

## Medical Billing Fraud at Tenet Healthcare Corporation

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This paper has four main purposes: to describe how health care billing occurs in the United States; to describe fraudulent billing by Tenet Healthcare Corporation; to apply Cressey's fraud triangle to the case; and to show the impact of the fraud on Tenet's financial statements and stock price, financially impacting directly the shareholders of Tenet's stock. In addition to providing practitioners with additional information about this fraud, the authors hope that it will provide another case example academics could use in a variety of courses.

Fraud can occur in any institution and in any industry. Healthcare funding is unique from all other industries in the United States primarily because the "customer" or patient rarely directly pays for the services rendered in a medical setting ranging from a quick doctor's office visit to a lengthy hospitalization. The uniqueness of healthcare billing provides a window of opportunity for a unique type of fraud and this is the focus of this paper. To understand the fraud that occurred by Tenet Healthcare Corporation, it is paramount to first understand diagnostic related groups or "DRG's" as they are applied to a significant amount of the government health care funding that occurs in the United States.

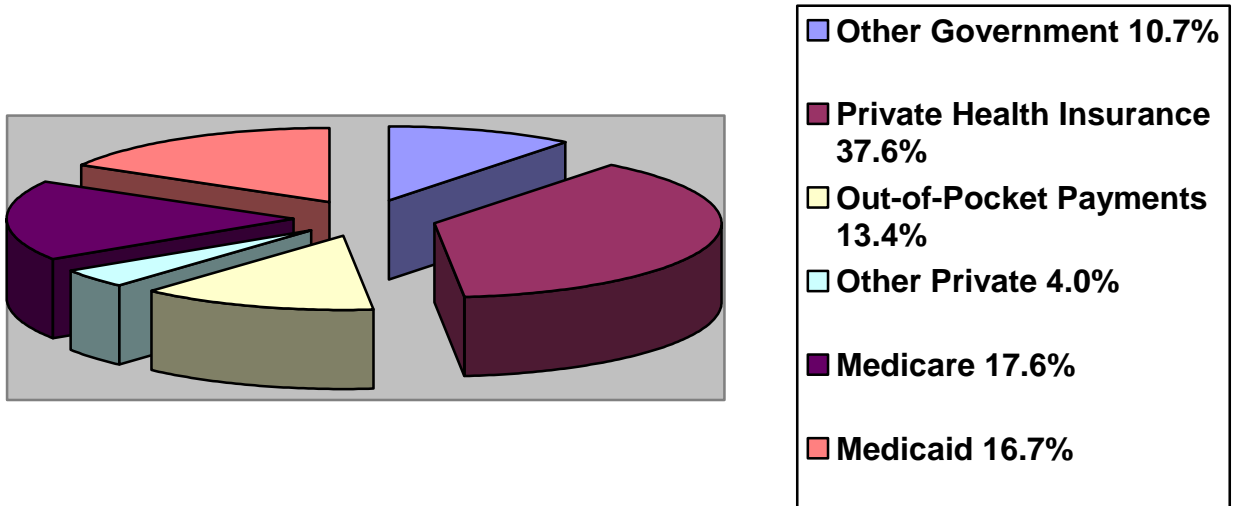
### Background information

Revenue recognition in the healthcare industry is unique. To comprehend the nature of the Tenet fraud requires an understanding of how hospitals generate revenues and cash flows. The funding for services rendered to inpatients of a hospital setting can come from a number of sources ranging from a personal payment to that of a "third party" payer which could include an insurance company, the state government or the federal government.

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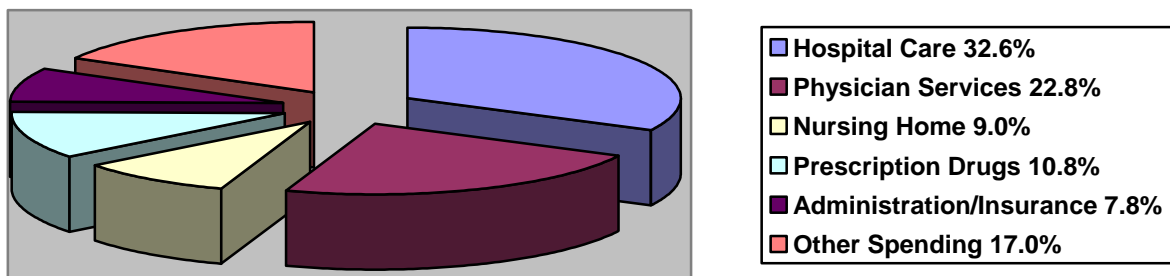
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The nation's health care dollar is **funded** from a variety of sources as identified below:



Source: "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," by C. Smith et al., Jan/Feb 2006, *Health Affairs*, 25(1), p.187.

