

MAR 28 2025

PETER A. MOORE, JR., CLERK
US DISTRICT COURT, EDNC
BY CRP DEP CLK

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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
EASTERN DIVISIONNO. 4:25-CR-15-FL

UNITED STATES OF AMERICA)

v.)

KIMBERLY MABLE SIMS)

CRIMINAL INFORMATION

[Filed Under Seal]

The United States Attorney charges that at all times relevant to this Criminal Information:

I. STATUTORY AND REGULATORY BACKGROUND**A. The Anti-Kickback Statute**

1. Title 42, United States Code, Section 1320a-7b, makes it illegal to knowingly offer or pay, directly or indirectly, overtly or covertly, in cash or in kind, any remuneration, including any kickback, bribe, or rebate, to induce a person to purchase, order, or arrange for the purchase or order of any service for which payment may be made under a Federal health care program.

B. Kickbacks in Laboratory Referrals

2. The Eliminating Kickbacks in Recovery Act ("EKRA"), enacted in 2018 as a part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, prohibits anyone from paying,

receiving, or soliciting, any remuneration including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referrals to, among other things, laboratories.

3. EKRA defines a laboratory as a facility for the biological, microbiological, serological, chemical, immune-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings.

C. The Medicaid Program

4. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., (the “Act”) establishes the Medicaid Program. The North Carolina Medicaid Program is a state-administered health care benefit program aided by federal funds and designed to provide medical assistance for low-income families and children that reside in North Carolina.

5. Under the Act, each state has a single state agency to administer the Medicaid program for the benefit of recipients within its borders. In North Carolina, the Division of Health Benefits (“DHB”), formerly known as the Division of Medical Assistance or DMA, which is within North Carolina’s Department of Health and Human Services (“DHHS”), administers the Medicaid program. The North Carolina Medicaid program, administered through DHB is referred to herein as “NC-Medicaid.”

6. An individual qualified to receive Medicaid's publicly funded assistance is referred to as a "beneficiary" or "recipient." For recipients, Medicaid functions like a medical insurance plan, which defrays the cost of receiving covered and medically necessary services. Covered services include substance abuse treatment and urine drug testing as part of substance abuse treatment.

7. If qualified, an individual can enroll as a NC-Medicaid recipient. At the time of enrollment, a recipient is assigned a unique alphanumeric identification number by Medicaid, known as a Medicaid identification number. Recipients use their Medicaid identification numbers to receive covered services.

8. Under Medicaid, a "provider" is an individual (rendering provider) or entity (billing providers) that furnishes Medicaid services to recipients under a provider agreement with the Medicaid Agency. In North Carolina, every provider who participates in NC-Medicaid must apply for and be assigned a unique provider number by DHB. Rendering providers and billing providers must also obtain a federal identification number, known as a National Provider Identifier or NPI number.

9. All NC-Medicaid providers must certify that they will comply with applicable federal laws, rules, and regulations, including the Anti-kickback statute and EKRA.

10. For a provider to obtain reimbursement from the Medicaid Program for providing services to a Medicaid recipient, the provider electronically submits a claim to NC-Medicaid, containing, among other things, the provider's name, address, and

provider NPI number, the patient's name and Medicaid identification number, the date of service, a brief description of the charges, the provider's signature, and date of billing. For direct billings to NC-Medicaid, claims for services are electronically transmitted through a program known as "NCTracks."

11. As an alternative to direct fee-for-service billing through NCTracks, NC-Medicaid also includes a managed care structure consisting of Prepaid Health Plans (PHPs). In Medicaid managed care, DHHS remains responsible for all aspects of NC-Medicaid but delegates the direct management of certain health services to PHPs. The PHPs assume financial risk through capitated contracts and contract with providers to provide services for beneficiaries. Claims for these services are submitted directly to the PHP, as opposed to being submitted through NCTracks, and are paid by and through the PHP. The claim generally includes, but is not limited to, the date of the alleged service, the Medicaid Identification Number of the beneficiary, the nature of the service rendered, and the provider number or federally issued NPI number. As used herein, the term "NC-Medicaid" includes services billed to and paid by a PHP, as well as claims billed directly to Medicaid through NCTracks.

12. As a component of the NC-Medicaid program, some beneficiaries, recipients of services for mental health, developmental disabilities or substance use disorders, contract with Medicaid Managed Care Organizations (MCOs). MCOs are organizations that contract with a network of providers to provide covered services to enrolled beneficiaries in exchange for payment from Medicaid. MCOs apply Medicaid's rules and regulations and serve as the PHP.

