management, dispatch and communication center expertise and disaster response on a local and national level. Evolution Health, which draws upon the competencies of EmCare and AMR, partners with payors, hospitals and hospitalist physicians to

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provide physician-led coordinated care teams in multiple settings. The quality and cost-effectiveness of care delivered by these care teams is enhanced by our medical command center for remote tele-medicine, our community-based paramedics for in-home patient monitoring and our transportation services for transferring patients between medical settings. Through the coordination of care among our service lines, we believe that we can deliver a differentiated offering of comprehensive care solutions across the patient continuum.

***Ability to Attract and Retain High-Quality Physicians and Other Clinicians.*** Through our differentiated recruiting databases and processes, we are able to identify and target high-quality clinicians, many with a local market connection, to optimally match the needs of our facility-based and community-based customers. We offer physicians and other clinicians substantial flexibility in terms of geographic location, scheduling work hours, benefit packages and opportunities for career development. We also offer clinicians the ability to provide care across the patient continuum, including in pre-hospital, hospital and post-hospital environments. We believe that our national presence and operating infrastructure enable us to provide attractive opportunities for our clinicians to enhance their skills through extensive clinical and leadership development programs. At EmCare, we have established what we believe is a highly effective medical director leadership development program. At AMR, we believe we have developed the largest paramedic and emergency medical technician training program in the country. We believe that our differentiated recruiting, training and development programs strengthen our customer and provider relationships, enhance our strong contract and clinician retention rates and allow us to efficiently recruit clinicians to support our robust new contract pipeline across each of our businesses.

***Significant Recurring Revenue with Strong and Stable Cash Flow.*** We believe that our business model and the contractual nature of our businesses drive a meaningful amount of recurring revenue. We believe that our ability to consistently deliver high levels of customer service to improve our customers' key metrics is illustrated by our long-term customer relationships. The ten largest customers at EmCare and AMR have an average tenure of 12.5 and 32 years, respectively. During 2013, approximately 89% of our net revenue was generated under exclusive contracts that historically have yielded high retention rates. We believe that our recurring revenue, when combined with our attractive operating margins and relatively low capital expenditure and working capital requirements, has resulted in strong and predictable cash flows. We believe that our geographic, customer, facility and service line diversification further supports the stability of our business model and cash flows.

***Efficient Cost Structure and Disciplined Approach to Sustainable Growth.*** We have a strong track record of achieving profitable growth, increasing operating margins and identifying cost reduction opportunities. From 2008 to 2013, our revenue grew at a compound annual growth rate ("CAGR") of 9.1%. Over the same time period, our Adjusted EBITDA CAGR was 12.5%, with Adjusted EBITDA margins increasing 171 basis points, which we believe was driven primarily by our disciplined approach to obtaining new business as well as continued efficiency and productivity improvements. We have improved our AMR operations by investing in enhanced deployment technology and processes, re-aligning our support costs and exiting certain underperforming contracts, resulting in improved operating margins. At EmCare, we have implemented initiatives to improve physician productivity, including more efficient scheduling around peak and off-peak hours, use of mid-level providers and re-aligning physician compensation programs, each of which resulted in improved hospital metrics. We believe there are significant additional opportunities to improve productivity and reduce operating costs.

***Scalable Technologies and Systems.*** As the healthcare industry evolves towards value-based care, we believe that our technology investments and underlying technology infrastructure will facilitate improved productivity and patient outcomes. Our recent proprietary technology investments include: (i) real-time patient reporting systems at EmCare to enhance tracking of key patient metrics and

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improve information flow to our hospital customers, (ii) ePCR at AMR to enhance clinical data collection and improve billing system automation and (iii) innovative medical command center at Evolution Health, which provides for clinical intervention with patients through remote access to physicians and other clinicians and tele-medicine solutions. We believe that our existing technology infrastructure and continued technology investments will enhance our value proposition and further differentiate us from our competitors.

***Strong and Experienced Management Team with Demonstrated Track Record of Performance.*** We have a strong and innovative senior management team who established a track record of success while working together at our company for more than a decade. We are led by William Sanger, our Chief Executive Officer, who has 38 years of industry experience. Randel Owen, our Executive Vice President, Chief Operating Officer and Chief Financial Officer, has 31 years of industry experience. Todd Zimmerman, EmCare's Chief Executive Officer and one of our Executive Vice Presidents, has 23 years of industry experience. Edward Van Horne, the President of AMR, has 24 years of industry experience. Our management team has recently implemented a number of value-enhancing initiatives which have resulted in strong organic revenue growth and improved operating margins.

**Business Strategy**

We intend to enhance our leading market positions by implementing the following key elements of our business strategy:

***Capitalize on Organic Growth Opportunities.*** Our scale and scope, leading market positions and long operating history combined with our value-enhancing initiatives since 2011, provide us with competitive advantages to continue to grow our business. We intend to gain market share from local, regional and national competitors as well as through continued outsourcing of clinical services by healthcare facilities, communities and payors. We believe that EmCare is well-positioned to continue to generate significant organic growth due to its integrated service offerings, differentiated, data-driven processes to recruit and retain physicians, scalable technology and sophisticated risk management programs. We believe these factors have driven EmCare's strong track record in obtaining new contracts and retaining existing customers. At AMR, we believe market share gains will be driven by our strong clinical expertise, high-quality service, strong brand recognition and advanced information technology capabilities. In particular, our proprietary clinical database of patient transports, including detailed tracking of mortality rates and resuscitation metrics, provides analytical support to AMR's differentiated clinical results and has been a key factor in obtaining new contracts. We anticipate driving significant organic growth in Evolution Health by adding new contracts to meet the demand for physician-led care management solutions outside the hospital.

***Grow Complementary and Integrated Service Lines.*** Our continued focus on cross-selling and offering integrated services across the patient continuum has helped hospital systems, communities and payors to realize economic benefits and clinical value for patients. We continue to enter complementary service lines at both EmCare and AMR that are designed to leverage our core competencies. At EmCare, we continue to expand and integrate our ED, anesthesiology, hospitalist, post-hospital, radiology, tele-radiology and surgery services. Our ability to cross-sell EmCare services is enhanced by our national and regional contracts that provide preferred access to certain healthcare facilities throughout the United States. In addition, our Complete Care package, which is an integrated offering of ED and hospitalist services in primarily rural communities, has been one of our most successful recent initiatives at adding new customers. These factors, among others, have increased the percentage of healthcare facilities utilizing multiple EmCare service lines from 11% in 2009 to 22% in 2013. At AMR, we have expanded service lines, such as our managed transportation operations, fixed-wing air transportation services and community paramedic programs, with both new and existing customers. We

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expect Evolution Health to be a catalyst for cross-selling our services across all of our businesses and not just within a particular segment or service line.

**Supplement Organic Growth with Selective Acquisitions.** The markets in which we compete are highly fragmented, with only a few national providers. We believe we have a successful track record of completing and integrating selective acquisitions in both our EmCare and AMR segments that have enhanced our presence in existing markets, facilitated our entry into new geographies and expanded the scope of our services. For the five-year period from 2007 through 2011, we successfully completed and integrated 24 acquisitions that were funded primarily through operating cash flows. In 2012 and 2013, we acquired five companies in each year for total consideration of more than \$190 million and \$34 million, respectively. We combined two of these acquired entities in 2012 to create our Evolution Health business. We believe there are substantial opportunities for additional acquisitions across our businesses. We will continue to follow a disciplined strategy in exploring future acquisitions by analyzing the strategic rationale, financial impact and organic growth profile of each potential opportunity.

**Enhance Operational Efficiencies and Productivity.** We believe there continue to be significant opportunities to build upon our success in improving our productivity and profitability. At AMR, we expect to benefit from additional investments in technology aimed at improving deployment of our resources. We also expect to benefit from enhancing our ePCR billing and clinical data collection capabilities. In addition, we believe there are opportunities in areas such as optimization of field operations and fleet management. At EmCare, we continue to focus on initiatives to improve productivity. These include more efficient scheduling, continued use of mid-level providers, enhancing our leadership training programs and improving and re-aligning compensation programs. Furthermore, in both segments, we will continue to utilize risk mitigation programs for loss prevention and early intervention including continued use of clinical "fail-safes" and technology and equipment in ambulances to reduce vehicular incidents and lifting injuries. We believe that our significant investments in scalable technology systems will facilitate additional cost reductions and efficiencies. Opportunities include improved efficiencies in the deployment of our ambulance resources, enhancing our risk-mitigation program, improving billing/collection cycle times and reducing costs with the implementation of electronic medical record systems at our client facilities.

**Expand our Evolution Health Business.** We believe that our strong market positions in integrated facility-based physician services and community-based medical transportation services uniquely position us to provide physician-led care management solutions outside the hospital. We offer an attractive value proposition through our business model which helps payors reduce their cost of care, promote the most appropriate care in the most appropriate setting, identify member health risks, enable self-care and independence at home, and reduce hospital lengths of stay and readmissions. For hospitals, we believe our business model can improve patient flow coordination, decrease lengths of stay and reduce readmission rates. We are implementing our strategy by first utilizing analytics to identify eligible patients and then employing multiple techniques and physician-led services to manage the quality and cost of patient care, including transitional care teams, direct patient care and care coordination by clinicians outside the acute-care setting, tele-monitoring and tele-medicine.

**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.

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***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 2013, we received approximately 22% of our net revenue from Medicare and 5% from Medicaid. To participate in these programs, we must comply with stringent and often complex enrollment and reimbursement requirements from the federal and state governments. We are subject to governmental reviews and audits of our bills and claims for reimbursement. Retroactive adjustments to amounts previously reimbursed from these programs can and do occur on a regular basis as a result of these reviews and audits. In addition, these programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, all of which may materially increase or decrease the payments we receive for our services as well as affect the cost of providing services. In recent years, Congress has consistently attempted to curb federal spending on such programs.

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

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

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

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

Due to the nature of our business and our participation in the Medicare and Medicaid reimbursement programs, we are involved from time to time in regulatory reviews, audits or investigations by government agencies of matters such as compliance with billing regulations and rules. We may be required to repay these agencies if a 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.

We establish an allowance for discounts applicable to Medicare, Medicaid and other third party payors and for doubtful accounts, or uncompensated care, based on credit risk applicable to certain types of payors, historical trends, and other relevant information. We review our allowance for doubtful accounts, or uncompensated care, 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 rate increases to specific payors, cost reductions, increased volume, the introduction of additional procedures or otherwise.

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**Medicare Physician Fee Schedule.** Medicare pays for all physician services based upon the Physician Fee Schedule which contains a list of uniform rates. The payment rates under the Physician Fee Schedule are determined based on (i) national uniform relative value units for the services provided, (ii) a geographic adjustment factor and (iii) a conversion factor. Payment rates under the Physician 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 Sustainable Growth Rate ("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 Physician Fee Schedule which required Congress to take legislative action to reverse the scheduled payment cuts. For 2012, the Center for Medicaid and Medicare Services ("CMS") projected a rate reduction of 27.4% under the statutory formula. The American Taxpayer Relief Act, enacted January 2, 2013 postponed the reductions through December 31, 2013, which was extended until March 31, 2014 under the Continuing Appropriations Resolution 2014 (Public Law 113-67). Congress has been working in the first quarter of 2014 to pass a bill that permanently repeals and replaces the SGR formula, as well as a permanent extension to the work floor for rural and small hospitals. Medicare reimbursement to physicians could be reduced approximately 25% after March 31, 2014 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 directly receive Medicare payments related to the services of independent contractor physicians. However, the Medicare Modernization Act amended the Medicare reassignment statute as of December 8, 2003 and now permits our independent contractor physicians to reassign their Medicare receivables to us under certain circumstances. In 2004, CMS promulgated regulations implementing this statutory change. The regulations impose two additional program integrity safeguard requirements on reassignments made under the independent contractor exception. These require that both the entity receiving payment and the physician be jointly and severally responsible for any Medicare overpayment to that entity, and the physician have unrestricted access to claims submitted by an entity for services provided by the physician. We have taken steps to ensure all reassignments by independent contractor physicians comply with these regulatory requirements.

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

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

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

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

***Physician Certification Statements.*** Under applicable Medicare rules, ambulance providers are required to obtain a certification of medical necessity from the ordering physician in order to bill

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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 CMS, issued the Ambulance Fee Schedule that revised Medicare policy on the coverage of ambulance transport services, effective April 1, 2002. The Ambulance Fee Schedule 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 Ambulance Fee Schedule categorizes seven levels of ground ambulance services, ranging from BLS 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 for inflation. 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 Ambulance Fee Schedule 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.

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 ("Medicare Modernization Act") made temporary modifications to the amounts payable under the Ambulance Fee Schedule in order to mitigate decreases in reimbursement in some regions caused by the Ambulance Fee Schedule. 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 exceeded the national Ambulance Fee Schedule, the regional fee schedule was blended with the national Ambulance 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. As partial relief, 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 in rates which was in effect through December 31, 2009 and was subsequently

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extended to December 31, 2013 pursuant to legislative enactments, including, most recently, The American Taxpayer Relief Act, enacted January 2, 2013, and further extended until March 31, 2014 under the Continuing Appropriations Resolution 2014 (Public Law 113-67). We have been able to substantially mitigate the phase-in reductions of the BBA through additional fee and subsidy increases.

