2018R00919/DCH



UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

| | | |
|---|---|---|
| UNITED STATES OF AMERICA | : | Hon. |
| | : | |
| | : | Crim. No. |
| v. | : | |
| | : | 18 U.S.C. § 2 |
| | : | 18 U.S.C. § 371 |
| JEAN WILSON | : | 18 U.S.C. § 1349 |
| | : | 18 U.S.C. § 1956(h) |
| | : | 26 U.S.C. § 7201 |
| | : | 26 U.S.C. § 7206(1) |
| | : | 42 U.S.C. § 1320a-7b(b)(1)(B) |

**SUPERSEDING INDICTMENT**

The Grand Jury in and for the District of New Jersey, sitting at Newark, charges:

**COUNT 1**
**(Conspiracy to Defraud the United States and Pay and Receive Health Care Kickbacks)**

1. At all times relevant to this Superseding Indictment:

**Individuals and Entities**

a. Defendant JEAN WILSON was a United States citizen who resided in Bayonne, New Jersey and Richmond Hill, Georgia.

b. Reinaldo Wilson was a United States citizen who resided in Bayonne, New Jersey and Richmond Hill, Georgia.

c. Person A owned and operated Company A, which was a patient recruiting company that did business in Tampa, Florida, and elsewhere.

d. Person B owned and operated Company B, which was an orthotic brace supplier that did business in New York, New York.

e. Person C and Person D owned and operated Company C, which was a patient recruiting company that did business in New Jersey and elsewhere.

f. Advantage Choice Care, LLC ("ACC") was a New York Limited Liability Company owned and operated by JEAN WILSON and others that did business in Bayonne, New Jersey, and elsewhere.

g. Tele Medcare LLC ("Tele Medcare") was a New York Limited Liability Company owned and operated by JEAN WILSON and others that did business in Bayonne, New Jersey, and elsewhere.

h. AIM Healthcare, P.A. ("AIM," and together with ACC and Tele Medcare, the "ACC Network") was a Maryland Corporation owned and operated by JEAN WILSON and others that did business in New Jersey and elsewhere.

i. Integrity Home Visits Corporation ("Integrity") was a New Jersey C Corporation.

j. JEAN WILSON and others owned, controlled, and/or operated the following entities:

| Entity | Date of Formation | Formation Location |
|---|---|---|
| Choice Care Medical, LLC | March 14, 2017 | New Jersey |
| Southeastern DME, LLC | March 6, 2018 | Florida |
| Medical Advocate Network, LLC | August 28, 2017 | New Jersey |
| R&J Management Services, LLC | June 12, 2018 | Georgia |

**The Medicare Program**

k. The Medicare program ("Medicare") was a federal health care program providing benefits to persons who were 65 years of age or older, or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services ("HHS"). Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

l. Medicare was divided into four parts which helped cover specific services: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C), and prescription drug benefits (Part D).

m. Specifically, Medicare Part B covered medically necessary physician office services and outpatient care, including durable medical equipment ("DME"), such as Off-The-Shelf ankle braces, knee braces, back braces, elbow braces, wrist braces, and hand braces (collectively, "Braces"). Braces required minimal self-adjustment for appropriate use and do not require

expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

n. CMS contracted with various companies to receive, adjudicate, process, and pay Medicare Part B claims, including claims for Braces. CMS also contracted with Program Safeguard Contractors, or ZPICs, which were contractors that investigated fraud, waste, and abuse. As part of an investigation, the Program Safeguard Contractor or ZPIC conducted a clinical review of medical records to ensure that payment was made only for services that met all Medicare coverage and medical necessity requirements.

o. Brace companies, physicians, and other health care providers that provided services to Medicare beneficiaries were referred to as Medicare "providers." To participate in Medicare, providers were required to submit an application in which the providers agreed to abide by the policies and procedures, rules, and regulations governing reimbursement. To receive Medicare funds, enrolled providers, together with their authorized agents, employees, and contractors, were required to abide by all provisions of the Social Security Act, the regulations promulgated under the Act, and applicable policies, procedures, rules, and regulations issued by CMS and its authorized agents and contractors. Providers were given and provided with online access to Medicare manuals and services bulletins describing proper billing procedures and billing rules and regulations.

