TRIAD HOSPITALS INC
Form 10-K
March 29, 2002

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

FORM 10-K

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

For the fiscal year ended December 31, 2001

OR

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

For the transition period from ----- to -----

Commission file number 0-29816

Triad Hospitals, Inc.
(Exact name of registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	75-2816101 (I.R.S. Employer Identification No.)
13455 Noel Road, Suite 2000 Dallas, Texas (Address of principal executive offices)	75240 (Zip Code)

(972) 789-2700

(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: None

Securities Registered Pursuant to Section 12(g) of the Act:

TITLE OF EACH CLASS	NAME OF EACH EXCHANGE ON WHICH REGISTERED
Common Stock, $.01 Par Value	New York Stock Exchange
Preferred Stock Purchase Rights	New York Stock Exchange

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, and (2) has been subject to such filing requirements for the past 90 days.

YES [X] 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 Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this

YES [ ] NO [X]

Indicate the number of shares outstanding of each of the issuer's classes of common stock of the latest practical date.

As of March 15, 2002, the number of shares of common stock of Triad Hospitals, Inc. outstanding was 72,365,176. As of March 15, 2002 the aggregate market value of the common stock held by non-affiliates was approximately $2,245,755,666. For purposes of the foregoing calculation only, the Registrant's directors, executive officers, and the Triad Hospitals, Inc. Retirement Savings Plan have been deemed to be affiliates.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive proxy statement for the 2002 Annual Meeting of Stockholders of Triad Hospitals, Inc. are incorporated by reference into Part III hereof.

Part I

Item 1. Business

General

Triad Hospitals, Inc. is one of the largest publicly owned hospital companies in the United States and provides health care services through hospitals and ambulatory surgery centers that it owns and operates in small cities and selected urban markets primarily in the southern, midwestern and western United States. Triad's hospital facilities include 46 general acute care hospitals and 14 ambulatory surgery centers located in the states of Alabama, Arizona, Arkansas, California, Indiana, Kansas, Louisiana, Mississippi, Missouri, New Mexico, Ohio, Oklahoma, Oregon, South Carolina, Texas and West Virginia. One hospital included among these facilities is operated through a 50/50 joint venture that is not consolidated for financial reporting purposes. Triad is also a minority investor in three joint ventures that own seven general acute care hospitals in Georgia and Nevada. Through its wholly-owned subsidiary, Quorum Health Resources, LLC ("QHR"), Triad also provides management and consulting services to independent general acute care hospitals located throughout the United States. The terms "we", "our", "the Company", "us", and "Triad" refer to the business of Triad Hospitals, Inc. and its subsidiaries as a consolidated entity, except where it is clear from the context that such terms mean only Triad Hospitals, Inc.

Triad's general acute care hospitals typically provide a full range of services commonly available in hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics, obstetrics, diagnostic and emergency services. These hospitals also generally provide outpatient and ancillary health care services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Outpatient services also are provided by ambulatory surgery centers operated by Triad. In addition, some of Triad's general acute care hospitals have a limited number of licensed psychiatric beds and provide psychiatric skilled nursing services.

In addition to providing capital resources and general management, Triad makes available a variety of management services to its health care facilities. These services include ethics and compliance programs, national supply and

equipment purchasing and leasing contracts, accounting, financial and clinical systems, governmental reimbursement assistance, information systems, legal support, personnel management, internal audit, access to regional managed care networks, resource management, and strategic and business planning.

Our Formation

Triad was incorporated under the laws of the State of Delaware in 1999. On May 11, 1999, Triad became an independent, publicly traded company owning and operating the healthcare service business which had comprised the Pacific Group of HCA, Inc. ("HCA"). On that date, Triad was spun-off from HCA through the distribution of all outstanding shares of Triad common stock to the stockholders of HCA. Information regarding HCA in this Annual Report is derived from reports and other information filed by HCA with the Securities and Exchange Commission (the "Commission").

On April 27, 2001, Triad completed its merger of Quorum Health Group, Inc. ("Quorum") with and into Triad for approximately $2.4 billion in cash, stock and assumption of debt. Each former Quorum shareholder became entitled to receive $3.50 in cash and 0.4107 shares of Triad common stock for each outstanding share of Quorum stock, plus cash in lieu of fractional shares of Triad common stock. See "NOTE 3 - ACQUISITIONS" in the consolidated financial statements for a more detailed description of the transaction.

The common stock of Triad is listed on the New York Stock Exchange (Symbol: TRI). Information about the distribution and certain indemnification and other arrangements entered into by Triad and HCA in connection with the distribution is included in "Management's Discussion and Analysis of Financial Condition and Results of Operations" and in the consolidated financial statements.

Principal Executive Offices

Our principal executive offices are located at 13455 Noel Road, 20th Floor, Dallas, Texas 75240, and our phone number is (972) 789-2700. Our corporate Website address is http://www.triadhospitals.com. Information contained on our Website is not part of this Annual Report.

Triad's Markets

Most of Triad's owned facilities are located in two distinct types of markets primarily in the southern, midwestern and western United States. Over three-quarters of Triad's owned hospitals are located in small cities, generally with populations of less than 150,000 residents and located more than 60 miles from a major urban center. Triad's hospitals are usually either the only hospital or one of two or three hospitals in the community. The remainder of Triad's owned hospitals are located in selected larger urban areas. Triad owns and operates hospitals in 16 states. Approximately half of Triad's facilities are located in the states of Alabama, Indiana, and Texas.

Through QHR its separate contract management services and consulting subsidiary, Triad also provides management services to independent hospitals and hospital systems located throughout the United States.

Small City Markets

Triad believes that the small cities of the southern, midwestern and western United States are attractive to health care service providers as a result of favorable demographic, economic and competitive conditions. Thirty-six

of the 46 general acute care hospitals that Triad operated as of December 31, 2001 were located in these small city markets. Of these, 19 hospitals were located in communities where they were the sole hospital and 17 hospitals were located in communities where they were one of only two or three hospitals. Triad believes that small city markets can support specialty services which generally produce higher revenues than other health care services. In addition, in small city markets, managed care penetration is generally lower than in urban areas, and Triad believes that it is in a better position to negotiate more favorable managed care contracts in these markets.

While Triad's hospitals located in these small cities are more likely to face direct competition than facilities located in smaller rural markets, that competition often is limited to a single competitor in the relevant market. Triad believes that the smaller populations and relative strength of the one or two acute care hospitals in these markets also limit the entry of alternate non-hospital providers, such as outpatient surgery centers or rehabilitation or diagnostic imaging centers, as well as managed care plans.

Selected Larger Urban Markets

Ten of the 46 general acute care hospitals that Triad operated as of December 31, 2001 are located in selected larger urban markets of the southern, midwestern and western United States.

In addition to the direct competition Triad faces from other health care providers in its markets, there are higher levels of managed care penetration in the larger urban markets (a higher relative proportion of the market population enrolled in managed care programs such as HMOs and PPOs).

Business Strategy

Triad's primary objective is to provide quality health care services and simultaneously generate strong financial performance using the following strategies:

Unique Operating Strategy

- Operating Strategy Components
  - Develop strong relationships with the physicians in our communities.
  - Maximize community involvement by empowering local Board of Trustees.
  - Build strategic relationships with employees, including our nurses.
  - Launch quality initiatives to maximize patient, physician and employee satisfaction

- Operating Strategy Objectives
  - Grow volumes through the operating strategy and by adding specialty and outpatient services.
  - Improve reimbursement rates by leveraging improved market positions.

  - Increase operating margins through volume growth and collaborative resource management.
  - Increase the margins methodically without being the "low cost" provider.

Capital Investment Strategy

- Invest capital in same-facility expansions, new-facility development and selected acquisitions.

- Enhance and expand healthcare services and simultaneously generate appropriate financial returns.
- Focus on small cities and selected larger urban markets compatible with Triad's operating strategies.
- Form joint ventures with other providers, including not-for-profit healthcare providers.

Contract Management and Consulting Services Strategy

- Grow core business by adding new contracts with independent hospitals.
- Negotiate new and renewal contract terms that achieve an appropriate balance of risk and reward.
- Acquire and invest selectively in independent hospitals, if invited.

Operations

Triad's general acute care hospitals typically provide a full range of services commonly available in hospitals, such as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics and obstetrics, as well as diagnostic and emergency services. These hospitals also generally provide outpatient and ancillary health care services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Outpatient services also are provided by ambulatory surgery centers operated by Triad. In addition, certain of Triad's general acute care hospitals have a limited number of licensed psychiatric beds.

Each of Triad's hospitals is governed by a local Board of Trustees, which is composed entirely of local community leaders and members of the hospital's medical staff. The Board of Trustees establishes policies concerning the medical, professional and ethical practices at each hospital, monitors such practices, and is responsible for ensuring that these practices conform to established standards. Triad maintains quality assurance programs to support and monitor quality of care standards and to meet accreditation and regulatory requirements. Patient care evaluations and other quality of care assessment activities are monitored on a continuing basis.

Services and Utilization

Hospital revenues depend upon inpatient occupancy levels, the volume of outpatient procedures and the charges or negotiated payment rates for such services. Charges and reimbursement rates for inpatient routine services vary significantly depending on the type of service, such as medical/surgical, intensive care or psychiatric, the payer and the geographic location of the hospital.

Triad believes that important factors relating to the overall utilization of a hospital include the quality and market position of the hospital and the number, quality and specialties of physicians providing patient care within the facility. Generally, Triad believes that the ability of a hospital to meet the health care needs of its community is determined by its breadth of services, level of technology, emphasis on quality of care and convenience for patients and physicians. Other factors which impact utilization include the growth in local population, local economic conditions, market penetration of managed care programs and the availability of reimbursement programs such as Medicare and Medicaid. Utilization across the industry also is being affected by improved treatment protocols as a result of advances in medical technology and pharmacology.

The following table sets forth certain statistics for hospitals owned by Triad for each of the past five years. The comparability of the statistics has been affected by the acquisition of Quorum on April 27, 2001. Medical/surgical hospital operations are subject to certain seasonal fluctuations, including decreases in patient utilization during holiday periods and increases in patient utilization during the cold weather months.