We estimate that the impact of the ambulance service rate decreases under the national fee schedule mandated under the BBA, as modified by the phase-in provisions of the Medicare Modernization Act, resulted in a decrease in AMR's net revenue of approximately \$18 million in 2010, an increase of less than \$1 million in 2011, and an increase of \$6 million in 2012. In 2013, we expected an increase of approximately \$3 million from the provisions outlined above, but the sequestration cuts implemented on April 1, 2013 offset the increase resulting in a reduction of approximately \$2 million for the full year 2013. 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 ("COB"). The rules governing COB are complex, particularly when one of the payors is Medicare or another government program. Under these rules, in some cases Medicare or other government payors can be billed as a "secondary payor" only after recourse to a primary payor (e.g., a liability insurer) has been exhausted. In some instances, multiple payors may reimburse us an amount which, in the aggregate, exceeds the amount to which we are entitled. In such cases, we are obligated to process a refund. If we improperly bill Medicare or other government payors as the primary payor when that program should be billed as the secondary payor, or if we fail to process a refund when required, we may be subject to civil or criminal penalties. Although we believe we currently have procedures in place to assure that we comply with applicable COB rules, and that we process refunds when we receive overpayments, we cannot assure you that payors or enforcement agencies will not find that we have violated these requirements.

**Consequences of Non-compliance.** 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.

**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

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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, statutory provisions were added which allow improper retention of an overpayment for 60 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. The PPACA includes a provision codifying this view as to the Anti-Kickback Statute by stating 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 Act.

***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, (i) the referral of a person covered by Medicare, Medicaid or other governmental programs, (ii) the furnishing or arranging for the furnishing of items or services reimbursable under Medicare, Medicaid or other governmental programs or (iii) 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. As part of the PPACA, Congress amended the intent requirement of the federal anti-kickback and criminal healthcare 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 programs as well as civil and criminal penalties, including fines of \$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 ("HIPAA") 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 SNFs, patient co-payment responsibilities, compensation methodologies under a management services arrangement, and ambulance restocking

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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 the U.S. Department of Health and Human Services ("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 (i) transports for which the facility must pay the ambulance company and (ii) 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 DOJ and a Corporate Integrity Agreement ("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. The term of that CIA has expired, we have filed a final report, and this CIA was released in February 2012.

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

***Fee-Splitting; Corporate Practice of Medicine***

EmCare employs or contracts with physicians or physician-owned professional corporations to deliver services to our hospital customers and their patients. We frequently enter into management services contracts with these physicians and professional corporations pursuant to which we provide them with billing, scheduling and a wide range of other services, and they pay us for those services out of the fees they collect from patients and third party payors. These activities are subject to various state laws that prohibit the practice of medicine by 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 the 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

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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 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***

Among other directives, the Administrative Simplification Provisions of HIPAA required the federal 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 certain individually identifiable personal health information ("PHI") by "HIPAA covered entities", which include entities like AMR and EmCare.

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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 PHI 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 American Recovery and Reinvestment Act, enacted on February 18, 2009, included the Health Information Technology for Economic and Clinical Health Act ("HITECH"), which modified the HIPAA legislation significantly. Pursuant to HITECH, certain provisions of the HIPAA privacy and security regulations become directly applicable to "HIPAA business associates", which include EmCare when we are working on behalf of our affiliated medical groups. A final rule implementing HITECH was published in the Federal Register on January 25, 2013. That rule, which has been enforced by HHS since September 23, 2013, enhances the protection of PHI and steps up penalties for violations of HIPAA.

Violations of the HIPAA privacy and security standards, as amended by HITECH, may result in civil and criminal penalties. The civil penalties range from \$100 to \$50,000 per violation, with a cap of \$1.5 million per year for violations of the same standard during the same calendar year. However, a single breach incident can result in violations of multiple standards. We must also comply with the "breach notification" regulations, which implement certain provisions of HITECH. Under these regulations, in addition to reasonable remediation, covered entities must promptly notify affected individuals in the case of a breach of "unsecured PHI" as defined by HHS guidance, which may compromise the privacy, security or integrity of the PHI. In addition, notification must be provided to the HHS Secretary and the media in cases where a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals must be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches by the business associate.

Under HITECH, State Attorneys General now have the right to prosecute HIPAA violations committed against residents of their states. In addition, HITECH mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities and their business associates. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the Civil Monetary Penalty fine paid by the violator. In light of HITECH, we expect increased federal and state HIPAA privacy and security enforcement efforts.

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.

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. On January 16, 2009, HHS released the final rule mandating that everyone covered by HIPAA must implement International Classification of Diseases, 10<sup>th</sup> Edition ("ICD-10") for medical coding on October 1, 2013. In the final rule released August 24, 2012, CMS delayed ICD-10 compliance for one year, moving the date from October 1, 2013 to October 1, 2014. We believe we have complied with these mandates.

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***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 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. See "Risk Factors Risks 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 EDs and others to assess and stabilize any patient presenting to the hospital's EDs or urgent care center requesting care

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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.

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: (i) business ethics, (ii) compliance with applicable federal, state and local laws, and (iii) business conduct. We have an Ethics and Compliance Department whose focus is to prevent, detect and mitigate regulatory risks. We attempt to accomplish this mission through:

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

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

resolving regulatory matters, and

enhancing the ethical culture and leadership of the organization.

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

formal policies and written procedures,

designation of a Compliance Officer,

education and training programs,

internal monitoring and reviews,

responding appropriately to detected misconduct,

open lines of communication, and

discipline and accountability.

In addition, our Board of Directors reviews our corporate compliance program on an annual basis. The Board of Directors made a determination that the program was effective for 2013.

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 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 U.S. 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 were and 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 have completed our obligations under that CIA, including our final report, and this CIA was released in February 2012. 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 (i) a compliance officer and committee, (ii) written standards including a code of conduct and policies and procedures, (iii) general and specific training and education, (iv) claims review by an independent review organization,

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(v) disclosure program for reporting of compliance issues or questions, (vi) screening and removal processes for ineligible persons, (vii) notification of government investigations or legal proceedings, (viii) establishment of safeguards applicable to our contracting processes and (ix) reporting of overpayments and other "reportable events". In May 2013, we entered into an agreement to divest substantially all of the assets underlying AMR's services in New York, although the obligations of our compliance program will remain in effect for ongoing AMR operations following the expected divestiture. The divestiture was completed on July 1, 2013.

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

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

**Additional Information**

Our principal executive offices are located at 6200 S. Syracuse Way, Suite 200, Greenwood Village, CO 80111, and our general telephone number at that address is (303) 495-1200. We were incorporated in February 2011 in the State of Delaware. The Company files electronically with the SEC required reports on Form 8-K, Form 10-Q and Form 10-K; proxy materials; ownership reports for insiders as required by Section 16 of the Securities Exchange Act of 1934; registration statements and other forms or reports as required. Certain of the Company's officers and directors also file statements of changes in beneficial ownership on Form 4 with the Securities and Exchange Commission ("SEC"). The public may read and copy any materials that the Company has filed with the SEC at the SEC's Public Reference Room located at 100 F Street, NE, Washington, D.C. 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 800-SEC-0330. Such materials may also be accessed electronically on the SEC's Internet site ([www.sec.gov](http://www.sec.gov)). We maintain an Internet website at <http://www.evhc.net> and make available free of charge on or through our website our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, Section 16 reports and any amendments to these reports in the Investor Relations section of our website as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC.

Copies of our key corporate governance documents, code of ethics, and charters of our audit, compensation, compliance, and corporate governance and nominating committees are also available on our website [www.evhc.net](http://www.evhc.net) under the headings "Corporate Governance" and "Code of Business Conduct and Ethics."

Our website address is provided as an inactive textual reference. The contents of our website are not incorporated by reference herein or otherwise a part of this Annual Report.

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### **Executive Officers of the Registrants**

Set forth below are the name, age, position and description of the business experience of our executive officers. The respective age of each individual in the table below is as of December 31, 2013.

| <b>Name</b>              | <b>Age</b> | <b>Title(s)</b>                                                                         |
|--------------------------|------------|-----------------------------------------------------------------------------------------|
| William A. Sanger        | 63         | Director, President and Chief Executive Officer                                         |
| Randel G. Owen           | 54         | Director, Executive Vice President, Chief Operating Officer and Chief Financial Officer |
| Todd G. Zimmerman        | 48         | President and Chief Executive Officer of EmCare and Executive Vice President            |
| Edward Van Horne         | 44         | President of AMR                                                                        |
| Dighton C. Packard, M.D. | 65         | Chief Medical Officer                                                                   |
| Steve G. Murphy          | 59         | Senior Vice President of Government and National Services                               |
| Kimberly Norman          | 48         | Senior Vice President of Human Resources                                                |
| Steve W. Ratton, Jr.     | 52         | Executive Vice President, Chief Strategy Officer and Treasurer                          |
| Nicholas A. Poan         | 35         | Senior Vice President, Chief Accounting Officer and Controller                          |
| Craig A. Wilson          | 45         | Senior Vice President, General Counsel and Secretary                                    |

*William A. Sanger* has been a director, the President and the Chief Executive Officer of Holding since May 2011. In addition, he has been the Chief Executive Officer of Corporation and its predecessor since February 2005, and the President of Corporation 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, and 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 M.B.A. from the Kellogg School of Management at Northwestern University.

*Randel G. Owen* has been a director since August 2011, the Chief Financial Officer and Executive Vice President since May 2011 and the Chief Operating Officer since September 2012, all of Holding. He has served as Chief Financial Officer since February 2005 and as Executive Vice President since December 2005 of Corporation and its predecessor. In addition, 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 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 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 Executive Vice President of Holding since May 2011 and of Corporation and its predecessor since December 2005, the President of EmCare since April 2010 and the Chief Executive Officer of EmCare since February 2013. Prior to this role, he served as General Counsel of Corporation and its predecessor from February 2005 through March 2010. Mr. Zimmerman was appointed General Counsel and Executive Vice President of EmCare in July 2002 and of AMR in

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May 2004. Mr. Zimmerman joined EmCare in October 1997 in connection with EmCare's acquisition of Spectrum Emergency Care, Inc., an ED 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.

*Edward Van Horne* has been President of AMR since June 2013. Prior to his current position, he served as the Chief Executive Officer for AMR's South Region from January 2007 to June 2013, encompassing the southern and southeastern United States. Mr. Van Horne also served in management positions with AMR as a market General Manager and Vice President of Business Development from November 2002 through December 2006. Mr. Van Horne holds a B.S. from Rochester Institute of Technology and an M.B.A. from the University of Phoenix and started his career in ambulance services in 1990.

*Dighton C. Packard, M.D.* has been Chief Medical Officer of Holding since May 2011, of Corporation and its predecessor since April 2005 and of EmCare since 1990. 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. 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.

*Steve G. Murphy* has been Senior Vice President of Government and National Services of Holding since May 2011, of Corporation and its predecessor since December 2005 and of 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 EMS 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* has been Senior Vice President of Human Resources of Holding since May 2011 and of Corporation and its predecessor since December 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.

*Steve W. Ratton, Jr.* has been Executive Vice President and Chief Strategy Officer of Holding since June 2013. He has also been Treasurer of Holding since May 2011 and of Corporation and its predecessor since February 2005. He previously served as the Senior Vice President of Mergers and Acquisitions of Holding from May 2011 to June 2013 and of Corporation and its predecessor from December 2005 to June 2013. 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.

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*Nicholas A. Poan* was appointed as Senior Vice President, Chief Accounting Officer and Controller of both Holding and Corporation in November 2013. Previously, he was at Alliance Healthcare Services, a diagnostic imaging and cancer treatment company, for 10 years and served as both Senior Vice President Corporate Finance and Chief Accounting Officer. Mr. Poan has a B.S. degree from Chapman University in Accounting.

*Craig A. Wilson* has been Senior Vice President, General Counsel and Secretary of Holding since May 2011. He has also served as General Counsel of Corporation since April 2010 and Secretary of Corporation since August 2011. Mr. Wilson previously served as Assistant Secretary from April 2010 to August 2011 and Corporate Counsel of Corporation and its predecessor 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.

**ITEM 1A. RISK FACTORS**

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

**Risks Related to Our Business**

*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 84% of our net revenue for the year ended December 31, 2013, 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 "Risks Related to Healthcare Regulation Changes in the rates or methods of third party reimbursements, including due to political discord in the budgeting process outside our control, may adversely affect our revenue and operations".

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 EDs to treat all patients presenting to the ED 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 EDs because they frequently do not have a primary care physician with whom to consult.

