

TRIAD HOSPITALS INC
Form 424B3
June 28, 2005
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The information in this prospectus supplement and accompanying prospectus is not complete and may be changed. This prospectus supplement and the accompanying prospectus are not an offer to sell these securities and are not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

Filed Pursuant To Rule 424(b)(3)

Registration No. 333-123294

Subject to Completion

Preliminary Prospectus Supplement dated June 28, 2005

PROSPECTUS SUPPLEMENT

(To prospectus dated March 31, 2005)

3,642,987 Shares

Common Stock

We are selling 3,642,987 shares of our common stock.

Our common stock is listed on the New York Stock Exchange under the symbol TRI. The last reported sale price of our common stock on the New York Stock Exchange on June 27, 2005 was \$54.90 per share.

Investing in our common stock involves risks that are described in the Risk Factors section beginning on page S-4 of this prospectus supplement.

	<u>Per Share</u>	<u>Total</u>
Public offering price	\$	\$
Underwriting discount	\$	\$
Proceeds, before expenses, to us	\$	\$

The underwriters may also purchase up to an additional 546,448 shares of our common stock from us at the public offering price, less the underwriting discount, within 30 days from the date of this prospectus supplement to cover overallocments.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus supplement or the accompanying prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

The shares will be ready for delivery on or about _____, 2005.

Joint Book-Running Managers

Merrill Lynch & Co.

Citigroup

Banc of America Securities LLC

The date of this prospectus supplement is _____, 2005.

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You should rely only on the information contained or incorporated by reference in this prospectus supplement and the accompanying prospectus. We have not, and the underwriters have not, authorized any other person to provide you with different information. If anyone provides you with different or inconsistent information, you should not rely on it. We are not, and the underwriters are not, making an offer to sell these securities in any jurisdiction where the offer or sale is not permitted. You should assume that the information appearing in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference is accurate only as of their respective dates. Our business, financial condition, results of operations and prospects may have changed since those dates.

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ABOUT THIS PROSPECTUS SUPPLEMENT

This prospectus supplement and the accompanying prospectus are part of a registration statement that we filed with the Securities and Exchange Commission, or SEC, utilizing a shelf registration process. This prospectus supplement provides you with the specific details regarding this offering, including the price, the amount of common stock being offered and the risks of investing in our common stock. The accompanying prospectus provides you with more general information, some of which does not apply to the offering of our common stock. To the extent information in this prospectus supplement is inconsistent with the accompanying prospectus or any of the documents incorporated by reference into this prospectus supplement and the accompanying prospectus, you should rely on this prospectus supplement. You should read both this prospectus supplement and the accompanying prospectus together with the additional information described under the heading **Where You Can Find More Information**.

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SUMMARY

This summary highlights selected information appearing elsewhere in this prospectus supplement and the accompanying prospectus and may not contain all of the information that is important to you. You should carefully read this prospectus supplement, the accompanying prospectus and the other documents we refer to or incorporate by reference before making an investment decision. In this prospectus supplement and the accompanying prospectus, the terms we, us, our, our company and Triad refer to Triad Hospitals, Inc. and its subsidiaries, except where it is clear from the context that such term means only Triad Hospitals, Inc.

Our Company

We are one of the largest publicly owned hospital companies in the United States and provide health care services through hospitals and ambulatory surgery centers that we own and operate in small cities and selected urban markets primarily in the southern, midwestern and western United States. Our hospital facilities currently include 52 general acute care hospitals and 9 ambulatory surgery centers located in the states of Alabama, Alaska, Arizona, Arkansas, Indiana, Louisiana, Mississippi, Nevada, New Mexico, Ohio, Oklahoma, Oregon, South Carolina, Texas and West Virginia. Included among these facilities is one hospital operated through a 50/50 joint venture that is not consolidated for financial reporting purposes. We are also a minority investor in three joint ventures that own seven general acute care hospitals in Georgia and Nevada. Through our wholly-owned subsidiary, Quorum Health Resources, LLC, or QHR, we also provide management and consulting services to independent general acute care hospitals located throughout the United States.

Our 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. Our 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 that we operate. In addition, some of our 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, we make available a variety of management services to our 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 principal executive offices are located at 5800 Tennyson Parkway, Plano, Texas 75024, and our phone number is (214) 473-7000. Our corporate website address is <http://www.triadhospitals.com>. Information contained on our website is not part of this prospectus supplement.

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The Offering

Issuer	Triad Hospitals, Inc.
Common stock offered by us	3,642,987 shares
Shares outstanding after the offering	85,345,830 shares(1)
Use of proceeds	We estimate that the net proceeds from this offering, assuming no exercise of the overallotment option, after deducting fees and expenses will be approximately \$189.0 million. We intend to use the net proceeds for general corporate purposes, including capital expenditures for development of new facilities, potential acquisitions of new facilities and expansion of our existing facilities and services; working capital; and repayment of indebtedness. See Use of Proceeds.
Risk Factors	See Risk Factors beginning on page S-4 of this prospectus supplement and other information included in this prospectus supplement and the accompanying prospectus for a discussion of factors you should carefully consider before deciding to invest in shares of our common stock.
New York Stock Exchange Symbol	TRI

- (1) The number of shares outstanding after the offering excludes 14,312,229 shares reserved for issuance under our stock option plans, of which options to purchase 8,621,362 shares at a weighted average option price of \$32.79 have been issued. This number assumes that the underwriters' overallotment option is not exercised. If the overallotment option is exercised in full, we will issue and sell an additional 546,448 shares. For a more complete description of our common stock, see Description of Common Stock in the accompanying prospectus.