	Years ended December 31,				
	2001	2000	1999	1998	1997
Number of hospitals at end of period (a) ...	46	28	29	39	3
Number of licensed beds at end of period (b)	7,557	3,520	3,722	5,902	5,85
Weighted average licensed beds (c)	6,379	3,633	4,745	5,905	5,86
Admissions (d)	233,888	128,645	145,889	169,590	172,92
Adjusted admissions (e)	396,256	220,590	241,547	276,771	275,12
Average length of stay (days) (f)	4.8	4.4	4.5	4.9	4.
Average daily census (g)	3,060	1,532	1,818	2,263	2,32
Occupancy rate (h)	54%	49%	55%	44%	4

(a) This table does not include any operating statistics for non-consolidating joint ventures and facilities leased to others.
(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
(c) Represents the average number of licensed beds weighted based on periods owned.
(d) Represents the total number of patients admitted (in the facility for a period in excess of 23 hours) to Triad's hospitals and is used by management and certain investors as a general measure of inpatient volume.
(e) Adjusted admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Adjusted admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The adjusted admissions computation "adjusts" outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general measure of combined inpatient and outpatient volume.
(f) Represents the average number of days admitted patients stay in Triad's hospitals.
(g) Represents the average number of patients in Triad's hospital beds each day.
(h) Represents the percentage of hospital licensed beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.

Triad's hospitals have historically experienced shifts from inpatient to outpatient care as well as decreases in average lengths of inpatient stay, primarily as a result of improvements in technology and clinical practices and hospital payment changes by Medicare, insurance carriers and self-insured employers. Some of these indicators increased during 2001 due to the acquisition of Quorum, but Triad believes that these shifts will continue in the future. These hospital payment changes generally encourage the utilization of outpatient, rather than inpatient,

services whenever possible, and shortened lengths of stay for inpatient care. Triad has responded to the outpatient trend by enhancing its hospitals' outpatient service capabilities, including:

(1) dedicating resources to its freestanding ambulatory surgery centers at or near certain of its hospital facilities,
(2) reconfiguring certain hospitals to more effectively accommodate outpatient treatment by, among other things, providing more convenient registration procedures and separate entrances, and
(3) restructuring existing surgical capacity to allow a greater number and range of procedures to be performed on an outpatient basis.

Triad expects the growth in outpatient services to continue in the future. Triad's facilities will continue to emphasize those outpatient services that can be provided on a quality, cost-effective basis and that Triad believes will experience increased demand.

Sources of Revenue

Triad receives payment for patient services from the federal government primarily under the Medicare program, state governments under their respective Medicaid programs, and HMOs, PPOs and other private insurers as well as directly from patients. The approximate percentages of patient revenues of Triad's facilities from such sources during the periods specified below were as follows:

	Years Ended December 31,		
	2001	2000	1999
Medicare	31.9%	29.6%	31.9%
Medicaid	4.4	6.4	6.9
Managed care plans	28.9	31.0	32.7
Other sources	34.8	33.0	28.5
Total	100.0%	100.0%	100.0%

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. Medicaid is a federal-state program administered by the states which provides hospital benefits to qualifying individuals who are unable to afford care. All of Triad's hospitals are certified as providers of Medicare and Medicaid services. Amounts received under the Medicare and Medicaid programs are generally significantly less than the hospital's customary charges for the services provided. See "Reimbursement."

To attract additional volume, most of Triad's hospitals offer discounts from established charges to certain large group purchasers of health care services, including private insurance companies, employers, HMOs, PPOs and other managed care plans. These discount programs limit Triad's ability to increase charges in response to increasing costs. See "Competition."

Patients are generally not responsible for any difference between customary hospital charges and amounts reimbursed for such services under Medicare, Medicaid, some private insurance plans, and HMOs or PPOs, but are responsible for services not covered by such plans, exclusions, deductibles or co-insurance features of their coverage. The amount of such exclusions, deductibles and co-insurance has generally been increasing each year. Collection of amounts due from individuals is typically more difficult than from governmental or business payers. For more information on the reimbursement programs on which Triad's revenues are dependent, see "Reimbursement."

Hospital Management Services

QHR is a leading provider of management and consulting services to acute care hospitals, providing management services to approximately 200 hospitals as of December 31, 2001. QHR provides management services to independent hospitals and hospital systems under management contracts and provides selected consulting, educational and related services. In addition, QHR provides turnaround management consulting services to distressed independent hospitals. QHR assists hospitals in improving their financial performance and the scope of their services. Most of the hospitals for which QHR performs management, consulting or support services are

independent not-for-profit hospitals. These hospitals are generally located in non-urban areas. Sixty-five percent (65%) of these hospitals have less than 100 beds. Upon entering into a management contract, QHR first assesses the operations of the hospital, including the hospital's financial management, the economic and population-related factors affecting the hospital's market, physician relationships and staffing requirements. Then, based on its assessment, QHR develops and recommends a management plan to the hospital's governing board.

To implement the management plan adopted for each hospital, QHR provides the hospital with personnel to serve as the hospital's chief executive officer and, typically, a chief financial officer. Although these people are QHR employees, they operate under the direction and control of the hospital's governing body, and the balance of the hospital staff remain employees of the hospital under the control and supervision of the hospital. QHR's hospital-based team is supported by its regional and corporate management staff. QHR currently has 22 regional offices located throughout the United States. QHR's regional office staff is experienced in providing management services to hospitals of all sizes in diverse markets throughout the United States. Each regional office is responsible for the management services provided within its geographic area.

QHR's hospital management contracts generally have a term of three to five years. QHR's management contract fees are based on amounts agreed upon by QHR and the hospital's governing body, and generally are not related to the hospital's revenues or other variables. Under QHR's hospital management contracts, QHR is not responsible for hospital licensure, certificates of need, liability coverage, capital expenditures or for other functions which are normally the responsibility of a hospital's governing body.

QHR offers consulting and related educational and management services to hospitals that are not part of its contract management program. QHR's consulting services are directed at many of the operational needs of hospitals, including accounts receivable management, health information management, human resources, facility design and various operational services. QHR also provides consulting services to large, sophisticated medical institutions that need hospital management advice for specific issues.

Competition

The hospital industry is highly competitive. Triad competes with other hospitals and health care providers for patients. The competition among hospitals and other health care providers for patients has intensified in recent years. In some cases, competing hospitals are more established than Triad's hospitals. Certain of these competing facilities, particularly in urban markets, offer services, including extensive medical research and medical education programs, which are not offered by Triad's facilities. In addition, in certain

of the markets where Triad operates, there are large teaching hospitals which provide highly specialized facilities, equipment and services which may not be available at Triad's hospitals. Although some of Triad's hospitals are located in geographic areas where they are currently the sole provider of general, acute care hospital services in their communities, these hospitals also face competition from other hospitals, including larger tertiary care centers. Despite the fact that these competing hospitals may be as far as 30 to 50 miles away, patients in these markets increasingly may migrate to these competing facilities as a result of local physician referrals, managed care incentives or personal choice.

In addition, some of the hospitals that compete with Triad are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals can make capital expenditures without paying sales taxes, and are generally exempt from property and income taxes. Triad also faces competition from other specialized care providers, including outpatient surgery, orthopedic, oncology and diagnostic centers.

State certificate of need laws, which place limitations on a hospital's ability to expand hospital services and add new equipment, also may have the effect of restricting competition. Five states in which Triad operates, Alabama, Mississippi, Ohio, South Carolina and West Virginia, have certificate of need laws ("CON laws"). The application process for approval of covered services, facilities, changes in operations and capital expenditures in these states is, therefore, highly competitive. In those states which have no CON laws or which set relatively high thresholds before expenditures become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent.

The number and quality of the physicians on a hospital's staff are important factors in a hospital's competitive advantage. Physicians decide whether a patient is admitted to the hospital and the procedures to be performed. Triad believes that physicians refer patients to a hospital primarily on the basis of the quality of services it renders to patients and physicians, the quality of other physicians on the medical staff, the location of the hospital and the quality of the hospital's facilities, equipment and employees. Admitting physicians may be on the medical staff of other hospitals in addition to those of Triad's hospitals.

One element of Triad's business strategy is expansion through the acquisition of acute care hospitals in select markets. The competition to acquire hospitals is significant. Triad intends to acquire, on a selective basis, hospitals that are similar to those currently owned and operated. However, suitable acquisitions may not be accomplished on favorable terms.

Another major factor in the competitive position of a hospital is management's ability to negotiate service contracts with purchasers of group health care services, such as HMOs and PPOs, which attempt to direct and control the use of hospital services through managed care programs and to obtain discounts from hospitals' established charges. Employers and traditional health insurers are also increasingly interested in containing costs through negotiations with hospitals for managed care programs and discounts from established charges. Generally, hospitals compete for service contracts with group health care service purchasers on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. The importance of obtaining contracts with managed care organizations varies from market to market depending on the market strength of

such organizations.

QHR also faces competitive challenges in the area of management services. In seeking management services, hospitals have a variety of alternatives. Hospitals managed by hospital management companies represent less than 10% of the total acute care hospitals in the United States. Most hospitals have their own management staff. Some hospitals choose to obtain management services from large, tertiary care facilities that create referral networks with smaller surrounding hospitals.

Triad, and the health care industry as a whole, face the challenge of continuing to provide quality patient care while dealing with rising costs, strong competition for patients and a general reduction of reimbursement rates by both private and government payers. As both private and government payers reduce the scope of what may be reimbursed and reduce reimbursement levels for what is covered, federal and state efforts to reform the health care system may further impact reimbursement rates. Changes in medical technology, existing and future legislation, regulations and interpretations and competitive contracting for provider services by private and government payers may require changes in Triad's facilities, equipment, personnel, rates and/or services in the future.

The hospital industry and Triad's hospitals continue to have significant unused capacity. Inpatient utilization, average lengths of stay and average occupancy rates have historically been negatively affected by payer-required pre-admission authorization, utilization review and payer pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Admissions constraints, payer pressures and increased competition are expected to continue. Triad endeavors to meet these challenges by expanding many of its facilities to include outpatient centers, offering discounts to private payer groups, upgrading facilities and equipment and offering new programs and services.

Employees and Medical Staff

At December 31, 2001, Triad had approximately 33,000 employees, including approximately 9,000 part-time employees, as well as approximately 600 employees providing hospital management and consulting services. Employees at two hospitals are currently represented by labor unions. Triad considers its employee relations to be good. While Triad's non-union hospitals experience union organizational activity from time to time, Triad does not expect such efforts to materially affect its future operations. Triad's hospitals, like most hospitals, have experienced labor costs rising faster than the general inflation rate, primarily in nursing. There can be no assurance as to future availability and cost of qualified medical personnel.

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Triad's hospitals are staffed by licensed physicians who have been admitted to the medical staff of individual hospitals. Physicians generally are not employees of Triad's hospitals although there are varying levels of employed physicians in certain markets. Some physicians provide services in Triad's hospitals under contracts, which generally describe a term of service, provide and establish the duties and obligations of such physicians, require the maintenance of certain performance criteria and fix compensation for such services. Any licensed physician may apply to be admitted to the medical staff of any of Triad's hospitals, but admission to the staff must be approved by the hospital's medical staff and the appropriate governing board of the hospital in accordance with established credentialing criteria. Members of the medical staffs of Triad's hospitals located in areas where there are other hospitals often also serve on the medical staffs of other hospitals and may terminate

their affiliation with a hospital at any time.