*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 patient encounters and fees for services we provide under existing contracts, the addition of new contracts and the increase in the number of emergency and non-emergency transports. Substantially all of our net revenue in the year ended December 31, 2013 was generated under contracts, including exclusive contracts that accounted for approximately 89% of our 2013 net revenue. Our contracts with hospitals generally have terms of three years and the term of our contracts with communities to provide

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"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 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. Starting new contracts in a number of our service lines may also negatively impact cash flow as we absorb various expenses before we are able to bill and collect revenue associated with the new contracts. 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.

***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. 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 in part on our ability to recruit and retain physicians and other 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

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physicians and professional corporations from competing with us, potentially resulting in the loss of some of our hospital contracts.

***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 includes several initiatives, including capitalizing on organic growth opportunities, growing complementary and integrated services lines, pursuing selective acquisitions, enhancing operational efficiencies and productivity, and expanding our Evolution Health business. 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, profitability, and ability to service our debt will 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.

***Our margins may be negatively impacted by cross-selling to existing customers or selling bundled services to new customers.***

One of our growth strategies involves the continuation and expansion of our efforts to sell complementary services across our businesses. There can be no assurance that we will be successful in our cross-selling efforts. As part of our cross-selling efforts, we may need to offer a bundled package of services that are at a lower price point to existing or new customers as compared to the price of individual services or otherwise offer services which may put downward price pressure on our services. Such price pressure may have a negative impact on our operating margins. In addition, if a complementary service offered as part of a bundled package underperforms as compared to the other services included in such package, we could face reputational harm which could negatively impact our relationships with our customers and ultimately our results of operations.

***We may not succeed in our efforts to develop our Evolution Health business, which is subject to additional rules, prohibitions, regulations and reimbursement requirements that differ from our facility-based physician and medical transportation services.***

We have only recently expanded our EmCare physician-led services outside the hospital through the formation of Evolution Health. Currently, Evolution Health accounts for less than 5% of our consolidated net revenue and provides services in only four states. A key component of our growth strategy is to continue to expand our Evolution Health business by adding new customers and entering new geographic markets. As part of this strategy, we intend to expand the non-hospital care services we provide through Evolution Health to hospital systems, transitional care programs, accountable care organizations and health plans. This anticipated expansion will expose us to additional risks, in part because our Evolution Health business requires compliance with additional federal and state laws and regulations, including those that govern licensure, enrollment, documentation, prescribing, coding, and scope of practice, which may differ from the laws and regulations that govern our other businesses. For example, we utilize nurses and other allied health personnel in providing care to patients outside the acute-care setting. It is necessary for us to make sure that these personnel only provide services within the scope of their license. Compliance with applicable laws and regulations may result in unanticipated expenses. In addition, if we are unable to comply with the additional legal requirements, we could incur

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liability which could materially and adversely affect our business, financial condition or results of operations.

The implementation of the PPACA is not complete, and is subject to various uncertainties that could affect our Evolution Health business, including (i) the degree to which the United States moves away from its traditional "fee-for-service" delivery model to an outcome-based delivery model, (ii) the number of additional healthcare consumers currently without means of payment that will ultimately gain access to insurance and (iii) the scope of reimbursement changes to the U.S. healthcare system. As such, there can be no assurance that our expansion efforts in this business will ultimately be successful. In addition, realizing growth opportunities in physician-led care management solutions outside the hospital setting will require significant attention from our management team, and if management is unable to provide such attention, implementation of this strategy could be delayed or hindered and thereby negatively impact our business.

***We may enter into partnerships with payors and other healthcare providers, including risk-based partnerships under the PPACA. If this strategy is not successful, our financial performance could be adversely affected.***

In recent years, we have entered into strategic business partnerships with hospital systems and other large payors to take advantage of commercial opportunities in our facility-based physician services business. For example, EmCare entered into a joint venture agreement with a large hospital system to provide physician services to various healthcare facilities. However, there can be no assurance that our efforts in these areas will continue to be successful. Moreover, joint venture and strategic partnership models expose us to commercial risks that may be different from our other business models, including that the success of the joint venture or partnership is only partially under our operational and legal control and the opportunity cost of not pursuing the specific venture independently or with other partners. In addition, under certain joint venture or strategic partnership arrangements, the hospital system partner has the option to acquire our stake in the venture on a predetermined financial formula, which, if exercised, would lead to the loss of our associated revenue and profits which may not be offset fully by the immediate proceeds of the sale of our stake. Furthermore, joint ventures may raise fraud and abuse issues. For example, the OIG has taken the position that certain contractual joint ventures between a party which makes referrals and a party which receives referrals for a specific type of service may violate the federal Anti-Kickback Statute if one purpose of the arrangement is to encourage referrals.

In addition, we plan to take advantage of various opportunities afforded by the PPACA to enter into risk-based partnerships designed to encourage healthcare providers to assume financial accountability for outcomes and work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Examples of such initiatives include the CMS Bundled Payments for Care Improvement initiative, the Medicare Shared Savings Program and the Independence at Home Demonstration. We view taking advantage of targeted initiatives in the new regulatory environment as an important part of our business strategy in order to develop our integrated service offerings across the patient continuum, further develop our relationships with hospitals, hospital systems and other payors and prepare for the possibility that Medicare may require us to participate in a capitated or value-based payment system for certain of our businesses in the future.

Advancing such initiatives can be time consuming and expensive, and there can be no assurance that our efforts in these areas would ultimately be successful. In addition, if we succeed in our efforts to enter into these risk-based partnerships but fail to deliver quality care at a cost consistent with our expectations, we may be subject to significant financial penalties depending on the program, and an unsuccessful implementation of such initiatives could materially and adversely affect our business, financial condition or results of operations.

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

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 generally procures professional liability insurance coverage for its affiliated medical professionals and professional and corporate entities. Beginning January 1, 2002, insurance coverage has been provided by affiliates of CCC, which then reinsure the entire program, procured primarily by EmCare's wholly owned insurance subsidiary, EMCA. AMR currently has an insurance program which includes a combination of insurance purchased from third parties and large self-insured retentions and/or deductibles for all of its insurance programs subsequent to September 1, 2001. AMR reinsures a portion of these self-insured retentions and/or deductibles through an arrangement with EMCA. Under these insurance programs, we establish reserves, using actuarial estimates, for all losses covered under the policies. Moreover, in the normal course of our business, we are involved in lawsuits, claims, audits and investigations, including those arising out of our billing and marketing practices, employment disputes, contractual claims and other business disputes for which we may have no insurance coverage, and which are not subject to actuarial estimates. The outcome of these matters could have a material effect on our results of operations in the period when we identify the matter, and the ultimate outcome could have a material adverse effect on our financial position, results of operations, or cash flows.

Our liability to pay for EmCare's and certain of AMR's insurance program losses is partially collateralized by funds held through EMCA and letters of credit issued by Corporation 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. If our AMR losses with respect to such claims exceed the collateral held by AMR's insurance providers or the collateral held through EMCA, and the letters of credit issued by Corporation in connection with our self-insurance program or the limits of our insurance policies, we will have to fund such amounts.

***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 ("IRS"), the U.S. 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 Retraining 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 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

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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.

See " Risks Related to Healthcare Regulation".

***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 consolidated financial statements. The long-term portion of insurance reserves was \$175.4 million and \$189.4 million as of December 31, 2013 and 2012, respectively. 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.

***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 on our financial position or performance. Future volatility could, however, negatively impact the insurance collateral balances and result in additional funding requirements.

***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

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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.

*The high level of competition in our segments of the market for 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, National Emergency Services Healthcare Group, and IPC, 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, counties, 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, Falck, 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. In 2011, the California state legislature passed legislation which may make public agencies eligible for additional federal funding for Medicaid ambulance transports. If these additional funds become available, it may provide an option to certain public agencies, including local fire departments, to enter into the ambulance transportation market or provide additional ambulance transports, which could increase competition in the California market. As of December 31, 2013, we are unaware of any public agencies receiving funds from this program.

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***We are required to make capital expenditures, particularly for our medical transportation business, in order to remain compliant and 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 net capital expenditures from purchases and sales of assets totaled \$65.0 million, \$53.0 million, and \$64.6 million in the years ended December 31, 2013, 2012 and 2011, 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 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.

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***We may not be able to adequately protect our intellectual property and other proprietary rights that are material to our business, or to defend successfully against intellectual property infringement claims by third parties.***

Our ability to compete effectively depends in part upon our intellectual property rights, including but not limited to our trademarks and copyrights, and our 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 rights and proprietary technology 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 infringes upon such third party's intellectual property rights. Any intellectual property litigation or claims brought against us, whether or not meritorious, could result in substantial costs and diversion of our resources, and there can be no assurances that favorable final outcomes will be obtained in all cases. The terms of any settlement or judgment may require us to pay substantial amounts to the other party or cease exercising our rights in such intellectual property, including ceasing the use of certain trademarks used by us to distinguish our services from those of others or ceasing the exercise of our rights in copyrightable works. In addition, we may have to seek a license to continue practices found to be in violation of a third party's rights, which may not be available on reasonable terms, or at all. Our business, financial condition or results of operations could be adversely affected as a result.

***A successful challenge by tax authorities to our treatment of certain physicians as independent contractors or the elimination of an existing safe harbor could materially increase our costs relating to these physicians.***

As of December 31, 2013, we contracted with approximately 4,200 physicians and clinical personnel as independent contractors to fulfill our contractual obligations to customers. Because we treat these physicians 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 with respect to them, (iii) provide workers compensation insurance with respect to them (except in states that require us to do so for independent contractors), or (iv) allow them to participate in benefits and retirement programs available to employed physicians. Our contracts with these physicians obligate them to pay these taxes and other costs. Whether these physicians are properly classified as independent contractors generally 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 treatment of them as independent contractors. Under current federal tax law, however, if our treatment of these physicians is 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 would qualify under a "safe harbor" and, consequently, we would be protected from the imposition of taxes. However, if a challenge to our treatment of these physicians as independent contractors by federal or state taxing authorities were successful and these physicians were treated as employees instead of independent contractors, we could be liable for taxes, penalties and interest to the extent that these physicians did not fulfill their contractual obligations to pay those taxes. In addition, there are currently, and have been in the past, proposals made to eliminate the safe harbor, and similar proposals could be made in the future. If such a challenge were successful or if the safe harbor were eliminated, there could be a material increase in our costs relating to these physicians and, therefore, there could be a material adverse effect on our business, financial condition and results of operations.

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

Approximately 44% of AMR employees are represented by 37 active collective bargaining agreements. There are 25 operational locations representing approximately 4,795 employees currently in the process of negotiations or will be subject to negotiation in 2014. In addition, six collective bargaining agreements, representing 600 employees will be subject to negotiations in 2015. 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 past five years of the FEMA contract, our annual revenues from services rendered under this contract have varied by approximately \$44 million. In its present form, the contract generates significant 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.

**Risks 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, overpayment recoupment loss of enrollment status 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.

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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 (i) "coordination of benefits" rules that dictate which payor we must bill first when a patient has potential coverage from multiple payors, (ii) requirements that we obtain the signature of the patient or patient representative, or, in certain cases, alternative documentation, prior to submitting a claim, (iii) requirements that we make repayment within a specified period of time to any payor which pays us more than the amount to which we are entitled, (iv) requirements that we bill a hospital or nursing home, rather than Medicare, for certain ambulance transports provided to Medicare patients of such facilities, (v) "reassignment" rules governing our ability to bill and collect professional fees on behalf of our physicians, (vi) requirements that our electronic claims for payment be submitted using certain standardized transaction codes and formats and (vii) 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, HIPAA, 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.

A number of states have enacted false claims acts that are similar to the federal False Claims Act. Additional states are expected to enact such legislation in the future because Section 6031 of the Deficit Reduction Act of 2005 ("DRA") amended the federal law to encourage these types of changes, along with a corresponding increase in state initiated false claims enforcement efforts. Under the DRA, if a state enacts a false claims act that is at least as stringent as the federal statute and that also meets

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certain other requirements, such state will be eligible to receive a greater share of any monetary recovery obtained pursuant to certain actions brought under such state's false claims act. The OIG, in consultation with the Attorney General of the United States, is responsible for determining if a state's false claims act complies with the statutory requirements. Currently, at least 32 states and the District of Columbia have some form of state false claims act. As of April 2013, the OIG has reviewed 28 of these and determined that four of these satisfy the DRA standards. We anticipate this figure will continue to increase.

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

On January 16, 2009, HHS released the final rule mandating that everyone covered by the Administrative Simplification Provisions of HIPAA, which includes EmCare and AMR, must implement ICD-10 for medical coding on October 1, 2013. ICD-10 codes contain significantly more information than the ICD-9 codes currently used for medical coding and will require covered entities to code with much greater detail and specificity than ICD-9 codes. HHS subsequently postponed the deadline for implementation of ICD-10 codes until October 1, 2014. We may incur additional costs for computer system updates, training, and other resources required to implement these changes.

Other changes to the Medicare program intended to implement Medicare's new "pay for performance" philosophy may require us to make investments to receive maximum Medicare reimbursement for our services. These program revisions may include (but are not necessarily limited to) the Medicare Physician Quality Reporting System (the "PQRS"), formerly known as the Medicare Physician Quality Reporting Initiative, which provides additional Medicare compensation to physicians who implement and report certain quality measures.

