TRIAD HOSPITALS INC
Form 10-K
March 11, 2005

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, 2004

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	**75-2816101**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
5800 Tennyson Parkway	
Plano, Texas	**75024**
(Address of principal executive offices)	**(Zip Code)**

(214) 473-7000

(Registrant s telephone number, including area code)

Securities Registered Pursuant to Section 12(b) 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

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

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Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15 (d) of the Securities Exchange Act of 1934 during the preceding 12 months, 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 Form 10-K. ¨

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Exchange Act). YES x NO ¨

At June 30, 2004, the aggregate market value of the common stock held by non-affiliates was approximately $2.7 billion. For purposes of the foregoing calculation, the Registrant s directors, executive officers, and the Triad Hospitals, Inc. Retirement Savings Plan have been deemed to be affiliates.

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

As of February 15, 2005, the number of shares of common stock of Triad Hospitals, Inc. outstanding was 78,595,093.

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 currently include 52 general acute care hospitals and 14 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. 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 health care 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 SEC).

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.

The common stock of Triad is listed on the New York Stock Exchange (symbol: TRI). Information about 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

Triad s principal executive offices are located at 5800 Tennyson Parkway, Plano, Texas 75024, and its telephone number is (214) 473-7000. Triad s corporate Website address is http://www.triadhospitals.com.

Information contained on such Website is not part of this Annual Report. Annual reports, quarterly reports, current reports and amendments to those reports filed with the SEC are available free of charge through the Website as soon as reasonably practicable after such material is electronically filed with, or furnished to, the SEC.

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. These 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 15 states. Over half of Triad s facilities are located in the states of Alabama, Arkansas, Indiana, and Texas.

Through QHR, a 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. 40 of the 52 general acute care hospitals that Triad owns and operates are located in these small city markets. Of these, 22 hospitals are located in communities where they are the sole hospital and 18 hospitals are located in communities where they are 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 good position to negotiate 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 specialty hospitals and alternate non-hospital providers, such as outpatient surgery centers or rehabilitation or diagnostic imaging centers, as well as managed care plans, compared to urban markets.

Selected Larger Urban Markets

12 of the 52 general acute care hospitals that Triad owns and operates 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 these 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).

Triad s Mission

Triad s mission is to continuously improve the quality of health care services provided to the communities it serves by creating an environment that fosters physician participation, recognizes the value and contributions of its employees and strives to meet the unique health care needs of the local communities. Triad s objective is to provide quality health care services to its communities, while simultaneously generating strong financial performance and appropriate returns to its investors, through disciplined and balanced execution of a comprehensive business strategy that reinforces both quality of care and financial strength.

Business Strategy

Triad s business strategy combines an operating strategy devoted to working with providers, employees and communities and a capital strategy devoted to investing capital in a disciplined manner into internal and external development projects that enhance patient care and provide appropriate returns to investors. Triad believes its business strategy differentiates it from many peers and competitors.

Operating Strategy

The foundation of Triad s operating strategy is to work cooperatively and collaboratively with physicians, communities and employees in a manner that benefits all constituents. Triad actively involves local providers, local community leaders and employees in critical decision making in order to enhance the quality of physicians practices, the quality of the health care environment in each community and the professional satisfaction of employees. Triad believes this strategy results in increased volumes, rates and operating margins, and in external development opportunities with not-for-profit hospitals attracted to Triad s operating strategy. Triad s collaborative operating strategy has several components:

Actively involve health care providers in decision making. Triad believes that working cooperatively and collaboratively with physicians to develop and maintain strong, mutually beneficial relationships with them leads to improved physician satisfaction, resource management and quality of care. Triad believes that this results in higher volumes, rates and operating margins and in external development opportunities. To reinforce the collaboration, Triad has established in each market a Physician Leadership Group (PLG) consisting of leading physicians who practice at Triad s local hospitals. Each PLG meets monthly with corporate and hospital management to establish local priorities and address physician concerns. A national PLG, consisting of representatives from the local PLGs, meets regularly with members of Triad s corporate management to address broader corporate and national objectives. Triad s corporate management includes a team of experienced physicians who focus entirely on maintaining physician relations. Triad also believes the PLGs generate and facilitate external development opportunities as more physicians and not-for-profit hospitals are able to learn through physician word-of-mouth about Triad s operating strategy of working collaboratively with providers.

Similarly, Triad believes that working cooperatively and collaboratively with its nurses and other employees to develop and maintain strong, mutually beneficial relationships with them leads to improved satisfaction, morale and retention of its employees, as well as better quality of care for its patients. Triad believes that this leads to higher patient satisfaction, volumes, rates and operating margins. In each of its markets, Triad has a Nursing Leadership Group (NLG) chaired by the facility Chief Nursing Officer and comprising facility nurses who work with corporate and hospital management to establish local priorities and company-wide best practices for nursing care. A national NLG, consisting of representatives from the local NLGs, addresses broader corporate and national objectives with members of Triad s corporate management team. Triad has also created Departmental Operations Committees that address key clinical and support functions represented by specific hospital departments, including radiology, dietary and plant operations. Members, chosen for their leadership qualities demonstrated at Triad s facilities, meet regularly to share best practices and other initiatives, both locally and nationally.

Actively involve communities in decision making. Triad s community philosophy is a simple one: our stockholders own the bricks and mortar, but the hospitals effectively belong to the communities we serve. Triad seeks to have each community embrace its hospital as an important local asset in order to make the facility successful. To that end, Triad has created for each of its facilities local Boards of Trustees consisting solely of local physicians and community leaders. Triad empowers each local Board of Trustees with responsibilities related to strategic and capital planning and overall supervision of the quality of care provided to the community. By involving local communities in key decisions affecting their hospitals, Triad believes it can achieve higher volumes, rates and operating margins.

Actively partner with not-for-profit hospitals. An integral part of Triad s operating strategy is to be a preferred partner for the not-for-profit hospitals that comprise approximately 85% of the nation s acute care hospitals. For not-for-profit hospitals, Triad offers three alternatives for potentially improving their performance: contract management, consulting services and capital partnership. Triad believes that these relationships can result in attractive growth opportunities that are consistent with, and that reinforce, the other components of its business strategy.

Triad provides management and consulting services through its QHR subsidiary to approximately 180 not-for-profit hospitals in the United States. These are typically independent hospitals in rural communities that Triad believes benefit from the management infrastructure QHR provides, infrastructure that they might not otherwise afford on their own.

Triad also provides an attractive alternative to not-for-profit hospitals that need capital. Triad can either buy the hospital or partner with the not-for-profit in a joint venture, often for the purpose of developing a new or replacement hospital for the community. Triad believes it often has a competitive advantage over some of its peers and competitors in buying or partnering with not-for-profit hospitals as a result of:

- its operating strategy of working cooperatively and collaboratively with physicians, employees and communities, which appeals to many not-for-profits;
- its QHR management subsidiary s relationship and reputation with leading not-for-profits nationwide; and
- its flexibility regarding shared governance and ownership with not-for-profits through joint ventures with those who prefer to retain some ownership rather than sell.

Capital Strategy

Triad s capital strategy consists of the disciplined investment of capital for routine maintenance projects as well as internal and external development projects intended to grow volumes, rates and operating margins. Except for routine maintenance projects, its capital projects are typically projected to generate a return greater than the weighted average cost of capital for that project. Triad is, however, willing to trade short-term returns for longer-term returns that it believes will be superior.

For existing facilities, Triad currently expects to spend approximately $120 to $180 million annually on routine maintenance capital expenditures for structural and cosmetic repairs and maintaining market share at its facilities. Triad also identifies and invests in expansion opportunities where it perceives that demand is not being adequately met due to population growth or insufficient existing health care services. Expansion opportunities may include adding beds, adding operating rooms or introducing specialty services in order to meet demand and decrease outmigration.

For external development, Triad pursues potential acquisitions, but only selectively and opportunistically. In situations where sellers are concerned solely with obtaining the highest price, especially in an auction, Triad generally does not have a competitive advantage over others and thus generally does not prevail. However, in situations where sellers also place value on its collaborative culture and strategy, Triad believes it often has a competitive advantage and sometimes can prevail, even in an auction, and even when Triad may not submit the highest financial offer. Triad also builds new hospitals, either on its own or in partnership with not-for-profit hospitals, especially in small-city markets with populations of 50,000-200,000 and in other markets that tend to be most receptive to its strategy of working collaboratively with providers and communities. Triad also builds replacement facilities for existing facilities, usually by becoming a capital partner with a not-for-profit hospital that lacks capital to rebuild an old or aging facility but has a favorable clinical reputation and market position.