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FORWARD-LOOKING STATEMENTS

Certain information included or incorporated by reference in this prospectus supplement may be deemed to be forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, as amended, or Exchange Act. 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, intend, should, plan, These forward-looking statements are based on our current plans and expectations and are subject to a number of uncertainties and risks that could significantly affect our current plans and expectations and our future financial condition and results. These factors include, but are not limited to:

the highly competitive nature of the health care business;

the efforts of insurers and other payers, health care providers and others to contain health care costs;

possible changes in the Medicare, Medicaid and other government programs that may further limit reimbursements to health care providers;

changes in Federal, state or local regulations affecting the health care industry;

the possible enactment of Federal or state health care reform;

our 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 our common stock;

changes in accounting standards;

changes in general economic conditions or geopolitical events;

future acquisitions, joint venture developments or divestitures which may result in additional charges;

our ability to enter into managed care provider arrangements on acceptable terms;

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the availability and terms of capital to fund the expansion of our business;

changes in business strategy or development plans;

our 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 us or on our behalf. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this prospectus supplement. We do not undertake any obligation to update publicly or revise any forward-looking statements.

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RISK FACTORS

You should carefully consider the risks described in this prospectus supplement and the accompanying prospectus, in addition to the other information contained or incorporated by reference in this prospectus supplement and the accompanying prospectus, before making an investment decision. These risks are not the only ones facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially and adversely affect our business operations. Any of these risks could materially and adversely affect our business, financial condition or results of operations. In such cases, you may lose all or part of your investment.

Risks Relating to Our Company

Our substantial leverage could have a significant effect on our operations.

We are a highly leveraged company. As of March 31, 2005, our consolidated long-term debt equaled approximately \$1.65 billion. As of March 31, 2005, we also were able to draw upon a revolving line of credit in an aggregate principal amount of up to \$400.0 million, and, as of such date, there were no amounts outstanding thereunder. There were \$21.8 million of letters of credit issued as of March 31, 2005 that reduced amounts available under the line of credit. In June 2005, we entered into an amended and restated credit agreement, which replaced our existing credit facility. The new credit agreement provides for senior secured credit facilities aggregating up to \$1.1 billion, consisting of a six year \$500 million Term Loan A facility and a six year \$600 million revolving credit facility. No amounts are currently outstanding under the revolving credit facility. We will record a pre-tax charge of approximately \$8.4 million in the second quarter of 2005 related to this refinancing. We also have the ability to incur significant amounts of additional debt, subject to the conditions imposed by the terms of our credit facility and the indentures governing our outstanding debt securities.

Although we believe that our future operating cash flow, together with available financing arrangements, will be sufficient to fund our operating requirements, our leverage and debt service obligations could have important consequences to you, including the following:

The terms of our existing debt obligations contain, and the terms of any future debt obligations may contain, numerous financial and other restrictive covenants, which, among other things, restrict our ability to pay dividends, incur additional debt and sell assets. If we do not comply with these obligations, it may cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately.

We may be more vulnerable in the event of downturns in our businesses, in our industries, in the economy generally or if the government implements further limitations on reimbursement under Medicare and Medicaid.

We may have difficulty obtaining additional financing at favorable interest rates to meet our requirements for working capital, capital expenditures, acquisitions, general corporate purposes or other purposes.

We may be required to dedicate a substantial portion of our cash flow to the payment of principal and interest on our indebtedness, which could reduce the amount of funds available for operations.

Any borrowings we may make at variable interest rates leave us vulnerable to increases in interest rates generally.

A significant portion of our revenues is dependent on Medicare and Medicaid payments, and reductions in Medicare or Medicaid payments or the implementation of other measures to reduce reimbursements may reduce our revenues.

A significant portion of our revenues is derived from the Medicare and Medicaid programs, which are highly regulated and subject to frequent and substantial changes. We derived approximately 36.1% and 35.8% of

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our revenues from the Medicare and Medicaid programs for the year ended December 31, 2004 and the three months ended March 31, 2005, respectively.

In recent years, legislative changes have resulted in limitations on, and, in some cases, reduced levels of payment and reimbursement for, a substantial portion of hospital procedures and costs. Other legislative changes have altered the method and amounts of payment for various services under the Medicare and Medicaid programs. In addition, the Fiscal Year 2006 Budget, which Congress recently approved, contemplates, among other things, an approximately \$10 billion reduction in Medicaid spending over five years. Moreover, as a result of budgetary constraints, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures and to provide universal coverage and additional care, including enrolling Medicaid recipients in managed care programs and imposing additional taxes on hospitals to help finance or expand the states' Medicaid systems.

We believe that hospital operating margins have been, and may continue to be, under significant pressure because of deterioration in pricing flexibility and payer mix, and growth in operating expenses in excess of the increase in prospective payments under Medicare or Medicaid. Future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs may have a material adverse effect on our business, financial condition, results of operations or prospects.

Our revenue and profitability may be constrained by future cost containment initiatives undertaken by purchasers of healthcare services.