13. NC-Medicaid, including any claims paid directly or through a PHP, is a “health care benefit program,” as defined in Title 18, United States Code, Section 24(b).

D. Medicaid Audits

14. As an administrator of NC-Medicaid benefits, MCOs are required by DHHS to have compliance plans which include methods to prevent, detect and report fraud, waste and abuse by providers who submit billings to such MCOs. MCO oversight of fraud, waste, and abuse, includes among other things, efforts to identify and eliminate violations of the Anti-Kickback Statute and EKRA. To carry out this function, MCOs enter into written agreements with each provider that comply with applicable federal and state laws, rules and regulations. These agreements further require the provider to participate in the MCO’s utilization management, care management, quality management, and program integrity functions. Providers are required to comply with MCO audits and investigations that are meant to ensure integrity and efficiency to determine compliance with federal and state law, compliance with program rules and policies, and to ensure that Medicaid funds are used properly.

15. The audit process typically involves a notification of the audit, a site visit, request for records, interviews of recipients, and interviews of employees or associates of providers. During an audit, medical records, billing claims, and other documentation are reviewed to verify the accuracy and lawfulness of claims.

16. An audit or investigation by an MCO may be initiated in a number of ways, including among other things, complaints from recipients, proactive data analysis showing billing irregularities or suspicious billing patterns, a history of noncompliance with Medicaid regulations, or a random selection process.

17. As a part of these audits or investigations, providers are required to cooperate with all announced and unannounced site visits, post-payment reviews, and other program integrity activities conducted by an MCO. Providers are required to provide truthful information and documentation when requested by the MCO. Providers who fail to grant prompt and reasonable access or who fail to timely provide specifically designated documentation to an MCO to properly investigate potential violations may be terminated from the network and NC- Medicaid programs.

18. Substantiation of violations by program auditors may lead to further action to protect Medicaid dollars. These actions may include, among other things, recoupment from the provider of proceeds obtained as a result of the violation, payment suspension, a law enforcement referral, and termination from the Medicaid program.

E. Civil Fraud Investigation

19. The Medicaid Investigations Division (“MID”) of the North Carolina Department of Justice, Attorney General’s Office, serves as the Medicaid Fraud Control Unit (“MFCU”) for the State of North Carolina and investigates civil and criminal frauds upon NC-Medicaid. State MFCUs are charged under federal law with the authority to investigate violations of all applicable state laws, including false

claims statutes and other civil authorities, pertaining to fraud in the administration of the NC-Medicaid program. As a central feature of MID's Medicaid oversight authority, compulsory production of requested documents and information from NC-Medicaid providers to MID is mandated by federal regulations. Furthermore, in its agreement with DHB, providers specifically agree to cooperate fully with requests for information by the state's MFCU.

20. Under civil investigations, MID attorneys issue Civil Investigative Demands requesting the production of records to providers who are the subject of investigation. The production of documentary material in response to a Civil Investigative Demand must be made under a sworn certificate of production. As such, responses to such requests are expected to constitute truthful, genuine records.

21. MID civil attorneys may also conduct interviews of employees or associates of providers and NC-Medicaid recipients as a part of their investigation. Answers to questions by providers and their employees in such interviews are also expected to be truthful.

II. FACTUAL BACKGROUND

A. Relevant Parties and Entities

22. Life Touch, LLC ("Life Touch") was a North Carolina corporation formed on June 16, 2009, in the Eastern District of North Carolina. B.S. was its organizer and only listed member. By no later than October 1, 2009, Life Touch had been registered as a Medicaid provider with NC-Medicaid providing substance abuse services.

23. During times relevant to this Criminal Information, Life Touch was contracted with Eastpointe Human Services (“Eastpointe”), a MCO, to provide substance abuse services to Medicaid recipients within the Eastern District of North Carolina. B.S. operated two Life Touch service locations: one in Goldsboro, North Carolina and one in Kinston, North Carolina.

24. KIMBERLY MABLE SIMS (“K. SIMS”), defendant herein, initially worked for B.S. at Life Touch, providing such services as handling intakes of recipients and answering the phone at Life Touch’s Kinston office.

25. F.S. also worked for B.S. at Life Touch. F.S. primarily worked as the office manager of the Kinston location. F.S. was also the mother of K. SIMS and B.S.