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. Triad s 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 includes 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 and additional acquisitions in 2002 and 2003. Prior years statistics have been restated to reflect the reclassification of discontinued operations. See NOTE 4 - DISCONTINUED OPERATIONS in the consolidated financial statements for a more detailed description. 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,				
	2004	2003	2002	2001	2000
Number of hospitals at end of period (a)	51	49	42	40	22
Number of licensed beds at end of period (b)	8,071	7,986	7,271	7,014	3,001
Weighted average licensed beds (c)	8,037	7,392	7,128	5,823	3,081
Admissions (d)	312,494	277,229	263,917	212,842	107,297
Adjusted admissions (e)	542,453	478,531	454,258	365,725	187,633
Average length of stay (days) (f)	4.7	4.9	4.9	4.8	4.3
Average daily census (g)	3,983	3,705	3,523	2,789	1,259
Occupancy rate (h)	56%	55%	51%	49%	48%

(a) Number of hospitals excludes discontinued operations and facilities under construction at December 31st of each year. This table does not include any operating statistics for discontinued operations and non-consolidating joint ventures.
(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 available beds occupied by patients. Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.

Triad s hospitals have been affected by the trend toward certain services being performed more frequently on an outpatient basis 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 and patients to perform certain procedures as outpatient care rather than 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, although possibly at a slower rate, 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, managed care plans and other private insurers as well as directly from patients. The approximate percentages of patient revenues, restated for discontinued operations, of Triad s facilities from such sources during the periods specified below were as follows:

	Years Ended December 31,		
	2004	2003	2002
Medicare	31.0%	30.5%	31.7%
Medicaid	5.1	5.4	5.3
Managed care plans	42.5	41.9	39.5
Other sources	21.4	22.2	23.5
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 various discounts from established charges to certain large group purchasers of health care services, including private insurance companies, employers, and 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 managed care plans, 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. During 2003 and 2004, Triad experienced significant growth in uninsured receivables and deterioration in the collectibility of these receivables. Beginning in the fourth quarter of 2004, Triad implemented a new self-pay discount program. The self-pay discount program offers discounts to uninsured patients based on personal financial criteria and means testing. The amount of the discount varies based on each patient s financial condition. Triad anticipates implementing an additional component to its self-pay discount program during the second quarter of

2005. This additional component would offer a discount for all uninsured patients based on the lowest managed care discount in each hospital location. See Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations for a more detailed discussion.

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 180 hospitals as of December 31, 2004. QHR provides management services to independent hospitals and hospital systems under management contracts and also provides selected consulting, educational and related services. 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. Approximately 70% 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 typically provides the hospital with personnel to serve as the hospital s chief executive officer and 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 5 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 and typically have a renewal rate of approximately 79%. 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 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 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 specialty hospitals, outpatient surgery, orthopedic, oncology and diagnostic centers.

State certificate of need laws (CON 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. Seven states in which Triad operates, Alabama, Alaska, Mississippi, Ohio, Oregon, South Carolina and West Virginia, have CON laws. The application process for approval of covered services, facilities, changes in operations and capital expenditures (including certain acquisitions of facilities) 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 may acquire or develop on a selective basis, hospitals that are similar to those currently owned and operated. However, suitable acquisitions may not be accomplished due to unfavorable terms. Triad may also seek to expand through the formation of joint ventures with other providers, including not-for-profit health care providers.

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 managed care plans, which attempt to direct and control the use of hospital services and to obtain discounts from hospitals established charges. Employers and traditional health insurers are also 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 pressures by both private and government payers to control reimbursement rates. As both private and government payers reduce the scope of what may be reimbursed and control 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, patient preference 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, 2004, Triad had approximately 38,600 employees, including approximately 10,500 part-time employees, as well as approximately 430 employees providing hospital management and consulting services. Employees at three 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.

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 periodically performs both employee and physician satisfaction surveys. The surveys are used by management to enhance the operating performance of each hospital.

Triad s Ethics and Compliance Program

It is Triad s policy that its business be conducted with integrity and in compliance with applicable 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 ethics and compliance program.

On November 1, 2001, Triad entered into a five-year corporate integrity agreement with the Office of the Inspector General (the OIG) 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. The cost to maintain the compliance program was approximately $3.1 million, $4.4 million and $3.0 million in 2004, 2003, and 2002, respectively. Continuing compliance 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 hospital service 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 OIG 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. For Federal fiscal year 2003, hospitals generally received the market basket index minus 0.55% and for Federal fiscal year 2004 the update was the full market basket. For Federal fiscal year 2005, 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.

Outpatient services provided at general, acute care hospitals typically are reimbursed under a PPS system for outpatient hospital services (APCs). APCs were updated by the market basket for Federal fiscal years 2003 and 2004. For Federal fiscal year 2005, APCs will be updated by the full market basket index. 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 are made under a PPS system for skilled nursing facility services, home health services and inpatient rehabilitation hospital services. The update for 2003 was the market basket minus 0.5% and for 2004 was the full market basket. For Federal fiscal year 2005, the rates will be updated by the market basket. There is also 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, 2004, 21 of Triad s hospitals operated skilled nursing facilities.

Home health services are reimbursed under a PPS system, although in fiscal year 2003, payments were reduced by approximately 7%. For 2004 through 2006 the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for a reduction in the annual payment update and adds a 5% rural add-on for discharges between April 1, 2004 through March 31, 2005. For the year ended December 31, 2004, 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. On November 15, 2004, final rules were issued to convert reimbursement for PPS-exempt psychiatric hospitals and units to a prospective payment system. Reimbursement will be based on a prospectively determined per diem for cost reporting periods beginning on or after January 1, 2005. The per diem rules have four tiers, the highest for the first day of the stay, a lower rate for the second through fourth day, a third tier for the fifth through eighth day, and a final tier. The payment system will be phased in over a three-year period. Also, during this period there will be a stop loss provision equal to at least 70 percent of the amount that would have been paid under the reasonable cost reimbursement system. For the year ended December 31, 2004, less than 1% of Triad s patient revenues were derived from psychiatric services.

On November 20, 2004, Congress passed the FY 2005 Omnibus Appropriations bill. Included in this bill was a provision delaying the enforcement of the inpatient rehabilitation facility (IRF) 75% rule (the IRF 75% Rule) up to 60 days after a Government Accountability Office (GAO) report is completed on this issue. The IRF 75% Rule, implemented in 1983, is one of the key eligibility criteria for IRFs. In May 2004, CMS issued a final rule that included restrictive changes to the conditions that qualify under the IRF 75% Rule. This rule requires that beginning July 1, 2004, at least 50% of Medicare patients are classified in one of the thirteen medical categories. The threshold increases to 60% beginning July 1, 2005, 65% on July 1, 2006, and up to the original 75% on July 1, 2007. A hospital not meeting these thresholds will receive reduced payments based on Medicare DRGs instead of IRF payments. Triad in the interim intends to fully comply with the provisions of the May 2004 final rule.

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 16 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 may 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 that provides medical insurance benefits to government employees has special payment provisions for hospitals recognized as sole community hospitals for Medicare purposes.

Medicare provides, in the form of outlier payments, for additional payment, beyond standard DRG payments, for covered hospital services furnished to a Medicare beneficiary if the operating costs of furnishing those services exceed a certain threshold. During 2002, CMS initiated an outlier reimbursement review process to assess nationally whether or not the amount of outlier payments being made to selected hospitals was appropriate. CMS issued proposed regulations in March 2003 that became effective October 1, 2003 that modified certain elements of the outlier reimbursement calculation. Triad derives less than 1% of patient revenues from outlier payments and the modifications did not have a material impact on its financial condition or results of operations.

MMA was signed into law on December 8, 2003. In addition to creating a new Medicare prescription drug benefit, MMA provides for a number of other significant changes in the Medicare program. These changes include a reduction in the annual update for ambulatory surgery center payments from April 2004 through the third quarter of 2005 and no payment update for the fourth quarter of 2005 through 2009. MMA also provides for reductions in the annual update in home health agency payments for 2004 through 2006, and for a reduction in the annual update for inpatient hospital payments from 2005 through 2007 for hospitals that do not submit to the Medicare program quality reporting data specified under the National Voluntary Hospital Reporting Initiative. MMA also includes a number of provisions designed to increase Medicare payments to small urban and rural hospitals, increasing the limit on disproportionate share payments that rural hospitals may receive, and permitting an adjustment to the calculation of the standardized payment to benefit hospitals in low-wage areas, such as rural hospitals and equalizes the DRG base payment rate among hospitals. Triad received an additional $9.5 million in reimbursement from MMA in 2004 and anticipates it may receive $13 million in reimbursement from MMA in 2005.