Triad's Ethics and Compliance Program

It is Triad's policy that its business be conducted with integrity and in compliance with the law. Triad has developed a corporate-wide ethics and compliance program, which focuses on all areas of policy and regulatory compliance, including physician recruitment, reimbursement and cost reporting practices and laboratory operations.

This ethics and compliance program is intended to assure that high standards of conduct are maintained in the operation of Triad's business and to help assure that policies and procedures are implemented so that employees act in full compliance with all applicable laws, regulations and company policies. Under the ethics and compliance program, Triad provides initial and periodic legal compliance and ethics training to every employee, reviews various areas of Triad's operations, and develops and implements policies and procedures designed to foster compliance with the law. Triad regularly monitors its ongoing compliance efforts. The program also includes a mechanism for employees to report, without fear of retaliation, any suspected legal or ethical violations to their supervisors or designated compliance officers in Triad's hospitals, as well as a national "hotline" to which employees can report, on an anonymous basis if preferred, any suspected violations. Triad has also established a separate committee of the Board of Directors to monitor the compliance program.

On November 1, 2001, Triad entered into a five-year corporate integrity agreement with the Office of the Inspector General and agreed to maintain its compliance program in accordance with the corporate integrity agreement. This obligation could result in greater scrutiny by regulatory authorities. Violations of the integrity agreement could subject Triad's hospitals to substantial monetary penalties. Complying with the corporate integrity agreement may impose expensive and burdensome requirements on certain operations which could have a material adverse impact on Triad. The compliance measures and reporting and auditing requirements for Triad's hospitals contained in the integrity agreement include:

- Continuing the duties and activities of corporate compliance officers and committees and maintaining a written code of conduct and written policies and procedures;
- Providing general training on the compliance policy and the agreement and specific training for the appropriate personnel on billing, coding and cost report issues;
- Having an independent third party conduct periodic audits of inpatient DRG coding and laboratory billing;
- Continuing a confidential disclosure program and compliance hotline and implementing enhanced screening to ensure ineligible employees and contractors are not hired;
- Reporting material deficiencies resulting in an overpayment by a federal healthcare program and probable violations of certain laws, rules and regulations; and
- Submitting annual reports to the Inspector General describing the operations of the corporate compliance program for the past year.

Reimbursement

Medicare. Under the Medicare program, acute care hospitals generally receive reimbursement under a prospective payment system ("PPS") for inpatient hospital services. Psychiatric, specially designated children's hospitals and certain designated cancer research hospitals, as well as psychiatric units that are distinct parts of a

hospital and meet the Centers for Medicare and Medicaid Services ("CMS") criteria for exemption, are currently exempt from PPS and are reimbursed on a cost-based system, subject to certain cost limits known as TEFRA limits.

Under PPS, fixed payment amounts per inpatient discharge are established based on the patient's assigned diagnosis related group ("DRG"). DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. DRG rates have been established for each hospital participating in the Medicare program, are based upon a statistically normal distribution of severity and are adjusted for area wage differentials but do not consider a specific hospital's costs. DRG rates are updated and re-calibrated annually and have been affected by several recent Federal enactments. The index used to adjust the DRG rates, known as the "market basket index," gives consideration to the inflation experienced by hospitals (and entities outside of the health care industry) in purchasing goods and services. Although for several years the percentage increases to the DRG rates have been lower than the percentage increases in the costs of goods and services purchased by hospitals, the Benefits Improvement Protection Act of 2000 ("BIPA") has updated the rates hospitals receive so that hospitals generally received the market basket index minus 1.1% for discharges occurring on or after October 1, 2000 and before March 31, 2001 or the market basket index plus 1.1% for discharges occurring on or after April 1, 2001 and before October 1, 2001. Triad received approximately $16.0 million of additional reimbursement from BIPA in 2001 and anticipates the receipt of approximately $17.0 million of additional reimbursement in 2002. For Federal fiscal years 2002 and 2003, hospitals generally will receive the market basket index minus 0.55%. For Federal fiscal year 2004, hospitals generally will receive the full market basket. Future legislation may decrease the rate of increase for DRG payments, which could make it more difficult to grow revenue and to maintain or improve operating margins.

Until August 1, 2000, outpatient services provided at general, acute care hospitals typically were reimbursed by Medicare based on a fee schedule. The Balanced Budget Act of 1997 ("BBA") contains provisions that affect outpatient hospital services, including a requirement that CMS adopt a PPS system for outpatient hospital services, which became effective August 1, 2000. Based on provisions of BIPA, the fee schedule is to be updated by the market basket minus 0.8% and 1.0% in Federal fiscal years 2001 and 2002, respectively, and market basket for Federal fiscal years 2003 and beyond. Similarly, effective January 1, 1999, therapy services rendered by hospitals to outpatients and inpatients not reimbursed under Medicare are reimbursed according to the Medicare Physician fee schedule.

Payments for Medicare skilled nursing facility services and home health services historically have been paid based on costs, subject to certain adjustments and limits. Although BBA mandates a PPS system for skilled nursing facility services, home health services and inpatient rehabilitation hospital services, BIPA has made adjustments to the PPS payments for these health care service providers. Specifically, for skilled nursing facilities, BBA set the annual inflation update at the market basket index minus 1.0% in 2001 and 2002. However, BIPA adjusts the update to the full market basket index in 2001 and the market basket index minus 0.5% in 2002 and 2003. In addition to the creation of a PPS system for skilled nursing, the BBA also institutes consolidated billing for skilled nursing facility services, under which payments for most non-physician services for beneficiaries no longer eligible for skilled nursing facility care will be made to the facility, regardless of whether the item or service was furnished by the facility, by others under arrangement, or under any other contracting or consulting arrangement. Consolidated billing is being implemented on a transition basis. As of December 31, 2001, 24 of Triad's hospitals operated skilled nursing facilities.

In addition to establishing a PPS system for home health services, BBA requires a 15% payment reduction in payment limits to home health agencies. However, BIPA delayed the implementation of this reduction until 2002. As of December 31, 2001, less than 1% of Triad's revenues were derived from home health services.

Payments to PPS-exempt hospitals and units, such as inpatient psychiatric hospital services are based upon reasonable costs, subject to a cost per discharge target. These limits are updated annually by a market basket index. Significantly, BIPA increases payments to PPS-exempt hospitals. In particular, total payments for rehabilitation hospitals in 2002 are to equal the amounts of payments that would have been made if the rehabilitation PPS system had not been enacted, and rehabilitation facilities are able to make a one-time election before the start of the PPS to be paid based on a fully phased-in PPS rate. In addition, BIPA increases the incentive payments paid for inpatient

psychiatric services from 2% to 3%, raises the national cap on long term care hospital reimbursement by 2% and increases the individual long-term care hospital target amounts by 35%.

Currently, physicians are paid by Medicare according to the physician fee schedule. However, physicians working in rural health clinics, such as those maintained by Triad, are reimbursed for their professional and administrative services through the rural health clinic subject to per visit limits unless the rural health clinic is based at a rural hospital with less than 50 beds. There are 20 rural health clinics affiliated with Triad's hospitals.

Medicare has special payment provisions for "sole community hospitals." A sole community hospital is generally the only hospital in at least a 35-mile radius. Eight of Triad's facilities qualify as sole community hospitals under Medicare regulations. Special payment provisions related to sole community hospitals include a higher reimbursement rate, which is based on a blend of hospital-specific costs and a national reimbursement rate, and a 90% payment "floor" for capital costs which guarantees the sole community hospital capital reimbursement equal to 90% of capital cost. In addition, the TRICARE program has special payment provisions for hospitals recognized as sole community hospitals for Medicare purposes.

On November 19, 1999, Congress passed the Balanced Budget Refinement Act of 1999 (the "Refinement Act") to reduce certain of the perceived adverse effects of the BBA on various health care providers. Among other things, the Refinement Act did reduce certain outpatient PPS reimbursement reductions proposed by CMS as a part of its implementation of a PPS for outpatient hospital services by attempting to limit certain losses sustained through the implementation of such system during the first three years of implementation. The Refinement Act also provided certain reimbursement increases for certain skilled nursing facilities, in part by allowing such facilities the option of choosing to be reimbursed at the new Federal PPS rate for certain cost reporting periods beginning after December 15, 1999, as opposed to the three-year phase-in described above. Triad received approximately $3.0 million and $1.0 million in additional reimbursement as a result of the Refinement Act in 2001 and 2000, respectively.

Medicaid. Most state Medicaid payments are made under a PPS, or under programs which negotiate payment levels with individual hospitals. Medicaid reimbursement is often less than a hospital's cost of services. Medicaid is currently funded jointly by the state and the Federal governments. The Federal government and many states are currently considering significant reductions in

the level of Medicaid funding while at the same time expanding Medicaid benefits, which could adversely affect future levels of Medicaid reimbursement received by our hospitals.

Annual Cost Reports. All hospitals participating in the Medicare program, whether paid on a reasonable cost basis or under PPS, are required to meet certain financial reporting requirements. Federal regulations require submission of annual cost reports covering medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries. Review of previously submitted annual cost reports and the cost report preparation process are areas included in the ongoing government investigations of HCA. See "Governmental Investigations - Governmental Investigation of HCA and Related Litigation." The investigations, actions and claims affecting HCA relate to HCA and its subsidiaries, including subsidiaries that prior to the spin-off from HCA owned facilities now owned by Triad. It is too early to predict the outcome of these investigations, but if Triad, or any Triad facility is found to be in violation of Federal or state laws relating to Medicare, Medicaid or similar program, Triad could be subject to substantial monetary fines, civil and criminal penalties and exclusion from participation in the Medicare and Medicaid programs. Any such sanctions could have a material adverse effect on Triad's financial position and results of operations. HCA has agreed to indemnify Triad in respect of losses arising from such government investigations for the period prior to the spin-off. See "Governmental Investigations - Governmental Investigation of HCA and Related Litigation" for more information regarding such arrangement.

Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to Triad under these reimbursement programs. These audits often require several years to reach the final determination of amounts earned under the programs. Providers also have rights of appeal, and it is common to contest issues raised in audits of prior years' reports. The due dates for cost reports for cost reporting periods ending after August 31, 2000 have been delayed due to CMS not issuing the final payment schedules for outpatient PPS. Triad has not filed cost reports for these periods, although the estimated impact of filing these cost reports has been reflected in the financial statements. The delay in filing these cost reports will extend the time period of final determination of amounts earned. Pursuant to

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the terms of the spin-off distribution agreement, Triad will be responsible for the Medicare, Medicaid and Blue Cross cost reports, and associated receivables and payables, for Triad's facilities for all periods ending after the spin-off. HCA has agreed to indemnify Triad for any payments which it is required to make with respect to the Medicare, Medicaid and Blue Cross cost reports for Triad facilities operated by HCA prior to the spin-off relating to periods ending on or prior to the spin-off and Triad agreed to indemnify HCA for and pay to HCA any payments received by Triad relating to such cost reports.

Managed Care. Pressures to control the cost of health care have historically resulted in increases in admissions attributable to managed care payers, although admissions for managed care payers declined in 2001 due, in part, to the Quorum acquisition. Triad expects that volumes related to managed care payers will increase in the future. Triad generally receives lower payments from managed care payers than from traditional commercial/indemnity insurers; however, as part of its business strategy, Triad intends to take steps to improve its managed care position. The percentage of Triad's revenues attributable to managed care payers were 28.9%, 31.0% and 32.7% for the years ended December 31, 2001, 2000 and 1999, respectively. See "Business Strategy"

for a more detailed discussion of such strategy.

Commercial Insurance. Triad hospitals provide services to some individuals covered by private health care insurance. Private insurance carriers make direct payments to such hospitals or, in some cases, reimburse their policy holders, based upon the particular hospital's established charges and the particular coverage provided in the insurance policy.

Commercial insurers are continuing efforts to limit the payments for hospital services by adopting discounted payment mechanisms, including prospective payment or DRG based payment systems, for more inpatient and outpatient services. To the extent that such efforts are successful and reduce the insurers' reimbursement to hospitals and the costs of providing services to their beneficiaries, such reduced levels of reimbursement may have a negative impact on the operating results of the hospitals of Triad.

Government Regulation and Other Factors

Licensure, Certification and Accreditation. Health care facilities are subject to Federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection laws. Facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. All of Triad's health care facilities are properly licensed under appropriate state laws.

All of the hospitals affiliated with Triad are certified under the Medicare and Medicaid programs and all are accredited by the Joint Commission on Accreditation of Healthcare Organizations, the effect of which is to permit the facilities to participate in the Medicare and Medicaid programs. Should any facility lose its accreditation by this Joint Commission, or otherwise lose its certification under the Medicare and/or Medicaid program, the facility would be unable to receive reimbursement from the Medicare and Medicaid programs. The facilities of Triad are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, it may be necessary for Triad to effect changes in its facilities, equipment, personnel and services.

Certificates of Need. The construction of new facilities, the acquisition of existing facilities, and the addition of new beds or services may be subject to review by state regulatory agencies under a CON program. Triad operates in five states (Alabama, Mississippi, Ohio, South Carolina, and West Virginia) that require CON approval to expand certain acute care hospital services. Such laws generally require state agency determination of public need and approval prior to the addition of beds or services or certain other capital expenditures. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, complete an acquisition or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license.

State Rate Review. The state of Arizona adopted legislation mandating rate or budget review for hospitals. In the aggregate, state rate or budget review and indigent tax provisions have not materially adversely affected the results of operations of Triad. Triad is not able to predict whether any additional state rate or budget review or indigent tax provisions will be adopted and, accordingly, is not able to assess the effect thereof on its results of

operations or financial condition.

Utilization Review. Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards, are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by peer review organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of DRG classifications and the appropriateness of cases of extraordinary length of stay or cost. Peer review organizations may deny payment for services provided, may assess fines and also have the authority to recommend to the Department of Health and Human Services ("HHS") that a provider which is in substantial noncompliance with the standards of the peer review organization be excluded from participation in the Medicare program. Utilization review is also a requirement of most non-governmental managed care organizations.

The Federal False Claims Act and Similar State Laws. A trend affecting the health care industry today is the increased use of the Federal False Claims Act, and, in particular, actions being brought by individuals on the government's behalf under the False Claims Act's qui tam, or whistleblower, provisions. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the Federal government.

When a defendant is determined by a court of law to be liable under the False Claims Act, the defendant must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,000 to $10,000 for each separate false claim. Settlements entered into prior to litigation usually involve a less severe damages methodology. There are many potential bases for liability under the False Claims Act. Liability often arises when an entity knowingly submits a false claim for reimbursement to the Federal government. In addition, a number of states have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit on behalf of the state in state court. From time to time, companies in the health care industry, including Triad, may be subject to actions under the False Claims Act. For a more complete discussion of litigation brought against Triad under the False Claims Act, see "Governmental Investigations."

Federal and State Fraud and Abuse. Participation in the Medicare program is heavily regulated by Federal statute and regulation. If a hospital fails substantially to comply with the numerous conditions of participation in the Medicare program or performs certain prohibited acts, such hospital's participation in the Medicare program may be terminated or civil or criminal penalties may be imposed upon it under certain provisions of the Social Security Act. For example, the Social Security Act prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration intended to induce referrals of patients to receive goods or services covered by a Federal health care program (the "Anti-Kickback Statute"). In addition to felony criminal penalties (fines up to $25,000 and imprisonment), the Social Security Act establishes civil monetary penalties and the sanction of excluding violators from participation in the Federal health care programs.

The Anti-Kickback Statute has been interpreted broadly by Federal regulators and certain courts to prohibit the intentional payment of anything of value if even one purpose of the payment is to influence the referral of Medicare or Medicaid business. Therefore, many commonplace commercial arrangements between hospitals and physicians could be considered by the government to violate the Anti-Kickback Statute.

As authorized by Congress, the Office of the Inspector General has

published final safe harbor regulations that outline categories of activities that are deemed protected from prosecution under the Anti-Kickback Statute. Currently, there are safe harbors for various activities, including, but not limited to: investment interest, space rental, equipment rental, practitioner recruitment, personal services and management contracts, sale of practice, discounts, employees, investments in group practices, and ambulatory surgery centers. The fact that conduct or a business arrangement does not fall within a safe harbor does not automatically render the conduct or business arrangement

unlawful under the Anti-Kickback Statute. The conduct and business arrangements, however, do risk increased scrutiny by government enforcement authorities.

Triad has a variety of financial relationships with physicians who refer patients to Triad's hospitals. Triad also has contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases, and professional service agreements. Triad also provides financial incentives, including loans and minimum revenue guarantees, to recruit physicians into the communities served by Triad's hospitals. Several of Triad's freestanding surgery centers have physician investors and physicians own interests in certain of Triad's hospitals. Some of the arrangements with physicians do not expressly meet requirements for safe harbor protection. It cannot be assured that regulatory authorities that enforce the Anti-Kickback Statute will not determine that any of these arrangements violate the Anti-Kickback Statute or other Federal or state laws.

The Social Security Act also imposes criminal and civil penalties for submitting false claims to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered, billing for services without prescribed documentation, misrepresenting actual services rendered in order to obtain higher reimbursement and cost report fraud. Like the Anti-Kickback Statute, these provisions are very broad. Further, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") created civil penalties for conduct including improper coding and billing for unnecessary goods and services. HIPAA also broadened the scope of the fraud and abuse laws by adding several criminal provisions for health care fraud offenses that apply to all health benefit programs.

The Social Security Act also includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship if these entities provide certain designated health services that are reimbursable by Medicare, including inpatient and outpatient hospital services. Sanctions for violating the Stark Law include civil money penalties up to $15,000 per prohibited service provided, assessments equal to twice the dollar value of each such service provided and exclusion from the Federal health care programs. There are a number of exceptions to the self-referral prohibition, including an exception for a physician's ownership interest in an entire hospital as opposed to an ownership interest in a hospital department. There are also exceptions for many of the customary financial arrangements between physicians and providers, including employment contracts, leases and recruitment agreements.

On January 4, 2001, CMS issued final regulations subject to comment intended to clarify parts of the Stark Law and some of the exceptions to it. These regulations are considered Phase I, of a two-phase process, with the remaining regulations to be published at an unknown future date. Phase I of the regulations became effective January 4, 2002, except in the case of the provisions relating to home health agencies, which became effective April 5,

2001.

Many of the states in which Triad operates also have adopted laws that prohibit payments to physicians in exchange for referrals similar to the Anti-Kickback Statute and the Stark Law, some of which apply regardless of the source of payment for care. These statutes typically provide criminal and civil penalties as well as loss of licensure. Little precedent exists for the interpretation or enforcement of these state laws.

Corporate Practice of Medicine. Some of the states in which Triad operates have laws that prohibit corporations and other entities from employing physicians or that prohibit certain direct and indirect payments or fee-splitting arrangements between health care providers. In addition, some states restrict certain business relationships between physicians and pharmacies. Possible sanctions for violation of these restrictions include loss of a physician's license and civil and criminal penalties. These statutes vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. Although Triad exercises care to structure its arrangements with health care providers to comply with the relevant state law, and believes such arrangements comply with applicable laws in all material respects, there can be no assurance that governmental officials charged with responsibility for enforcing these laws will not assert that Triad, or certain transactions in which it is involved, is in violation of such laws, or that such laws ultimately will be interpreted by the courts in a manner consistent with the interpretations of Triad.

Health Care Reform. Health care, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. In recent years, an increasing number of legislative proposals have been introduced or proposed in Congress and in some state legislatures that would effect major changes in the health care system, either nationally or at the state level. Proposals that have been considered include cost controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, patients' bills of rights and requirements that all businesses offer health insurance coverage to their employees. The costs of certain proposals would be funded in significant part by reductions in payments by governmental programs, including Medicare and Medicaid, to health care providers such as hospitals. There can be no assurance that future health care legislation or other changes in the administration or interpretation of governmental health care programs will not have a material adverse effect on the business, financial condition or results of operations of Triad.

Administrative Simplification. The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for health care claims and payment transactions submitted or received electronically. On August 17, 2000, CMS published final regulations establishing electronic data transmission standards that all health care providers must use when submitting or receiving certain health care transactions electronically. Compliance with these regulations is required by October 2002 subject to certain recently enacted exceptions, but Triad cannot yet predict the impact that these final regulations will have.