26. K.J. worked for B.S. at Life Touch and served as the office manager of the Goldsboro location. K.J. also worked as the Medicaid biller for both Life Touch locations.

27. K. SIMS formed 1st Choice Healthcare Services, LLC (“1st Choice”) on or about November 22, 2016, in the Eastern District of North Carolina. By no later than October 10, 2019, K. SIMS had enrolled 1st Choice as a provider with NC-Medicaid.

B. Scheme to Pay Illegal Remunerations to Life Touch Recipients

28. Beginning at a time unknown but no later than January 2018, and continuing to a time unknown, but no earlier than November 16, 2023, Life Touch, by and through B.S., K. SIMS, F.S., K.J., and others, routinely engaged in the payment of stored value cards, also known as “gift cards,” to NC-Medicaid recipients to incentivize their receipt of substance abuse services from Life Touch. In some

instances, Life Touch, by and through its agents, also paid patients other things of value, such as cash and rent payments.

29. Life Touch, by and through its agents and patients, solicited patients to receive services at Life Touch by, among other things, informing them that they could receive a gift card in connection with each week of treatment. Patients had the opportunity to earn an extra gift card for bringing new patients to Life Touch for substance abuse services.

30. Under the scheme, Life Touch recipients were required to attend treatment in order to receive a gift card. Although exact amounts varied over the course of the scheme, recipients who attended treatment five times per week generally received a \$60 gift card; recipients who attended four times per week generally received a \$50 gift card; and recipients who attended three times per week generally received a \$45 gift card.

31. By incentivizing Medicaid recipients to attend Life Touch, Life Touch was able to attract, retain, and ultimately bill NC-Medicaid for, in some instances, years of substance abuse services, known as Substance Abuse Intensive Outpatient Program (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment Program (SACOT).

32. The purpose of the SAIOP and SACOT programs was ultimately to aid Medicaid recipients to live a drug-free life through counseling and treatment. Ideally, under these programs, Medicaid recipients were to receive the treatment that they

needed, become sober, and transition to a lower level of care, at a significantly lower cost to the government.

33. At Life Touch, however, recipients routinely exhausted all available substance abuse services under one program, before transitioning to the other program, thereby exhausting all services under both SAIOP and SACOT programs during the Medicaid fiscal year. Even after exhausting all available benefits under both programs, Life Touch recipients were incentivized to remain in the programs through payment of gift cards and were routinely re-enrolled in these programs from year to year.

34. In sum, over the life of the scheme, Life Touch received as much as \$25 Million in NC-Medicaid proceeds derived from an inducement of recipients through gift card payments, totaling more than \$1 Million.

C. Scheme to Defraud Medicaid Concerning Payment of Kickbacks to Life Touch Patients

35. **January 2018 Eastpointe Audit.** In January of 2018, Eastpointe Program Integrity conducted an audit of Life Touch involving alleged payment of gift cards to patients (hereinafter the “January 2018 Eastpointe Audit”). In particular, Eastpointe auditors were investigating an allegation by a NC-Medicaid recipient. This recipient had alleged that he/she had been approached by an individual and told that if they provided their Medicaid number to Life Touch, and attended substance abuse classes offered by Life Touch, they would be given a Visa gift card for each class they attended.

36. The January 2018 Eastpointe Audit included among other things, interviews of Life Touch patients, reviews of claims data, an on-site visit to Life Touch, Life Touch employee interviews, and a request for document production. The document production specifically called for the medical records of fifteen identified patients; personnel records; Life Touch's policies and procedures for providing substance abuse services, soliciting members, billing claims, conducting/processing drug screens, discharge criteria and gift giving to members; and the Eastpointe Provider Operations Manual.

37. Upon conclusion of the audit, Eastpointe auditors found that Life Touch had submitted claims for payment without following all federal and state laws, rules, and regulations. Specifically, Eastpointe substantiated that Life Touch had provided gift cards with monetary value between \$45 to \$60 to Life Touch patients receiving SAIOP services, depending on their attendance.

38. Notably, the January 2018 Eastpointe Audit did not entail a comprehensive examination of all of Life Touch's Medicaid billings for substance abuse services. Instead, only approximately 1,052 claims of the member sample, covering only a period between January 1, 2017, and December 31, 2018, were reviewed as a part of the audit. As such, auditors found that \$14,325.77 in Medicaid proceeds should be recouped from Life Touch, since such proceeds resulted from the payment of kickbacks, in the form of gift cards, to patients to encourage members to receive SAIOP services from Life Touch during the dates under review.