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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. If Triad or any Triad facility is found to be in violation of Federal or state laws relating to Medicare, Medicaid or similar programs, 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 periods 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 were delayed due to CMS not issuing the final payment schedules for APCs. Beginning in October 2002, the final payment schedules for APCs began to be issued for cost reporting periods ended after August 31, 2000. Triad has filed cost reports for these periods. The delay in filing these cost reports will extend the time period of final determination of amounts earned. Pursuant to the terms of the spin-off distribution agreement, HCA 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. Triad was responsible for the Medicare, Medicaid and Blue Cross cost reports, and associated receivables and payables, for Triad s facilities for all periods prior to the spin-off subject to the above indemnifications from HCA. In July 2003, HCA finalized a settlement agreement with the government relating to cost report periods ending before August 1, 2001 which includes the indemnified cost reports.

Managed Care. Pressures to control the cost of health care have historically resulted in increases in volumes attributable to managed care payers compared to traditional commercial/indemnity insurers. Triad generally receives lower payments from managed care payers than from traditional commercial/indemnity insurers; however, as part of its business strategy, Triad has taken steps to improve its managed care position. 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. Triad s facilities 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 seven states (Alabama, Alaska, Mississippi, Ohio, Oregon, 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 $5,500 to $11,000 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 OIG 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 certain inpatient and outpatient hospital services. Sanctions for violating the Stark Law include civil 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.

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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. 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. On March 25, 2004, CMS published Phase II of these regulations. These Phase II regulations, referred to as interim final regulations , became effective on July 26, 2004. Phase II addresses the statutory exceptions related to ownership and investment interests, statutory exceptions for certain compensation arrangements, and reporting requirements. Phase II also creates some new regulatory exceptions and addresses public comments on Phase I. These regulations mandated certain changes to certain of Triad s practices and procedures, but Triad cannot yet predict all of the effects that the interim final regulations might have.

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, requirements that hospitals publicly report certain quality indicators 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. 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, which required compliance by October 16, 2003. Triad is currently in compliance with these regulations.

In December 2000, CMS acting under HIPAA released final regulations, which required compliance by April 2003, relating to adoption of standards to protect the security and privacy of health-related information. These privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. CMS has also promulgated final regulations under HIPAA establishing standards to protect the security of health-related information. These regulations were published in February 2003 and require compliance by April 2005. These regulations require health care providers to implement organizational and technical practices to protect the security of electronically maintained or transmitted health-related information. The privacy regulations extensively

regulate the use and disclosure of individually identifiable health-related information. The privacy regulations and the security regulations could impose significant costs on Triad in order to comply with these standards. Violations of the regulations 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 certain joint ventures between for-profit and not-for-profit hospitals. The tax ruling could limit joint venture development with not-for-profit hospitals.

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. The cost of malpractice and other liability insurance rose significantly in 2003 and 2002, although these costs were relatively stable in 2004. 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 elected to obtain 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 recorded an estimated liability for deductibles related to general and professional liability risks of $124.5 million at December 31, 2004. Any losses incurred in excess of amounts maintained under insurance policies 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 1 ACCOUNTING POLICIES Self-Insured Liability Risks in the consolidated financial statements for a more detailed discussion of such arrangements.

Governmental Investigations

False Claims Act Litigation. As a result of its ongoing discussions with the government prior to the merger of Quorum with and into Triad on April 27, 2001, 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 on these items prior to the merger and the matter remains under seal. 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. The government has stated that it intends to investigate certain other allegations.

On September 9, 2003, Triad was 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 QHR, which is named as an additional defendant. The Federal government elected not to intervene in the case and the complaint was unsealed. While Triad intends to vigorously defend this matter, Triad is not yet able to form a view as to any probable liability for any of the claims alleged in the complaint.

On May 18, 2004, Triad was 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. The Federal government elected not to intervene in the case and the complaint was recently unsealed. While Triad intends to vigorously defend this matter, it is not yet able to form a view as to the probable liability for any of the claims alleged in the complaint.

At this time Triad 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 Triad 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. Triad 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, Triad 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 Triad. Any current or future investigations or actions could have a material adverse effect on Triad s results of operations or financial position.

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 it unless and to the extent such are unsealed. If any of those matters were successfully asserted against Triad, there could be a material adverse effect on Triad s business, financial position, results of operations or prospects.

Governmental Investigation of HCA and Related Litigation. 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. Triad is unable to predict the effect or outcome of the SEC investigation, or whether any additional investigations or litigation will be commenced. In connection with the spin-off from HCA, Triad entered into a distribution agreement with HCA providing that HCA will indemnify, or make specified cash payments to, Triad for certain losses (other than consequential damages) resulting from certain governmental investigations and litigation to which HCA was previously subject and related acts. 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, results of operations or prospects. The extent to which Triad may or may not be affected by the ongoing investigation of HCA and the initiation of additional investigations, if any, cannot be predicted. These matters could have a material effect on Triad s business, financial condition, results of operations or prospects.

Item 2. Properties

The following table lists the hospitals owned by Triad as of December 31, 2004.

Facility Name	City	State	Licensed Beds
Flowers Hospital	Dothan	AL	235
Medical Center Enterprise	Enterprise	AL	131
Gadsden Regional Medical Center	Gadsden	AL	346
Crestwood Medical Center	Huntsville	AL	120
Jacksonville Hospital	Jacksonville	AL	89
Valley Hospital (1)	Palmer	AK	40
Northwest Medical Center of Benton County	Bentonville	AR	128
Medical Center of South Arkansas (2)	El Dorado	AR	166
Medical Park Hospital	Hope	AR	79
National Park Medical Center	Hot Springs	AR	166
Willow Creek Women s Hospital	Johnson	AR	30
NEA Regional Medical Center (3)	Jonesboro	AR	104
St. Mary s Regional Medical Center	Russellville	AR	170
Central Arkansas Hospital	Searcy	AR	193
Northwest Medical Center of Washington County	Springdale	AR	222
Northwest Medical Center	Tucson	AZ	278
Bluffton Regional Medical Center	Bluffton	IN	79
Dupont Hospital (4)	Fort Wayne	IN	86
Lutheran Hospital of Indiana	Fort Wayne	IN	402
St. Joseph s Hospital	Fort Wayne	IN	191
Dukes Memorial Hospital	Peru	IN	50
Kosciusko Community Hospital	Warsaw	IN	72
Women & Children s Hospital	Lake Charles	LA	84
Wesley Medical Center	Hattiesburg	MS	211
River Region Health System (5)	Vicksburg	MS	372
Carlsbad Medical Center	Carlsbad	NM	127
Lea Regional Medical Center	Hobbs	NM	250
MountainView Regional Medical Center	Las Cruces	NM	127
Mesa View Regional Hospital	Mesquite	NV	25
Barberton Citizens Hospital (6)	Barberton	OH	311
Doctors Hospital of Stark County	Massillon	OH	166
Claremore Regional Hospital	Claremore	OK	89
SouthCrest Hospital	Tulsa	OK	180
Woodward Regional Hospital (7)	Woodward	OK	87
Willamette Valley Medical Center	McMinnville	OR	80
McKenzie-Willamette Hospital (8)	Springfield	OR	114
Carolinas Hospital System Florence	Florence	SC	372
Carolinas Hospital System Lake City (9)	Lake City	SC	48
Mary Black Memorial Hospital (10)	Spartanburg	SC	209
Abilene Regional Medical Center	Abilene	TX	187
Brownwood Regional Medical Center (11)	Brownwood	TX	216
College Station Medical Center	College Station	TX	115
Navarro Regional Hospital	Corsicana	TX	162
Denton Community Hospital (12)	Denton	TX	122
Longview Regional Medical Center	Longview	TX	166
Woodland Heights Medical Center	Lufkin	TX	146
Pampa Regional Medical Center	Pampa	TX	115
San Angelo Community Medical Center	San Angelo	TX	168
DeTar Healthcare System	Victoria	TX	328

Gulf Coast Medical Center	Wharton	TX	161
Greenbrier Valley Medical Center	Ronceverte	WV	122

(1) A wholly-owned subsidiary of Triad holds a 76.2% interest in, and is the manager of, the entity owning this facility. The entity is currently building a replacement hospital for this facility.
(2) Triad holds a 50% equity interest in a non-consolidated joint venture which owns and operates this facility. Triad is the manager of this facility.
(3) A wholly-owned subsidiary of Triad holds a 60.0% interest in, and is the manager of, the entity owning this facility.
(4) A wholly-owned subsidiary of Triad holds an 81.3% interest in, and is the manager of, the entity owning this facility.
(5) A wholly-owned subsidiary of Triad holds a 71.5% interest in, and is the manager of, the entity owning this facility.