HIPAA also requires CMS to adopt standards to protect the security and privacy of health-related information. Regulations were proposed on August 12, 1998, but have not yet been finalized. However, as proposed, these regulations would require health care providers to implement organizational and technical practices to protect the security of electronically maintained or transmitted health-related information. In addition, CMS released final regulations

containing privacy standards in December 2000 and which require compliance by February 2003. As currently drafted, the privacy regulations will extensively regulate the use and disclosure of individually identifiable health-related information. The security regulations, as proposed, and the privacy regulations, when they become effective, could impose significant costs on Triad's facilities in order to comply with these standards. Violations of the Administrative Simplification provisions of HIPAA could result in civil penalties of up to $25,000 per type of violation in each calendar year and criminal penalties of up to $250,000 per violation.

In addition, Triad's facilities will continue to remain subject to any state laws that are more restrictive than the regulations issued under HIPAA, which vary by state and could impose additional penalties.

Conversion Legislation. Many states have enacted or are considering enacting laws affecting the conversion or sale of not-for-profit hospitals. These laws, in general, include provisions relating to attorney general approval, advance notification and community involvement. In addition, state attorneys general in states without specific conversion legislation may exercise authority over these transactions based upon existing law. In many states there has been an increased interest in the oversight of not-for-profit conversions. The adoption of conversion legislation and the increased review of not-for-profit hospital conversions may increase the cost and difficulty or prevent the completion of transactions with not-for-profit organizations in certain states in the future.

Revenue Ruling 98-15. During March 1998, the IRS issued guidance regarding the tax consequences of joint ventures between for-profit and not-for-profit hospitals. Triad has not determined the impact of the tax ruling on the development of future ventures. The tax ruling could limit joint venture development with not-for-profit hospitals, and could influence the exercise of "put agreements"--agreements that require the purchase of the partner's interest in the joint venture--by Triad's existing joint venture partner.

Environmental Matters. Triad is subject to various Federal, state and local statutes and ordinances regulating the discharge of materials into the environment. Triad does not expect that it will be required to expend any material amounts in order to comply with these laws and regulations or that compliance will materially affect its capital expenditures, earnings or competitive position.

Insurance. As is typical in the health care industry, Triad is subject to claims and legal actions by patients in the ordinary course of business. To cover these claims, Triad maintains professional malpractice liability insurance and general liability insurance in amounts which it believes to be sufficient for its operations, although it is possible that some claims may exceed the scope of the coverage in effect. At various times in the past, the cost of malpractice

and other liability insurance has risen significantly. Therefore, there can be no assurance that such insurance will continue to be available at reasonable prices which will allow Triad to maintain adequate levels of coverage. Substantially all losses in periods prior to the spin-off are insured through a wholly-owned insurance subsidiary of HCA and excess loss policies maintained by HCA. HCA has agreed to indemnify Triad in respect of claims covered by such insurance policies arising prior to the spin-off. After the spin-off, Triad obtained insurance coverage on a claims incurred basis from HCA's wholly-owned insurance subsidiary with excess coverage obtained from other carriers which is

subject to certain deductibles which Triad considers to be reasonable. For the facilities acquired in the Quorum transaction, Triad obtained tail coverage, subject to certain deductibles, to cover claims incurred prior to July 31, 2001. These facilities were converted to Triad's existing coverage on August 1, 2001.

Triad has a reserve for general and professional liability risks of $36.0 million at December 31, 2001. Any losses incurred in excess of amounts maintained under such insurance will be funded from working capital. There can be no assurance that the cash flow of Triad will be adequate to provide for professional and general liability claims in the future. See "NOTE 2 - ACCOUNTING POLICIES - General and Professional Liability Risks" in the consolidated financial statements for a more detailed discussion of such arrangements.

Governmental Investigations

False Claims Act Litigation. At a meeting in September 1998, Quorum learned from the government that the government would likely join in a lawsuit filed against Quorum under the False Claims Act. The suit was filed in January 1993 by a former employee of a hospital managed by a Quorum subsidiary. These lawsuits, commonly known as qui tam actions, are filed "under seal." That means that the claims are kept secret until the government decides whether to join the case. The person who files the lawsuit is called a "relator." The government joined the case against Quorum in October 1998. The relator's lawsuit named Quorum, QHR, HCA and all hospitals that Quorum or HCA owned, operated or managed from 1984 through 1997, as defendants. The unsealed complaint, prepared by the relator, alleged that Quorum knowingly prepared and caused to be filed cost reports which claimed payments from Medicare and other government payment programs greater than the amounts due.

On February 24, 1999, the government filed its own complaint in the case. The new complaint alleged that Quorum, on behalf of hospitals it managed between 1985 and 1995 and hospitals it owned from 1990 to the date of the complaint, violated the False Claims Act by knowingly submitting or causing to be submitted false Medicare cost reports, resulting in the submission of false claims to Federal health care programs.

The government asserted that the false claims in cost reports were, in part, reflected in "reserve analyses" created by Quorum. The complaint also alleged that these cost report filings were prepared as the result of company policy. This qui tam action sought three times the amount of damages caused to the United States by Quorum's submission of any alleged false claims to the government, civil penalties of not less than $5,000 nor more than $10,000 for each claim, and the relator's attorneys' fees and costs. On April 23, 2001, a settlement agreement was signed and a stipulation of dismissal was filed with the court dismissing all claims against Quorum, QHR and the other Quorum subsidiaries named in the lawsuit. The settlement provided for a payment of $82.5 million in compensation to the government, plus interest accruing on $77.5 million at 7.25% per annum from October 2, 2000 (the date on which an understanding with the government to settle this lawsuit was reached) to the payment date. The settlement was paid in April 2001. The settlement agreement also provides, on certain conditions, for a release of all hospitals currently or formerly managed by QHR electing to participate in the settlement.

In connection with the settlement, Quorum entered into a corporate integrity agreement with the Office of the Inspector General containing, among other things, an affirmative obligation to report certain violations of applicable laws and regulations. On August 10, 2001, the Office of Inspector General agreed to suspend Quorum's obligations under this corporate integrity agreement until November 1, 2001, in exchange for Triad's agreement to negotiate a corporate integrity agreement that would also include the hospitals owned by Triad at the time of its merger with Quorum, as well as hospitals Triad might

subsequently acquire. (In the distribution agreement with HCA at the time of its spin-off, Triad agreed to participate in the negotiation of a corporate integrity agreement with the Office of Inspector General.) These negotiations of a "combined" corporate integrity agreement were concluded and the agreement became effective on November 1, 2001. See "Triad's Ethics and Compliance Program".

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Other Qui Tam Actions and Related Investigations. In May 1998, Quorum was informed that it was a defendant in another qui tam action involving home health services provided by two of its owned hospitals and alleging that Quorum had violated Medicare laws. This action was filed under seal in June 1996 by a former employee, whom Quorum fired in April 1996. The United States Attorney's Office allowed Quorum an opportunity to review the results of the government's investigations and discuss the allegations made in the action prior to the government making a decision to intervene as a plaintiff. Quorum cooperated fully with the United States Attorney's Office and provided additional information and made employees available for interviews.

On October 26, 2000, Quorum completed settlement of a qui tam lawsuit which primarily involved allegedly improper allocation of costs at Flowers Hospital, Dothan, Alabama, to its home health agency (CV-96-P1638-S, N.D. Alabama). Quorum paid to the government on October 26, 2000 approximately $18 million in connection with this settlement. In addition to the settlement agreement, Quorum entered into a five year corporate integrity agreement covering Flowers Hospital with the Office of the Inspector General which was terminated upon the effective date of the Quorum corporate integrity agreement entered into in connection with the False Claims Act litigation discussed above. The government always reserves the right to investigate and pursue other allegations made by a relator under a complaint. However, under the settlement agreement, the relator is prohibited from pursuing these additional allegations.

As a result of its ongoing discussions with the government, prior to the merger Quorum learned that there are two additional unrelated qui tam complaints against it alleging violations of the False Claims Act for claims allegedly submitted to the government involving one owned and two managed hospitals. Quorum accrued $3.5 million on these items prior to the merger. Both matters remain under seal. With respect to the matter involving the two managed hospitals, the government has requested that Quorum conduct a self audit with respect to one Medicare cost report for one managed hospital and three other specific issues and that matter remains under seal. The government could undertake additional investigative efforts. The government has stated that it intends to investigate certain other allegations. With respect to the complaint involving the owned hospital, Triad reached an agreement to settle this matter through the payment to the government of $427,500 (plus interest to the date of actual payment), and payment of certain attorneys' fees to the relators under the complaint. Payment was made on January 15, 2002, and the case has been dismissed with prejudice. As Quorum's successor, Triad was also a defendant in another qui tam complaint, in which the government declined to intervene. After receipt of service, Triad filed motions to dismiss such litigation against Quorum and QHR and on October 9, 2001, the relators filed notices of voluntary dismissal, to which the government indicated its consent. The court dismissed such litigation on October 17, 2001.

From time to time, Triad may be the subject of additional investigations or a party to additional litigation which alleges violations of law. Triad may not know about such investigations, or about qui tam actions filed against Triad unless and to the extent such are unsealed.

Governmental Investigation of HCA and Related Litigation. In connection with the spin-off, Triad entered into a distribution agreement with HCA. The terms of the distribution agreement provide that HCA will indemnify Triad for any losses (other than consequential damages) which it may incur as a result of proceedings described below. HCA has also agreed to indemnify Triad for any losses (other than consequential damages) which it may incur as a result of proceedings which may be commenced by government authorities or by private parties in the future that arise from acts, practices or omissions engaged in prior to the date of the spin-off and that relate to the proceedings described below.

HCA is currently the subject of several Federal investigations into certain of its business practices, as well as governmental investigations by various states. HCA is cooperating in these investigations and understands, through written notice and other means, that it is a target in these investigations. Given the breadth of the ongoing investigations, HCA expects additional subpoenas and other investigative and prosecutorial activity to occur in these and other jurisdictions in the future. HCA is the subject of a formal order of investigation by the SEC. HCA understands that the SEC's investigation includes the anti-fraud, insider trading, periodic reporting and internal accounting control provisions of the Federal securities laws.

HCA is a defendant in several qui tam actions on behalf of the United States of America, which have been unsealed and served on HCA. The actions allege, in general, that HCA and certain subsidiaries and/or affiliated partnerships violated the False Claims Act, 31 U.S.C. ss. 3729 et seq., by submitting improper claims to the government for reimbursement. The lawsuits seek three times the amount of damages caused to the United States by the submission of any Medicare or Medicaid false claims presented by the defendants to the Federal government, civil penalties of not less than $5,000 nor more than $10,000 for each such Medicare or Medicaid claim, attorneys' fees and costs. HCA has disclosed that of the original 30 qui tam actions, the Department of Justice remains active in and has elected to intervene in 8 actions. HCA has also disclosed that it is aware of additional qui tam actions that remain under seal and believes that there may be other sealed qui tam cases of which it is unaware.