Conversely, the national health care dollar is **spent** in the following categories:



Source: "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," by C. Smith et al., Jan/Feb 2006, *Health Affairs*, 25(1), p.187.

Thus, the expenditure of the nation's health care dollar in the hospital settings is a significant component of the total national health care dollar (32.6%) and as such, provides the focus for this paper.

There are four classifications of payments in the hospital health care setting: 1) private cash payments (cash, personal credit card, or personal debit card); 2) insurance company payment (or partial payment); 3) the state government (Medicaid in 49 states, Medi-Cal in California) designed for low income individuals; 4) the federal government (Medicare) for those individuals who are over 65 years of age.

Within the category of insurance company payments are indemnity policies wherein the individual makes monthly payments (premiums) and the company provides selected services when needed. There may be annual deductibles to be achieved, co-payments for each service and/or lifetime maximum benefits prior to the payment to a provider. Another method of insurance is a company who contracts directly with medical providers for a fixed fee per patient per month (\$PPM). The medical providers receive funding regardless of the number of visits by their subscribed patients (including no visits whatsoever). The healthcare entities that utilize this type of payment method are labeled health maintenance organizations (HMO's).

The state providers (# 3 above) and the federal providers (#4 above) use a system to determine the fixed payment that a hospital or clinic will receive for each inpatient the facility serves. All of the services that a hospital patient receives are accumulated upon discharge as identified in the patient's medical record, which is produced by the physician of record. These services represent all labor and materials received by the patient during their inpatient stay.

All of the services rendered in a hospital setting are first divided into 23 groups by major medical diagnostic category (MDC) which is based on medical meaningfulness. For example, while the services rendered by a hospital for a patient who undergoes surgery for the removal of an inflamed appendix (diagnostic workup, operating room time, surgical supplies, drug administration, etc) may be similar to the resources received by a patient who undergoes surgery for a brain tumor, these two procedures are completely different medically speaking. Gastrointestinal surgeries are grouped together in one MDC and cancerous tumor removals are categorized into another, different MDC. Once the services of patients received in a hospital are categorized into the 23 MDC, further subcategorizing occurs using five criteria (other than medical meaningfulness).

The variables of age, primary procedure performed, secondary procedure performed, primary diagnosis and secondary diagnosis further divide the 23 MDC's into their final groupings: diagnosis related groups or DRG's. Each of 511 DRG's has a unique statistical profile with the length of stay (LOS) as the dependent variable. The standard deviation of the distribution of each of the 511 DRG's is the key to understanding how medical fraud could occur. An example below compares two profiles of very different statistical distributions but with similar mean length of stays.