(6) A wholly-owned subsidiary of Triad holds a 93.5% interest in, and is the manager of, the entity owning this facility.
(7) Held pursuant to an operating lease with an initial term of 20 years and a renewal term of 20 years.
(8) A wholly-owned subsidiary of Triad holds an 80% interest in, and is the manager of, the entity owning this facility. The entity plans to build a replacement hospital for this facility.
(9) Held pursuant to operating lease with initial term of ten years and two renewal options of five years.
(10) A wholly-owned subsidiary of Triad holds a 91.8% interest in, and is the manager of, the entity owning this facility.
(11) Triad currently leases this hospital pursuant to a long-term lease which provides the exclusive right to use and control the hospital operations.
(12) An entity, in which a wholly-owned subsidiary of Triad owns an 80.0% interest, is currently building a replacement hospital in Denton, Texas for this facility.

In addition to the hospitals listed in the table above, as of December 31, 2004, Triad operated 14 ambulatory surgery centers. Medical office buildings also are operated in conjunction with Triad s 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 the percentage ownership interest as of December 31, 2004. 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	State	Licensed Beds
Macon Healthcare LLC	Coliseum Medical Center (38%)	Macon	GA	250
Macon Healthcare LLC	Coliseum Psychiatric Center (38%)	Macon	GA	60
Macon Healthcare LLC	Macon Northside Hospital (38%)	Macon	GA	103
Summerlin Hospital Medical Center LLC	Summerlin Hospital Medical Center (26%)	Las Vegas	NV	257
Valley Health System LLC	Desert Springs Hospital (28%)	Las Vegas	NV	346
Valley Health System LLC	Valley Hospital Medical Center (28%)	Las Vegas	NV	409
Valley Health System LLC	Spring Valley Hospital Medical Center (28%)	Las Vegas	NV	176

Triad s headquarters are located in approximately 150,000 square feet of space in one office building that Triad leases in Plano, Texas.

QHR leases regional offices located throughout the United States.

In addition to the information provided above, Triad opened a newly constructed 96-bed hospital in Tucson, Arizona in January 2005. 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

None.

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 2004.

Part II.

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

Triad s common stock is listed on the New York Stock Exchange (symbol TRI). The table below sets forth, for the calendar quarters indicated, the high and low reported closing sales prices per share reported on the New York Stock Exchange for Triad s common stock for the years ended December 31, 2003 and 2004.

2003	High	Low
First Quarter	$ 30.68	$ 24.12
Second Quarter	27.59	20.53
Third Quarter	33.06	24.36
Fourth Quarter	34.74	28.25
2004		
First Quarter	$ 37.45	$ 29.95
Second Quarter	37.23	30.90
Third Quarter	38.00	31.50
Fourth Quarter	37.37	31.88

At the close of business on February 15, 2005 there were approximately 10,660 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 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, 2004, 2003, 2002, 2001 and 2000 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. Prior years selected financial data has been restated to reflect discontinued operations. See NOTE 4 - DISCONTINUED OPERATIONS in the consolidated financial statements for a more detailed description.

	Years Ended December 31,				
	2004	2003	2002	2001	2000
	(Dollars in millions, except per share amounts)				
Summary of Operations:					

Revenues	$ 4,450.2	$ 3,734.4	$ 3,321.4	$ 2,462.2	$ 1,042.4
Income (loss) from continuing operations (a)	138.0	104.5	138.1	21.3	(0.5)
Net income (b)	191.0	95.2	141.5	2.8	4.4
Basic earnings (loss) per share:					
Income (loss) from continuing operations	$ 1.84	$ 1.42	$ 1.93	$ 0.37	$ (0.02)
Net income	$ 2.54	$ 1.29	$ 1.97	$ 0.04	$ 0.14
Shares used in computing basic earnings (loss) per share (in millions)	75.2	73.5	71.7	57.7	31.7
Diluted earnings (loss) per share:					
Income (loss) from continuing operations	$ 1.80	$ 1.38	$ 1.84	$ 0.35	$ (0.02)
Net income	$ 2.49	$ 1.26	$ 1.89	$ 0.05	$ 0.14
Shares used in computing diluted earnings (loss) per share (in millions)	76.6	75.4	75.0	61.1	31.7
Financial Position:					
Assets	$ 4,981.4	$ 4,735.4	$ 4,381.6	$ 4,165.3	$ 1,400.5
Long-term debt, including amounts due within one year	1,667.0	1,758.1	1,689.2	1,770.2	586.3
Working capital	511.6	512.5	555.7	547.4	391.1
Capital expenditures	436.0	281.1	296.6	200.6	94.4
Operating Data:					
Number of hospitals at end of period (c)	51	49	42	40	22
Number of licensed beds at end of period (d)	8,071	7,986	7,271	7,014	3,001
Weighted average licensed beds (e)	8,037	7,392	7,128	5,823	3,081
Number of available beds at end of period (f)	7,230	7,147	6,596	6,252	2,641
Admissions (g)	312,494	277,229	263,917	212,842	107,297
Adjusted admissions (h)	542,453	478,531	454,258	365,725	187,633
Average length of stay (days) (i)	4.7	4.9	4.9	4.8	4.3
Average daily census (j)	3,983	3,705	3,523	2,789	1,259
Occupancy rate (k)	56%	55%	51%	49%	48%

(a) Includes charges related to impairment of long-lived assets of $1.9 million ($1.2 million after tax benefit) and $8.0 million ($4.7 million after tax benefit) for the years ended December 31, 2001 and 2000, respectively.

(b) Includes charges related to impairment of long-lived assets of discontinued operations of $18.5 million ($12.4 million after tax benefit) and $21.2 million ($19.9 million after tax benefit) for the years ended December 31, 2003 and 2001, 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 and 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 a facility actually has in use.

	161,900				
		2/15/2017	67,500	$ 20.53	$ 865,708
Eric Risser		149,900			
		2/15/2017	55,000	$ 20.53	$ 705,392
Jon Wigginton, M.D.		178,000			
		2/15/2017	67,500	$ 20.53	$ 865,708

(1) Reflects target awards under the Company s annual incentive cash plan. There are no threshold or maximum award levels under this plan. For information about the actual payouts under the plan, which were determined by the Compensation Committee on February 22, 2018, see Compensation Discussion and Analysis-Elements of Compensation-Annual Incentive Cash Bonus and the Summary Compensation Table.
(2) Equity grants made to named executive officers in the first quarter of 2017 in connection with the Compensation Committee s review of 2016 performance are described in footnote (3) of the Summary Compensation Table above.
(3) Exercise or base price represents the market closing stock price on the date of award.
(4) The amounts reflect the grant date fair value for awards granted during the year indicated. The grant date fair value was computed in accordance with Financial Accounting Standards Board Accounting Standards Codification Topic 718, *Compensation-Stock Compensation*. The assumptions used in the valuation of these awards are set forth in Note 6 to our financial statements, which are included in our Form 10-K.

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Outstanding Equity Awards at Fiscal Year End

The following table sets forth certain information with respect to the value of all unexercised options previously awarded to the Company s named executive officers as of December 31, 2017:

		Option Awards				Stock Awards	
Name	Grant Date (1)	Number of Securities Underlying Unexercised Options Exercisable (#)	Number of Securities Underlying Unexercised Options Unexercisable (#)	Option Exercise Price ($)	Option Expiration Date	Number of Shares or Units of Stock That Have Not Vested (#) (2)	Market Value of Shares or Units of Stock That Have Not Vested ($) (2)
Scott Koenig, M.D., Ph.D.	1/11/2009	79,897		0.94	1/10/2019		
	3/14/2012	133,163		0.94	3/13/2022		
	1/6/2013	53,265		1.51	1/5/2023		
	10/9/2013	152,525		16.00	10/9/2023		
	12/12/2014	107,526	32,474	29.68	12/12/2024		
	12/18/2015	76,590	73,410	31.43	12/18/2025		
	2/15/2017	39,326	160,674	20.53	2/15/2027		
James Karrels	4/10/2008	6,516		0.94	4/9/2018		
	1/11/2009	13,314		0.94	1/10/2019		
	1/10/2010	5,326		0.94	1/9/2020		
	1/9/2011	9,320		0.94	1/8/2021		
	3/14/2012	10,653		0.94	3/13/2022		
	1/6/2013	13,316		1.51	1/5/2023		
	10/9/2013	48,791		16.00	10/9/2023		
	12/12/2014	32,526	7,474	29.68	12/12/2024		
	12/18/2015	24,090	20,910	31.43	12/18/2025		
	2/15/2017	11,869	43,131	20.53	2/15/2027		
Ezio Bonvini, M.D.	10/9/2013	24,395		16.00	10/9/2023		
	12/12/2014	40,026	9,974	29.68	12/12/2024		
	12/18/2015	29,090	25,910	31.43	12/18/2025		
	9/14/2016	10,454	19,546	28.94	9/14/2026		
	2/15/2017	13,447	54,053	20.53	2/15/2027		
Eric Risser	3/24/2009	31,497		0.94	3/23/2019		
	1/10/2010	2,662		0.94	1/9/2020		
	1/9/2011	7,989		0.94	1/8/2021		
	3/14/2012	10,653		0.94	3/13/2022		
	1/6/2013	26,632		1.51	1/5/2023		
	10/9/2013	24,395		16.00	10/9/2023		
	12/12/2014	40,026	9,974	29.68	12/12/2024		
	12/18/2015	24,090	20,910	31.43	12/18/2025		
	9/14/2016	8,891	16,109	28.94	9/14/2026		