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.

***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.***

HIPAA required 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 by covered entities or their business associates. 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.

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HITECH, as implemented by an omnibus final rule published in the Federal Register on January 25, 2013, significantly expands the scope of the privacy and security requirements under HIPAA and increases penalties for violations. Prior to HITECH, 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 HITECH, which now imposes mandatory penalties for certain violations of HIPAA that are due to "willful neglect". Penalties start at \$100 per violation and are not to exceed \$50,000, subject to a cap of \$1.5 million for violations of the same standard in a single calendar year. HITECH 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. In addition, HITECH mandates that the Secretary of HHS conduct periodic compliance audits of a cross-section of HIPAA covered entities or business associates. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the Civil Monetary Penalty fine paid by the violator.

HITECH and implementing regulations enacted by HHS further require that patients be notified of any unauthorized acquisition, access, use, or disclosure of their 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". HITECH and implementing regulations specify that such notifications must be made "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach". If a breach affects 500 patients or more, it must be reported immediately to HHS, which will post the name of the breaching entity on its public web site. Breaches affecting 500 patients or more in the same state or jurisdiction must also 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. These 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.

Many states in which we operate also have state 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 impact of recent healthcare reform legislation and other changes in the healthcare industry and in healthcare spending on us is currently unknown, but may adversely affect our business model, financial condition or results of operations.***

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 PPACA, commonly referred to as "the healthcare reform legislation", which made major changes in how healthcare is delivered and reimbursed, and increased access to health insurance benefits to the uninsured and underinsured population of the United States. The PPACA, among other things, increases the number of individuals with Medicaid and private insurance 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, strengthens enforcement of fraud and abuse laws, and encourages the use of information technology. Many of these changes will not go into effect until 2014, and many require implementing regulations which have not yet been drafted or have been released only as proposed rules.

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The impact of many of these provisions is unknown at this time. For example, the PPACA provides for establishment of an Independent Payment Advisory Board that could recommend changes in payment for physicians under certain circumstances not earlier than January 15, 2014, which HHS generally would be required to implement unless Congress enacts superseding legislation. The PPACA also requires HHS to develop a budget neutral value-based payment modifier that provides for differential payment under the Medicare Physician Fee Schedule (the "Physician Fee Schedule") for physicians or groups of physicians that is linked to quality of care furnished compared to cost. HHS has begun implementing the modifier through the Physician Fee Schedule rulemaking for 2013, by, among other things, specifying the initial performance period and how it will apply the upward and downward modifier for certain physicians and physician groups, beginning January 1, 2015, and all physicians and physician groups starting not later than January 1, 2017. During this rulemaking process, HHS considered whether it should develop a value-based payment modifier option for hospital-based physicians, but ultimately, HHS decided to deal with this issue in future rulemaking. The impact of this payment modifier cannot be determined at this time.

In addition, certain provisions of the PPACA authorize voluntary demonstration projects, which include the development of bundling payments for acute, inpatient hospital services, physician services, and post-acute services for episodes of hospital care. The Medicare Acute Care Episode Demonstration is currently underway at several healthcare system demonstration sites. The impact of these projects on us cannot be determined at this time.

Furthermore, the PPACA may adversely affect payors by increasing their medical cost trends, which could have an effect on the industry and potentially impact our business and revenues as payors seek to offset these increases by reducing costs in other areas, although the extent of this impact is currently unknown.

Following challenges to the constitutionality of certain provisions of the PPACA by a number of states, on June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the individual mandate provisions of the PPACA, but struck down the provisions that would have allowed HHS to penalize states that do not implement Medicaid expansion provisions through the loss of existing federal Medicaid funding. As of February 2014, at least 24 states have implemented or are planning to implement the Medicaid expansion. It is uncertain whether the remaining states will implement the expansion at a later date, or whether any participating states will discontinue the expansion. While the PPACA will increase the likelihood that more people in the United States will have access to health insurance benefits, we cannot quantify or predict with any certainty the likely impact of the PPACA on our business model, financial condition or results of operations.

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

The 2009 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 application 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.

In addition, the PPACA added additional enrollment requirements for Medicare and Medicaid enrollment. Those statutory requirements have been further enhanced through implementing

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regulations and increased enforcement scrutiny. Every enrolled provider must revalidate its enrollment at regular intervals, and must update the Medicare contractors and many state Medicaid programs with significant changes on a timely (and typically very short) basis. If we fail to provide sufficient documentation as required to maintain our enrollment, Medicare could deny continued future enrollment or revoke our enrollment and billing privileges.

***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.

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.

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 routinely take the steps we believe are necessary 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

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to comply with these laws and rules, our financing agreements may prohibit such modifications and require us to obtain the consent of the holders of such debt or require the refinancing of such debt.

***Our relationships with healthcare providers and facilities and our 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 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.

Like other ambulance companies, we have provided discounts to our healthcare facility customers (nursing homes and hospitals) 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 CIA. The term of that CIA has expired, we have filed a final report with the OIG and this CIA was released in February 2012.

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. 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

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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 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. Further, the PPACA amended the Anti-Kickback Statute in a manner which makes it easier for the government to demonstrate intent to violate the statute which is an element of a violation.

In addition to AMR's contracts with healthcare facilities and public agencies, 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.

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.

***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. Our changes in corporate structure and ownership involving changes in our beneficial ownership required us in some instances 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.

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

In the last seven years, we have entered into two settlement agreements with the U.S. 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 U.S. Department of Justice ("DOJ") and a CIA 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 required us to maintain a compliance program which included the training of employees and safeguards involving our contracting process nationwide (including tracking of contractual arrangements in Texas). The term of that CIA has expired, we have filed a final report with the OIG and this CIA was released in February 2012.

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 CIA 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. In May 2013, we entered into an agreement to divest substantially all of the assets underlying AMR's service in New York, although the obligations of our compliance program will remain in effect for ongoing AMR operations following the expected divestiture. The divestiture was completed on July 1, 2013.

In July 2011, AMR received a subpoena from the Civil Division of the U.S. Attorney's Office for the Central District of California ("USAO") seeking certain documents concerning AMR's provision of ambulance services within the City of Riverside, California. The USAO indicated that it, together with the OIG, was 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 conducted a parallel state investigation for possible violations of the California False Claims Act. In December 2012, we were notified that both investigations were concluded and that the agencies had closed the matter. There were no findings made against AMR, and the closure of the matter did not require any payments from AMR.

On August 7, 2012, EmCare received a subpoena from the OIG requesting copies of documents for the period from January 1, 2007 through the present that appears to primarily be focused on EmCare's contracts for services at hospitals that are affiliated with Health Management Associates, Inc. ("HMA"). The Company has been cooperating with the government during its investigation and, as such, continues to gather responsive documents. During the months of December 2013 and January 2014, several lawsuits filed by whistleblowers on behalf of the federal and certain state governments

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against HMA have been unsealed; the Company is a named defendant in two of these lawsuits. Although the federal government intervened in these lawsuits in connection with certain of the allegations against HMA, the federal government has not, at this time, disclosed whether it will intervene in these matters as they relate to the Company. The Company continues to engage in meaningful dialogue with the relevant government representatives and, at this time, the Company is unable to determine the potential impact, if any, that will result from this investigation.

On February 14, 2013, EmCare received a subpoena from the OIG requesting documents and other information relating to EmCare's relationship with Community Health Services, Inc. ("CHS"). The Company intends to cooperate with the government during its investigation and, as such, is in the process of gathering responsive documents, formulating a written response to the subpoena and is seeking to engage in a meaningful dialogue with the relevant government representatives. At this time, we are unable to determine the potential impact, if any, that will result from these investigations.

In November 2013, AMR received a subpoena from the New Hampshire Department of Insurance directed to American Medical Response of Massachusetts, Inc. The subpoena requested documents relating to ambulance services provided to approximately 150 patients residing in the state of New Hampshire who had been involved in motor vehicle accidents and who were ultimately transported by AMR. In addition, the subpoena requested information relating to any agreements for reimbursement between AMR and Progressive Insurance. The Company is cooperating with the Department during its investigation and, as such, is in the process of gathering responsive documents, formulating a response to the subpoena, and is seeking to engage in a meaningful dialogue with the relevant New Hampshire Department of Insurance and Attorney General's Office representatives. At this time, we are unable to determine the potential impact, if any, that will result from this investigation.

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. The PPACA was signed into law in 2010 and is currently in the implementation stages. See "Risks Related to Healthcare Regulation" The impact of recent healthcare reform legislation and other changes in the healthcare industry and in healthcare spending on us is currently unknown, but may adversely affect our business model, financial condition or results of operations". The PPACA 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 additional fundamental changes in the healthcare delivery system.

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

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

***Changes in the rates or methods of third party reimbursements, including due to political discord in the budgeting process outside our control, 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. The PPACA could ultimately result 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 the PPACA, 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. For example, Congress has mandated that the Medicare Payment Advisory Commission, commonly known as "MedPAC", provide it with a report making recommendations regarding certain aspects of the Medicare ambulance fee schedule. MedPAC issued a Report to the Congress on Medicare and the Health Care Delivery System in June 2013. In that report, MedPAC recommended reductions in payment for some types of ambulance services and increases in others. If Congress implements these recommendations it is possible that the resultant changes in the ambulance fee schedule will decrease payments by Medicare for our ambulance services. 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 the ambulance service rate decreases under the national fee schedule mandated under the BBA, as modified by the phase-in provisions of the Medicare Modernization Act, resulted in a decrease in AMR's net revenue of approximately \$18 million in 2010, an increase of less than \$1 million in 2011, and an increase of \$6 million in 2012. In 2013, we expected an increase of approximately \$3 million from the provisions outlined above, but the sequestration cuts implemented on April 1, 2013 offset the increase resulting in a reduction of approximately \$2 million for the full year 2013. 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. Physician payments under the Physician Fee Schedule are updated on an annual basis according to a SGR. Because application of the statutory formula for the update factor would result in a decrease in total physician payments for the past several years, Congress has intervened with interim legislation to prevent the reductions. The Medicare and Medicaid Extenders Act of 2010, which was signed into law on December 15, 2010, froze the 2010 updates through 2011. For 2012, CMS projected a rate reduction of 27.4% from 2011 levels (earlier estimates had projected a 29.5% reduction). The Temporary Payroll Tax Cut Continuation Act of 2011, signed into law on December 23, 2011, froze the 2011 updates through February 29, 2012 and the American Taxpayer Relief Act, enacted January 2, 2013, extended this through December 31, 2013.

On December 26, 2013 the president signed into law the Continuing Appropriations Resolution 2014 (Public Law 113-67), which included a 3-month delay in the SGR 20% cuts, and a small update of

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0.5% in the conversion factor (the dollar amount paid per Relative Value Unit "RVU"). Further, the bill also extended the national floor of 1.0 for the Geographic Practice Cost Index (GPCI). This factor geographically adjusts the "work" portion of each RVU before it is paid, based on the locality labor costs. This "work floor" set at the national average labor rate of 1.0 was set to expire after December 31, 2013. Like the SGR delays, the work floor will expire starting April 1, 2014. Therefore, Congress is working in the first quarter of 2014 to pass a bill that permanently repeals and replaces the SGR formula, as well as a permanent extension to the work floor for rural and small hospitals. However, despite the benefits of the delays in both SGR cuts and the RVU's work floor, the Congressional actions do not avert the scheduled 2% sequestration cuts for Medicare.

The modest update factor of 0.5% does not translate to 2014 payment rates increased uniformly from the 2013 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 lower payments due to a variety of regulatory factors. Each physician service bill codes given weights that measure its costliness relative to other physician services. CMS is required to make periodic assessments regarding the weighting of procedures, impacting the payment amounts. For 2014, CMS published estimates of changes by specialty based on a number of factors. The full impact of these changes on any given practice went into effect at the beginning of 2014. CMS estimated that the impact for 2014 is a 2% increase for emergency medicine, 1% increase in anesthesiology, a 1% increase for internal medicine, and a 2% reduction in radiology. At this time, we cannot predict the impact, if any, these 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.

On August 2, 2011, the Budget Control Act of 2011 (Public Law 112-25) (the "Budget Control Act") was enacted. Under the Budget Control Act, a Joint Select Committee on Deficit Reduction (the "Joint Committee") was established to develop recommendations to reduce the deficit, over 10 years, by \$1.2 to \$1.5 trillion, and was required to report its recommendations to Congress by November 23, 2011. Under the Budget Control Act, Congress was then required to consider the Joint Committee's recommendations by December 23, 2011. If the Joint Committee failed to refer agreed upon legislation to Congress or did not meet the required savings threshold set out in the Budget Control Act, a sequestration process would be put into effect, government-wide, to reduce federal outlays by the proposed amount. Because the Joint Committee failed to report the requisite recommendations for deficit reduction, the sequestration process was set to automatically start, impacting Medicare and certain other government programs beginning in January 2013. Congress passed the American Taxpayer Relief Act, signed into law on January 2, 2013, delaying the start of sequestration until March 1, 2013. In order to provide its contractors and providers sufficient lead time to implement the cuts in Medicare, CMS delayed implementation of the cuts until April 1, 2013. As there has been no further Congressional action with respect to the sequestration, reimbursements were cut by 2% for Medicare providers, including physicians and ambulance providers, starting April 1, 2013, and cuts are scheduled annually through 2021. A subsequent round of budget sequestration cuts took effect in January 2014, further reducing Medicare provider reimbursements by another 2% for 2014. The Continuing Appropriations Resolution 2014 (Public Law 113-67), enacted December 26, 2013, extends the annual budget sequestration cuts to Medicare provider payments for an additional two years through 2023.