p. If Medicare approved a provider's application, Medicare assigned the provider a Medicare Provider Identification Number ("PIN" or

"provider number"). A provider who was assigned a Medicare PIN and provided services to beneficiaries was able to submit claims for reimbursement to the Medicare contractor/carrier that included the PIN assigned to that provider. Payments by Medicare were often made directly to a provider of the items or services, rather than to a Medicare beneficiary. This payment occurred when the provider submitted the claim to Medicare for payment, either directly or through a billing company.

q. Under Medicare Part B, Braces were required to be reasonable and medically necessary for the treatment or diagnosis of the patient's illness or injury. Medicare used the term "ordering/referring" provider to identify the physician or nurse practitioner who ordered, referred, or certified an item or service reported in a claim for a Brace. Individuals ordering or referring Braces were required to have the appropriate training, qualifications, and licenses to provide Braces. A Medicare claim was required to set forth, among other things, the beneficiary's name, the date the items services were provided, the cost of the items or services, the name and identification number of the physician or other provider who ordered the items or services, and the name and identification number of the provider that provided the items or services. Providers conveyed this information to Medicare by submitting claims using billing codes and modifiers.

**Medicare Part D Plans**

r. Medicare Part D provided prescription drug coverage to persons who were eligible for Medicare. Medicare beneficiaries obtained Part D benefits in

two ways: (a) by joining a Prescription Drug Plan, which covered only prescription drugs; or (b) by joining a Medicare Advantage Plan, which covered both prescription drugs and medical services (collectively, "Part D Plans"). These Part D Plans were operated by private companies, often referred to as drug plan "sponsors," that were approved by Medicare.

s. For Brace providers, pharmacies, and diagnostic laboratories to submit claims to Medicare and Part D Plans for providing beneficiaries with DME, prescription drugs, and diagnostic testing services, those items and services needed to be prescribed and ordered by a licensed medical provider and needed to be medically necessary, among other requirements. Medicare would not pay claims procured through kickbacks and bribes.

t. Medicare regulations required providers enrolled with Medicare to maintain complete and accurate patient medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for payment were submitted by the physician. Medicare required complete and accurate patient medical records so that Medicare could verify that the services were provided as described on the claim form. These records were required to be sufficient to permit Medicare, through its contractors, to review the appropriateness of Medicare payments made to the provider.

u. To receive reimbursement for a covered service from Medicare, a provider submitted a claim, either electronically or using a form containing the

required information appropriately identifying the provider, patient, and items provided or services rendered, among other things.

**The Medicare Advantage Program (Part C)**

v. Medicare Part C, also known as the "Medicare Advantage" Program, provided Medicare beneficiaries with the option to receive their Medicare benefits through private managed care plans, including health maintenance organizations and preferred provider organizations. Medicare Advantage provided beneficiaries with the same items and services provided by an original fee-for-service Medicare plan, in addition to mandatory and optional supplemental benefits.

w. To receive Medicare Advantage benefits, a beneficiary was required to enroll in a managed care plan operated by a private company approved by Medicare. Those companies were often referred to as Medicare Advantage plan "sponsors." A beneficiary's enrollment in a Medicare Advantage plan was voluntary.

x. Rather than reimbursing based on the extent of the items and services provided, as CMS did for providers enrolled in fee-for-service Medicare, CMS made fixed, monthly payments to a plan sponsor for each Medicare Advantage beneficiary enrolled in one of the sponsor's plans, regardless of the items and services rendered to the beneficiary that month or the cost of covering the beneficiary's health benefits that month.