The competitive position of our hospitals is also affected by the increasing number of initiatives undertaken during the past several years by major purchasers of healthcare, including Federal and state governments, insurance companies and employers, to revise payment methodologies and monitor healthcare expenditures in order to contain healthcare costs. As a result of these initiatives, managed care organizations offering prepaid and discounted medical services packages represent an increasing portion of our admissions, which may result in reduced hospital revenue growth. In addition, private payers increasingly are attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. An increasing number of managed care organizations have experienced financial difficulties in recent years, in some cases resulting in bankruptcy or insolvency. Managed care organizations with whom we do business may encounter similar difficulties in paying claims in the future. We believe that reductions in the payments that we receive for our services, coupled with the increased percentage of patient admissions from organizations offering prepaid and discounted medical services and difficulty in collecting receivables from managed care organizations, could reduce our overall revenues and profitability.

We conduct business in a heavily regulated industry; changes in or violations of regulations may result in increased costs or sanctions that could reduce our revenue and profitability.

The healthcare industry is subject to extensive Federal, state and local laws and regulations relating to:

licensure and certificate of need requirements;

conduct of operations;

ownership of facilities;

addition of facilities and services;

financial relationships with physicians and other referral sources;

confidentiality, maintenance and security issues associated with medical records;

billing for services; and

prices for services.

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These laws and regulations are extremely complex and subject to interpretation. In many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of these laws and regulations. In certain public statements, governmental authorities have taken positions on issues for which little official interpretation was previously available. Some of these positions appear to be inconsistent with common practices within the industry but have not previously been challenged.

We have a variety of financial relationships with physicians who refer patients to our hospitals. We have contracts with physicians providing services under a variety of financial arrangements such as employment contracts, leases and professional service agreements. We also provide financial incentives, including loans and minimum revenue guarantees, to recruit physicians into the communities served by our hospitals. Several of the freestanding surgery centers affiliated with us have physician investors. In several of our locations, physicians have acquired ownership interests in hospitals and other healthcare providers in which we own a majority interest. Some of our arrangements with our physicians do not expressly meet the requirements for safe harbor protection.

A determination that we have violated any of these laws could subject us to liability including:

criminal penalties;

civil sanctions, including civil monetary penalties; and

exclusion from participation in government programs such as Medicare and Medicaid or other Federal healthcare programs.

Consequently, a determination that we have violated these laws, or even a public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects and our business reputation could suffer significantly.

We have experienced deterioration in the collectibility of our uninsured accounts receivable, resulting in an increase in our allowance for doubtful accounts, and we may continue to experience such deterioration in the future.

We record our accounts receivable at the estimated net realizable amount, and maintain allowances for doubtful accounts for estimated losses resulting from payers' inability to make payments on accounts. We analyze the ultimate collectibility of our accounts receivable after one year, using a regression analysis of the historical net write-offs to determine the amount of those accounts receivable that were ultimately not collected. The results of this analysis are then applied to the current accounts receivable to determine the allowance necessary for that period. This process is augmented by other analytical methods such as changes in the level of uninsured receivables, accounts receivable days, cash collections and accounts receivable agings. Our operating results for the year ended December 31, 2003 reflected a \$63.9 million pre-tax increase in our allowance for doubtful accounts. This increase reflected growth in our uninsured receivables and deterioration in the collectibility of those uninsured receivables. We believe that the growth and deterioration in uninsured receivables resulted from weak economic conditions and rising health care costs and we may have greater amounts of uninsured receivables in the future. If the collectibility of our uninsured receivables deteriorates, further increases in our allowance for doubtful accounts may be required, which could materially adversely impact our operating results and financial condition.

Our new self-pay discount program could reduce our profitability.

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We recently implemented a new self-pay discount program offering discounts to uninsured patients based on personal financial criteria and means testing. This program reduced revenues by approximately \$10.8 million in the fourth quarter of 2004 and \$20.7 million in the first quarter of 2005 with a similar reduction to the provision for doubtful accounts in both periods. In the second quarter of 2005, we implemented an additional

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component to this program offering a discount to all uninsured patients based on the lowest managed care discount at each hospital. Although we do not anticipate that this program will have a significant impact on our earnings per share, we have not yet had sufficient experience with this program to assess its ongoing impact on our results of operations. If our provision for doubtful accounts does not continue to decrease in an amount similar to the reduction in our revenue from the self-pay discount program, our profitability could decline.

Our future success depends on our ability to maintain good relationships with the physicians at our hospitals.

Because physicians generally direct the majority of hospital admissions, our success has been, in part, dependent upon the number and quality of physicians on our hospitals' medical staffs, the admissions practices of the physicians at our hospitals and our ability to maintain good relations with our physicians. Physicians are generally not employees of the hospitals at which they practice and, in many of the markets that we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. If we are unable to successfully maintain good relationships with physicians, our hospitals' admissions may decrease and our operating performance may decline.

Our revenues are heavily concentrated in Texas, Indiana, Alabama and Arkansas, which makes us particularly sensitive to economic and other changes in these states.

For the year ended December 31, 2004, our:

Texas facilities generated approximately 18.1% of revenues, 13.7% of EBITDA and 8.1% of income from continuing operations before income tax provision;

Indiana facilities generated approximately 14.9% of revenues, 32.3% of EBITDA and 57.8% of income from continuing operations before income tax provision;

Alabama facilities generated approximately 10.7% of revenues, 12.6% of EBITDA and 12.5% of income from continuing operations before income tax provision; and

Arkansas facilities generated approximately 11.6% of revenues, 5.5% of EBITDA and (1.1)% of income from continuing operations before income tax provision.