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**Risks Related to Our Substantial Indebtedness**

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

We have substantial indebtedness. As of December 31, 2013, we had total indebtedness, including capital leases, of approximately \$1,907.7 million, including, \$607.8 million of Corporation's 8.125% Senior Notes due 2019 ("2019 Notes"), \$1,298.7 million of borrowings under the senior secured term loan facility ("Term Loan Facility"), and approximately \$1.2 million of other long-term indebtedness. In addition, as of December 31, 2013, after giving effect to approximately \$132.5 million of letters of credit issued under the asset-backed revolving credit facility ("ABL Facility"), we are able to borrow approximately \$279.9 million under the ABL Facility. As of December 31, 2013, we also had approximately \$153.2 million in operating lease commitments.

The degree to which we are leveraged may have important consequences for holders of our common stock. 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 purposes;

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.

***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 Company is not subject to any restriction on its ability to incur indebtedness. The terms of the indenture governing the Senior Notes due 2019 ("2019 Notes") and the credit agreements governing the ABL Facility and the Term Loan Facility do not fully prohibit our subsidiaries and our affiliated professional corporations from doing so. If the Company's subsidiaries are in compliance with certain incurrence ratios set forth in the credit agreements governing the ABL Facility and the Term Loan Facility and the indenture governing the 2019 Notes, the Company's subsidiaries may be able to incur substantial additional indebtedness, which may increase the risks created by our current substantial indebtedness. Our affiliated professional corporations are not subject to the covenants governing any of our indebtedness. After giving effect to \$132.5 million of letters of credit issued under the ABL Facility, as of December 31, 2013, we are able to borrow an additional \$279.9 million under the ABL Facility.

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***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.***

The Company and Corporation are each holding companies, and as such they have no independent operations or material assets other than their ownership of equity interests in their respective subsidiaries and our subsidiaries' contractual arrangements with physicians and professional corporations. The Company and Corporation each depend on their respective subsidiaries to distribute funds to them so that they may pay their obligations and expenses, including satisfying their indebtedness. Our ability to make scheduled payments on, or to refinance our obligations under, our indebtedness and to fund planned capital expenditures and other corporate expenses will depend on the ability of our subsidiaries to make distributions, dividends or advances, 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 us in an amount sufficient to enable it to satisfy our obligations under our indebtedness or to fund our other needs. In order for us to satisfy our obligations under our respective indebtedness and fund our 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 on commercially reasonable terms or at all.

***The indenture governing the 2019 Notes and the credit agreements governing the ABL Facility and the Term Loan Facility restrict the ability of our subsidiaries to engage in some business and financial transactions.***

***Indenture.*** The indenture governing the 2019 Notes contains restrictive covenants that, among other things, limit our ability and the ability of our subsidiaries to:

incur additional indebtedness or issue certain preferred shares;

pay dividends on, redeem or repurchase stock or make other distributions in respect of our capital stock;

make investments;

repurchase, prepay or redeem subordinated indebtedness;

agree to payment restrictions affecting the ability of our restricted subsidiaries to pay dividends to us or make other intercompany transfers;

incur additional liens;

transfer or sell assets;

consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;

enter into certain transactions with our affiliates; and

designate any of our subsidiaries as unrestricted subsidiaries.



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**Senior Secured Credit Facilities.** The credit agreements governing the ABL Facility and the Term Loan Facility (together, the "Senior Secured Credit Facilities") contain a number of covenants that limit our ability and the ability of our restricted subsidiaries to:

incur additional indebtedness or issue certain preferred shares;

pay dividends on, redeem or repurchase stock or make other distributions in respect of our capital stock;

make investments;

repurchase, prepay or redeem junior indebtedness;

agree to payment restrictions affecting the ability of our restricted subsidiaries to pay dividends to us or make other intercompany transfers;

incur additional liens;

transfer or sell assets;

consolidate, merge, sell or otherwise dispose of all or substantially all of our assets;

enter into certain transactions with affiliates;

agree to payment restrictions affecting our restricted subsidiaries;

make negative pledges; and

designate any of our subsidiaries as unrestricted subsidiaries.

The credit agreement governing the ABL Facility also contains other covenants customary for asset-based facilities of this nature. Our ability to borrow additional amounts under the credit agreement governing the ABL Facility 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 governing the 2019 Notes and the credit agreements governing the ABL Facility and the Term Loan Facility 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.

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

Our indebtedness under the ABL Facility bears interest at variable rates and, to the extent the rate for deposits in U.S. dollars in the London interbank market (adjusted for maximum reserves) for the applicable interest period ("LIBOR") exceeds 1.00%, 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 December 31, 2013, assuming all ABL Facility revolving loans were fully drawn and

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LIBOR exceeded 1.00%, each one percentage point increase in interest rates would result in approximately a \$17.5 million increase in annual interest expense on the ABL Facility and the Term Loan Facility. 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.

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***We may be unable to raise funds necessary to finance the change of control repurchase offers required by the indenture governing the 2019 Notes.***

Under the indenture governing the 2019 Notes, upon the occurrence of specific kinds of change of control, Corporation must offer to repurchase the 2019 Notes at a price equal to 101% of the principal amount of the 2019 Notes plus accrued and unpaid interest to the date of purchase. The occurrence of specified events that would constitute a change of control under the indenture governing the 2019 Notes would also constitute a default under the credit agreements governing the ABL Facility and the Term Loan Facility that permits the lenders to accelerate the maturity of borrowings thereunder and would require Corporation to offer to repurchase the 2019 Notes under the indenture governing the 2019 Notes. In addition, the ABL Facility and the Term Loan Facility may limit or prohibit the purchase of the 2019 Notes by us in the event of a change of control, unless and until the indebtedness under the ABL Facility and the Term Loan Facility is repaid in full. As a result, following a change of control event, Corporation may not be able to repurchase the 2019 Notes unless all indebtedness outstanding under the ABL Facility and the Term Loan Facility is first repaid and any other indebtedness that contains similar provisions is repaid, or Corporation may obtain a waiver from the holders of such indebtedness to provide it with sufficient cash to repurchase the 2019 Notes. Any future debt agreements that we enter into may contain similar provisions. We may not be able to obtain such a waiver, in which case Corporation may be unable to repay all indebtedness under the 2019 Notes. We may also require additional financing from third parties to fund any such repurchases, and we may be unable to obtain financing on satisfactory terms or at all. Further, our ability to repurchase the 2019 Notes may be limited by law. In order to avoid the obligations to repurchase the 2019 Notes and events of default and potential breaches of the credit agreements governing the ABL Facility and the Term Loan Facility, we may have to avoid certain change of control transactions that would otherwise be beneficial to us.

**Risks Related to Holding's Common Stock**

***Holding is a holding company with no operations of its own, and it depends on its subsidiaries for cash to fund all of its operations and expenses, including to make future dividend payments, if any.***

Holding's operations are conducted entirely through its subsidiaries and its ability to generate cash to fund all of its operations and expenses, to pay dividends or to meet any debt service obligations is highly dependent on the earnings and the receipt of funds from its subsidiaries via dividends or intercompany loans. We do not currently expect to declare or pay dividends on Holding's common stock for the foreseeable future; however, to the extent that we determine in the future to pay dividends on Holding's common stock, none of its subsidiaries will be obligated to make funds available to us for the payment of dividends. Further, the indenture governing the 2019 Notes and the agreements governing the ABL Facility and the Term Loan Facility significantly restrict the ability of Holding's subsidiaries to pay dividends, make loans or otherwise transfer assets to Holding. In addition, Delaware law may impose requirements that may restrict Holding's ability to pay dividends to holders of its common stock.

***The market price of Holding's common stock may fluctuate significantly.***

The market price of Holding's common stock may fluctuate significantly. Among the factors that could affect Holding's stock price are:

industry or general market conditions;

domestic and international economic factors unrelated to Holding's performance;

changes in Holding's customers' preferences;

new regulatory pronouncements and changes in regulatory guidelines;

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lawsuits, enforcement actions and other claims by third parties or governmental authorities;

actual or anticipated fluctuations in Holding's quarterly operating results;

changes in securities analysts' estimates of Holding's financial performance or lack of research and reports by industry analysts;

action by institutional stockholders or other large stockholders (including the CD&R Affiliates), including future sales;

speculation in the press or investment community;

investor perception of Holding and its industry;

changes in market valuations or earnings of similar companies;

announcements by Holding or its competitors of significant contracts, acquisitions or strategic partnerships;

any future sales of Holding's common stock or other securities; and

additions or departures of key personnel.

The stock markets have experienced extreme volatility in recent years that has been unrelated to the operating performance of particular companies. These broad market fluctuations may adversely affect the market price of Holding's common stock. In the past, following periods of volatility in the market price of a company's securities, class action litigation has often been instituted against such company. Any litigation of this type brought against Holding could result in substantial costs and a diversion of management's attention and resources, which would harm Holding's business, operating results and financial condition.

***Future sales of shares by existing stockholders could cause Holding's stock price to decline.***

Sales of substantial amounts of Holding's common stock in the public market, or the perception that these sales could occur, could cause the market price of Holding's common stock to decline. As of March 1, 2014, we had 181,131,273 outstanding shares of common stock. Of these shares, all of the 79,925,000 shares of common stock sold in Holding's initial public offering and in the February 2014 secondary offering by certain of Holding's stockholders, including the CD&R Affiliates, are freely transferable without restriction or further registration under the Securities Act of 1933, as amended (the "Securities Act"), unless purchased by Holding's "affiliates" as that term is defined in Rule 144 under the Securities Act. The remaining shares of Holding's common stock outstanding as of March 1, 2014 are restricted securities within the meaning of Rule 144 under the Securities Act, but are eligible for resale subject to applicable volume, means of sale, holding period and other limitations of Rule 144 under the Securities Act or pursuant to an exception from registration under Rule 701 under the Securities Act, subject to the terms of the lock-up agreements entered into by Holding, the CD&R Affiliates and Holding's executive officers and directors in connection with the February 2014 secondary offering.

In August 2013, we filed a registration statement under the Securities Act to register the shares of common stock to be issued under Holding's equity compensation plans and, as a result, all shares of common stock acquired upon exercise of stock options granted under Holding's plans will also be freely tradable under the Securities Act, subject to the terms of the lock-up agreements, unless purchased by Holding's affiliates. As of December 31, 2013, there were stock options outstanding to purchase a total of 16,322,148 shares of Holding's common stock and there were 79,255 shares of Holding's common stock subject to restricted stock units. In addition, 16,614,307 shares of Holding's common stock are reserved for future issuances under our Omnibus Incentive Plan.



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In connection with the February 2014 secondary offering, Holding, the CD&R Affiliates and our executive officers and directors signed lock-up agreements under which, subject to certain exceptions, they agreed not to sell, transfer or dispose of or hedge, directly or indirectly, any shares of Holding's common stock or any securities convertible into or exercisable or exchangeable for shares of Holding's common stock until May 6, 2014. Following the expiration of this lock-up period, 101,206,273 shares of Holding's common stock will be eligible for future sale, subject to the applicable volume, manner of sale, holding period and other limitations of Rule 144 under the Securities Act.

In the future, we may issue additional shares of common stock or other equity or debt securities convertible into common stock in connection with a financing, acquisition, litigation settlement or employee arrangement or otherwise. Any of these issuances could result in substantial dilution to Holding's existing stockholders and could cause the trading price of Holding's common stock to decline.

***If securities or industry analysts do not publish research or publish misleading or unfavorable research about Holding's business, Holding's stock price and trading volume could decline.***

The trading market for Holding's common stock will depend in part on the research and reports that securities or industry analysts publish about Holding or its business. If one or more analyst downgrades Holding's stock or publishes misleading or unfavorable research about its business, Holding's stock price would likely decline. If one or more of these analysts ceases coverage of Holding or fails to publish reports on us regularly, demand for Holding stock could decrease, which could cause Holding's stock price or trading volume to decline.

***The CD&R Affiliates have significant influence over Holding and may not always exercise their influence in a way that benefits Holding's public stockholders.***

The CD&R Affiliates own approximately 54.2% of the outstanding shares of Holding's common stock. As a result, the CD&R Affiliates will exercise significant influence over all matters requiring stockholder approval for the foreseeable future, including approval of significant corporate transactions, which may reduce the market price of Holding's common stock.