The investigations, actions and claims affecting HCA relate to HCA and its subsidiaries, including subsidiaries that, prior to the spin-off, owned facilities now owned by Triad. On May 5, 2000, Triad was advised that one of the qui tam cases which had been unsealed listed three of Triad's hospitals as defendants. This qui tam action alleges various violations arising out of the relationship between Curative Health Services and the other defendants, including allegations of false claims relating to contracts with Curative Health Services for the management of certain wound care centers and excessive and unreasonable management fees paid to Curative Health Services and submitted for reimbursement. Two of the three Triad hospitals named as defendants terminated their relationship with Curative Health Services prior to the spin-off and the third hospital terminated its contract thereafter.

In July 1999, Olsten Corporation and its subsidiary, Kimberly Home Health (neither of which is affiliated with HCA), announced that they would pay $61 million to settle allegations that both companies defrauded the Medicare program. Kimberly pled guilty to three separate felony charges (conspiracy, mail fraud and violating the Medicare Anti-Kickback statute) filed by the U.S. Attorneys in the Middle and Southern Districts of Florida and the Northern District of Georgia. While HCA was not specifically named in these guilty pleas, the guilty pleas refer to the involvement of a "Company A" or a "company not

named as a defendant." HCA has disclosed that it believes these references refer to HCA or its subsidiaries.

HCA is a defendant in a number of other suits, which allege, in general, improper and fraudulent billing, overcharging, coding and physician referrals, as well as other violations of law. Certain of the suits have been conditionally certified as class actions. Since April 1997, numerous securities class action and derivative lawsuits have been filed in the United States District Court for the Middle District of Tennessee against HCA and a number of its current and former directors, officers and/or employees. Several derivative actions have been filed in state court by certain purported stockholders of HCA against certain of its current and former officers and directors alleging breach of fiduciary duty, and failure to take reasonable steps to ensure that HCA did not engage in illegal practices thereby exposing it to significant damages.

On December 14, 2000, HCA announced that it had entered into a settlement agreement with the Civil Division of the Department of Justice resolving certain civil claims actions against HCA relating to diagnosis related group coding, outpatient laboratory billing and home health issues. HCA paid $745 million in compensation to the government, with interest accruing at a fixed rate of 6.5% per annum (beginning May 18, 2000), and HCA's existing letter of credit agreement with the government was reduced from $1 billion to $250 million. HCA also entered into a corporate integrity agreement with the Health and Human Services Office of the Inspector General. Civil issues relating to cost reporting and physician relations are not covered by the settlement agreement.

On December 14, 2000, HCA also announced that it had signed an agreement with the Criminal Division of the Department of Justice and various U.S. Attorney's offices to resolve pending Federal criminal actions against HCA. HCA received a full release from criminal liability for conduct arising from or relating to certain specified billing and reimbursement for services provided pursuant to Federal health care benefit programs. In addition, the government agreed not to prosecute HCA for other possible criminal offenses which are or have been under investigation by the Department of Justice arising from or relating to billing and reimbursement for services provided pursuant to Federal health care benefit programs. As part of the criminal agreement, HCA paid the government $95 million and two non-operating subsidiaries of HCA entered certain pleas in respect of the criminal actions.

The agreements announced on December 14, 2000 relate only to conduct that was the subject of the Federal investigations resolved in the agreements, and HCA has stated publicly that it continues to discuss civil claims relating to cost reporting and physician relations with the government. These agreements with the government do not resolve various qui tam actions filed by private parties against HCA, or any pending state actions. In addition to other claims not covered by these agreements, the government also reserved its rights under these agreements to pursue any claims it may have for:

- any civil, criminal or administrative liability under the Internal Revenue Code;
- any other criminal liability;
- any administrative liability, including mandatory exclusion from Federal health care programs;
- any liability to the United States (or its agencies) for any conduct other than the conduct covered in the government's investigation;
- any express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services, provided by HCA;

- any claims for personal injury or property damage or for other similar consequential damages arising from the conduct subject to the investigation; and
- any civil or administrative claims of the United States against individuals.

In addition, 14 of Triad's current and former hospitals received notices in early 2001 from CMS that it was re-opening for examination cost reports for Medicare and Medicaid reimbursement filed by these hospitals for periods between 1993 and 1998, which pre-dates Triad's spin-off from HCA. Furthermore, two of Triad's hospitals formerly owned by Quorum have received such notices. HCA or its predecessors owned these hospitals during the period covered by the notices. HCA is obligated to indemnify Triad for liabilities arising out of cost reports filed during these periods.

On March 28, 2002, HCA announced that it had reached an understanding with CMS to resolve all Medicaid cost report appeal issues between HCA and CMS on more than 2,600 cost reports for reporting periods from 1993 through July 31, 2001. The understanding, which is subject to approval of the Department of Justice and execution of a mutually satisfactory definitive written agreement, would require HCA to pay CMS the sum of $250 million. The understanding does not include resolution of outstanding civil issues with the Department of Justice and relators under HCA's various qui tam cases with respect to cost reports and physician relations.

HCA has agreed that, in the event that any hospital owned by Triad at the time of the spin-off is permanently excluded from participation in the Medicare and Medicaid programs as a result of the proceedings described above, then HCA will make a cash payment to Triad, in an amount (if positive) equal to five times the excluded hospital's 1998 income from continuing operations before depreciation and amortization, interest expense, management fees, impairment of long-lived assets, minority interests and income taxes, as set forth on a schedule to the distribution agreement, less the net proceeds of the sale or other disposition of the excluded hospital.

HCA will not indemnify Triad under the distribution agreement for losses relating to any acts, practices or omissions engaged in by Triad after the spin-off, whether or not Triad is indemnified for similar acts, practices and omissions occurring prior to the spin-off. HCA also will not indemnify Triad under the distribution agreement for similar qui tam litigation, governmental investigations and other actions to which Quorum was subject, some of which are described above. If indemnified matters were asserted successfully against Triad or any of its facilities, and HCA failed to meet its indemnification obligations, then this event could have a material adverse effect on Triad's business, financial condition, and results of operations or prospects.

Triad is unable to predict the effect or outcome of any of the ongoing investigations or qui tam and other actions, or whether any additional investigations or litigation will be commenced. The extent to which Triad may or may not continue to be affected by the ongoing investigations of HCA and the initiation of additional investigations, if any, cannot be predicted. These matters could have a material adverse effect on Triad's business, financial condition, and results of operations or prospects.

Item 2. Properties

The following table lists the hospitals owned, except as otherwise indicated, by Triad as of December 31, 2001.

Facility Name	City	State	Licensed Beds
Flowers Hospital	Dothan	AL	400
Medical Center Enterprise	Enterprise	AL	131
Gadsden Regional Medical Center	Gadsden	AL	346
Crestwood Medical Center	Huntsville	AL	120
Jacksonville Hospital	Jacksonville	AL	89
Bates Medical Center	Bentonville	AR	63
Medical Center of South Arkansas (1)	El Dorado	AR	166
Medical Park Hospital	Hope	AR	91
Northwest Medical Center	Springdale	AR	222
El Dorado Hospital	Tucson	AZ	166
Northwest Medical Center	Tucson	AZ	193
San Leandro Hospital	San Leandro	CA	122
Bluffton Regional Medical Center	Bluffton	IN	96
Dupont Hospital (2)	Fort Wayne	IN	86
Lutheran Hospital of Indiana	Fort Wayne	IN	404
St. Joseph Hospital	Fort Wayne	IN	191
Kosciusko Community Hospital	Warsaw	IN	72
Overland Park Regional Medical Center (3)	Overland Park	KS	--
Women & Children's Hospital	Lake Charles	LA	80
Wesley Medical Center	Hattiesburg	MS	211
River Region Health System (4)	Vicksburg	MS	385
Independence Regional Health Center (3)	Independence	MO	--
Carlsbad Medical Center	Carlsbad	NM	127
Lea Regional Medical Center	Hobbs	NM	250
Barberton Citizens Hospital (5)	Barberton	OH	327
Doctors Hospital of Stark County (5)	Massillon	OH	166
Claremore Regional Hospital	Claremore	OK	89
SouthCrest Hospital	Tulsa	OK	116
Willamette Valley Medical Center	McMinnville	OR	80
Carolinas Hospital System - Florence	Florence	SC	372
Carolinas Hospital System - Lake City (6)	Lake City	SC	48
Mary Black Memorial Hospital (7)	Spartanburg	SC	209
Abilene Regional Medical Center	Abilene	TX	187
Alice Regional Medical Center	Alice	TX	138
Brownwood Regional Medical Center	Brownwood	TX	218
College Station Medical Center	College Station	TX	119
Navarro Regional Hospital	Corsicana	TX	162
Denton Community Hospital	Denton	TX	122
Longview Regional Medical Center	Longview	TX	164
Woodland Heights Medical Center	Lufkin	TX	146
Pampa Regional Medical Center	Pampa	TX	115
San Angelo Community Medical Center	San Angelo	TX	162
Medical Center at Terrell (8)	Terrell	TX	130
DeTar Healthcare System	Victoria	TX	359
Gulf Coast Medical Center	Wharton	TX	161
Greenbrier Valley Medical Center	Lewisburg	WV	122

(1) Triad holds a 50% equity interest in a non-consolidated joint venture which owns and operates this facility.

(2) Owned by a limited liability company which owns an 81.3% interest and is the manager.

(3) Triad continues to own the assets related to this hospital, but has transferred the exclusive rights to use and control the hospital's operations to a separate, independent entity pursuant to a long-term lease agreement effective as of January 1, 1999. There are 726 licensed beds at the leased facilities.
(4) Owned by a limited liability company which owns a 64.5% interest and is the manager.
(5) Owned by a limited liability company which owns a 95% interest and is the manager.
(6) Carolinas Hospital System - Lake City is held pursuant to operating leases with initial terms of ten years and two renewal options of five years each.
(7) Owned by a limited liability company which owns an 89.4% interest and is the manager.
(8) Triad currently leases this hospital pursuant to a long-term lease which provides the exclusive right to use and control the hospital operations.

In addition to the hospitals listed in the table above, as of December 31, 2001, Triad operated 14 ambulatory surgery centers, including three surgery centers that are operated by an unaffiliated third party pursuant to a long-term lease. Medical office buildings also are operated in conjunction with its hospitals. These office buildings are primarily occupied by physicians who practice at Triad's hospitals.

The following table lists the hospitals owned by joint venture entities in which Triad is the minority owner and our percentage ownership interest as of December 31, 2001. Information on licensed beds was provided by the majority owner and manager of each joint venture. HCA is the majority owner of Macon Healthcare LLC. Universal Health Systems is the majority owner of Summerlin Hospital Medical Center LLC and Valley Health System LLC.