y. Medicare Advantage beneficiaries chose to enroll in a managed care plan administered by private health insurance companies, health

maintenance organizations, or preferred provider organizations. A number of entities were contracted by CMS to provide managed care to Medicare Advantage beneficiaries through various approved plans. Such plans covered DME and related health care benefits, items, and services. Among its responsibilities, these Medicare Advantage plans received, adjudicated, and paid the claims of authorized suppliers seeking reimbursement for the cost of DME and other health care benefits, items, or services supplied to Medicare Advantage beneficiaries.

z. Medicare, Medicare sponsors, and the Part D plans were "Federal health care program[s]," as defined in Title 42, United States Code, Section 1320a-7b(f), and "health care benefit program[s]," as defined in Title 18, United States Code, Section 24(b).

**Telemedicine**

aa. Telemedicine provided a means of connecting patients to health care providers by using telecommunications technology, such as video or the telephone.

bb. Telemedicine companies hired physicians and other health care providers to furnish telemedicine services to individuals. Telemedicine companies typically paid health care providers a fee to conduct consultations with patients. In order to generate revenue, telemedicine companies typically either billed Medicare or other health insurance program, or offered a membership program to customers.

cc. Medicare Part B covered expenses for specified telehealth services if certain requirements were met. These requirements included: (a) that the beneficiary was located in a rural area (outside a Metropolitan Statistical Area or in a rural health professional shortage area); (b) that the services were delivered via an interactive audio and video telecommunications system; and (c) that the beneficiary was at a practitioner's office or a specified type of medical facility – not at the beneficiary's home – during the telehealth service furnished by a remote practitioner.

dd. Some telemedicine companies offered membership programs to patients who signed a contract for telemedicine services, paid a set dollar amount per month, and paid a fee each time the customer had a telehealth encounter with a physician.

2. From in or around March 2017, and continuing through in or around April 2019, in the District of New Jersey, and elsewhere, the defendant,

JEAN WILSON,

did intentionally and knowingly, combine, conspire, confederate, and agree with Reinaldo Wilson and others, known and unknown to the Grand Jury, to:

a. defraud the United States by cheating the United States government and any of its agencies and departments out of money and property, and by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of HHS in its administration and oversight of Medicare;

b. knowingly and willfully violate Title 42, United States Code, Section 1320a-7b(b)(1)(A)–(B), by soliciting and receiving remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, in return for referring individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part by a Federal health care program, and in return for purchasing, leasing, ordering, and arranging for and recommending purchasing, leasing, and ordering any good, facility, service, and item for which payment may be made in whole and in part under a Federal health care program; and

c. knowingly and willfully violate Title 42, United States Code, Section 1320a-7b(b)(2)(A)–(B), by offering and paying remuneration, specifically, kickbacks and bribes, directly and indirectly, overtly and covertly, to any person to induce such person to refer individuals for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part by a Federal health care program, and to purchase, lease, order, and arrange for and recommend purchasing, leasing, and ordering any good, facility, service, and item for which payment may be made in whole and in part under a Federal health care program.

**Goal of the Conspiracy**

3. It was the goal of the conspiracy for defendant JEAN WILSON and other co-conspirators to unlawfully enrich themselves by, among other things: (a) submitting and causing the submission of false and fraudulent claims to Medicare, Medicare sponsors, and the Part D plans for items and services that

were medically unnecessary, not eligible for Medicare reimbursement, not provided as represented, and procured through kickbacks and bribes; (b) concealing the submission of false and fraudulent claims to Medicare, Medicare sponsors, and the Part D plans, and the receipt and transfer of the proceeds of the fraud; and (c) diverting the proceeds of the fraud for the personal use and benefit of the defendant and her co-conspirators.