	2/15/2017	10,957	44,043	20.53	2/15/2027		
Jon Wigginton, M.D.	7/19/2013	50,448		4.70	7/18/2023		
	12/12/2014	32,526	7,474	29.68	12/12/2024		
	12/18/2015	29,090	25,910	31.43	12/18/2025		
	2/25/2016				2/25/2026	30,000	613,200
	2/15/2017	14,360	53,140	20.53	2/15/2027		

(1) Options vest and become exercisable with respect to (a) 12.5 percent of the underlying shares six months after the grant date and (b) the remainder of the underlying shares in 14 equal quarterly installments.

(2) Reflects restricted stock units granted to Dr. Wigginton, which vested on February 25, 2018, the second anniversary of the date of grant. The market value is based on the closing stock price on the date of grant.

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Options Exercised and Stock Vested Table

The following table sets forth certain information concerning the exercise of stock options held by the named executive officers during the fiscal year ended December 31, 2017. There was no vesting of restricted stock units held by the named executive officers during the fiscal year ended December 31, 2017.

Name	Number of Shares Acquired on Exercise (#)	Value Realized on Exercise ($) (1)	Number of Shares Acquired on Vesting (#)	Value Realized Vesting ($) (2)
Scott Koenig, M.D., Ph.D.	79,898	1,470,922		
James Karrels	13,000	229,280		
Ezio Bonvini, M.D.	53,264	864,741		
Eric Risser	2,000	34,680		
Jon Wigginton, M.D.	35,000	535,809		

(1) This amount represents the difference between the sales price and the exercise price.
(2) Based on the closing price of the Company s common stock, as reported on the Nasdaq on the date on which the stock vested, or, if the stock vested on a weekend or holiday, the closing price of the stock on the next day the Company s common stock was traded.

Perquisites and Other Personal Benefits

All of the named executive officers are eligible to participate in the Company s employee benefit plans, including health, dental, and vision insurance, a prescription drug plan, flexible spending accounts, short and long-term disability, life insurance, and a 401(k) plan. These plans are offered to all employees and do not discriminate in favor of named executive officers.

Tax and Accounting Implications

In evaluating compensation program alternatives, the Compensation Committee considers the potential impact on the Company of Section 162(m) of the Internal Revenue Code. Section 162(m) eliminates the deductibility of compensation over $1 million paid to the CEO and three other most highly-compensated named executive officers (other than the CEO), excluding performance-based compensation. Compensation programs generally will qualify as performance-based if compensation is based on pre-established objective performance targets, the programs material features have been approved by stockholders, and there is no discretion to increase payments after the performance targets have been established for the performance period.

It should be noted that the Tax Cuts and Jobs Act signed on December 22, 2017 eliminates the exception for performance-based compensation beginning with the 2018 tax year.

To the extent a named executive officer would otherwise earn over $1 million in compensation in any calendar year, the Compensation Committee generally endeavors to maximize deductibility of compensation under Section 162(m) of the Internal Revenue Code to the extent practicable while maintaining a competitive, performance-based compensation program. However, tax consequences are subject to many factors (such as changes in the tax laws and

regulations or interpretations thereof and the timing and nature of various decisions by officers regarding stock options) that are beyond the control of either the Compensation Committee or the Company. In addition, the Compensation Committee believes that it is important for it to retain maximum flexibility in designing compensation programs that meet its stated objectives and fit within the Compensation Committee s guiding principles. Also, the actual impact of the loss of deduction for compensation paid to the CEO and the other three most highly compensated executives over the $1 million limitation may be small and have a *de minimis* impact on the Company s overall tax position. For these and other reasons, the Compensation Committee, while considering tax deductibility as a factor in determining compensation, will not limit compensation to those levels or types that will be deductible.

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Anti-Hedging and Anti-Pledging Policies

Our insider trading policy prohibits all directors and officers from pledging or engaging in hedging or similar transactions in our stock, including but not limited to prepaid variable forwards, equity swaps, collars, puts, calls and short sales.

Compensation Risk Assessment

Our compensation policies and programs are designed to encourage our employees to remain focused on both our short- and long-term goals. Our management assesses and discusses with our Compensation Committee our compensation policies and practices for our employees as they relate to our risk management and, based upon this assessment, we believe that any risks arising from such policies and practices are not reasonably likely to have a material adverse effect on the Company in the future. The Compensation Committee believes that the mix of long-term equity incentive, short-term cash incentive bonus and base salary appropriately balances both short- and long-term performance goals.

Overview of Employment and Change in Control Agreements

As of December 31, 2017, the Company had employment agreements in place with each of its named executive officers. The employment agreements provide for certain payments upon a named executive officer s termination, as described below. All of the named executive officers are at-will employees.

Dr. Koenig

In October 2013, we entered into an employment agreement with Dr. Koenig. Dr. Koenig is employed at-will, which means that he has no definitive term of employment.

Dr. Koenig s employment agreement includes non-competition and non-solicitation provisions that will prohibit him from competing with us, soliciting our customers or employees, or hiring our employees for a period of two years following the end of his employment with us for any reason and, with respect to the non- competition provisions, for the period during which he is receiving severance benefits. Under his employment, Dr. Koenig is also subject to confidentiality and invention disclosure and assignment obligations. Dr. Koenig is eligible to receive severance benefits in specified circumstances.

Under the terms of the agreement, upon execution and delivery of an irrevocable release of claims against the Company and subject to his continued compliance with the non-competition and non-solicitation, confidentiality and invention assignment provisions, Dr. Koenig will be entitled to severance benefits if we terminate his employment without Cause or if he terminates employment with us for Good Reason, absent or in connection with a Change of Control.

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The following table summarizes the schedule of severance benefits Dr. Koenig would receive in the event of such a qualifying termination.

Scenario	Salary Continuation	Continuation of Health Benefits	Acceleration of Unvested Equity
Absent a Change of Control	24 months of base salary and target bonus (55% of base salary)	12 months (or until Dr. Koenig obtains other employment which provides the same type of benefit, if earlier)	50% of the shares with respect to which the stock option is not vested
Termination occurs within Two Years Following a Change of Control	24 months of base salary and target bonus (55% of base salary)	12 months (or until Dr. Koenig obtains other employment which provides the same type of benefit, if earlier)	100% of the shares with respect to which the stock option is not vested

The following definitions are used in Dr. Koenig s employment agreement:

Cause means: (a) a failure to substantially perform the duties with us (if the failure to substantially perform is not cured, if curable, within thirty (30) days after receipt of written notice from the Board of Directors that specifies the conduct constituting Cause under this clause (a); (b) willful misconduct, or gross negligence in the performance of duties to us; (c) the conviction or entry of a guilty plea or plea of no contest with respect to, any crime that constitutes a felony or involves fraud, dishonesty or moral turpitude; (d) commission of an act of fraud, embezzlement or misappropriation against us; (e) a material breach of the fiduciary duty owed to us; (f) engaging in any improper conduct that has or is likely to have an adverse economic or reputational impact on us; or (g) a material breach of the employment agreement.

Change of Control means: (a) any person (excluding our employee benefit plans) is or becomes the beneficial owner (as defined in Rules 13d-3 and 13d-5 under the Exchange Act directly or indirectly, of securities representing more than fifty percent (50%) of the combined voting power of our then outstanding securities; (b) we consummate a merger, consolidation, share exchange, division or other reorganization or transaction with any other corporation unless our outstanding securities immediately prior to the transaction continue to represent at least 50% of the combined voting power immediately after the transaction; or (c) stockholder approval of the liquidation or winding-up of our company or the consummation of the sale or disposition of all or substantially all of our assets; or (d) during any period of 24 consecutive months, individuals who at the beginning of such period constituted our Board (including for this purpose any new director whose election or nomination for election by the stockholders was approved by a vote of at least two-thirds of the directors then still in office who were directors at the beginning of such period or whose appointment, election or nomination was previously so approved or recommended) cease for any reason to constitute at least a majority of the Board of Directors.