As long as the CD&R Affiliates continue to own at least 50% of our outstanding common stock, the CD&R Affiliates generally will be able to determine the outcome of corporate actions requiring stockholder approval, including the election of the members of Holding's Board of Directors, the approval of significant corporate transactions such as mergers and the sale of substantially all of Holding's assets. Even after the CD&R Affiliates reduce their beneficial ownership below 50% of Holding's outstanding common stock, they will likely still be able to assert significant influence over Holding's Board of Directors and certain corporate actions. The CD&R Affiliates have the right to designate for nomination for election at least a majority of Holding's directors as long as the CD&R Affiliates own at least 50% of Holding's common stock. Because the CD&R Affiliates' interests may differ from your interests, actions the CD&R Affiliates take as Holding's controlling stockholder or as a significant stockholder may not be favorable to you. For example, the concentration of ownership held by the CD&R Affiliates could delay, defer or prevent a change of control of Holding or impede a merger, takeover or other business combination which another stockholder may otherwise view favorably. Other potential conflicts could arise, for example, over matters such as employee retention or recruiting, or Holding's dividend policy.

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***Under Holding's amended and restated certificate of incorporation, the CD&R Affiliates and their respective affiliates and, in some circumstances, any of Holding's directors and officers who are also a director, officer, employee, member or partner of the CD&R Affiliates and their respective affiliates, have no obligation to offer Holding corporate opportunities.***

The policies relating to corporate opportunities and transactions with the CD&R Affiliates set forth in Holding's second amended and restated certificate of incorporation ("amended and restated certificate of incorporation") address potential conflicts of interest between Holding, on the one hand, and the CD&R Affiliates and their respective officers and directors who are directors or officers of Holding, on the other hand. By becoming a stockholder in Holding, you will be deemed to have notice of and have consented to these provisions of our amended and restated certificate of incorporation. Although these provisions are designed to resolve conflicts between us and the CD&R Affiliates and their respective affiliates fairly, conflicts may not be so resolved.

***Future offerings of debt or equity securities, which would rank senior to our common stock, may adversely affect the market price of our common stock.***

If, in the future, we decide to issue debt or equity securities that rank senior to our common stock, it is likely that such securities will be governed by an indenture or other instrument containing covenants restricting our operating flexibility. Additionally, any convertible or exchangeable securities that we issue in the future may have rights, preferences and privileges more favorable than those of our common stock and may result in dilution to owners of our common stock. We and, indirectly, our stockholders, will bear the cost of issuing and servicing such securities. Because our decision to issue debt or equity securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of our future offerings. Thus, holders of our common stock will bear the risk of our future offerings reducing the market price of our common stock and diluting the value of their stock holdings in us.

***Fulfilling our obligations incident to being a public company, including with respect to the requirements of and related rules under the Sarbanes-Oxley Act of 2002, is expensive and time-consuming, and any delays or difficulties in satisfying these obligations could have a material adverse effect on our future results of operations and our stock price.***

Our initial public offering was completed on August 19, 2013. As a new public company, we are subject to the reporting and corporate governance requirements, under the listing standards of the New York Stock Exchange ("NYSE") and the Sarbanes-Oxley Act of 2002, that apply to issuers of listed equity, which impose certain significant compliance costs and obligations upon us. The changes necessitated by being a publicly listed company require a significant commitment of additional resources and management oversight which will increase our operating costs. These changes will also place additional demands on our finance and accounting staff and on our financial accounting and information systems. Other expenses associated with being a public company include increases in auditing, accounting and legal fees and expenses, investor relations expenses, increased directors' fees and director and officer liability insurance costs, registrar and transfer agent fees and listing fees, as well as other expenses. As a public company, we are required, among other things, to define and expand the roles and the duties of our Board of Directors and its committees and institute more comprehensive compliance and investor relations functions.

In particular, beginning with the year ending December 31, 2014 our independent registered public accounting firm will be required to provide an attestation report on the effectiveness of our internal control over financial reporting pursuant to Section 404(b) of the Sarbanes-Oxley Act of 2002. If our independent registered public accounting firm is unable to provide us with an unmodified report regarding the effectiveness of our internal control over financial reporting (at such time as it is required to do so), investors could lose confidence in the reliability of our consolidated financial

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statements. This could result in a decrease in the value of our common stock. Failure to comply with the Sarbanes-Oxley Act of 2002 could potentially subject us to sanctions or investigations by the SEC, the NYSE, or other regulatory authorities.

***We could be the subject of securities class action litigation due to future stock price volatility, which could divert management's attention and adversely affect our results of operations.***

The stock market in general, and market prices for the securities of companies like ours in particular, have from time to time experienced volatility that often has been unrelated to the operating performance of the underlying companies. A certain degree of stock price volatility can be attributed to being a newly public company. These broad market and industry fluctuations may adversely affect the market price of Holding's common stock, regardless of our operating performance. In certain situations in which the market price of a stock has been volatile, holders of that stock have instituted securities class action litigation against the company that issued the stock. If any of Holding's stockholders were to bring a similar lawsuit against Holding, the defense and disposition of the lawsuit could be costly and divert the time and attention of management and harm operating results.

***Anti-takeover provisions in Holding's amended and restated certificate of incorporation and amended and restated by-laws could discourage, delay or prevent a change of control of our company and may affect the trading price of Holding's common stock.***

Holding's amended and restated certificate of incorporation and amended and restated by-laws include a number of provisions that may discourage, delay or prevent a change in our management or control over Holding that stockholders may consider favorable. For example, Holding's amended and restated certificate of incorporation and amended and restated by-laws collectively:

authorize the issuance of "blank check" preferred stock that could be issued by Holding's Board of Directors to thwart a takeover attempt;

provide for a classified Board of Directors, which divides the Board of Directors into three classes, with members of each class serving staggered three-year terms, which prevents stockholders from electing an entirely new Board of Directors at an annual meeting;

limit the ability of stockholders to remove directors if the CD&R Affiliates cease to own at least 50% of the outstanding shares of Holding's common stock;

provide that vacancies on Holding's Board of Directors, including vacancies resulting from an enlargement of the Board of Directors, may be filled only by a majority vote of directors then in office;

prohibit stockholders from calling special meetings of stockholders if the CD&R Affiliates cease to own at least 50% of the outstanding shares of Holding's common stock;

prohibit stockholder action by written consent, thereby requiring all actions to be taken at a meeting of the stockholders, if the CD&R Affiliates cease to own at least 50% of the outstanding shares of Holding's common stock;

establish advance notice requirements for nominations of candidates for election as directors or to bring other business before an annual meeting of our stockholders; and

require the approval of holders of at least 66<sup>2</sup>/<sub>3</sub>% of the outstanding shares of Holding's common stock to amend Holding's amended and restated by-laws and certain provisions of Holding's amended and restated certificate of incorporation if the CD&R Affiliates cease to own at least 50% of the outstanding shares of Holding's common stock.

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These provisions may prevent our stockholders from receiving the benefit from any premium to the market price of Holding's common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of Holding's common stock if the provisions are viewed as discouraging takeover attempts in the future.

Holding's amended and restated certificate of incorporation and amended and restated by-laws may also make it difficult for stockholders to replace or remove management. These provisions may facilitate management entrenchment that may delay, deter, render more difficult or prevent a change in our control, which may not be in the best interests of our stockholders.

***We do not intend to pay dividends on Holding's common stock and, consequently, your ability to achieve a return on your investment will depend on appreciation in the price of Holding's common stock.***

We do not intend to declare and pay dividends on Holding's common stock for the foreseeable future. We currently intend to invest our future earnings, if any, to fund our growth, to develop our business, for working capital needs and for general corporate purposes. Therefore, you are not likely to receive any dividends on your common stock for the foreseeable future and the success of an investment in shares of Holding's common stock will depend upon any future appreciation in their value. There is no guarantee that shares of Holding's common stock will appreciate in value or even maintain the price at which stockholders have purchased their shares. In addition, operations are conducted almost entirely through its subsidiaries. As such, to the extent that we determine in the future to pay dividends on our common stock, none of its subsidiaries will be obligated to make funds available to us for the payment of dividends. Further, the indenture governing the 2019 Notes and the agreements governing the ABL Facility and the Term Loan Facility significantly restrict the ability of subsidiaries to pay dividends or otherwise transfer assets to Holding. In addition, Delaware law may impose requirements that may restrict our ability to pay dividends to holders of Holding's common stock.

***We are a "controlled company" within the meaning of the NYSE rules and, as a result, we qualify for, and currently rely on, exemptions from certain corporate governance requirements. You do not have the same protections afforded to stockholders of companies that are subject to such requirements.***

The CD&R Affiliates control a majority of the voting power of Holding's outstanding common stock. Accordingly, we qualify as a "controlled company" within the meaning of the NYSE corporate governance standards. Under the NYSE rules, a company of which more than 50% of the voting power is held by an individual, group or another company is a "controlled company" and may elect not to comply with certain NYSE corporate governance standards, including:

the requirement that a majority of the Board of Directors consist of independent directors;

the requirement that we have a nominating and corporate governance committee that is composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities;

the requirement that we have a compensation committee that is composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities; and

the requirement for an annual performance evaluation of the nominating and corporate governance and compensation committees.

We currently rely on these exemptions. As a result, we do not have a majority of independent directors, our nominating and corporate governance committee and compensation committee do not consist entirely of independent directors and such committees may not be subject to annual performance

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evaluations. Consequently, you do not have the same protections afforded to stockholders of companies that are subject to all of the NYSE corporate governance rules and requirements. Our status as a controlled company could make our common stock less attractive to some investors or otherwise harm our stock price.

*Holding's amended and restated certificate of incorporation designates the Court of Chancery of the State of Delaware as the exclusive forum for certain litigation that may be initiated by Holding's stockholders, which could limit its stockholders' ability to obtain a favorable judicial forum for disputes with Holding.*

Holding's amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware is the sole and exclusive forum for (i) any derivative action or proceeding brought on Holding's behalf, (ii) any action asserting a claim of breach of a fiduciary duty owed to Holding or its stockholders by any of its directors, officers, employees or agents, (iii) any action asserting a claim against Holding arising under the General Corporation Law of the State of Delaware ("DGCL") or (iv) any action asserting a claim against Holding that is governed by the internal affairs doctrine. The choice of forum provision in Holding's amended and restated certificate of incorporation may limit its stockholders' ability to obtain a favorable judicial forum for disputes with Holding.

**ITEM 1B. UNRESOLVED STAFF COMMENTS**

Not applicable.

**ITEM 2. PROPERTIES**

We lease approximately 73,000 square feet in an office building at 6200 S. Syracuse Way, Greenwood Village, Colorado for Holding, Corporation, EmCare and AMR corporate headquarters and which also serves as one of AMR's billing offices. Our leases for our business segments are described below.

**EmCare**

We lease approximately 144,000 square feet in an office building at 13737 Noel Road, Dallas, Texas, for certain of EmCare's key support functions and regional operations. Our primary lease expires in 2024. We also lease 69 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**

We lease approximately 530 administrative facilities and other facilities used principally for ambulance basing, garaging and maintenance in those areas in which we provide ambulance services. We own 15 facilities used principally for administrative services and stationing for our ambulances. We believe our present facilities are sufficient to meet our current and projected needs and that suitable space is readily available should our need for space increase. Our leases expire at various dates through 2025.

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**ITEM 3. LEGAL PROCEEDINGS**

We are subject to litigation arising in the ordinary course of our business, including litigation principally relating to professional liability, auto accident and workers compensation claims. There can be no assurance that our insurance coverage and self-insured liabilities 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 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 was effective for a period of five years beginning September 12, 2006, and which was released in February 2012.

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 AMR 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 CIA with the OIG in connection with this matter. Under the terms of the settlement, AMR paid \$2.7 million to the federal government. In connection with the settlement, we entered into a CIA for 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 its 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 entered into the settlement in order to avoid the uncertainties of litigation, and have not admitted any wrongdoing. In May 2013, we entered into an agreement to divest substantially all of the assets underlying AMR's services in New York, although the obligations of our compliance program will

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remain in effect for ongoing AMR operations following the expected divestiture. The divestiture was completed on July 1, 2013.

In July 2011, AMR received a subpoena from the Civil Division of the USAO seeking certain documents concerning AMR's provision of ambulance services within the City of Riverside, California. The USAO indicated that it, together with the OIG, was 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 conducted a parallel state investigation for possible violations of the California False Claims Act. In December 2012, we were notified that both investigations were concluded and that the agencies had closed the matter. There were no findings made against AMR, and the closure of the matter did not require any payments from AMR.

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, Laura 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, Aguilar and Karapetian cases have been coordinated in the Superior Court for the State of California, County of Los Angeles, and the Aguilar and Karapetian cases have subsequently been consolidated into a single action. Plaintiffs allege principally that the AMR entities failed to pay overtime wages pursuant to California law, and failed to provide required meal breaks, rest breaks or pay premium compensation for missed breaks. Plaintiffs are seeking to certify the classes and are seeking lost wages, penalties, attorneys' fees and other sanctions permitted under California law for violations of wage hour laws. At the present time, the courts have not certified classes in any of these cases. In a hearing on February 25, 2014 in the Banta and Aguilar/Karapetian cases, the court indicated that it intends to certify classes on some issues, and deny certification on some issues, but is has not signed an order to such effect. We are unable at this time to estimate the amount of potential damages, if any in any of these actions.