**Manner and Means of the Conspiracy**

4. The manner and means by which the defendant and her co-conspirators sought to accomplish the goal of the conspiracy included, among others, the following:

a. Defendant JEAN WILSON and Reinaldo Wilson falsely certified to Medicare that they would comply with all Medicare rules and regulations, and federal laws, including that they would not knowingly present or cause to be presented a false and fraudulent claim for payment by Medicare and that they would comply with the Federal Anti-Kickback Statute.

b. Defendant JEAN WILSON and Reinaldo Wilson created, owned, and controlled the ACC Network.

c. Defendant JEAN WILSON, Reinaldo Wilson, and others solicited and received illegal kickbacks and bribes from Person A, Person B, Person C, Person D, and others in exchange for arranging for the ordering of Braces and prescription drugs for Medicare beneficiaries.

d. Defendant JEAN WILSON, Reinaldo Wilson, and others caused the ACC Network to receive Medicare beneficiary information in order for the ACC Network health care providers to sign Brace orders.

e. Defendant JEAN WILSON, Reinaldo Wilson, and others facilitated the ordering of Braces and prescription drugs by refraining from charging a fee to Medicare beneficiaries or billing Medicare and Medicare sponsors for purported telemedicine consultations conducted by the ACC Network health care providers.

f. Defendant JEAN WILSON, Reinaldo Wilson, and others, through the ACC Network, paid health care providers to order Braces and prescription drugs for Medicare beneficiaries that were procured through the payment of kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented.

g. Defendant JEAN WILSON, Reinaldo Wilson, and others transferred Brace orders to Brace providers, Person A, Person B, Person C, Person D, recruiters, and others to support false and fraudulent claims to Medicare and Medicare sponsors that were submitted by Brace providers located in the District of New Jersey and elsewhere.

h. Defendant JEAN WILSON, Reinaldo Wilson, and others concealed and disguised the payment and receipt of illegal kickbacks and bribes by causing them to be paid to the ACC Network indirectly through nominee companies and bank accounts opened by Reinaldo Wilson, defendant JEAN WILSON, and others.

i. Defendant JEAN WILSON, Reinaldo Wilson, and others concealed and disguised the scheme by entering into sham contracts and agreements that labeled kickback and bribe payments as "medical" and "consultation" expenditures.

j. Defendant JEAN WILSON, Reinaldo Wilson, and others falsified, fabricated, altered, and caused the falsification, fabrication, and alteration of Brace orders and other records to support claims for Braces and prescription drugs that were procured through the payment of kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented.

k. Defendant JEAN WILSON, Reinaldo Wilson, and others caused Brace providers to submit and cause the submission of more than $137 million in claims to Medicare, Medicare sponsors, and Part D plans, for Braces and prescription drugs that were procured through the payment of kickbacks and bribes, medically unnecessary, ineligible for Medicare reimbursement, and not provided as represented. Medicare, Medicare sponsors, and Part D plans paid these Brace providers and pharmacies in excess of $66 million for these claims.

**Overt Acts**

5. In furtherance of the conspiracy and in order to accomplish its goal, defendant JEAN WILSON and her co-conspirators committed and caused the commission of the following overt acts in the District of New Jersey and elsewhere:

a. In or around March 2017, defendant JEAN WILSON and others solicited and received an illegal kickback and bribe from Person A and others in the form of a wire to ACC's bank account ending in x0183 in the approximate amount of $18,000.

b. In or around December 2018, defendant JEAN WILSON and others solicited and received an illegal kickback and bribe from Person C, Person D, and others in the form of a check to AIM's bank account ending in x5326 in the approximate amount of $51,300.

c. In or around December 2018, defendant JEAN WILSON, Reinaldo Wilson, and others solicited and received an illegal kickback and bribe from Person B and others in the form of a wire to AIM's bank account ending in x5326 in the approximate amount of $5,000.

d. In or around January 2019, defendant JEAN WILSON, Reinaldo Wilson, and others solicited and received an illegal kickback and bribe from Person B and others in the form of a wire to AIM's bank account ending in x5326 in the approximate amount of $3,465.

All in violation of Title 18, United States Code, Section 371.