Good Reason means the occurrence of any of the following events (without the executive s consent): (i) material adverse change in functions, duties, or responsibilities that would cause the executive s position to become one of materially lesser responsibility, importance, or scope or (ii) a material breach of the agreement by us. No resignation will be treated as good reason unless (a) the executive has given written notice of such event to us within ninety (90) days after the initial occurrence thereof, (b) we have failed to cure the condition constituting good reason within 30 days following the delivery of the notice, and (c) the executive terminates employment within thirty (30) days after expiration of such cure period.

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Mr. Karrels

In October 2013, we entered into an employment agreement with Mr. Karrels. Mr. Karrels is employed at-will, which means that he has no definitive term of employment.

Mr. Karrels employment agreement includes a non-competition provision that will prohibit him from competing with us for a period of 18 months following the end of his employment with us for any reason or for the period during which he is receiving severance benefits, as well as a non-solicitation provision that will prohibit him from soliciting our customers or employees, or hiring our employees for a period of two years following the end of his employment with us for any reason. Under his employment agreement, Mr. Karrels is also subject to confidentiality and invention disclosure and assignment obligations.

Mr. Karrels is eligible to receive severance benefits in specified circumstances. Under the terms of the agreement, upon execution and delivery of an irrevocable release of claims against the Company and subject to his continued compliance with the non-competition and non-solicitation, confidentiality and invention assignment provisions, Mr. Karrels will be entitled to severance benefits if we terminate his employment without Cause or if he terminates employment with us for Good Reason, absent or in connection with a Change of Control.

The following table summarizes the schedule of severance benefits Mr. Karrels would receive in the event of such a qualifying termination. Mr. Karrels employment agreement contains substantially similar definitions of the terms Cause, Change of Control, and Good Reason as those defined in Dr. Koenig s agreement, discussed above.

Scenario	Salary Continuation	Continuation of Health Benefits	Acceleration of Unvested Equity
Absent a Change of Control	12 months of base salary	12 months (or until Mr. Karrels obtains other employment which provides the same type of benefit, if earlier)	50% of the shares with respect to which the stock option is not vested
Termination occurs within Two Years Following a Change of Control	12 months of base salary and target bonus (35% of base salary)	12 months (or until Mr. Karrels obtains other employment which provides the same	100% of the shares with respect to which the stock option is not vested

type of benefit, if earlier)

Drs. Bonvini and Wigginton and Mr. Risser

In the first quarter of 2016, we entered into an employment agreement with each of Dr. Bonvini, Dr. Wigginton and Mr. Risser. Drs. Bonvini and Wigginton and Mr. Risser are each employed at-will, which means that each individual has no definitive term of employment.

Each of their employment agreements includes non-competition and non-solicitation provisions that will prohibit that individual from competing with us, soliciting our customers or employees, or hiring our employees for a period of 12 months following the end of his employment with us for any reason. Each individual is also subject to confidentiality and invention disclosure and assignment obligations.

Each of these individuals is also eligible to receive severance benefits in specified circumstances. Upon his death or termination for disability, each of Drs. Wigginton and Bonvini and Mr. Risser would be eligible to

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receive any earned but unpaid bonus obligation relating to the prior fiscal year and certain other accrued but unpaid obligations. Under the terms of each agreement, upon execution and delivery of an irrevocable release of claims against the Company and subject to his continued compliance with the non-competition and non- solicitation, confidentiality and invention assignment provisions, each such individual will be entitled to severance benefits if we terminate his employment without Cause or if he terminates employment with us for Good Reason, absent or in connection with a Change of Control. The table below summarizes the schedule of severance benefits each of these individuals would receive in the event of such a qualifying termination.

The employment agreement for each of Drs. Bonvini and Wigginton and Mr. Risser contains substantially similar definitions of the terms Cause, Change of Control and Good reason as those defined in Dr. Koenig s agreement, discussed above, except that the definition of Good Reason in these individuals agreements includes a material change in geographic location of his employment of at least 50 miles from our Rockville, Maryland, headquarters with no ability to telecommute. The table below summarizes the schedule of severance benefits each of these individuals would receive in the event of a qualifying termination.

The definition of Disability in the employment agreement for each of Drs. Bonvini and Wigginton and Mr. Risser is as follows: (a) the executive being determined to be totally disabled as defined by guidelines of the then-existing Company disability insurance plan in which the executive is participating, or (b) a determination by the Social Security Administration that the executive is totally disabled or (c) the executive s inability to engage in comparable professional activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or can be expected to last for a continuous period of not less than twelve months.

Scenario	Salary Continuation	Continuation of Health Benefits	Acceleration of Unvested Equity
Absent a Change in Control	12 months of base salary plus a pro-rated bonus at target for the current year	12 months (or until the executive obtains other employment which provides the same type of benefit, if earlier)	None
Termination occurs within One Year Following a Change in Control	12 months of base salary plus bonus at target	12 months (or until the executive obtains other employment which provides the same	100% of the shares with respect to which any stock options and any restricted stock units are not vested

type of benefit, if earlier)

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COMPENSATION COMMITTEE REPORT

The material in this report is not soliciting material, is not deemed filed with the SEC, and is not to be incorporated by reference into any filing by MacroGenics under the Securities Act, or the Exchange Act.

Our Compensation Committee has reviewed and discussed the Compensation Discussion and Analysis contained in this Proxy Statement with management. Based on our Committee s review of and the discussions with management with respect to the Compensation Discussion and Analysis, our Compensation Committee recommended to the Board that the Compensation Discussion and Analysis be included in this Proxy Statement and incorporated by reference in the Company s 2017 Annual Report on Form 10-K.

Compensation Committee

Matt Fust, Chair

Karen Ferrante, M.D.

Scott Jackson

David Stump, M.D.

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CEO PAY RATIO DISCLOSURE

As required by Section 953(b) of the Dodd-Frank Wall Street Reform and Consumer Protection Act and Item 402(u) of Regulation S-K, the Company is required to disclose the ratio of our principal executive officer s annual total compensation to the annual total compensation of our median employee. During fiscal 2017, the principal executive officer of MacroGenics was our President and Chief Executive Officer, Scott Koenig, M.D., Ph.D. For 2017, the annual total compensation for Dr. Koenig was $3,478,130, and for our median employee was $131,047, resulting in an estimated pay ratio of 27:1.

In accordance with Item 402(u) of Regulation S-K, we identified the median employee by (i) aggregating for each applicable employee (A) annual base salary as of November 30, 2017, or hourly rate multiplied by target work schedule, for hourly employees; (B) the target bonus for 2017; (C) equity received in 2017; and (ii) ranking this compensation measure for our employees from lowest to highest. This calculation was performed for all employees, excluding Dr.Koenig, whether employed on a full-time, part-time, or seasonal basis.

The pay ratio reported above is a reasonable estimate calculated in a manner consistent with SEC rules based on our internal records and the methodology described above. Because the SEC rules for identifying the median compensated employee and calculating the pay ratio based on that employee s annual total compensation allow companies to adopt a variety of methodologies, to apply certain exclusions, and to make reasonable estimates and assumptions that reflect their employee populations and compensation practices, the pay ratio reported by other companies may not be comparable to the pay ratio reported above, as other companies have different employee populations and compensation practices and may utilize different methodologies, exclusions, estimates and assumptions in calculating their own pay ratios.

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INFORMATION ABOUT EQUITY COMPENSATION PLANS

The following table provides certain information as of December 31, 2017, with respect to all of our equity compensation plans in effect on that date.

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity Compensation Plans Approved by Stockholders (1)(2)	4,504,642	$ 19.79	3,119,912
Equity Compensation Plans Not Approved by Stockholders			
Total	4,504,642		3,119,912

(1) Includes the MacroGenics, Inc. 2013 Equity Incentive Award Plan and 2003 Equity Incentive Plan.

(2) Includes 4,504,642 of equity available for issuance under our 2013 Plan. In addition to being available for future issuance upon exercise of stock options and vesting of restricted stock unit awards that have been or may be granted after December 31, 2017, our 2013 Plan provides for the issuance of restricted stock awards and other stock-based awards. The 2013 Plan contains an evergreen provision, pursuant to which the number of shares of common stock reserved for issuance or transfer pursuant to awards under the 2013 Plan shall be increased on the first day of each year beginning in 2014 and ending in 2023, equal to the lesser of (a) 1,960,168 shares, (b) 4.0% of the shares of common stock outstanding (on an as converted basis) on the last day of the immediately preceding fiscal year and (c) such smaller number of shares of stock as determined by our Board. As of December 31, 2017, 3,119,912 shares were available for future issuance, which number increased by 1,474,243 shares as of January 1, 2018, due to the effect of this evergreen provision.