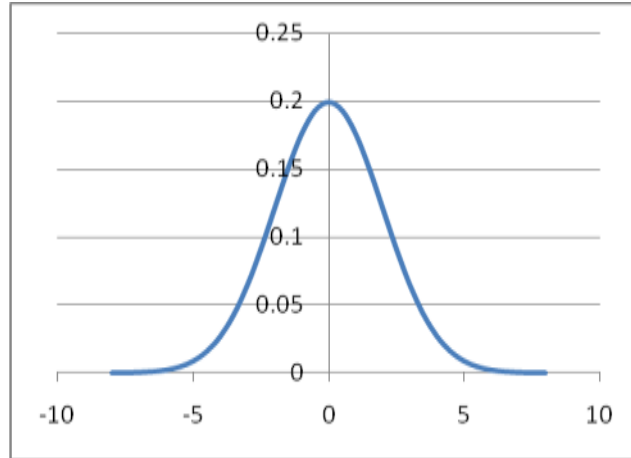


Figure A: Normal Distribution with a large standard deviation

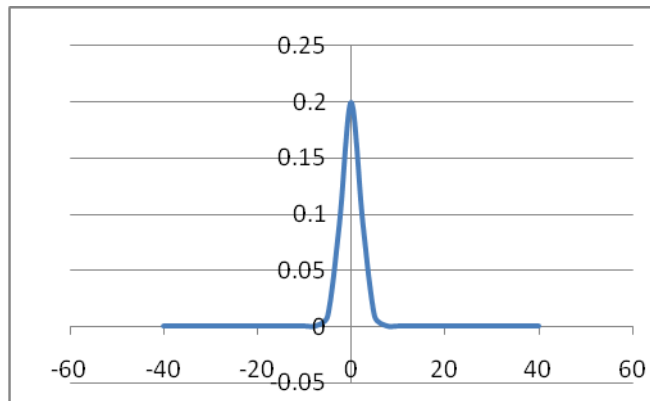


Figure B: Normal Distribution with a small standard deviation

The statistical measurement of “spread” for a normal distribution is standard deviation. As observed in the figure above, the standard deviation of figure A is very large; thus, the length of stay for patients who were provided services that yielded this DRG varied considerably. In contrast, the standard deviation of figure B exemplifies a much smaller standard deviation as more of the patients in this DRG stayed closer to the mean LOS days. An example of the small standard deviation DRG would be a group of doctors forming a clinic delivering a specialized service, such as obstetrics. The number of different services they render is relatively small (versus a hospital setting where many of the 511 DRG’s might be utilized in a fiscal year) yielding no more than 25-30 individual DRG’s. In addition, the practice pattern for the delivery of services at this clinic by the physicians is very likely to be similar: the use of supplies, pharmaceuticals, laboratory tests, and even the time spent with each patient yields a DRG for their billings with a very small variance or standard deviation. Conversely, the numerous physicians with admitting privileges to a large teaching hospital coupled with varying practice

patterns due to their medical training could yield very different uses of labor and materials for a particular DRG.

The most studied DRG deals with acute myocardial infarction (AMI or heart attacks) due to its extremely large standard deviation. It appears that physician practices handling patients with suspected heart attacks can vary dramatically with diagnostic work-up differences, drug regimens available to the doctors, and post operative care. In addition, with this particular DRG, there are often co-morbidity factors associated with patients who do suffer a heart attack. Many heart attack patients suffer from high blood pressure, diabetes, obesity, and are smokers of cigarettes which complicate the medical treatment provided to one patient versus another patient. The medical regimen and procedures used for one AMI patient could be very different from another AMI patient based exclusively on co-morbidity factors. Thus, the DRG for AMI is similar to Figure A above--a large standard deviation.

The funding of patients who are classified as low income and meeting the criteria for participation in Medicaid/Medi-Cal is based on DRG's. Additionally, the federal government's sponsored elderly patients who qualify for Medicare funding also use DRG-based reimbursement for hospitals. Each provider receives a single flat-rate payment for patients who are classified in any one DRG. This single, fixed payment is identical for all of the hospital's patients with that particular DRG profile, regardless of the actual labor and supplies used.

A second billing method, **days beyond one standard deviation in any individual DRG**, is critical in understanding the Tenet fraud.

When a patient needs additional days in the facility, the government funding system provides the hospital an opportunity to bill for additional funds. If a patient stays beyond the number of days that constitute the mean days plus one standard deviation the hospital can bill for additional funding. For example, let's say a patient stayed 12 days prior to discharge. Seven of those days are covered in the fixed payment of the DRG if the mean length of stay for that particular DRG is 7 days. Two of the days cover the one standard deviation day limit and the three additional days extend beyond one standard deviation. Thus, the hospital would be able to bill for the DRG dollar amount and request additional funding for the three additional days that extend beyond the one standard deviation from the mean length of stay (not 5 days, only 3). The health care term for this situation is an "outlier billing".

### Tenet Corporation

Tenet Healthcare Corporation is a second iteration entity. In 1967, a southern California healthcare management company was formed under the name National Medical Enterprise (NME). In July, 1994 NME had various issues with the Securities and Exchange Commission, the Department of Justice, and the Department of Health and Human Services (SEC). These issues related to improper and fraudulent revenue recognition and improper billings. While the company's name changed to Tenet Healthcare Corporation, the culture of fraud by the corporation's executives appears to have been carried forward.