Accordingly, any change in the current demographic, economic, competitive or regulatory conditions in Texas, Indiana, Alabama or Arkansas could have a material adverse effect on our business, financial condition, results of operations or prospects.

We depend heavily on our senior and local management personnel, and the loss of the services of one or more of our key senior management personnel or key local management personnel could weaken our management team and our ability to deliver healthcare services efficiently.

We are dependent upon the services and management experience of James D. Shelton and other of our executive officers. If Mr. Shelton or any of our other executive officers were to resign their positions or otherwise be unable to serve, our management could be weakened and our

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operating results could be adversely affected. In addition, our success depends on our ability to attract and retain local managers at our hospitals and related facilities, the ability of our officers and key employees to manage growth successfully and our ability to attract and retain skilled employees. If we are unable to attract and retain local management, our operating performance could decline.

Our success depends on our ability to attract and retain qualified healthcare professionals, and a shortage of qualified healthcare professionals in certain markets could weaken our ability to deliver healthcare services efficiently.

In addition to the physicians and management personnel whom we employ, our operations are dependent on the efforts, ability and experience of our other healthcare professionals, such as nurses, pharmacists

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and lab technicians. Nurses, pharmacists, lab technicians and other healthcare professionals are generally employees of our company. Our future success will be influenced by our ability to attract and retain these skilled employees. A shortage of healthcare professionals in certain markets, the loss of some or all of our key employees, or the inability to attract and retain sufficient numbers of qualified healthcare professionals could cause our operating performance to decline.

We rely on the information systems provided to us by HCA Inc. and our operations could suffer if our access to these systems is interrupted.

Since our spin-off from HCA, HCA continues to provide various information systems support services to us on a contractual basis. Our business depends significantly on effective information systems to process clinical and financial information. Under a contract with a term that expires in May 2008, HCA's wholly-owned subsidiary, Columbia Information Services, Inc., provides financial, clinical, patient accounting and network information services to us. The contract can be terminated prior to May 2008 in the event of bankruptcy or if either party fails to cure a breach within a specified notice period. If our access to these systems is limited or we fail to develop independent systems in the future, our operations could suffer. Moreover, as new information systems are developed, we must integrate them into our existing system. Our inability to successfully integrate new information systems could cause our operations to suffer.

We face intense competition from other hospitals and healthcare providers, which may result in a decline in our revenues, profitability and market share.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. In some cases, competing hospitals are more established than our 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 our facilities. Some of the hospitals that compete with ours are owned or operated by tax-supported governmental bodies or by private not-for-profit entities supported by endowments and charitable contributions, which can finance capital expenditures on a tax-exempt basis and are exempt from sales, property and income taxes. In some of these markets, we also face competition from other providers such as outpatient surgery, orthopedic, oncology and diagnostic centers.

Although some of our hospitals operate 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 plan incentives or personal choice.

Our healthcare consulting business competes in a fragmented industry for the small percentage of hospitals managed by hospital management companies. Competitors include large, national firms such as the national accounting firms, specialized healthcare firms, and numerous independent practitioners. Furthermore, some hospitals choose to obtain management services from the many large, tertiary care facilities that create referral networks with smaller surrounding hospitals. As a result, hospitals have various alternatives to the management services currently offered by us.

The intense competition we face from other healthcare providers and other firms may result in a decline in our revenues, profitability and market share.

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We may have difficulty in implementing our business strategy of growth through acquisitions and joint ventures and we may have difficulty effectively integrating future acquisitions and joint ventures into our ongoing operations. We also may have difficulty acquiring hospitals from not-for-profit entities due to increased regulatory scrutiny.

One element of our business strategy is expansion through the acquisition of acute care hospitals or the formation of joint ventures in selected markets. The competition to acquire hospitals and form joint ventures in

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the markets that we target is significant, and we may not be able to consummate suitable transactions on terms favorable to us if other healthcare companies, including those with greater financial resources than ours, are competing for the same target businesses. In order to consummate future acquisitions or joint ventures, we may be required to incur or assume additional indebtedness. We may not be able to obtain financing, if necessary, for any acquisitions or joint ventures that we might make or we may be required to borrow at higher rates and on less favorable terms. Additionally, we may not be able to effectively integrate the facilities that we acquire with our ongoing operations.

Acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although we have policies to conform the practices of acquired facilities to our standards, and generally will seek indemnification from prospective sellers covering these matters, we may become liable for past activities of acquired businesses.

Many states have enacted or are considering enacting laws affecting sales, leases or other transactions in which control of not-for-profit hospitals is acquired by for-profit entities. These laws, in general, include provisions relating to state attorney general approval, advance notification and community involvement. In addition, state attorneys general in states without specific legislation governing these transactions may exercise authority based upon charitable trust and other existing law. The increased legal and regulatory review of these transactions involving the change of control of not-for-profit entities may increase the costs required, or limit our ability, to acquire not-for-profit hospitals and may affect our ability to exercise existing purchase options for hospitals under hospital lease arrangements.

We may be subject to liabilities because of litigation and investigations that could have a material adverse effect on our operations.