Joint Venture	Facility Name	City	Sta
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	G
Macon Healthcare LLC	Coliseum Psychiatric Center (38%)	Macon	G
Macon Healthcare LLC	Macon Northside Hospital (38%)	Macon	G
Macon Healthcare LLC	Middle Georgia Hospital (38%)	Macon	G
Summerlin Hospital Medical Center LLC	Summerlin Hospital Medical Center (26%)	Las Vegas	N
Valley Health System LLC	Desert Springs Hospital (28%)	Las Vegas	N
Valley Health System LLC	Valley Hospital Medical Center (28%)	Las Vegas	N

Triad's headquarters are located in approximately 63,000 square feet of space in one office building in Dallas, Texas. Triad sub-leases this space from HCA. See "NOTE 13-AGREEMENTS WITH HCA" in the consolidated financial statements for a more detailed description of such arrangement.

QHR leases its headquarters in Brentwood, Tennessee and regional offices located throughout the United States.

Triad's hospitals and other facilities are suitable for their respective uses and are, in general, adequate for Triad's present needs.

Item 3. Legal Proceedings

On October 20, 2000, a purported class action, Samuel Brand v. Colleen Conway Welch, et al., Case No.: OCC-3066, was filed against Triad and members of

the board of directors of Quorum in the Circuit Court of Davidson County, Tennessee, on behalf of all public stockholders of Quorum. The complaint alleged, among other things, that Quorum's directors breached their fiduciary duties to Quorum and its stockholders in agreeing to the merger at an unfair price.

In April 2001, the parties negotiated a settlement that would result in the dismissal of the action. The settlement was subject to a number of conditions, including Court approval. Court approval was obtained, and on October 22, 2001 the court dismissed the action pursuant to the terms of the agreed upon settlement and Triad paid the settlement. The settlement did not have a material effect on Triad's financial position or results of operations.

In October and November 1998, some of Quorum's stockholders filed lawsuits against Quorum in the U.S. District Court for the Middle District of Tennessee. In January 1999, the court consolidated these cases into a single

lawsuit (M.D. Tenn. No. 3-98-1004). The plaintiffs filed an amended complaint in March 1999. The plaintiffs seek to represent a class of plaintiffs who purchased Quorum's common stock from October 25, 1995 through October 21, 1998, except for Quorum's insiders and their immediate families. The amended complaint names Quorum, several of Quorum's former officers, and one of Quorum's former outside directors, as defendants.

The amended complaint alleges that defendants violated the Securities Exchange Act of 1934. The plaintiffs claim that Quorum materially inflated Quorum's net revenues during the class period by including in those net revenues amounts received from the settlement of cost reports that had allegedly been filed in violation of applicable Medicare regulations years earlier and that, because of that practice, this statement, which first appeared in Quorum's Form 10-K filed in September 1996, was false: "The Company believes that its owned hospitals are in substantial compliance with current federal, state, local, and independent review body regulations and standards." In May 1999, Quorum filed a motion to dismiss the complaint. On November 13, 2000, the judge denied Quorum's motion to dismiss the complaint against Quorum and James E. Dalton, Jr., Quorum's former President/CEO. The judge granted Quorum's motion to dismiss as to all other defendants. The judge has heard oral argument on Mr. Dalton's motion to reconsider the judge's denial of Mr. Dalton's motion to dismiss and on April 19, 2001 granted Mr. Dalton's motion to dismiss. The parties recently tentatively agreed to submit the class action to non-binding mediation. As Quorum's successor, Triad intends to vigorously defend the claims and allegations in this action.

Item 4. Submission of Matters to a Vote of Security Holders

No matters were submitted to a vote of security holders during the fourth quarter of 2001.

Part II.

Item 5. Market For Registrant's Common Equity and Related Stockholder Matters

Triad's common stock commenced trading on the Nasdaq Stock Market National Market, on May 11, 1999 (symbol "TRIH"). On April 30, 2001, Triad's common stock commenced trading on the New York Stock Exchange (symbol "TRI"). The table below set forth, for the calendar quarters indicated, the high and low reported closing sales prices per share reported on by Nasdaq and New York Stock Exchange for Triad's common stock for the years ended December 31, 2000 and 2001.

2000	High	Low
First Quarter	$18.75	$13.44
Second Quarter	25.00	14.88
Third Quarter	33.00	21.94
Fourth Quarter	34.38	25.44
2001		
First Quarter	$33.81	$24.81
Second Quarter	31.42	24.49
Third Quarter	36.70	29.95
Fourth Quarter	36.50	25.70

At the close of business on March 15, 2002, there were approximately 13,000 holders of record of Triad's common stock.

Triad has not paid any dividends on its shares of common stock and is restricted from paying dividends by certain bank indebtedness covenants. See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources".

Item 6. Selected Financial Data

The following consolidated selected financial data as of and for the years ended December 31, 2001, 2000, 1999, 1998 and 1997 should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Triad's consolidated financial statements and related notes to the consolidated financial statements, which are included herein.

	Years Ended Decem		
	2001	2000	1999
	(Dollars in millions, except per sha		
Summary of Operations:			
Revenues	$ 2,669.5	$ 1,235.5	$ 1,329.1
Income (loss) from operations (a)	6.0	4.4	(95.6)
Net income (loss) (a)	2.8	4.4	(95.6)
Basic earnings (loss) per share:			
Income (loss) from operations	$ 0.10	$ 0.14	$ (3.12)
Net income (loss)	$ 0.04	$ 0.14	$ (3.12)
Shares used in computing basic earnings (loss) per share (in millions)	57.7	31.7	30.6
Diluted earnings (loss) per share:			
Income (loss) from operations	$ 0.10	$ 0.13	$ (3.12)
Net income (loss)	$ 0.05	$ 0.13	$ (3.12)
Shares used in computing diluted earnings (loss) per share (in millions)	61.1	34.1	30.6
Financial Position:			
Assets	$ 4,165.3	$ 1,400.5	$ 1,341.1
Long-term debt, including amounts due within one year	1,773.8	590.7	555.4
Intercompany balances payable to HCA	--	--	--

Working capital	381.0	191.9	187.6
Capital expenditures	200.6	94.4	132.7
Operating Data:			
EBITDA (b)	$ 361.1	$ 174.0	$ 124.5
Number of hospitals at end of period (c)	46	28	29
Number of licensed beds at end of period (d)	7,557	3,520	3,722
Weighted average licensed beds (e)	6,379	3,633	4,745
Number of available beds at end of period (f)	6,776	3,162	3,280
Admissions (g)	233,888	128,645	145,889
Adjusted admissions (h)	396,256	220,590	241,547
Average length of stay (days) (i)	4.8	4.4	4.5
Average daily census (j)	3,060	1,532	1,818
Occupancy rate (k)	54%	49%	55%
Selected Ratios:			
Ratio of earnings to fixed charges (l)	1.3x	1.3x	--

(a) Includes charges related to impairment of long-lived assets of $23.1 million ($21.1 million after tax benefit), $8.0 million ($4.7 million after tax benefit), $69.2 million ($55.8 million after tax benefit), $55.1 million ($32.9 million after tax benefit) and $13.7 million ($8.2 million after tax benefit) for the years ended December 31, 2001, 2000, 1999, 1998 and 1997, respectively.

(b) EBITDA is defined as income (loss) from operations before depreciation and amortization, interest expense, ESOP expense, management fees, gain on sales of assets, impairment of long-lived assets, minority interests in earnings of consolidated entities and income taxes. EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from EBITDA should not be considered in isolation or as an alternative to net income, cash flows generated by operating, investing or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. Because EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, EBITDA as presented may not be comparable to other similarly titled measures of other companies.

(c) This table does not include any operating statistics for non-consolidating joint ventures and facilities leased to others.

(d) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

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(e) Represents the average number of licensed beds, weighted based on periods owned.

(f) Available beds are those beds a facility actually has in use.

(g) Represents the total number of patients admitted (in the facility for a period in excess of 23 hours) to Triad's hospitals and is used by management and certain investors as a general measure of inpatient volume.

(h) Adjusted admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Adjusted admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The adjusted admissions computation "adjusts" outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general

measure of combined inpatient and outpatient volume.

(i) Represents the average number of days admitted patients stay in Triad's hospitals.

(j) Represents the average number of patients in Triad's hospital beds each day.

(k) Represents the percentage of hospital available beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.

(l) Triad's earnings were insufficient to cover fixed charges for the years ended December 31, 1999, 1998 and 1997 by $112.4 million, $115.6 million and $15.1 million, respectively.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

On April 27, 2001, Triad completed the merger of Quorum with and into Triad with Triad being the surviving corporation. Under the terms of the merger agreement, Quorum shareholders became entitled to receive $3.50 in cash and 0.4107 shares of Triad common stock for each outstanding share of Quorum stock, plus cash in lieu of fractional shares of Triad common stock. In addition, each outstanding option to purchase shares of Quorum common stock, whether or not vested or exercisable, was converted at the holder's election into either a fully vested and exercisable option to purchase shares of Triad common stock or cash and shares of Triad common stock. Triad issued 35,786,380 shares, paid $305.0 million in cash and issued 1,638,479 options to Quorum option holders in connection with the merger. The purchase price for the merger was determined using the average stock price at the time the merger was announced, cash paid, fair value of options converted and direct costs associated with the merger. The purchase price was approximately $2.4 billion. The merger was accounted for under the purchase method of accounting and the results of operations for Quorum are included in Triad's results of operations beginning May 1, 2001.

On May 2, 2001, Triad sold two of the acute care hospitals acquired in the merger with Quorum for $38.0 million plus $8.2 million for working capital. Additionally, one hospital acquired in the merger with Quorum was designated as held for sale prior to the completion of the merger. The purchase price allocation of this hospital was equal to the estimated sales price of the hospital plus the anticipated cash flows for its estimated holding period and the estimated interest expense on the incremental debt incurred for the purchase of the hospital. On August 7, 2001, Triad sold this hospital. The results of operations of this entity are not included in Triad's results of operations.

Subsequent to the merger, Triad recorded charges of approximately $31.8 million associated with coordinating Quorum's accounting policies, practices and estimation processes with those of Triad. These charges included an $8.3 million pre-tax reduction to revenue, $18.5 million pre-tax increase in provision for doubtful accounts and $5.0 million additional income tax provision.

During 2001, Triad acquired the remaining 50% interest in one of its joint ventures and sold one hospital. During 2000, Triad sold one hospital, ceased operations of two hospitals and purchased two hospitals. Triad sold its partnership interest in a rehabilitation hospital on March 31, 2000. During 1999 after the spin-off, Triad sold ten hospitals and two ambulatory surgery centers and opened one new hospital that was accounted for using the equity method.