**COUNT 2**
**(Conspiracy to Commit Health Care Fraud and Wire Fraud)**

6. Paragraph 1 of this Superseding Indictment is re-alleged here.

7. From in or around March 2017, and continuing through in or around April 2019, in the District of New Jersey, and elsewhere, the defendant,

JEAN WILSON,

did knowingly and intentionally combine, conspire, confederate, and agree with others known and unknown to the Grand Jury:

a. to knowingly and willfully execute a scheme and artifice to defraud a health care benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit programs, in connection with the delivery of and payment for health care benefits, items, and services, contrary to Title 18, United States Code, 1347; and

b. to knowingly and intentionally devise and intend to devise a scheme and artifice to defraud, and for obtaining money and property by means of materially false and fraudulent pretenses, representations, and promises, knowing that the pretenses, representations, and promises were false and fraudulent when made, and to knowingly transmit and cause to be transmitted, by means of wire communication in interstate commerce, writings, signs, signals, pictures, and sounds for the purpose of executing such scheme and artifice to defraud, contrary to Title 18, United States Code, Section 1343.

**Goal of the Conspiracy**

8. Paragraph 3 of this Superseding Indictment is re-alleged here.

**Manner and Means of the Conspiracy**

9. Paragraph 4 of this Superseding Indictment is re-alleged here.

All in violation of Title 18, United States Code, Section 1349.

## COUNTS 3 – 5
**(Soliciting and Receiving of Health Care Kickbacks)**

10. Paragraphs 1 and 3 through 5 of this Superseding Indictment are re-alleged here.

11. On or about the dates set forth below, in the District of New Jersey, and elsewhere, the defendant,

JEAN WILSON,

did knowingly and willfully solicit and receive remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, in return for purchasing, leasing, ordering, and arranging for and recommending purchasing, leasing, and ordering any good, facility, service, and item for which payment may be made in whole and in part under a Federal health care program, as defined by 42 U.S.C. § 1320a-7b(f), namely, Medicare, as follows:

| Count | Date | Payor | Payee | Amount |
|---|---|---|---|---|
| 3 | March 17, 2017 | Company A | ACC | $18,000 |
| 4 | December 7, 2018 | Company C | AIM | $51,300 |
| 5 | December 10, 2018 | Company B | AIM | $5,000 |

Each in violation of 42 U.S.C. § 1320a-7b(b)(1)(B) and 18 U.S.C. § 2.

## COUNT 6
## (Conspiracy to Commit Money Laundering)

12. Paragraphs 1 and 3 through 5 of this Superseding Indictment are re-alleged here.

13. From in or around March 2017, and continuing through in or around February 2020, in the District of New Jersey, and elsewhere, the defendant,

JEAN WILSON,

did knowingly combine, conspire, confederate, and agree with others known and unknown to the Grand Jury, to commit certain offenses against the United States in violation of Title 18, United States Code, Section 1956, that is:

a. to knowingly engage and attempt to engage, in monetary transactions by, through, and to a financial institution, affecting interstate and foreign commerce, in criminally derived property of a value greater than $10,000 and such property having been derived from a specified unlawful activity, that is, conspiracy to defraud the United States and pay and receive kickbacks relating to a Federal health care program, namely, Medicare, in violation of Title 18, United States Code, Section 371, and conspiracy to commit health care fraud and wire fraud, in violation of Title 18, United States Code, Section 1349, contrary to Title 18, United States Code, Section 1957; and

b. to knowingly conduct and attempt to conduct financial transactions affecting interstate and foreign commerce, which transactions involved proceeds of specified unlawful activity, that is, a conspiracy to defraud

the United States and pay and receive kickbacks relating to a Federal health care program, that is Medicare, in violation of Title 18, United States Code, Section 371, and a conspiracy to commit health care fraud and wire fraud, in violation of Title 18, United States Codes, Section 1349, knowing that the transactions were designed in whole or in part to conceal and disguise the nature, location, source, ownership, and control of the proceeds of specified unlawful activity, and that while conducting and attempting to conduct such financial transactions, knew that the property involved in the financial transactions represented the proceeds of some form of unlawful activity, contrary to Title 18, United States Code, Section 1956(a)(1)(B)(i).