As a company in the health care industry, we are subject to the increased use of the *qui tam*, or whistleblower, provisions of the Federal False Claims Act. These provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the Federal government, such as when an entity knowingly submits a false claim for reimbursement to the Federal government. An entity found liable under the False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus certain civil penalties. A number of states have adopted their own false claims provisions and whistleblower provisions.

As a result of its ongoing discussions with the government prior to our merger with it, Quorum Health Group, Inc., or Quorum, learned of two *qui tam* complaints against it alleging violations of the False Claims Act for claims allegedly submitted to the government involving two managed hospitals. Quorum accrued the estimated liability for these items prior to the merger and the matters remain under seal. The government requested that Quorum conduct a self audit with respect to one Medicare cost report for one managed hospital and three other specific issues. The government has stated that it intends to investigate certain other allegations.

On September 9, 2003, we were served with a *qui tam* complaint alleging, among other things, the submission of false claims for reimbursement and improper allocation of costs at a hospital in Mississippi managed by our subsidiary, QHR, which is named as an additional defendant. The Federal government has apparently elected not to intervene in the case and the complaint was unsealed. We are vigorously defending this matter and have filed a motion to dismiss, which is pending before the court. While we believe that we have no liability for the claims alleged in this complaint, discovery has not been completed and at this time we cannot predict the final effect or outcome of the complaint.

On May 18, 2004, we were served with a *qui tam* complaint alleging, among other things, the submission of false claims for reimbursement at two hospitals in Georgia formerly managed by QHR. On April 26, 2005, we received a copy of a *qui tam* complaint alleging, among other things, the submission of false claims for reimbursement at a hospital in Pennsylvania managed by QHR. The Federal government has elected not to

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intervene in these cases and the complaints were recently unsealed. While we are vigorously defending these matters, we are not yet able to form a view as to any probable liability for any of the claims alleged in the complaints.

Neither our merger agreement with Quorum nor the distribution agreement entered into with HCA in connection with our spin-off will provide indemnification to us in respect of the Quorum litigation and investigations described above. If we incur material liabilities as a result of other *qui tam* litigation or governmental investigation, these matters could have a material adverse effect on our business, financial condition, results of operations or prospects.

At this time we cannot predict the final effect or outcome of the ongoing investigations or *qui tam* actions. If violations of Federal or state laws relating to Medicare, Medicaid or other government programs are found, then we may be required to pay substantial fines and civil and criminal damages and also may be excluded from participation in the Medicare and Medicaid programs and other government programs. Similarly, the amount of damages sought in the *qui tam* actions or in the future may be substantial. We could be subject to substantial costs resulting from defending, or from an adverse outcome in, any current or future investigations, administrative proceedings or litigation. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement. Amounts paid to settle any of these matters may be material. Agreements entered into as a part of any settlement could also materially adversely affect us. Any current or future investigations or actions could have a material adverse effect on our results of operations or financial position.

We from time to time may be the subject of additional investigations or a party to additional litigation that alleges violations of law. We may not know about those investigations, or about *qui tam* actions filed against us, unless and to the extent such matters are unsealed. If any of those matters were successfully asserted against us, there could be a material adverse effect on our business, financial position, results of operations or prospects.

If we fail to comply with our corporate integrity agreement, we could be required to pay significant monetary penalties.

On November 1, 2001, we entered into a five-year corporate integrity agreement with the Office of the Inspector General of the United States Department of Health and Human Services and agreed to maintain our compliance program in accordance with the corporate integrity agreement. This obligation could result in greater scrutiny by regulatory authorities. Violations of the corporate integrity agreement could subject our 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 us.

We may be subject to liabilities because of claims arising from our hospital management activities.

We may be subject to liabilities from the activities or omissions of the employees of hospitals we manage or our employees in connection with the management of such hospitals. Recently, we and other hospital management companies have been subject to complaints alleging that these companies violated laws on behalf of hospitals they managed. In some cases, plaintiffs brought actions against the management company instead of, or in addition to, their individually managed hospital clients for these violations. Our hospital management contracts generally require the hospitals we manage to indemnify us against certain claims and maintain specified amounts of insurance. However, our managed hospitals or other third parties may not indemnify us against losses we incur arising out of the activities or omissions of the employees of the hospitals we manage. If we are held liable for amounts exceeding the limits of insurance coverage or for claims outside the scope of that coverage or any indemnity, or if any indemnity agreement is determined to be unenforceable, then any such liability could adversely affect our business, results of operations and financial condition.

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We may be subject to general liabilities or liabilities because of claims brought against our owned and leased hospitals, we are experiencing rising malpractice insurance premiums, and our insurance carriers could become insolvent.

In recent years, plaintiffs have brought actions against hospitals and other healthcare providers, alleging malpractice, product liability or other legal theories. Many of these actions involved large claims and significant defense costs. We maintain professional malpractice liability and general liability insurance coverage, subject to certain deductibles, to cover claims arising out of the operations of our owned and leased hospitals. Some of the claims, however, could exceed the scope of the coverage in effect or coverage of particular claims could be denied. While our professional and other liability insurance has been adequate in the past to provide for liability claims, such insurance may not be available for us to maintain adequate levels of insurance. Moreover, healthcare providers in our industry have experienced significant increases in the premiums for malpractice insurance, and such costs may rise in the future. Malpractice insurance coverage may not continue to be available at a cost allowing us to maintain adequate levels of insurance with acceptable deductible amounts. In addition, because of the significant increase in medical malpractice insurance premiums in certain states, we may encounter difficulty recruiting and retaining physicians or continuing to provide certain services at our hospitals. In addition, one or more of our insurance carriers may become insolvent and unable to fulfill its obligation to defend, pay or reimburse us when that obligation becomes due.