Tenet Healthcare Corporation is one of the largest investor-owned health care delivery systems in the nation. It owned 49 acute care hospitals in 11 states and 57 outpatient centers with 13,601 licensed beds, 519,390 admissions and 3.88 million outpatient visits in calendar year 2009. At the time of this writing, Tenet owns or manages 59 hospitals in 12 states. While Tenet owns facilities in 11 of the 50 states, it is concentrated heavily in three states: California, Texas and Florida with over two-thirds of their hospitals in these three states. "The greatest concentrations of licensed beds in its hospitals are Florida (25.0%), California (24.4%) and

Texas (17.1%)” (Tenet Healthcare Corporation Morningstar Analysis, Page 3). The net operating revenues for calendar year 2009 were \$9.01 billion.

Every hospital bills some outlier billings but they are considered relatively rare, especially in large numbers. “Before 2003 a loophole existed in which a hospital could increase its Medicare outlier payments by raising its prices quickly from year to year. Tenet earned \$1.6 billion through this loophole, leading to an investigation and indictment by the Department of Justice for its dishonest billing practices” (Ibid page 1). A review of Tenet billings to various states for Medicare and Medicaid/Medi-Cal sponsored patients identified an excessively large number of outlier billings which triggered a formal review. The State of California Medi-Cal Division investigated Tenet’s outlier claims of DRG outlier billings seeking comparisons of similar facilities within the State to that of those billed by Tenet’s hospitals. Their goal was to identify if, in fact, the number of Tenet’s outlier billings exceeded the statistical norm for the patient profiles in the numerous Tenet facilities throughout the State of California. Similarly, Florida reviewed Tenet’s billing practices associated with outlier billings. The lawsuit from Florida provided the documentation of fraud from SEC court documents. In the final analysis, Tenet overbilled Medicare by \$1 billion. (Appleby 2005). “Tenet eventually decided to make a settlement and agreed to pay \$900 million” (Ibid page 1).

### **People involved in the case**

Although it’s easy to speak in the abstract about the “Tenet fraud,” the fact remains that one or more **individuals** had to make the decisions that led to overbilling and other fraudulent acts; in the final analysis, corporations do not commit fraud—people commit fraud. Four names are consistently associated with the Tenet fraud in the literature:

- David Dennis, chief financial officer
- Thomas B. Mackey, chief operating officer and co-president
- Raymond L. Mathiasen, chief accounting officer
- Christi R. Sulzbach, general counsel and chief compliance officer

Dennis joined Tenet’s management in 2000 (Business Wire, 2000). Previously, he had been co-head of the health care group for an international investment banking firm. “Among the transactions with which he has been closely involved were Tenet’s 1995 acquisition of American Medical International and its 1997 acquisition of OrNda Healthcare. He has also advised on most of Tenet’s corporate financings over the past five years.” (Business Wire, 2000)

Mackey’s affiliation with Tenet began in 1985. By 1999, he had risen through the ranks to become Tenet’s “executive vice president for operations in the western half of the country.” (Business Wire, 1999) At that time, he received yet another promotion, sharing responsibilities with another manager in the office of the president; his official title was chief operating officer.

With respect to the fraud (Dow Jones / The Associated Press, 2007):

The S.E.C. depicted Mr. Mackey as the principal architect of the scheme. In 1999, under his direction, Tenet management calculated the precise increase to Tenet’s gross charges needed to increase Medicare payments to a level that would allow the company to meet earnings targets, according to the S.E.C. By

2002, revenue from treating extraordinarily sick Medicare patients had more than tripled, accounting for over 40 percent of earnings in fiscal 2002, the S.E.C. said.

Mathiasen “joined National Medical Enterprises. . .in 1985 as vice president in its accounting department. He became chief accounting officer of Tenet in March 1996 and remained in that position until August 2003.” (Modern Healthcare, 2007) As a result of the fraud, Mathiasen’s CPA license was suspended by the California Board of Accountancy. According to their disciplinary records (California Board of Accountancy, 2008):

Mr. Mathiasen admitted that on or about June 8, 2007, the Securities and Exchange Commission (SEC) suspended Mr. Mathiasen from practicing before the SEC as an accountant. Mr. Mathiasen also admitted that he did not report the opening of the SEC's formal investigation against him and did not report the SEC's suspension to the Board. The SEC's imposition of discipline was based on its complaint that alleged that while serving as the Chief Accounting Officer for Tenet Healthcare, Mr. Mathiasen participated in a fraudulent scheme in which Tenet made misleading disclosures in its SEC filings for its fiscal year ending May 31, 2002, and the first quarter of its fiscal year 2003 ending August 30, 2002. Mr. Mathiasen consented to the entry of the SEC's judgment without admitting or denying the allegations of the SEC's complaint.