All in violation of Title 18, United States Code, Section 1956(h).

**COUNTS 7 – 11**
**(Income Tax Evasion)**

14. Paragraphs 1 and 3 through 5 of this Superseding Indictment are re-alleged here.

15. During the calendar years provided below, the defendant,

JEAN WILSON,

received taxable income, upon which there was income tax due and owing to the United States of America. Knowing the foregoing facts and failing to make an income tax return on or before the dates set forth below, as required by law, to any proper officer of the Internal Revenue Service, and to pay the income tax to the Internal Revenue Service, defendant JEAN WILSON, during the periods set forth below, in the District of New Jersey, and elsewhere, willfully attempted to evade and defeat income tax due and owing by her to the United States of

America, for the calendar years set forth below, by committing the following affirmative acts, among others:

a. Working as an independent contractor for telemedicine and other health care companies and directing payment to Integrity rather than a personal bank account;

b. Paying personal expenses using bank accounts in the name of Integrity; and

c. Not reporting these expenses on the income returns of Integrity.

| Count | Tax Year | Date Return Due |
|---|---|---|
| 7 | 2014 | April 15, 2015 |
| 8 | 2015 | April 18, 2016 |
| 9 | 2016 | April 18, 2017 |
| 10 | 2017 | April 17, 2018 |
| 11 | 2018 | April 15, 2019 |

Each in violation of Title 26, United States Code, Section 7201.

## COUNTS 12 – 13
**(Income Tax Evasion)**

16. Paragraphs 1 and 3 through 5 of this Superseding Indictment are re-alleged here.

17. During the calendar years provided below, the defendant,

JEAN WILSON,

received taxable income, upon which there was income tax due and owing to the United States of America. Knowing the foregoing facts and failing to make an income tax return on or before the dates set forth below, as required by law, to any proper officer of the Internal Revenue Service, and to pay the income tax to the Internal Revenue Service, defendant JEAN WILSON, during the periods set forth below, in the District of New Jersey, and elsewhere, willfully attempted to evade and defeat income tax due and owing by her to the United States of America, for the calendar years set forth below, by committing the following affirmative acts, among others:

a. Operating companies in the names of nominee owners;

b. Depositing income into bank accounts in the names of nominee owners;

c. Paying her personal expenses using bank accounts in the names of companies and corporations; and

d. Not reporting these expenses on personal income returns.

| Count | Tax Year | Date Return Due |
|---|---|---|
| 12 | 2018 | April 15, 2019 |
| 13 | 2019 | July 15, 2020 |

Each in violation of Title 26, United States Code, Section 7201.

**COUNTS 14 – 15**
**(Income Tax Evasion)**

18. Paragraphs 1 and 3 through 5 of this Superseding Indictment are re-alleged here.

19. During the calendar years provided below, the defendant,

JEAN WILSON,

received taxable income, upon which there was income tax due and owing to the United States of America. Knowing the foregoing facts and failing to make an income tax return on or before the dates set forth below, as required by law, to any proper officer of the Internal Revenue Service, and to pay the income tax to the Internal Revenue Service, defendant JEAN WILSON, during the periods set forth below, in the District of New Jersey, and elsewhere, willfully attempted to evade and defeat income tax due and owing by her to the United States of America, for the calendar years set forth below, by committing the following affirmative acts, among others:

a. Operating a purported telemedicine company and receiving payments into AIM;

b. Paying personal expenses using bank accounts in the name of AIM; and

c. Not reporting these expenses on the income tax returns of AIM.

| Count | Tax Year | Date Return Due |
|---|---|---|
| 14 | 2018 | April 15, 2019 |
| 15 | 2019 | July 15, 2020 |

Each in violation of Title 26, United States Code, Section 7201.