In addition, we self-insure portions of our workers compensation, health insurance, and general and professional liability insurance coverage and maintain excess loss policies. The liabilities estimated for these self-insured portions are based on actuarially determined estimates which are determined based on a number of factors including amount and timing of historical payments, severity of individual cases, anticipated volume of services provided and discount rates for future cash flows. The amounts of any ultimate actual payments for workers compensation and general and professional liability risks may not become known for several years after incurrence. Moreover, any factors changing the underlying data used in determining these estimates would result in revisions to the liabilities which could result in a decrease in income.

We could incur substantial liability if our spin-off from HCA was found to be taxable.

On March 30, 1999, HCA received a private letter ruling from the Internal Revenue Service, or IRS, concerning the United States Federal income tax consequences of the spin-off of our company and LifePoint Hospitals, Inc. by HCA and the restructuring transactions that preceded the spin-off. The private letter ruling provided that the spin-off generally was tax-free to HCA and HCA's stockholders, except for any cash received instead of fractional shares. The IRS has issued additional private letter rulings that supplement its March 30, 1999 ruling, including supplemental rulings stating that the Quorum merger and certain other transactions occurring subsequent to the spin-off do not adversely affect the private letter rulings previously issued by the IRS. The March 30, 1999 ruling and the supplemental rulings are based upon the accuracy of representations as to numerous factual matters and as to certain intentions of HCA, our company and LifePoint. The inaccuracy of any of those representations could cause the IRS to revoke all or part of any of the rulings retroactively.

If the spin-off were to fail to qualify for tax-free treatment, then, in general, additional corporate tax, which would be substantial, would be payable by the consolidated group of which HCA is the common parent. Each member of HCA's consolidated group at the time of the spin-off, including our company, would be jointly and severally liable for this tax liability. In addition, we entered into a tax sharing and indemnification agreement with HCA and LifePoint, which prohibits us from taking actions that could jeopardize the tax treatment of either the spin-off or the restructuring transactions that preceded the spin-off, and requires us to indemnify HCA and LifePoint for any taxes or other losses that result from our actions, which amounts could be substantial. If we are required to make any indemnity payments or otherwise are liable for additional taxes relating to the spin-off, our results of operations could be materially adversely affected.

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Risks Relating to This Offering

Our common stock price may be volatile.

The trading price of our common stock has been and may continue to be subject to wide fluctuations over short and long periods of time. Our common stock price may fluctuate in response to a number of events and factors, including:

actual or anticipated quarterly fluctuations in our financial results, particularly if they differ from investors' expectations;

future announcements concerning our business;

changes in financial estimates and recommendations by securities analysts;

actions of our competitors and changes in the market valuations, strategies and capabilities of our competitors;

operating and stock price performance of companies that investors deem comparable to us;

changes in government regulation and other changes and developments affecting the health care industry; and

general economic, market and political conditions, including war or acts of terrorism.

Shares eligible for future sale may harm our common stock price.

Sales of substantial numbers of additional shares of our common stock, including sales of shares in connection with future acquisitions, or the perception that such sales could occur, may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us because investors could purchase shares in the public market instead of directly from us. Furthermore, certain of our executive officers have entered into written trading plans designed to comply with Rule 10b5-1 of the Exchange Act under which they have been selling shares of our common stock in the public market, which sales could have an adverse effect on our stock price.

Provisions in our charter documents and Delaware law could make it more difficult to acquire our company.

Our charter contains provisions that may discourage, delay or prevent a third party from acquiring us, even if doing so would be beneficial to our stockholders. Our charter divides our board of directors into three classes of directors, with the term of each class expiring in a different year. Our charter also limits stockholder action to annual or special meetings of stockholders, prohibits stockholder action by written consent in lieu of

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a meeting and provides that special meetings of stockholders can be called only by the Chairman of the Board or the Chief Executive Officer, either at their discretion or at the written request of a majority of the board of directors. In addition, our charter contains a fair price provision that may discourage or prevent certain proposed business combinations with a related party, which requires approval by holders of not less than 85% of the voting power of all of the outstanding shares of voting stock held by stockholders other than the related person, unless fair price and procedural requirements are met or unless the business combination is approved by the affirmative vote of at least 66 ²/₃% of the continuing directors who are not affiliated with the related party. See Description of Common Stock Certain Anti-Takeover Provisions in the accompanying prospectus for other provisions in our charter that could make it more difficult for a third party to acquire us.

Our charter also authorizes the issuance of blank check preferred stock that could be issued by our board of directors to increase the number of outstanding shares, making a takeover of our company more difficult and expensive. In addition, we have adopted a stockholders rights plan, commonly known as a poison pill, which could result in the significant dilution of the proportionate ownership of any person that engages in an unsolicited attempt to take over our company and, accordingly, could discourage potential acquirors, even if

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doing so would be beneficial to our stockholders. This may have a harmful effect on prevailing market prices for our common stock. See Description of Common Stock Preferred Stock Purchase Rights in the accompanying prospectus.