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SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The following table presents information as to the beneficial ownership of our common stock as of March 23, 2018 for:

- each person, or group of affiliated persons, known by us to beneficially own more than 5% of our common stock;
- each of our named executive officers;
- each of our directors; and
- all executive officers and directors as a group.

The number of shares beneficially owned and the percentage of shares beneficially owned are based on 37,022,921 shares of common stock outstanding as of March 23, 2018, except as otherwise noted. Unless otherwise indicated in the footnotes to the table, and subject to community property laws where applicable, to the best of our knowledge, the following persons have sole voting and investment control with respect to the shares beneficially owned by them. In accordance with SEC rules, if a person has a right to acquire beneficial ownership of any shares of common stock, on or within 60 days of March 23, 2018, upon exercise of outstanding options, vesting of restricted stock units or otherwise, the shares are deemed beneficially owned by that person and are deemed to be outstanding solely for the purpose of determining the percentage of our shares that person beneficially owns. These shares are not included in the computations of percentage ownership for any other person. Except as otherwise indicated, the address of each of the named executive officers and directors in this table is 9704 Medical Center Drive, Rockville, Maryland 20850.

Name of Beneficial Owner	Shares of Common Stock (1)	Shares of Common Stock Issuable within 60 Days (2)	Total Number of Shares of Common Stock Beneficially Owned	Beneficial Ownership%
Greater than 5% Stockholders				
Oppenheimer Funds, Inc. and affiliated persons (3)	3,933,906		3,933,906	10.63
FMR LLC and affiliated persons (4)	3,639,537		3,639,537	9.83
Boxer Capital, LLC and affiliated persons (5)	3,177,426		3,177,426	8.58
BlackRock, Inc. and affiliated persons (6)	2,653,178		2,653,178	7.17
BB Biotech AG (7)	2,600,412		2,600,412	7.02
Johnson & Johnson and Johnson & Johnson Innovation-JJDC, Inc. (8)	1,923,077		1,923,077	5.19
Named executive officers and Directors:				
Scott Koenig, M.D., Ph.D. (9)	1,004,358	683,676	1,688,034	4.56

James Karrels (10)	114,847	180,341	295,188	*
Jon Wigginton, M.D.	18,930	134,844	153,774	*
Ezio Bonvini, M.D. (11)	154,208	132,315	286,523	*
Eric Risser	9,100	189,098	198,198	*
Paulo Costa	59,435	62,817	122,252	*
Karen Ferrante, M.D.		30,000	30,000	*
Matthew Fust	500	47,773	48,273	*
Kenneth Galbraith	46,875	47,773	94,648	*
Edward Hurwitz	18,074	47,773	65,847	*
Scott Jackson		30,000	30,000	*
Jay Siegel, M.D.		9,960	9,960	*
David Stump, M.D.		47,773	47,773	*
All directors and executive officers as a group (16 persons)	1,428,520	1,837,899	3,266,419	8.82

* Represents beneficial ownership of less than one percent of the outstanding shares of common stock.

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(1) Beneficial ownership is determined in accordance with the rules and regulations of the SEC and includes voting or investment power with respect to shares of our common stock. The information set forth in the table above is not necessarily indicative of beneficial ownership for any other purpose, and the inclusion of any shares deemed beneficially owned in this table does not constitute an admission of beneficial ownership of those shares.

(2) Consists of shares of common stock subject to stock options exercisable as of, or within 60 days of March 23, 2018, and shares of common stock issuable under restricted stock unit awards that vest within 60 days of March 23, 2018.

(3) Oppenheimer Funds, Inc. and affiliated persons reported shared dispositive power with respect to 3,933,906 shares of our common stock as of December 31, 2017, in a Schedule 13G/A filed with the SEC on February 6, 2018. The address of Oppenheimer Funds Inc. and its affiliated persons is 2 World Financial Center, 225 Liberty Street, New York, NY 10281.

(4) FMR LLC and affiliated persons reported sole dispositive power with respect to 3,639,537 shares of our common stock as of December 31, 2017, in a Schedule 13G/A filed with the SEC on January 10, 2018. The address of FMR LLC and its affiliated persons is 245 Summer Street, Boston, Massachusetts 02210.

(5) Boxer Capital, LLC and affiliated persons reported sole dispositive power with respect to 3,177,426 shares of our common stock as of February 14, 2018, in a Schedule 13G/A filed with the SEC on February 14, 2018. The address of Boxer Capital LLC is 11682 El Camino Real, Suite 320, San Diego, CA 92130.

(6) BlackRock, Inc. and affiliated persons reported sole dispositive power with respect to 2,653,178 shares of our common stock as of December 31, 2017, in a Schedule 13G/A filed with the SEC on January 25, 2018. The address of BlackRock, Inc. and its affiliated persons is 55 East 52nd Street, New York, NY 10055.

(7) BB Biotech AG and its wholly-owned subsidiary, Biotech Target N.V. reported shared dispositive power with respect to 2,600,412 shares of our common stock as of December 31, 2017, in a Schedule 13G/A filed with the SEC on February 14, 2018. The address of BB Biotech AG is Schwertstrasse 6, CH-8200 Schaffhausen, Switzerland. The address of Biotech Target N.V. is Snipweg 26, Curacao.

(8) Johnson & Johnson, a New Jersey corporation (J&J), and its wholly owned subsidiary, JJDC, each reported shared voting and dispositive power with respect to 1,923,077 shares of our common stock as reported in a Shedule 13G filed with the SEC on February 5, 2015. We are not aware of any changes in J&J or JJDC s ownership of our common stock since that time. The securities reported herein as being held by J&J and JJDC are held by JJDC. J&J may be deemed to indirectly own the securities that are held by JJDC. The address of J&J and JJDC is One Johnson & Johnson Plaza, New Brunswick, NJ 08933.

(9) Consists of (i) 53,265 shares of common stock, (ii) 783,311 shares of common stock owned jointly by Dr. Koenig and his spouse, of which Dr. Koenig has shared voting and dispositive power and (iii) 167,782 shares of common stock held by the Scott Koenig Family Trust, an irrevocable trust, of which Dr. Koenig s spouse and brother-in-law are co-trustees, and of which Dr. Koenig may be deemed to have shared voting and dispositive power.

(10) Consists of 114,847 shares of common stock jointly owned by Mr. Karrels and his spouse.

(11) Consists of (i) 146,658 shares of common stock, and (ii) 7,550 shares of common stock held by the Bonvini Family 2015 Irrevocable Trust for the benefit of an immediate family member, of which is managed by a third-party trustee and of which Dr. Bonvini may be deemed to have shared voting and dispositive power.

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SECTION 16(a) BENEFICIAL OWNERSHIP REPORTING COMPLIANCE

Section 16(a) of the Exchange Act requires the Company s directors and executive officers, and persons who own more than 10% of a registered class of the Company s equity securities, to file with the SEC initial reports of ownership and reports of changes in ownership of common stock and other equity securities of the Company. Officers, directors and greater than 10% stockholders are required by SEC regulations to furnish the Company with copies of all Section 16(a) forms they file.

To the Company s knowledge, based solely on a review of the copies of such reports furnished to the Company and written representations that no other reports were required, during the year ended December 31, 2017, none of our officers, directors and greater than 10% beneficial owners failed to file on a timely basis reports required by Section 16(a) of the Exchange Act.

HOUSEHOLDING OF PROXY MATERIALS

In order to reduce printing costs and postage fees, we mail only one copy of the Notice of the Annual Meeting, which includes instructions on how to access our 2017 Annual Report and Proxy Statement on the internet, and the proxy card to any one address, unless we receive contrary instructions from any stockholder at that address (known as householding).

We will deliver upon written or oral request a separate copy of the 2017 Annual Report and Proxy Statement to any stockholder at a shared address to which a single copy of the above mentioned materials was delivered. If you are a stockholder of record, you may contact us by writing c/o the Corporate Secretary at our corporate headquarters located at 9704 Medical Center Drive, Rockville, Maryland 20850, or by calling us at (301) 251-5172. If you are a beneficial but not record owner, you can request additional copies, or you can request householding, by notifying your broker, bank or other nominee.