The above described events significantly affect the comparability of the results of operations for the years ended December 31, 2001, 2000, and 1999.

Forward-Looking Statements

This "Management's Discussion and Analysis of Financial Condition and Results of Operations" contains disclosures which are "forward-looking statements." Forward-looking statements include all statements that do not relate solely to historical or current facts, and can be identified by the use of words such as "may," "believe," "will," "expect," "project," "estimate," "anticipate," "plan" or "continue." These forward-looking statements are based on the current plans and expectations of Triad and are subject to a number of uncertainties and risks that could significantly affect current plans and expectations and the future financial condition and results of Triad. These factors include, but are not limited to,

- the highly competitive nature of the health care business,
- the efforts of insurers, health care providers and others to contain health care costs,
- possible changes in the Medicare and Medicaid programs that may limit reimbursements to health care providers and insurers,
- changes in federal, state or local regulation affecting the health care industry,
- the possible enactment of federal or state health care reform,
- the ability to attract and retain qualified management and personnel, including physicians and nurses,
- the departure of key executive officers from Triad,
- claims and legal actions relating to professional liabilities and other matters,
- fluctuations in the market value of Triad common stock,
- changes in accounting practices,
- changes in general economic conditions,
- future divestitures which may result in additional charges,
- the ability to enter into managed care provider arrangements on acceptable terms,
- the availability and terms of capital to fund the expansion of Triad's business,
- changes in business strategy on development plans,
- the ability to obtain adequate levels of general and professional liability insurance,
- potential adverse impact of known and unknown government investigations,
- timeliness of reimbursement payments received under government programs, and
- other risk factors described herein.

As a consequence, current plans, anticipated actions and future financial condition and results may differ from those expressed in any forward-looking statements made by or on behalf of Triad. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Critical Accounting Policies and Estimates

Triad's discussion and analysis of its financial condition and results of operations are based upon Triad's consolidated financial statements, which have been prepared in accordance with accounting principles generally accepted in the United States. The preparation of these financial statements requires Triad to make estimates and judgments that affect the reported amounts of assets, liabilities, revenues and expenses and related disclosures of contingent assets and liabilities. On an on-going basis, Triad evaluates its estimates, including those related to third-party payer discounts, bad debts, property and equipment, intangible assets, income taxes, general and professional liability risks and

contingencies and litigation. Triad bases its estimates on historical experience and on various other assumptions that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions. Triad believes the following critical accounting policies affect its more significant judgments and estimates used in the preparation of its consolidated financial statements.

Revenue Recognition

Triad's health care facilities have entered into agreements with third-party payers, including government programs and managed care health plans, under which the facilities are paid based upon several methodologies including established charges, the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from established charges. Revenues are recorded at estimated net amounts due from patients, third-party payers and others for health care services provided. Settlements under reimbursement agreements with third-party payers are estimated and recorded in the period the related services are rendered and are adjusted in future periods as adjustments become known or as the service years are no longer subject to audit, review or investigation. Laws and regulations governing the Medicare and Medicaid programs are extremely complex, subject to interpretation and are routinely modified for provider reimbursement. All hospitals participating in the Medicare and Medicaid programs are required to meet certain financial reporting requirements. Federal regulations require submission of annual cost reports covering medical costs and expenses associated with the services provided by each hospital to program beneficiaries. Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to Triad under these reimbursement programs. These audits often require several years to reach the final determination of amounts earned under the programs. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Bad Debt

Triad maintains allowances for doubtful accounts for estimated losses resulting from payers' inability to make payments on accounts. Triad estimates these allowances based on historical net write-offs of uncollectible accounts. If payers' ability to pay deteriorates, additional allowances may be required.

Property and Equipment and Intangible Assets

Triad evaluates the carrying value of long-lived assets and long-lived assets to be disposed of, certain identifiable intangibles and goodwill related to those assets, and recognizes impairment losses when the fair value is less than the carrying value. The fair value of assets to be held and used is determined using discounted future cash flows. The fair value of assets held for sale is determined using estimated selling values. When events, circumstances and operating results indicate that the carrying values of certain long-lived assets and the related identifiable intangible assets might be impaired, Triad prepares projections of the undiscounted future cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate that the recorded amounts are not expected to be recoverable, such amounts are reduced to estimated fair value. If market conditions become less favorable than those projected by management, additional impairments may be required.

Income Taxes

Triad records a valuation allowance to reduce its deferred tax assets to the amount that is more likely than not to be realized. While Triad has considered several items including ongoing prudent and feasible tax planning strategies in assessing the need for the valuation allowance, in the event Triad were to determine that the realization of its deferred tax asset in the future is different than its net recorded amount, an adjustment to income would be necessary.

General and Professional Liability Risks

Triad self-insures portions of its workers compensation, health insurance and general and professional liability insurance coverage and maintains excess loss policies. The reserves for these self insured portions are based on actuarially determined estimates. Any factors changing the underlying data used in determining these estimates would result in revisions to the reserves which could result in an adjustment to income.

Contingencies

Triad is subject to claims and suits arising from governmental investigations and other matters in the ordinary course of business. In certain of these actions the claimants may seek punitive damages against Triad, which are usually not covered by insurance. Triad is required to assess the likelihood of any adverse judgments or outcomes to these matters as well as potential ranges of probable losses. A determination of the amount of reserves required, if any, for these contingencies is made after careful analysis of each individual issue. The required reserves may change in the future due to new developments in each matter or changes in approach, such as a change in settlement strategy in dealing with these matters, which would result in an adjustment to income.

Results of Operations

Revenue/Volume Trends

As discussed previously, Triad completed the merger with Quorum on April 27, 2001. The effective date of the transaction for accounting purposes was May 1, 2001. Triad also acquired the remaining 50% interest in one of its joint ventures effective January 1, 2001 and two hospitals in the fourth quarter of 2000. The merger and acquisitions collectively contributed revenue of $1,390.5 million for the year ended December 31, 2001.

Triad's revenues continue to be affected by an increasing proportion of revenue being derived from fixed payment, higher discount sources, including Medicare, Medicaid and managed care plans. In addition, insurance companies, government programs, other than Medicare, and employers purchasing health care services for their employees are also negotiating discounted amounts that they will pay health care providers rather than paying standard prices. Triad expects patient volumes from Medicare and Medicaid to continue to increase due to the general aging of the population and expansion of state Medicaid programs. However, under the Balanced Budget Act, Triad's reimbursement from the Medicare and Medicaid programs has been reduced. Certain of the reductions from the Balanced Budget Act have been mitigated by the Refinement Act and were further mitigated by BIPA. Additional reimbursement from BIPA was approximately $16.0 million in the year ended December 31, 2001. Triad anticipates receiving

approximately $17.0 million in additional reimbursement in 2002. The Balanced Budget Act has accelerated a shift, by certain Medicare beneficiaries, from traditional Medicare coverage to medical coverage that is provided under managed care plans. Triad generally receives lower payments per patient under managed care plans than under traditional indemnity insurance plans. With an increasing proportion of services being reimbursed based upon fixed payment amounts, where the payment is based upon the diagnosis, regardless of the cost incurred or level of service provided, revenues, earnings and cash flows are being significantly reduced. As part of the Balanced Budget Act, CMS implemented outpatient PPS on August 1, 2000 which reduced reimbursement in 2000. Patient revenues related to Medicare and Medicaid patients were 36.3%, 36.0%, and 38.8% of total patient revenues for the years ended December 31, 2001, 2000 and 1999, respectively. Patient revenues related to managed care plan patients were 28.9%, 31.0% and 32.7% of total patient revenues for the years ended December 31, 2001, 2000 and 1999, respectively. Patient revenues from capitation arrangements, or prepaid health service agreements, are less than 1% of patient revenues in each period presented. See Item I "Business - Reimbursement."

Management of Triad has focused on streamlining its portfolio of facilities to eliminate those with poor financial performance, weak competitive market positions or locations in certain urban markets. Triad sold one hospital during the year ended December 31, 2001, sold one hospital and ceased operations of two hospitals during the year ended December 31, 2000, and sold ten hospitals during the year ended December 31, 1999. Revenues for these facilities were $60.5 million, $118.8 million and $249.9 million for the years ended December 31, 2001, 2000 and 1999, respectively.

Triad's revenues also continue to be affected by the trend toward certain services being performed more frequently on an outpatient basis. Growth in outpatient services is expected to continue in the health care industry as procedures performed on an inpatient basis are converted to outpatient procedures through continuing advances in pharmaceutical and medical technologies. The redirection of certain procedures to an outpatient basis is also influenced by pressures from payers to perform certain procedures as outpatient care rather than inpatient care. Outpatient revenues were 45.6% in the year ended December 31, 2001 compared to 45.3% in the comparable period in 2000.

Reductions in the rate of increase in Medicare and Medicaid reimbursement, increasing percentages of the patient volume being related to patients participating in managed care plans and continuing trends toward more services being performed on an outpatient basis are expected to present ongoing challenges. The challenges presented by these trends are magnified by Triad's inability to control these trends and the associated risks. To maintain and improve its operating margins in future periods, Triad must increase patient volumes while controlling the costs of providing services. If Triad is not able to achieve reductions in the cost of providing services through operational efficiencies, and the trend toward declining reimbursements and payments continues, results of operations and cash flows will deteriorate.

Management believes that the proper response to these challenges includes the delivery of a broad range of quality health care services to physicians and patients with operating decisions being made by the local management teams and local physicians.

In connection with the spin-off, HCA agreed to indemnify Triad for any payments which it is required to make in respect of Medicare, Medicaid and Blue Cross cost reports for former HCA facilities owned by Triad at the time of the

spin-off from HCA relating to periods ending on or prior to the date of the spin-off, and Triad agreed to indemnify HCA for and pay to HCA any payments received by it relating to such cost reports relating to periods ending on or prior to the date of the spin-off. Triad will be responsible for the filing of these cost reports and any terminating cost reports. Triad has recorded a receivable from HCA relating to the indemnification of $24.2 million as of December 31, 2001.

Operating Results Summary

Following are comparative summaries of results from operations for the years ended December 31, 2001, 2000 and 1999. Dollars are in millions, except per share amounts and ratios.

	Years Ended December			
	2001		2000	
	Amount	Percentage	Amount	Percent
Revenues..	$ 2,669.5	100.0	$ 1,235.5	100.
Salaries and benefits..........................	1,128.5	42.3	511.1	41.
Reimbursable expenses..........................	41.6	1.6	--	-
Supplies..				