39. Nevertheless, Life Touch was given written notice of the substantiated kickback allegation, and also written guidance from the United States Department of Health and Human Services, Office of the Inspector General (OIG), concerning the unlawfulness of providing kickbacks to patients receiving services.

40. **Subsequent Audits.** Even after being warned of the illegality of the payment of gift cards to patients, Life Touch, by and through its employees and agents, including K. SIMS, continued to pay gift cards to patients. As such, NC-Medicaid continued to receive complaints regarding the payment of gift cards to patients. These complaints resulted in additional investigations, record requests from Life Touch, and interviews of Life Touch employees, agents, and patients.

41. In response to these audits, rather than providing truthful information and genuine records to auditors, Life Touch, by and through B.S., F.S., K.J., K. SIMS and others, engaged in a scheme to trick Eastpointe, and NC-Medicaid generally, into believing that gift cards were no longer given to patients by Life Touch when, in fact, they were.

42. During the course of the scheme, B.S., F.S., K.J., and others, attempted to deceive NC-Medicaid regarding Life Touch's ongoing purchase and dissemination of the gift cards. They did this by, among other things, making it appear that third parties were purchasing and providing gift cards to Life Touch patients. These third parties included nonprofits known as "Refuge House of God," and Changing Lives Community Resources, LLC, known as "Changing Lives."

43. In a further effort to deceive NC-Medicaid, during a 2021 audit, K.J., informed auditors that Life Touch did not provide incentives anymore and that a third-party nonprofit, Refuge House of God, provided gift cards to recipients. When interviewed again in reference to a 2022 audit, K.J. again informed Eastpointe auditors that Life Touch did not give gift cards to patients, and a third-party, Changing Lives, provided gift cards to Life Touch recipients.

44. In a further effort to conceal the purchase and dissemination of the gift cards to Life Touch patients, the conspirators used financial accounts other than Life Touch's business accounts to purchase the gift cards. Specifically, accounts in the names of B.S., K. SIMS, F.S., K.J., and others were used to purchase large quantities of gift cards, which were then disseminated by Life Touch staff. Although purchased in the names of other individuals, Life Touch financed the gift card purchases.

45. By way of example, more than 5,700 gift cards, totaling in excess of \$460,000, were purchased through K. SIMS' Navy Federal Accounts. These accounts were funded primarily through monies that originated from Life Touch's business accounts, 1st Choice's business account, and large cash deposits.

46. It was also a part of the scheme that, in an effort to obstruct possible audits and make it appear that gift cards were not routinely being given to patients, F.S. and K.J. generated false and fraudulent documents that were provided to Life Touch recipients, Life Touch staff, and Eastpointe. These documents included such false statements as "Life Touch LLC does not do motivational incentives." Recipients were required to acknowledge receipt of the documentation and signed copies were

filed in patient charts. F.S., K.J., also created patient consent forms that made it appear as though information on patient progress could be shared to outside parties, such as Refuge House of God and Changing Lives, to facilitate the delivery of rewards by those outside entities when, in fact, Life Touch and its staff were purchasing and delivering the gift cards to patients. F.S., K.J., and others, also directly told patients that gift cards were not being provided by Life Touch, when, in fact, they were. All of these false statements and documents were part of a ploy to deceive and defraud the Medicaid program regarding the ongoing payment of gift cards to patients.

D. Scheme to Pay Illegal Remunerations to Life Touch Employees

47. In order to establish the effectiveness of the SACOT and SAIOP services, periodic urine samples from patients were needed to assess compliance. The laboratory analysis of such urine samples was conducted by an outside lab that separately billed NC-Medicaid for such services. Based upon the statutes cited above, labs were not permitted to pay a kickback, in the form of a percentage of the lab's Medicaid proceeds, to the source of the lab referral.

48. Prior to 2020, Life Touch had utilized a lab, known as United Diagnostic Laboratories ("UDL"), to analyze urine samples for its SACOT and SAIOP services. In or about February 2022, however, the owner of this lab was charged with Conspiracy to Commit Health Care Fraud, Illegal Remunerations, and Aggravated Identity Theft; Illegal Renumerations; Conspiracy to Commit Money Laundering; and Money Laundering, in connection with the payment of kickbacks to the source of

lab referrals. K. SIMS, B.S., F.J., and K.J., became aware of the charges when they were publicly announced.