WHERE YOU CAN FIND MORE INFORMATION

We are required to file annual, quarterly and current reports, proxy statements and other information with the SEC. You may read and copy these proxy materials and any other documents we have filed at the SEC s Public Reference Room at 100 F Street, N.E., Room 1580, Washington, D.C. 20549. Please call the SEC at 1-800-SEC-0330 for further information on the Public Reference Room. Our SEC filings are also available to the public at the SEC s website at www.sec.gov.

It is important that your shares are represented at the Annual Meeting. Whether or not you plan to attend the Annual Meeting, please vote your shares as described in this proxy statement, so your shares will be represented at the Annual Meeting.

The form of proxy and this proxy statement have been approved by the Board and are being mailed or delivered to stockholders by its authority.

By Order of the Board of Directors

James Karrels

Corporate Secretary

Rockville, Maryland

April 6, 2018

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ANNUAL MEETING OF Stockholders of MacroGenics, Inc.

Date: May 17, 2018
Time: 9:00 am
Place: Hilton Garden Inn Rockville-Gaithersburg, 14975 Shady Grove Road,

Rockville, Maryland 20850.

Please make your marks like this: Use dark black pencil or pen only

Proposals - The Board of Directors recommends a vote FOR all the nominees listed in Proposal 1 and FOR Proposals 2 and 3.

1: To elect three Class II directors listed in these proxy materials to hold office until the 2021 Annual Meeting of Stockholders or until their successors are elected and qualified, or until their earlier death, resignation or removal:	**For**	**Withhold**
01 Kenneth Galbraith		
02 Scott Jackson		
03 David Stump		

	For	**Against**	**Abstain**
2: To ratify the selection of Ernst & Young LLP as the independent registered public accounting firm of the Company for its fiscal year ending December 31, 2018.			
3: To approve, on an advisory basis, the compensation of our named executive officers as disclosed in these proxy materials.			

To attend the meeting and vote your shares in person, please mark this box.

Authorized Signatures - This section must be completed for your instructions to be executed.

Please Sign Here Please Date Above

Please Sign Here Please Date Above

Please sign exactly as your name(s) appears on your stock certificate. If held in joint tenancy, all persons should sign. Trustees, administrators, etc., should include title and authority. Corporations should provide full name of corporation and title of authorized officer signing the proxy.

Notice of 2018 Annual Meeting of Stockholders

to be held on Thursday, May 17, 2018

for Stockholders as of March 23, 2018

This proxy is solicited by the Board of Directors

VOTE BY:

INTERNET

www.proxypush.com/MGNX

Cast your vote online.

View Meeting Documents.

OR

TELEPHONE

866-284-4925

Use any touch-tone telephone.

Have your Proxy Card/Voting Instruction Form ready.

Follow the simple recorded instructions.

MAIL

OR Mark, sign and date your Proxy Card/Voting Instruction Form.
Detach your Proxy Card/Voting Instruction Form.
Return your Proxy Card/Voting Instruction Form in the postage-paid envelope provided.

THE SHARES REPRESENTED BY THIS PROXY WILL BE VOTED USING THE INSTRUCTIONS PROVIDED BY THE STOCKHOLDER. IF NO DIRECTION IS GIVEN, THE PROXIES WILL HAVE AUTHORITY TO VOTE FOR ALL THE NOMINEES LISTED IN PROPOSAL 1 AND FOR PROPOSALS 2 AND 3. IN THEIR DISCRETION, THE PROXIES ARE AUTHORIZED TO VOTE UPON OTHER BUSINESS AS MAY PROPERLY COME BEFORE THE MEETING.

All votes must be received by 5:00 P.M., Eastern Time, May 16, 2018

PROXY TABULATOR FOR

P.O. BOX 8016

CARY, NC 27512-9903

EVENT #

CLIENT #

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Annual Meeting Materials are available at:
www.proxydocs.com/MGNX

IF YOU HAVE NOT VOTED VIA THE INTERNET OR TELEPHONE, FOLD ALONG THE PERFORATION, DETACH AND RETURN THE BOTTOM PORTION IN THE ENCLOSED ENVELOPE.

REVOCABLE PROXY MacroGenics, Inc.

ANNUAL MEETING OF STOCKHOLDERS

May 17, 2018

9.00 a.m.

THIS PROXY IS SOLICITED BY THE BOARD OF DIRECTORS

The stockholder(s) signing this proxy card hereby appoints Paulo Costa, James Karrels and Jeffrey Peters, or any of them, each with the power of substitution to act as attorneys and proxies for the stockholder(s) to vote all shares of common stock of MacroGenics, Inc. (the Company) that the stockholder(s) is entitled to vote at the Annual Meeting of Stockholders (Annual Meeting) to be held at the Hilton Garden Inn Rockville-Gaithersburg, 14975 Shady Grove Road, Rockville, Maryland 20850 at 9:00 am local time or at any postponement or adjournment thereof. Each of the individuals is authorized to cast all votes to which the stockholder(s) is entitled as follows:

THIS PROXY WILL BE VOTED AS DIRECTED, BUT IF NO INSTRUCTIONS ARE SPECIFIED, THIS PROXY WILL BE VOTED FOR EACH OF THE PROPOSITIONS AND NOMINEES LISTED ON THE REVERSE SIDE. IF ANY OTHER BUSINESS IS PRESENTED AT SUCH MEETING, THIS PROXY WILL BE VOTED BY THE ABOVE-NAMED PROXIES AT THE DIRECTION OF A MAJORITY OF THE BOARD OF DIRECTORS. AT THE PRESENT

TIME, THE BOARD OF DIRECTORS KNOWS OF NO OTHER BUSINESS TO BE PRESENTED AT THE MEETING.

Should the undersigned be present and elect to vote at the Annual Meeting or at any adjournment thereof and after notification to the Secretary of the Company at the Annual Meeting of the stockholder s decision to terminate this proxy, then the power of said attorneys and proxies shall be deemed terminated and of no further force and effect. This proxy may also be revoked by sending written notice to the Secretary of the Company at the address set forth on the Notice of Annual Meeting of Stockholders, or by the filing of a later dated proxy prior to a vote being taken on a particular proposal at the Annual Meeting.

The undersigned acknowledges receipt from the Company, prior to the execution of this proxy, of notice of the Annual Meeting, the Proxy Statement dated April 6, 2018 and the Company s Annual Report on Form 10-K for the year ended December 31, 2017.

PLEASE PROVIDE YOUR INSTRUCTIONS TO VOTE BY TELEPHONE OR THE INTERNET OR COMPLETE, DATE, SIGN, AND MAIL THIS PROXY CARD PROMPTLY IN THE ENCLOSED POSTAGE-PAID ENVELOPE.

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Important Notice Regarding the Availability of Proxy Materials for the 2018 Annual Meeting of

Stockholders to be held on May 17, 2018.

This communication presents only an overview of the more complete proxy materials that are available to you on the Internet. We encourage you to access and review all of the important information contained in the proxy materials before voting. To view the proxy statement and annual report, go to www.proxydocs.com/MGNX. To submit your proxy while visiting this site, you will need the 12 digit control number in the box below.

Under new United States Securities and Exchange Commission rules, proxy materials do not have to be delivered in paper. Proxy materials can be distributed by making them available on the Internet. We have chosen to use these procedures for our 2018 Annual Meeting and need YOUR participation.
If you want to receive a paper or e-mail copy of the proxy materials, you must request one. There is no charge to you for requesting a copy. In order to receive a paper package in time for this year s annual meeting, please make this request on or before May 7, 2018.

For a Convenient Way to VIEW Proxy Materials

and

VOTE Online go to: www.proxydocs.com/MGNX

Proxy Materials Available to View or Receive:

1. Proxy Statement 2. Annual Report

Printed materials may be requested by one of the following methods:

You must use the 12 digit control number

located in the shaded gray box below.

* If requesting material by e-mail, please send a blank e-mail with the 12 digit control number (located below) in the subject line. No other requests, instructions or other inquiries should be included with your e-mail requesting material.

	ACCOUNT NO.	SHARES

MacroGenics, Inc. Notice of 2018 Annual Meeting of Stockholders

Date: May 17, 2018
Time: 9:00 am
Place: Hilton Garden Inn Rockville-Gaithersburg

14975 Shady Grove Road, Rockville, Maryland 20850.

The purpose of the Annual Meeting is to take action on the following proposals:

1. To elect three Class II directors listed in these proxy materials to hold office until the 2021 Annual Meeting of Stockholders or until their successors are elected and qualified or until their earlier death, resignation or removal:

Nominees 01 Kenneth Galbraith 02 Scott Jackson 03 David Stump

2. To ratify the selection of Ernst & Young LLP as the independent registered public accounting firm of the Company for its fiscal year ending December 31, 2018.
3. To approve, on an advisory basis, the compensation of our named executive officers as disclosed in these proxy materials.