In addition, Section 203 of the Delaware General Corporation Law may discourage, delay or prevent a change in control by prohibiting us from engaging in a business combination with an interested stockholder for a period of three years after the person becomes an interested stockholder. See Description of Common Stock Certain Anti-Takeover Provisions Business Combinations in the accompanying prospectus.

We do not intend to pay dividends on our common stock in the foreseeable future.

We do not anticipate paying dividends on our common stock in the foreseeable future. Any payment of dividends will depend upon our financial condition, capital requirements, earnings and other factors deemed relevant by our board of directors. Further, the terms of certain covenants in our debt agreements limit the amount of dividends we are able to pay on our common stock.

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USE OF PROCEEDS

We estimate that the gross proceeds from this offering will be approximately \$200.0 million (or approximately \$230.0 million if the underwriters overallotment option is exercised in full) and that the net proceeds from this offering, after deducting the underwriting commission and estimated offering expenses payable by us, will be approximately \$189.0 million (or approximately \$217.5 million if the underwriters overallotment option is exercised in full). We intend to use the net proceeds from the sale of the shares offered by this prospectus supplement for general corporate purposes, including: capital expenditures for development of new facilities (including replacement facilities in connection with proposed joint ventures), as well as for potential acquisitions of new facilities; capital expenditures for expansion of our existing facilities and services, which may include adding beds, adding operating rooms and/or introducing specialty services; working capital; and repayment of indebtedness. Pending the use of these net proceeds, we intend to invest these funds in investment-grade, short-term interest bearing securities, other cash equivalents or, on a short-term basis, with financial institutions rated investment-grade.

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Table of Contents**CAPITALIZATION**

The following table sets forth our capitalization as of March 31, 2005 and as adjusted to give effect to the June 2005 refinancing of our bank credit facility and the sale of common stock offered hereby, as if these events had occurred on March 31, 2005. This table should be read together with our historical financial statements and the related notes incorporated by reference in this prospectus supplement.

	Historical	As Adjusted
	(dollars in millions)	
Cash and cash equivalents	\$ 125.4	\$ 365.2
Long-term debt, including amounts due in one year:		
Term Loan A	38.4	
Term Loan B	404.2	
New Term Loan A		500.0
Revolver (a)		
New Revolver (b)		
7% Senior Notes due 2012	600.0	600.0
7% Senior Subordinated Notes due 2013	600.0	600.0
Other debt	3.7	3.7
Total long-term debt, including amounts due in one year	1,646.3	1,703.7
Stockholders' Equity:		
Common stock	0.8	0.8
Additional paid-in capital	2,054.8	2,243.8
Unearned ESOP compensation	(12.9)	(12.9)
Accumulated other comprehensive loss	(1.5)	(1.5)
Accumulated earnings	447.4	441.8
Total stockholders' equity	2,488.6	2,672.0
Total capitalization	\$ 4,134.9	\$ 4,375.7

(a) \$378.2 million available for borrowing as of March 31, 2005; \$21.8 million letters of credit outstanding. In April 2005, we borrowed \$20 million from our revolving line of credit, which we repaid in May 2005.

(b) As adjusted, \$578.2 million available for borrowing; \$21.8 million letters of credit outstanding.

Table of Contents**SELECTED HISTORICAL FINANCIAL INFORMATION**

We derived our selected historical financial information for the years ended and as of December 31, 2000, 2001, 2002, 2003 and 2004 presented below from our audited financial statements, of which the statements of operations and cash flows for 2002, 2003 and 2004 and the balance sheets for 2003 and 2004 are incorporated by reference in this prospectus supplement. We derived our selected historical financial information for the three months ended and as of March 31, 2004 and 2005 presented below from our unaudited financial statements, which are incorporated by reference in this prospectus supplement.

The following selected historical financial information should be read in conjunction with the historical consolidated financial statements and related notes incorporated by reference in this prospectus supplement from the annual reports, quarterly reports and other information that we have filed with the SEC. See [Where You Can Find More Information](#) for information on where you can obtain copies of information we have filed with the SEC. Historical results are not necessarily indicative of the results to be expected in the future. Prior years' selected financial data has been restated to reflect discontinued operations.