49. Prior to the announcement of the UDL related charges, however, K. SIMS had established her own lab company, 1st Choice as a Medicaid provider in NC. Once operational, 1st Choice almost exclusively billed NC-Medicaid for lab services allegedly provided to Life Touch patients. A standing order requesting 1st Choice to repetitively test urine samples supplied by Life Touch was also created and used in furtherance of the scheme. Between October 10, 2019 and March 2023, K. SIMS and K.J, caused 1st Choice to bill Medicaid for more than \$2.5 Million in claims for urine drug testing of Life Touch patients.

50. Unbeknownst to NC-Medicaid, however, K. SIMS, F.S., and K.J. engaged in a scheme to pay illegal kickbacks to Life Touch employees K.J and F.S. out of the proceeds of 1st Choice billings for Life Touch patient laboratory screens. In fact, K. SIMS, F.S., and K.J. agreed to participate as equal partners in 1st Choice's billings to NC-Medicaid, with each receiving approximately one-third of the billings associated with Life Touch's substance abuse patients.

51. To carry out the scheme, when registering 1st Choice as a Medicaid provider, K. SIMS falsely identified herself as the sole owner. In fact, K. SIMS, F.S., and K.J. were equal partners of 1st Choice. As equal partners, all profits from the NC-Medicaid funds disbursed to 1st Choice were divided and shared between K. SIMS, F.S., and K.J.

52. Likewise, as the biller for 1st Choice, K.J. was not paid as an employee of 1st Choice. Instead, K.J. received more than \$400,000 in payments as a kickback from 1st Choice between 2019 and 2023, which was approximately one-third of the proceeds generated from the referral of urine drug testing to 1st Choice from Life Touch.

53. F.S. was not employed by and did not do any work for 1st Choice, but instead, only worked for Life Touch. K. SIMS paid F.S. payments in excess of \$400,000 between 2019 and 2023 from 1st Choice, representing approximately one-third of the proceeds generated from the referral of urine drug testing business to 1st Choice from Life Touch.

54. K. SIMS, F.S., and K.J., continued to pay and receive kickbacks from Life Touch patient labs, even after the announcement of charges in connection with UDL's lab kickback scheme in 2022. Additionally, K. SIMS, F.S, and K.J. concealed the receipt of the 1st Choice kickbacks by failing to report them on their taxes.

**E. Scheme to Defraud Concerning Payment of Kickbacks to Life
Touch Employees**

55. On various occasions following the creation of 1st Choice, K. SIMS caused 1st Choice to file applications and recertifications with NC-Medicaid for 1st Choice to be a provider of urine drug testing within North Carolina. These applications and recertifications contained false statements and representations as described herein.

56. By way of example, 1st Choice's provider enrollment form, under the section entitled "Ownership Information," included the question, "Do you have one or more Shareholders/Partners with 5% or more ownership?" K. SIMS falsely responded "No" to this question. In fact, at the time of the application, K. SIMS, F.S. and K.J. were equal partners.

57. As equal partners, K. SIMS, F.S. and K.J., divided and shared all profits of 1st Choice among the three of them.

58. In furtherance of the scheme, when interviewed during the MID civil investigation, K. SIMS stated that she organized 1st Choice, and she was the sole owner of the business. She also stated that K.J. was generally paid only 2% of the NC-Medicaid reimbursements for 1st Choice when, in fact, K.J. was paid approximately 33%.

COUNT ONE
Conspiracy
18 U.S.C. § 371

59. Paragraphs 1 through 58 of this Criminal Information are realleged and incorporated by reference.

60. Beginning at a time unknown, but no later than October 1, 2019, and continuing to a time unknown, but no earlier than November 16, 2023, in the Eastern District of North Carolina and elsewhere, K. SIMS, defendant herein, did knowingly combine, conspire, confederate, and agree with persons known to the United States Attorney, to defraud the United States and to commit offenses against the United States, that is:

- a.** To knowingly and willfully pay any remuneration, including kickback, directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person to purchase or order any facility or service for which payment may be made in whole or in part under a Federal health care program, in violation of Title 42, United States Code, Section 1320a-7b(b)(2)(B) (“Illegal Remunerations”);
- b.** To, with respect to services covered by a health care benefit program, in or affecting interstate commerce, pay any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of an individual to a laboratory, or in exchange for an individual using the services of that laboratory, in violation of Title 18, United States Code, Section 220(a)(2)(A)-(B) (“Illegal Remunerations – Laboratories”);
- c.** To knowingly and willfully execute and attempt to execute a scheme and artifice to defraud a health care benefit program and to obtain money and property owned by and under the custody and control of a health care program by means of materially false and fraudulent pretenses, representations, and promises in connection with the delivery of and payment for health care benefits, items and services, in violation of Title 18, United States Code, Section 1347 (“Health Care Fraud”);
- d.** To knowingly and willfully make or use any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statements or entries in connection with the delivery of

and payment for health care benefits, items and services, in violation of Title 18, United States Code, Section 1035(a)(2) (“False Health Care Statements”).