Sulzbach served as both general counsel and chief compliance officer—an interesting and somewhat contradictory pair of titles. According to Davis (2003), “As lead counsel, she was supposed to defend the company if it found itself in trouble. But as chief compliance officer -- and the captain of Tenet's promised journey to the straight-and-narrow -- she was supposed to make sure the company didn't wind up in hot water in the first place.” In numerous court citings, Sulzbach received internal documents (some of which she specifically requested financial data and revenue projections) which she then classified as “privileged” and prevented them from being distributed to other managers and also to the public. She had joined the firm in 1983, and resigned in 2003. (White, 2003)

### **Application of the fraud triangle**

The Tenet case comprises all three elements of Cressey's fraud triangle (1973): pressure, opportunity and rationalization.

Wells (2007) summarized six common sources of pressure originally identified by Cressey: violation of ascribed obligations, problems resulting from personal failure, business reversals, physical isolation, status gaining and employer-employee relations. Tenet's management was under significant pressure from at least two of those sources: violation of ascribed obligations and status gaining. The hospital's for-profit status put pressure on its management constantly to improve the bottom line; furthermore, Tenet violated its ascribed obligations by overbilling Medicare / Medicaid. The management of Tenet sought to gain status in the marketplace by showing superior financial results—similar to the situation at Enron and other frauds of the late 20<sup>th</sup> century. In the case of the Florida state government lawsuit against Tenet, the outlier overbilling and subsequent inflation of their cost of patient care influenced the statistical norm for those particular DRG's and thus each and every Florida hospital was affected by the redistribution of the statistical basis for comparison of costs and outlier frequencies.

Tenet's management also had ample opportunity to commit fraud. At least three factors contributed to that opportunity: (1) the design of the outlier billing process for DRGs described in the preceding section of this paper, (2) the use of technical clinical information in discharging patients and (3) the fact that medical doctors use their own personal judgment in making discharge decisions and that they are, in fact, the sole legal party authorized to discharge a patient. Thus, the Tenet fraud was not the sole work of one corporate individual; physicians must have agreed to the increased discharge date. Tenet owns hospitals in several states so clearly this practice was not the sole infraction of one physician. This elevates the fraud case to that of collusion by multiple parties within a "culture of corporate fraud".

The final element of the fraud triangle, rationalization, was also present in the Tenet case. A physician could rationalize the additional days in the hospital by pointing out that the patient would likely receive better care there than at home. In the case of Medicare-sponsored elderly individuals it may be true that there exists no home health-care assistance from a family member and thus, the hospital might be the best location for elderly care. Countering this argument is the reality that efficient health care facilities recognize the need to match appropriate care with the ideal site: continuous monitoring in a hospital's intensive care unit; professional nursing care in a floor bed in a hospital; transfer to a skilled nursing facility with 24 hour monitoring and professional staff; and finally the discharge to a home environment (with or without home nursing services). This hierarchy of health care patient services attempts to match the service and professional staffing to the medical needs of the individual patient. Each of the levels described above constitute a decreased cost per day from the most expensive ICU to the least expensive, home health care. Physicians who keep their patients "just one more day" in the hospital are providing their corporate owners additional revenue but they are also preventing another needy person access to that level of care in the hospital bed.

In addition, hospital staff may have realized that it was "cheaper to get caught" than to play by the rules with regard to patient length of stay. The penalty imposed by both the federal government and the individual states for medical infractions often is far less per individual infraction than the realized additional revenue from hundreds of cases. The medical billing system in today's environment is so complicated that most patients either never receive a copy of their ultimate bill and/or they have no medical expertise to understand the bill's contents. Thus, it is often difficult for a patient to realize that any inappropriate action has been taken, certainly not enough to initiate any form of legal action.

### **Financial impacts of the fraud**

The Tenet fraud occurred over the period 1999 through 2002 (SEC); it came to light in 2003, and the company continued to suffer from its effects long after its initial discovery. Consider the following data from Tenet's financial statements:

	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Current ratio	1.49	1.31	1.77	1.87
Debt to total assets	0.61	0.59	0.65	0.83



Cash flow:	2001	2002	2003	2004
operating	\$ 1,818	\$ 2,315	\$ 838	\$ (82)
investing	(574)	(1,227)	(333)	(12)
financing	(1,317)	(1,112)	(96)	129

Source: THKC 2007 10-K, Item 6, Page 26.