On August 7, 2012, EmCare received a subpoena from the OIG. The subpoena requests copies of documents for the period from January 1, 2007 through the present and appears to primarily be focused on EmCare's contracts for services at hospitals that are affiliated with HMA. The Company has been cooperating with the government during its investigation and, as such, continues to gather responsive documents. During the months of December 2013 and January 2014, several lawsuits filed by whistleblowers on behalf of the federal and certain state governments against HMA have been unsealed; the Company is a named defendant in two of these lawsuits. Although the federal government intervened in these lawsuits in connection with certain of the allegations against HMA, the federal government has not, at this time, disclosed whether it will intervene in these matters as they relate to the Company. The Company continues to engage in meaningful dialogue with the relevant government representatives and, at this time, the Company is unable to determine the potential impact, if any, that will result from this investigation.

On February 5, 2013, Air Ambulance Specialists, Inc. received a subpoena from the Federal Aviation Administration relating to its operations as an indirect air carrier and its relationships with Part 135 direct air carriers. We intend to cooperate with the government during its investigation and, as such, are in the process of gathering responsive documents, formulating a written response to the subpoena and seeking to engage in a meaningful dialogue with the relevant government representatives. At this time, we are unable to determine the potential impact, if any, that will result from this investigation.

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On February 14, 2013, EmCare received a subpoena from the OIG requesting documents and other information relating to EmCare's relationship with CHS. The Company intends to cooperate with the government during its investigation and, as such, is in the process of gathering responsive documents, formulating a written response to the subpoena and is seeking to engage in a meaningful dialogue with the relevant government representatives. At this time, we are unable to determine the potential impact, if any, that will result from this investigation.

In November 2013, AMR received a subpoena from the New Hampshire Department of Insurance directed to American Medical Response of Massachusetts, Inc. The subpoena requested documents relating to ambulance services provided to approximately 150 patients residing in the state of New Hampshire who had been involved in motor vehicle accidents and who were ultimately transported by AMR. In addition, the subpoena requested information relating to any agreements for reimbursement between AMR and Progressive Insurance. The Company is cooperating with the Department during its investigation and, as such, is in the process of gathering responsive documents, formulating a response to the subpoena, and is seeking to engage in a meaningful dialogue with the relevant New Hampshire Department of Insurance and Attorney General's Office representatives. At this time, we are unable to determine the potential impact, if any, that will result from this investigation.

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 business, financial condition, cash flows or results of operations.

**ITEM 4. MINE SAFETY DISCLOSURES**

Not applicable.

**PART II.**

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

**Holding**

*Market Information.* Holding's common stock is listed on the New York Stock Exchange (NYSE) under the symbol "EVHC". Holding's common stock began to trade on the NYSE on August 14, 2013. The high and low sale prices of Holding's common stock during 2013 on the NYSE are set forth below.

| <b>2013</b>                               | <b>High</b> | <b>Low</b> |
|-------------------------------------------|-------------|------------|
| Third Quarter (beginning August 14, 2013) | \$ 28.88    | \$ 24.62   |
| Fourth Quarter                            | \$ 35.55    | \$ 25.97   |

As of March 1, 2014, there were approximately 65 holders of record of Holding's common stock.

*Dividends.* We currently intend to retain any future earnings to support our operations and to fund the development and growth of our business. In addition, the payment of dividends by us to holders of Holding's common stock is limited by our senior secured credit facilities and Indenture. See Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations" and Item 8, "Financial Statements and Supplementary Data". Our future dividend policy will depend on the requirements of financing agreements to which we may be a party. On October 1, 2012, Holding paid a \$428.8 million cash dividend to stockholders of Holding common stock.

We did not pay dividends in 2013 and do not intend to pay cash dividends on our common stock in the foreseeable future. Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions.

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*Securities Authorized for Issuance Under Equity Compensation Plans.* See Item 12, "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K, which information will be set forth in Holding's Proxy Statement for the 2014 Annual Meeting of Stockholders.

**Corporation**

*Market Information.* There is no established public trading market for Corporation's common stock. Corporation had one record holder of common stock on March 1, 2014.

Prior to the Merger, Corporation's common stock was listed on the NYSE under the ticker symbol "EMS". As a result of the Merger, Corporation's common stock ceased to be traded on the NYSE after close of market on May 25, 2011.

*Dividends.* Corporation currently intends to retain any future earnings to support its operations and to fund the development and growth of its business. In addition, the payment of dividends by Corporation to holders of its common stock is limited by its senior secured credit facilities and Indenture. See Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations" and Item 8, "Financial Statements and Supplementary Data". Corporation's future dividend policy will depend on the requirements of financing agreements to which they may be a party.

Corporation did not pay dividends in 2013 or 2012 and does not intend to pay cash dividends on its common stock in the foreseeable future. Any future determination to pay dividends will be at the discretion of its board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions.

*Securities Authorized for Issuance Under Equity Compensation Plans.* No equity securities of Corporation are authorized for issuance under any equity compensation plan. However, officers and a limited number of key employees of Corporation are eligible for equity grants under Holding's Omnibus Incentive Plan.

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

Financial data for each of the periods indicated are derived from our audited consolidated financial statements (in thousands, except share and per share amounts).

Corporation has omitted the information required by this Item pursuant to General Instruction I to the Form 10-K.

|                                                                                | Successor                          |                                    |                                                          | Predecessor                                            |                                    |                                    |
|--------------------------------------------------------------------------------|------------------------------------|------------------------------------|----------------------------------------------------------|--------------------------------------------------------|------------------------------------|------------------------------------|
|                                                                                | Year ended<br>December 31,<br>2013 | Year ended<br>December 31,<br>2012 | Period from<br>May 25<br>through<br>December 31,<br>2011 | Period from<br>January 1<br>through<br>May 24,<br>2011 | Year ended<br>December 31,<br>2010 | Year ended<br>December 31,<br>2009 |
| <b>Statement of Operations Data Holding:</b>                                   |                                    |                                    |                                                          |                                                        |                                    |                                    |
| Revenue, net of contractual discounts                                          | \$ 6,771,522                       | \$ 5,834,632                       | \$ 3,146,039                                             | \$ 2,053,311                                           | \$ 4,790,834                       | \$ 4,333,847                       |
| Provision for uncompensated care                                               | (3,043,210)                        | (2,534,511)                        | (1,260,228)                                              | (831,521)                                              | (1,931,512)                        | (1,764,162)                        |
| Net revenue                                                                    | 3,728,312                          | 3,300,121                          | 1,885,811                                                | 1,221,790                                              | 2,859,322                          | 2,569,685                          |
| Compensation and benefits                                                      | 2,667,439                          | 2,307,628                          | 1,311,060                                                | 874,633                                                | 2,023,503                          | 1,796,779                          |
| Operating expenses                                                             | 424,865                            | 421,424                            | 259,639                                                  | 156,740                                                | 359,262                            | 334,328                            |
| Insurance expense                                                              | 106,293                            | 97,950                             | 65,030                                                   | 47,229                                                 | 97,330                             | 97,610                             |
| Selling, general and administrative expenses                                   | 106,659                            | 78,540                             | 44,355                                                   | 29,241                                                 | 67,912                             | 63,481                             |
| Depreciation and amortization expense                                          | 140,632                            | 123,751                            | 71,312                                                   | 28,467                                                 | 65,332                             | 64,351                             |
| Restructuring charges                                                          | 5,669                              | 14,086                             | 6,483                                                    |                                                        |                                    |                                    |
| Income from operations                                                         | 276,755                            | 256,742                            | 127,932                                                  | 85,480                                                 | 245,983                            | 213,136                            |
| Interest income from restricted assets                                         | 792                                | 625                                | 1,950                                                    | 1,124                                                  | 3,105                              | 4,516                              |
| Interest expense                                                               | (186,701)                          | (182,607)                          | (104,701)                                                | (7,886)                                                | (22,912)                           | (40,996)                           |
| Realized gains (losses) on investments                                         | 471                                | 394                                | 41                                                       | (9)                                                    | 2,450                              | 2,105                              |
| Interest and other (expense) income                                            | (12,760)                           | 1,422                              | (3,151)                                                  | (28,873)                                               | 968                                | 1,816                              |
| Loss on early debt extinguishment                                              | (68,379)                           | (8,307)                            |                                                          | (10,069)                                               | (19,091)                           |                                    |
| Income before income taxes and equity in earnings of unconsolidated subsidiary | 10,178                             | 68,269                             | 22,071                                                   | 39,767                                                 | 210,503                            | 180,577                            |
| Income tax benefit (expense)                                                   | 994                                | (27,463)                           | (9,328)                                                  | (19,242)                                               | (79,126)                           | (65,685)                           |

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|                                                                         | Successor                          |                                    |                                                          | Predecessor                                               |                                    |                                    |
|-------------------------------------------------------------------------|------------------------------------|------------------------------------|----------------------------------------------------------|-----------------------------------------------------------|------------------------------------|------------------------------------|
|                                                                         | Year ended<br>December 31,<br>2013 | Year ended<br>December 31,<br>2012 | Period from<br>May 25<br>through<br>December 31,<br>2011 | Period<br>from<br>January 1<br>through<br>May 24,<br>2011 | Year ended<br>December 31,<br>2010 | Year ended<br>December 31,<br>2009 |
| Income before equity in earnings of unconsolidated subsidiary           | 11,172                             | 40,806                             | 12,743                                                   | 20,525                                                    | 131,377                            | 114,892                            |
| Equity in earnings of unconsolidated subsidiary                         | 323                                | 379                                | 276                                                      | 143                                                       | 347                                | 347                                |
| Net income                                                              | 11,495                             | 41,185                             | 13,019                                                   | 20,668                                                    | 131,724                            | 115,239                            |
| Less: Net income attributable to noncontrolling interest                | (5,500)                            |                                    |                                                          |                                                           |                                    |                                    |
| Net income attributable to Envision Healthcare Holdings, Inc.           | \$ 5,995                           | \$ 41,185                          | \$ 13,019                                                | \$ 20,668                                                 | \$ 131,724                         | \$ 115,239                         |
| <b>Comprehensive Income:</b>                                            |                                    |                                    |                                                          |                                                           |                                    |                                    |
| Net income                                                              | \$ 11,495                          | \$ 41,185                          | \$ 13,019                                                | \$ 20,668                                                 | \$ 131,724                         | \$ 115,239                         |
| <i>Other comprehensive income (loss), net of tax:</i>                   |                                    |                                    |                                                          |                                                           |                                    |                                    |
| Unrealized holding gains (losses) during the period                     | (892)                              | 1,632                              | (41)                                                     | 182                                                       | 164                                | (1,413)                            |
| Unrealized gains (losses) on derivative financial instruments           | 266                                | 857                                | (2,661)                                                  | 25                                                        | 963                                | 3,662                              |
| Total other comprehensive income (loss), net of tax                     | (626)                              | 2,489                              | (2,702)                                                  | 207                                                       | 1,127                              | 2,249                              |
| Comprehensive income                                                    | 10,869                             | 43,674                             | 10,317                                                   | 20,875                                                    | 132,851                            | 117,488                            |
| Less: Comprehensive income attributable to noncontrolling interest      | (5,500)                            |                                    |                                                          |                                                           |                                    |                                    |
| Comprehensive income attributable to Envision Healthcare Holdings, Inc. | \$ 5,369                           | \$ 43,674                          | \$ 10,317                                                | \$ 20,875                                                 | \$ 132,851                         | \$ 117,488                         |
| <b>Weighted average shares outstanding (in millions):</b>               |                                    |                                    |                                                          |                                                           |                                    |                                    |
| Basic                                                                   | 150.2                              | 130.2                              | 129.5                                                    | 411.8                                                     | 408.8                              | 395.7                              |
| Diluted                                                                 | 157.0                              | 132.9                              | 130.8                                                    | 417.1                                                     | 415.6                              | 405.7                              |
| Earnings per share:                                                     | \$ 0.04                            | \$ 0.32                            | \$ 0.10                                                  | \$ 0.05                                                   | \$ 0.32                            | \$ 0.29                            |

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|                                                                                 |    |      |    |      |    |      |    |      |              |
|---------------------------------------------------------------------------------|----|------|----|------|----|------|----|------|--------------|
| Basic net income per share attributable to Envision Healthcare Holdings, Inc.   |    |      |    |      |    |      |    |      |              |
| Diluted net income per share attributable to Envision Healthcare Holdings, Inc. | \$ | 0.04 | \$ | 0.31 | \$ | 0.10 | \$ | 0.05 | \$ 0.32 0.28 |
| 83                                                                              |    |      |    |      |    |      |    |      |              |