MANNER AND MEANS

61. Introductory paragraphs 1 through 58 are realleged and incorporated as though fully set forth in this count.

OVERT ACTS

62. In furtherance of the conspiracy, and to effect the objects thereof, there were committed within the Eastern District of North Carolina various overt acts, including, but not limited to the following:

63. A member of the conspiracy enrolled a NC-Medicaid recipient to receive substance abuse treatment services from Life Touch.

64. A member of the conspiracy solicited another member of the conspiracy to purchase at least one gift card.

65. A member of the conspiracy transferred funds for the purchase of at least one gift card.

66. A member of the conspiracy purchased a gift card with funds transferred by another member of the conspiracy.

67. A member of the conspiracy distributed at least one gift card to a recipient for their attendance.

68. A member of the conspiracy told an Eastpointe auditor that Life Touch did not provide gift cards to patients.

69. A member of the conspiracy created a Life Touch document stating that Life Touch did not provide incentives to patients.

70. A member of the conspiracy caused at least one patient to execute a document stating that Life Touch did not provide incentives.

71. A member of the conspiracy billed NC-Medicaid for alleged SAIOP and SACOT services rendered to NC-Medicaid recipients that received gift cards for their attendance at said programs.

72. A member of the conspiracy working at Life Touch submitted urine samples, purportedly from NC-Medicaid recipients receiving substance abuse services from Life Touch, to 1st Choice to be tested.

73. A member of the conspiracy billed NC-Medicaid for the urine drug tests.

74. A member of the conspiracy paid another member of the conspiracy that was employed by Life Touch with NC-Medicaid funds received by 1st Choice.

75. A member of the conspiracy told Medicaid that 1st Choice had no other owners.

76. A member of the conspiracy that worked for Life Touch falsely told NC-Medicaid that they were not paid by 1st Choice.

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

COUNT TWO

77. Introductory paragraphs 1 through 58, are realleged and incorporated as though fully set forth in this count.

78. Beginning at an exact time unknown, but no later than October 1, 2019, and continuing to a time unknown, but no earlier than October 1, 2024, in the Eastern District of North Carolina and elsewhere, K. SIMS, willfully made and subscribed and filed and caused to be filed with the IRS a false U.S. Individual Income Tax Return, Form 1040, for calendar year 2020, which was verified by a written declaration that it was made under penalties of perjury and which K. SIMS did not believe to be true and correct as to every material matter. The taxable income per the return was \$73,519.00, whereas, K. SIMS knew the correct taxable income was \$270,222.00.

All in violation of Title 26, United States Code, Section 7206(1).

FORFEITURE NOTICE

Notice is hereby given that all right, title and interest in the property described herein is subject to forfeiture.

Upon conviction of any Federal health care offense as defined in 18 U.S.C. § 24(a), the defendant shall forfeit to the United States, pursuant to 18 U.S.C. § 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the said offense.

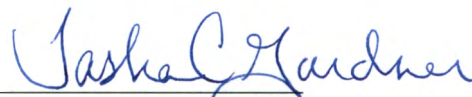
The forfeitable property includes, but is not limited to, the following:

Forfeiture Money Judgment:

- a) A sum of money representing the gross proceeds of the offense(s) charged herein against KIMBERLY MABLE SIMS, in the amount of at least \$1,845,276.95.

If any of the above-described forfeitable property, as a result of any act or omission of a defendant: cannot be located upon the exercise of due diligence; has been transferred or sold to, or deposited with, a third party; has been placed beyond the jurisdiction of the court; has been substantially diminished in value; or has been commingled with other property which cannot be divided without difficulty; it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p), to seek forfeiture of any other property of said defendant up to the value of the forfeitable property described above.

DANIEL P. BUBAR
Acting United States Attorney



BY: TASHA C. GARDNER
Special Assistant United States Attorney