In the seminal work by Lynn and Wertheim (1993), key financial ratios have the statistical ability to foretell hospital closures. While almost two decades old, the message is as relevant today as it was then: leverage, liquidity, capital efficiency, and resource availability are the *sin qua non* for efficient and healthy hospital financial management. In many instances, the financial ratios for those facilities that ultimately closed were identified two years prior to closure and one year prior to closure with a statistically significant difference between the hospitals that ultimately closed versus comparative hospitals that remained operational and open. As can be seen by Tenet's financial trend analysis in Table 1, the acquisition of additional debt dramatically increased over the four year period of review. Tenet drastically increased its leverage in 2004—possibly to shore up its declining operating cash flows from 2003.

The current ratio trends an increasing liquidity but this may be misleading in that many of their accounts receivables (bolstering the current ratio itself) may be inflated and uncollectable as their contractual adjustment component of accounts receivables may be understated with inappropriate outlier billings. Tenet's cash flow trend for the four years of 2001 through 2004 is perhaps the most telling in that funding available for continued hospital acquisitions, future investments, and operating fund availability has dramatically changed during this four year comparative period. Coupled with the fact that Tenet pays no dividends, the available "additions to retained earnings from profits" has clearly declined over time no doubt of concerned to common stock shareholders.

As exemplified on the table above, Tenet's legal issues have tied up cash (in the form of legal settlements) and reduced their operating income significantly. In June 2006, Tenet agreed to pay \$725 million in cash and give up \$175 million of Medicare payments for a total of \$900 million USD in fees to resolve claims it defrauded the federal government for over-billing Medicare claims during the 1990s ([Wikipedia.org/wiki/Tenet\\_Healthcare](http://Wikipedia.org/wiki/Tenet_Healthcare)). This cash poor situation continued for a number of years well past the original legal disclosures and public information presented in 2003.

Louis Bachelier first expressed the idea of the efficient-market hypothesis (EMH) in his 1900 doctoral dissertation. Eugene Fama developed the actual efficient-market hypothesis published in early 1960. The hypothesis asserts that information is reflected in the price of a share of common stock. The three major versions, "weak", "semi-strong" and "strong" form vary in the degree to which readily available public versus insider information is available to evaluators of common stock value. While the "strong" form breaks down with the published research of Nicholson, Basu, and Rosenberg et. al., there continues to be support for the "weak" and "semi-strong" forms of the Efficient-Market Hypothesis (Samuelson, 1965).

The “weak” form of the EMH claims that prices on common stock already reflect all past publicly available information. The “semi-strong” form claims that both all publically available information and new public information influence the price/value of a share of common stock. Supporting the ‘semi-strong” form of the efficient-market hypothesis is the action by investors of Tenet Healthcare Corporation’s common stock upon the public announcement of fraud investigation by state and federal government branches.

The investing community was quick to react to news regarding significant financial lawsuits and especially to the published use of the word “fraud”. As observed in Figure C below, the 2002 stock price, especially the annual high price of the \$52.50, plummeted by 69% (\$52.50 to \$16.50) with the public news about Tenet’s California and Florida cases. The continuing drop to one tenth of its 2002 stock value (\$52.50 to \$5.43) in the following six years is a testimony to the continued financial lack of confidence and trust by the business community in the value of Tenet’s stock ownership and of the decisions made by the management of the company.

Insider information (which could support the “strong” form of the efficient-market hypothesis) is not available to the authors. How many Tenet executives holding stock and/or stock options dumped their stock at the high price of over \$50.00 with insider information regarding the upcoming litigation will never be known. One can only speculate that actions by the Securities and Exchange Commission reflect those Tenet officers for which a case could be made. On September 10, 2009 Thomas B. Mackey, the former co-president and chief operating officer of Tenet, consented to a permanent injunction prohibiting him from future violations of antifraud provisions and to repay \$1,780,000 in funds gained from his exercise of Tenet stock options and to pay a \$400,000 civil penalty fine. He also agreed to be permanently barred from serving as an officer or director of any public company (SEC Action September 13, 2009).