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|                                                                            | Successor                          |                                    |                                                          | Predecessor                                            |                                    |                                    |
|----------------------------------------------------------------------------|------------------------------------|------------------------------------|----------------------------------------------------------|--------------------------------------------------------|------------------------------------|------------------------------------|
|                                                                            | Year ended<br>December 31,<br>2013 | Year ended<br>December 31,<br>2012 | Period from<br>May 25<br>through<br>December 31,<br>2011 | Period from<br>January 1<br>through<br>May 24,<br>2011 | Year ended<br>December 31,<br>2010 | Year ended<br>December 31,<br>2009 |
| <b>Other Financial Data Holding:</b>                                       |                                    |                                    |                                                          |                                                        |                                    |                                    |
| Cash flows provided by (used in):                                          |                                    |                                    |                                                          |                                                        |                                    |                                    |
| Operating activities                                                       | \$ 54,115                          | \$ 216,435                         | \$ 114,821                                               | \$ 67,975                                              | \$ 185,544                         | \$ 272,553                         |
| Investing activities                                                       | (98,597)                           | (154,043)                          | (2,965,976)                                              | (89,459)                                               | (158,865)                          | (116,629)                          |
| Financing activities                                                       | 191,362                            | (138,583)                          | 2,698,630                                                | 20,671                                                 | (72,206)                           | 30,791                             |
| Cash and cash equivalents                                                  | 204,712                            | 57,832                             | 134,023                                                  | 286,548                                                | 287,361                            | 332,888                            |
| Total assets                                                               | 4,300,017                          | 4,036,833                          | 4,013,108                                                |                                                        | 1,748,552                          | 1,654,707                          |
| Long-term debt and capital lease obligations, including current maturities | 1,907,699                          | 2,659,380                          | 2,372,289                                                |                                                        | 421,276                            | 453,930                            |
| Total equity                                                               | 1,609,753                          | 544,687                            | 913,490                                                  |                                                        | 847,205                            | 686,087                            |

**Quarterly Financial Information (unaudited)**

The following tables summarize our unaudited results for each quarter in the years ended December 31, 2013 and 2012 (in thousands, except per share amounts).

|                                                                               | 2013                  |            |               |              |
|-------------------------------------------------------------------------------|-----------------------|------------|---------------|--------------|
|                                                                               | For the quarter ended |            |               |              |
|                                                                               | March 31,             | June 30,   | September 30, | December 31, |
| <b>Holding:</b>                                                               |                       |            |               |              |
| Net revenue                                                                   | \$ 888,324            | \$ 899,255 | \$ 955,888    | \$ 984,845   |
| Income from operations                                                        | 62,862                | 65,703     | 63,503        | 84,687       |
| Net income (loss)                                                             | (3,847)               | 9,597      | (7,663)       | 13,408       |
| Net income (loss) attributable to Envision Healthcare Holdings, Inc.          | (3,847)               | 9,597      | (7,663)       | 7,908        |
| Earnings (loss) per share attributable to Envision Healthcare Holdings, Inc.: |                       |            |               |              |
| Basic                                                                         | (0.03)                | 0.07       | (0.05)        | 0.04         |
| Diluted                                                                       | (0.03)                | 0.07       | (0.05)        | 0.04         |

|                                                                        | 2012                  |            |               |              |
|------------------------------------------------------------------------|-----------------------|------------|---------------|--------------|
|                                                                        | For the quarter ended |            |               |              |
|                                                                        | March 31,             | June 30,   | September 30, | December 31, |
| <b>Holding:</b>                                                        |                       |            |               |              |
| Net revenue                                                            | \$ 806,294            | \$ 801,098 | \$ 820,811    | \$ 871,918   |
| Income from operations                                                 | 52,496                | 60,256     | 68,624        | 75,366       |
| Net income                                                             | 5,792                 | 7,841      | 15,209        | 12,343       |
| Net income attributable to Envision Healthcare Holdings, Inc.          | 5,792                 | 7,841      | 15,209        | 12,343       |
| Earnings per share attributable to Envision Healthcare Holdings, Inc.: |                       |            |               |              |
| Basic                                                                  | 0.04                  | 0.06       | 0.12          | 0.09         |
| Diluted                                                                | 0.04                  | 0.06       | 0.11          | 0.09         |

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

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

***Company Overview***

We are a leading provider of physician-led, outsourced medical services in the United States with more than 20,000 affiliated clinicians. We market our services on a stand-alone, multi-service and integrated basis, primarily under our EmCare and AMR brands. EmCare is a leading provider of integrated facility-based physician services, including emergency, anesthesiology, hospitalist/inpatient care, radiology, tele-radiology and surgery. EmCare also offers physician-led care management solutions outside the hospital. AMR is a leading provider and manager of community based medical transportation services, including emergency "911", non-emergency, managed transportation, fixed-wing ambulance and disaster response.

Holding indirectly owns all of the outstanding common stock of Corporation. In June 2013, CDRT Holding Corporation's name was changed to Envision Healthcare Holdings, Inc., and Emergency Medical Services Corporation's name was changed to Envision Healthcare Corporation.

On July 29, 2013, Holding effected a 9.3 for 1.0 stock split of Holding's common stock, resulting in 132,082,885 shares of common stock issued, not including 504,197 treasury shares. The accompanying consolidated financial statements give retroactive effect to the stock split for all periods presented

On August 13, 2013, Holding's Registration Statement was declared effective by the SEC for an initial public offering of its common stock, par value \$0.01 ("Common Stock"). Holding registered the offering and sale of 42,000,000 shares of Common Stock and an additional 6,300,000 shares of Common Stock, to be sold to the underwriters pursuant to their option to purchase additional shares at a price of \$23 per share. On August 19, 2013, Holding completed the offering of 48,300,000 shares of Common Stock, at a price of \$23 per share, for an aggregate offering price of \$1,110.9 million. At the closing, we received net proceeds of approximately \$1,025.9 million, after deducting the underwriters' discounts and commissions paid and offering expenses of approximately \$85.0 million, including a \$20.0 million payment to CD&R in connection with the termination of the consulting agreement with CD&R which was recorded to "Selling, general and administrative expenses" in the Company's consolidated statements of operations.

Net proceeds from the initial public offering were used to (i) redeem in full Holding's Senior PIK Toggle Notes due 2017 for a total of \$479.6 million, which included a call premium pursuant to the indenture governing the Senior PIK Toggle Notes due 2017 and all accrued but unpaid interest, (ii) pay CD&R the fee of \$20.0 million to terminate the consulting agreement with CD&R, (iii) pay \$16.5 million to repay all outstanding revolving credit facility borrowings, and (iv) redeem \$332.5 million in principal amount of the 2019 Notes of which \$5.2 million was held by our captive insurance subsidiary for a total of \$356.5 million, which included a call premium pursuant to the indenture governing the 2019 Notes and all accrued but unpaid interest. The remaining proceeds will be used for general corporate purposes which may include, among other things, repayment of indebtedness and acquisitions.

On February 5, 2014, Holding registered the offering and sale of 27,500,000 shares of Common Stock and an additional 4,125,000 shares of Common Stock, which were sold by CD&R Affiliates to

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the underwriters pursuant to their option to purchase additional shares at \$30.50 per share less the underwriting discount. The CD&R Affiliates, certain executive officers and directors of Holding and certain non-executives were the selling stockholders in the offering. Holding did not receive any of the proceeds from the sale of the shares being sold by the selling stockholders, including any shares sold pursuant to any exercise of the underwriters' option to purchase additional shares. Upon completion of this offering, Holding had 181,131,273 shares of Common Stock outstanding.

**EmCare**

Over its 40 years of operating history, EmCare has become the leading provider of integrated facility-based physician services to healthcare facilities, communities and payors in the United States based on number of contracts with hospitals and affiliated physician groups. During 2013, EmCare had approximately 12.1 million patient encounters in 45 states and the District of Columbia. As of December 31, 2013, EmCare had a 9% share of the total emergency department services market and a 13% share of the outsourced emergency department services market based on number of contracts. EmCare's share of the combined markets for anesthesiology, hospitalist, radiology and surgery services was approximately 1% as of such date.

EmCare has contracts covering 706 clinical departments with hospitals and independent physician groups to provide emergency, anesthesiology, hospitalist/inpatient care, radiology, tele radiology and surgery services as well as other administrative services. 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.

**AMR**

Over its nearly 55 years of operating history, AMR has developed the largest network of ambulance services and a leading position in other medical transportation services in the United States. As of December 31, 2013, AMR had a 6% 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 2013, AMR treated and transported approximately 2.8 million patients in 40 states and the District of Columbia by utilizing its fleet of nearly 4,300 vehicles that operated out of nearly 200 sites. As of December 31, 2013, AMR had more than 3,800 contracts with communities, government agencies, healthcare providers and insurers to provide ambulance transport services. During 2013, approximately 61% of AMR's net revenue was generated from emergency "911" ambulance transport services. Non-emergency ambulance transport services, including critical care transfer, wheelchair transports and other interfacility transports accounted for 24% of AMR's net revenue for the same period. The remaining balance of net revenue for 2013 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.

***Merger***

In February 2011, Corporation entered into the an Agreement and Plan of Merger (the "Merger Agreement") with Envision Healthcare Intermediate Corporation (formerly known as CDRT Acquisition Corporation) and CDRT Merger Sub, Inc. ("Sub"). In May 2011, pursuant to the Merger Agreement, Sub merged with and into Corporation with Corporation as the surviving entity and an indirect wholly owned subsidiary of Holding.

The Merger was funded primarily through a \$915 million equity contribution from the CD&R Affiliates and members of Corporation management and \$2.4 billion in debt financing discussed more fully in Note 10 to the accompanying consolidated financial statements. The acquisition consideration

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was approximately \$3.2 billion including approximately \$150 million in capitalized issuance costs, of which \$109 million are debt issuance costs.

Corporation applied business combination accounting to the opening balance sheet and results of operations on May 25, 2011 as the Merger occurred at the close of business on May 24, 2011. The business combination accounting adjustments had a material impact on the Successor period presented, the period from May 25, 2011 through December 31, 2011, due most significantly to the amortization of intangible assets and interest expense and will have a material impact on future earnings. Adjustments to allocate the acquisition consideration to fixed assets and identifiable intangible assets were recorded in the third and fourth quarters of 2011 based on a valuation report from a third party valuation firm.

### ***Presentation***

This MD&A is presented for the years ended December 31, 2013 and 2012, as well as the Successor period from May 25, 2011 through December 31, 2011, and the Predecessor period from January 1, 2011 through May 24, 2011. The full year 2011 is also presented on a Pro Forma basis. Predecessor and Successor results relate to the periods preceding the Merger and succeeding the Merger, respectively. The Company believes that the discussion on a Pro Forma basis is a useful supplement to the historical results as it allows the 2011 results of operations to be analyzed on a more comparable basis to the 2013 full year results. The Unaudited Pro Forma Combined Consolidated Statements of Operations reflect the consolidated results of operations of the Company as if the Merger had occurred on January 1, 2011. The historical financial information has been adjusted to give effect to events that are (1) directly attributed to the Merger, (2) factually supportable, and (3) with respect to the income statement, expected to have a continuing impact on the combined results. Such items include interest expense related to debt issued in conjunction with the Merger as well as additional amortization expense associated with the valuation of intangible assets. This unaudited Pro Forma information should not be relied upon as necessarily being indicative of the historical results that would have been obtained if the Merger had actually occurred on that date, nor of the results that may be obtained in the future. See Note 1 to the accompanying consolidated financial statements.

### ***Key Factors and Measures We Use to Evaluate Our Business***

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

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

The table below summarizes our approximate payor mix as a percentage of both net revenue and total transports and patient encounters for the years ended December 31, 2013, 2012 and 2011. In determining the net revenue payor mix, we use cash collections in the period as an approximation of net revenue recorded. As illustrated below, commercial insurance and managed care has consistently represented our largest payor group based on net revenue, comprising 52% of cash collections in

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2013. Separately, given the emergency nature of many of our services, self-pay (primarily uninsured patients) has represented approximately 17% - 19% of our total patient volume, but only 4% - 5% of our total cash collections. EmCare's ED volume is approximately 21% self-pay and AMR's ambulance volume is approximately 19% self-pay. The decrease in self-pay as a percentage of total revenue over the past three years has been due to additional EmCare service lines with lower self-pay, including our post-acute care services.

|                                       | Percentage of Cash<br>Collections (Net Revenue) |       |       | Percentage of Total<br>Volume |       |       |
|---------------------------------------|-------------------------------------------------|-------|-------|-------------------------------|-------|-------|
|                                       | Year ended December 31,                         |       |       | Year ended December 31,       |       |       |
|                                       | 2013                                            | 2012  | 2011  | 2013                          | 2012  | 2011  |
| Medicare                              | 22.2%                                           | 20.2% | 20.6% | 24.9%                         | 25.6% | 25.9% |
| Medicaid                              | 4.9                                             | 4.8   | 5.4   | 10.0                          | 10.8  | 12.5  |
| Commercial insurance and managed care | 52.0                                            | 52.3  | 50.5  | 47.4                          | 45.3  | 43.2  |
| Self-pay                              |                                                 |       |       |                               |       |       |