**COUNTS 16 – 18**
**(Filing False Individual Tax Returns)**

20. Paragraphs 1 and 3 through 5 of this Superseding Indictment are re-alleged here.

21. During the calendar years provided below:

a. Defendant JEAN WILSON made income related to her work for telemedicine and other health care companies as an independent contractor for Integrity;

b. Defendant JEAN WILSON failed to report total income for the tax years listed below on income that was paid to Integrity by telemedicine and other health care companies;

c. Defendant JEAN WILSON made personal purchases using the bank accounts in the name of Integrity and failed to report those purchases as income on her individual United States income tax returns; and

d. Defendant JEAN WILSON's individual United States income tax returns for the tax years listed below were not true and correct as to every material matter in that defendant JEAN WILSON failed to report all income.

22. On or about the dates listed below, in the District of New Jersey, the defendant,

JEAN WILSON,

knowingly and willfully did make and subscribe United States Individual Income Tax Returns, Forms 1040, for the tax years listed below, which she did not believe to be true and correct as to every material matter, as described below.

| **Count** | **Tax Year** | **Approximate Unreported Income** | **Line of Return Falsified** | **Date Filed** |
|---|---|---|---|---|
| 16 | 2015 | $44,014 | Line 22, Total Income | May 10, 2018 |
| 17 | 2016 | $238,379 | Line 22, Total Income | May 10, 2018 |
| 18 | 2017 | $33,228 | Line 22, Total Income | May 17, 2018 |

Each in violation of Title 26, United States Code, Section 7206(1) and Title 18, United States Code, Section 2.

**FORFEITURE ALLEGATIONS**
**(Counts 1–5)**

23. Upon conviction of one or more of the Federal health care offenses as defined in 18 U.S.C. § 24 alleged in Counts 1–5 of this Superseding Indictment, the defendant,

JEAN WILSON,

shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(7), all property, real and personal, the defendant obtained that constitutes or is derived, directly and indirectly, from gross proceeds traceable to the commission of such offense, and all property traceable to such property.

**FORFEITURE ALLEGATION**
**(Count 6)**

24. Upon conviction of the money laundering conspiracy offense in violation of 18 U.S.C. § 1956(h) alleged in Count 6 of this Superseding Indictment, the defendant,

JEAN WILSON,

shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(1), all property, real and personal, involved in the money laundering conspiracy offense, and all property traceable to such property.

**Substitute Assets Provision**
**(Applicable to All Forfeiture Allegations)**

25. If any of the above-described forfeitable property, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred or sold to, or deposited with, a third person;

c. has been placed beyond the jurisdiction of the Court;

d. has been substantially diminished in value; or

e. has been commingled with other property which cannot be subdivided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18 United States Code, Section 982(b), to seek forfeiture of any other property of defendant JEAN WILSON up to the value of the forfeitable property described above.

A True Bill,

[redacted]

Foreperson

PHILIP R. SELLINGER
United States Attorney
District of New Jersey

LORINDA I. LARYEA
Acting Chief
Criminal Division, Fraud Section
U.S. Department of Justice

DARREN C. HALVERSON
KELLY M. LYONS
Trial Attorneys
Criminal Division, Fraud Section

**CASE NUMBER: 20-111**

# United States District Court
# District of New Jersey

**UNITED STATES OF AMERICA**

**v.**

**JEAN WILSON**

## INDICTMENT FOR

**18 U.S.C. § 2**
**18 U.S.C. § 371**
**18 U.S.C. § 1349**
**18 U.S.C. § 1956(h)**
**26 U.S.C. § 7201**
**26 U.S.C. § 7206(1)**
**42 U.S.C. § 1320a-7b(b)(1)(B)**

**A True Bill,**

[redacted]

**Foreperson**

PHILIP R. SELLINGER
UNITED STATES ATTORNEY
FOR THE DISTRICT OF NEW JERSEY

DARREN C. HALVERSON
*TRIAL ATTORNEY, CRIMINAL DIVISION, FRAUD SECTION*
*202-880-2233*