	As of and for the Years Ended December 31,					As of and for the Three Months Ended	
	2000	2001	2002	2003	2004	2004	2005
(dollars in millions, except per share and statistical data)							
Summary of Operations:							
Revenues	\$ 1,042.4	\$ 2,462.2	\$ 3,321.4	\$ 3,734.4	\$ 4,450.2	\$ 1,105.8	\$ 1,212.2
Income (loss) from continuing operations(a)	(0.5)	21.3	138.1	104.5	138.0	48.8	65.2
Net income(b)	4.4	2.8	141.5	95.2	191.0	97.8	66.2
Basic earnings (loss) per share:							
Income (loss) from continuing operations	\$ (0.02)	\$ 0.37	\$ 1.93	\$ 1.42	\$ 1.84	\$ 0.66	\$ 0.84
Net income	\$ 0.14	\$ 0.04	\$ 1.97	\$ 1.29	\$ 2.54	\$ 1.31	\$ 0.85
Shares used in computing basic earnings (loss) per share (in millions)	31.7	57.7	71.7	73.5	75.2	74.4	77.9
Diluted earnings (loss) per share:							
Income (loss) from continuing operations	\$ (0.02)	\$ 0.35	\$ 1.84	\$ 1.38	\$ 1.80	\$ 0.64	\$ 0.82
Net income	\$ 0.14	\$ 0.05	\$ 1.89	\$ 1.26	\$ 2.49	\$ 1.29	\$ 0.83
Shares used in computing diluted earnings (loss) per share (in millions)	31.7	61.1	75.0	75.4	76.6	75.7	79.4
Financial Position:							
Assets	\$ 1,400.5	\$ 4,165.3	\$ 4,381.6	\$ 4,735.4	\$ 4,981.4	\$ 4,851.7	\$ 5,150.9
Long-term debt, including amounts due within one year	586.3	1,770.2	1,689.2	1,758.1	1,667.0	1,724.9	1,646.3
Working capital	391.1	547.4	555.7	512.5	511.6	547.0	591.3
Capital expenditures	94.4	200.6	296.6	281.1	436.0	103.9	100.3
Stockholders' equity	573.7	1,731.5	1,954.5	2,076.3	2,343.3	2,184.2	2,488.6
Operating Data:							
Cash flows provided by operating activities	\$ 71.6	\$ 318.3	\$ 358.2	\$ 363.7	\$ 358.0	\$ 56.4	\$ 126.4
Cash flows provided by (used in) investing activities	\$ (171.4)	\$ (1,453.1)	\$ (261.8)	\$ (436.5)	\$ (209.9)	\$ 52.8	\$ (95.6)
Cash flows provided by (used in) financing activities	\$ 35.6	\$ 1,144.4	\$ (44.5)	\$ 19.6	\$ (105.8)	\$ (32.0)	\$ 37.8
Number of hospitals at end of period(c)	22	40	42	49	51	49	52
Number of licensed beds at end of period(d)	3,001	7,014	7,271	7,986	8,071	7,988	8,208
Weighted average licensed beds(e)	3,081	5,823	7,128	7,392	8,037	8,031	8,208

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Number of available beds at end of period(f)	2,641	6,252	6,596	7,147	7,230	7,139	7,336
Admissions(g)	107,297	212,842	263,917	277,229	312,494	80,648	83,965
Adjusted admissions(h)	187,633	365,725	454,258	478,531	542,453	137,031	142,489
Average length of stay (days)(i)	4.3	4.8	4.9	4.9	4.7	4.8	4.7
Average daily census(j)	1,259	2,789	3,523	3,705	3,983	4,214	4,396
Occupancy rate(k)	48%	49%	51%	55%	56%	59%	60%

Other Data:

EBITDA (l)	\$ 127.2	\$ 344.3	\$ 517.0	\$ 509.7	\$ 596.8	\$ 156.2	\$ 183.3
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(footnotes on following page)

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- (a) Includes charges related to impairment of long-lived assets of \$8.0 million (\$4.7 million after tax benefit) and \$1.9 million (\$1.2 million after tax benefit) for the years ended December 31, 2000 and 2001, respectively.
- (b) Includes charges related to impairment of long-lived assets of discontinued operations of \$21.2 million (\$19.9 million after tax benefit) and \$18.5 million (\$12.4 million after tax benefit) for the years ended December 31, 2001 and 2003, respectively, in addition to the items referenced in (a).
- (c) Number of hospitals excludes facilities designated as discontinued operations and facilities under construction. This table does not include any operating statistics for facilities designated as discontinued operations or non-consolidating joint ventures.
- (d) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
- (e) Represents the average number of licensed beds, weighted based on periods owned.
- (f) Available beds are those beds that 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 our 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 our hospitals.
- (j) Represents the average number of patients in our 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) EBITDA is defined as earnings before depreciation, amortization, interest expense, interest income, refinancing transaction costs, income tax provision (benefit) and loss from discontinued operations. EBITDA is commonly used by our lenders and investors to assess our leverage capacity, debt service ability and liquidity. Many of our debt agreements use EBITDA, or a modification of EBITDA, in financial covenant calculations. EBITDA is used by management to evaluate financial performance and resource allocation for each facility and for us as a whole. EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from EBITDA are significant components in understanding and assessing financial performance. 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.

A reconciliation of EBITDA to cash provided by operating activities follows (in millions):

	As of and for the Years Ended December 31,					As of and for the Three Months Ended	
						March 31,	
	2000	2001	2002	2003	2004	2004	2005
EBITDA	\$ 127.2	\$ 344.3	\$ 517.0	\$ 509.7	\$ 596.8	\$ 156.2	\$ 183.3
Interest expense	(61.8)	(127.4)	(135.6)	(133.7)	(113.7)	(32.7)	(27.4)
Interest income	4.9	1.6	1.7	2.7	2.6	0.5	0.9
Non-cash interest expense	1.0	10.3	9.0	9.4	5.8	2.7	1.2
Deferred income tax provision (benefit)	11.8	39.6	83.7	48.3	3.3	(5.9)	(6.3)
Income tax provision	(7.0)	(39.7)	(92.1)	(68.7)	(85.3)	(30.7)	(40.3)
Provision for doubtful accounts	90.1	221.8	255.1	382.9	453.7	112.5	113.0
ESOP expense	7.1	9.3	10.8	8.5	10.3	2.4	3.3
Minority interests	8.2	6.3	13.6	6.7	5.4	1.9	4.6
Equity in (earnings) loss of affiliates	1.4	(14.5)	(21.7)	(25.4)	(20.5)	(5.6)	(10.1)
(Gain) loss on sales of assets	(7.9)	(23.1)	(4.5)	(1.4)			