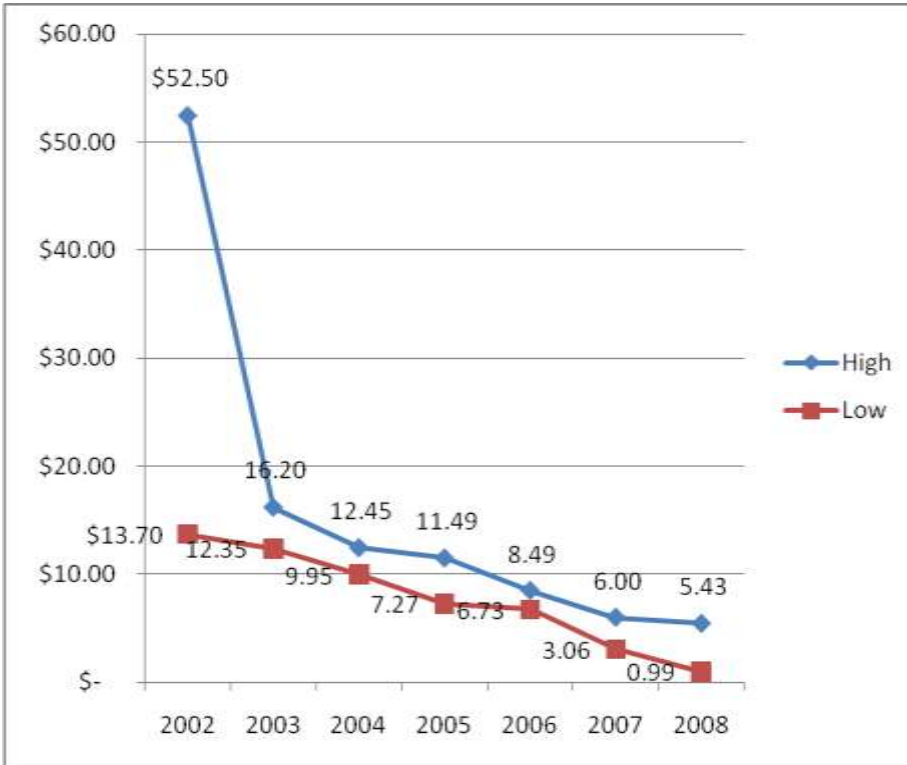


Figure C  
Tenet fourth-quarter stock prices

## **Conclusion**

The challenge facing external reviewers of the actions and decisions made by managers of a corporation is associated with understanding human behavior. Unless a reviewer can obtain insights directly from one of the executives (as in the situation of Aaron Beam's published account of HealthSouth's demise), a case of circumstantial evidence needs to be built. The power of the legal system provides entities like the Securities and Exchange Commission access to internal documents previously unavailable to the general public. Lastly, the financial community has access to SEC 10K annual reports which can be morphed into historical trends and ratio analyses providing a second-hand glimpse of what decisions occurred in the boardroom of Tenet.

In the case of Tenet Healthcare Corporation, an additional piece of information is available to external reviewers: the names of executives who started National Medical Enterprises (NME) and later became executives of Tenet carrying with them their culture of fraud from one organization to another. Some of Tenet Healthcare Corporation's executives came from an earlier corporate version which was morphed into the current national healthcare provider. The culture of fraud was documented in the previous NME business (which was forced to close) and continued in Tenet.

Tenet Healthcare Corporation intentionally overbilled for its DRG-based clients resulting in successful Federal and State lawsuits involving millions of dollars in fines and penalties. To pay for the legal judgments, the cash position of Tenet resulted in significant changes with the sale of some hospitals as well as the change in dividend policy. Some of the executives of Tenet are now banished from management in any future healthcare organization as a result of their illegal actions. Consumer confidence, as evidenced by the precipitous stock price drop of almost 90% of the value, is clearly a litmus test of the financial community's low tolerance of fraud. The fact that the company's stock price has continued to stay below \$5 a share further exemplifies that this was not a knee-jerk reaction to a single event but a testimony to the continued lack of confidence in Tenet's management.

Cressey's triangle provided a framework to understand actions but the best that can be done is piece together all of the available information to hypothesize the reasoning for actions taken by the management of a company. This paper utilized information available, public, legal documents, and financial data in an effort to piece together Tenet's fraud.

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