

PRESS RELEASE

8 Arrested in Health Care Fraud Takedown, Including Owners of Hospices that Billed Taxpayers Millions of Dollars to Serve the ‘Dying’

Thursday, April 2, 2026

For Immediate Release

U.S. Attorney's Office, Central District of California

More Than \$50 Million in Intended Health Care Fraud Losses Charged

LOS ANGELES – In coordination with the Vice President’s Task Force to Eliminate Fraud, eight defendants, including three nurses, a chiropractor, and a psychologist, have been arrested on federal charges that they schemed to defraud the nation’s health care system out of more than \$50 million – including by running sham hospice care facilities that bilked Medicare by using people without terminal illnesses as beneficiaries, the Justice Department announced today.

Six of the defendants arrested today are expected to make their initial appearances this afternoon in United States District Court in downtown Los Angeles. One defendant is expected to make his initial appearance in U.S. District Court in Idaho.

“We are enforcing a zero-tolerance policy for criminals who defraud American taxpayers,” said First Assistant United States Attorney Bill Essayli. “The defendants arrested this morning who are charged with stealing millions of dollars of health care benefits got caught and now face years in federal prison.”

“The Southern California region is a high-risk environment for hospice-related and many other forms of health care fraud,” said Akil Davis, the Assistant Director in Charge of the FBI’s Los Angeles Field Office. “The United States loses hundreds of billions of dollars annually to healthcare fraud at the expense of all American taxpayers, whose benefits decrease as premiums, co-payments and taxes grow. Our aim is to reverse that trend with ‘Operation Never Say Die’ and others like it.”

“The defendants charged today allegedly turned hospice care into a cash producing operation, resulting in more than \$50 million in losses to taxpayers. The magnitude of the losses underscores a deliberate abuse of the authority and trust afforded to health care providers,” said Inspector General T. March Bell of the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). “Today’s takedown reflects HHS-OIG’s commitment to deploy every tool at our disposal, and collaborate with our law enforcement partners, to dismantle hospice operations built on deception. Anyone

who seeks to weaponize hospice care to bilk Medicare should expect to be held accountable.”

“Today’s arrests are another decisive strike in our war on fraud,” said U.S. Department of Labor Inspector General Anthony P. D’Esposito. “My office is relentlessly pursuing those who target union benefit plans and exploit employee healthcare programs for personal gain. Working side-by-side with the FBI, the Department of Labor’s Employee Benefits Security Administration, and our law-enforcement partners, we are aggressively dismantling fraud schemes and taking down those who exploit American workers. Let this be a warning: If you steal from workers or taxpayers, your time is up. We will find you, investigate you, and hold you accountable.”

“When employee benefit plans become targets for fraud, it’s not just the plans that are hurt – everyday working Americans who earned those benefits honestly, their families, and the communities they live in are hurt,” said Robert Prunty, Acting Regional Director U.S. Department of Labor Employee Benefits Security Administration’s Los Angeles Regional Office. “In the Trump Administration, we will relentlessly seek out fraud and ensure those responsible are brought to justice.”

“Health care fraud undermines federal programs, threatens public trust, diverts resources away from legitimate patient care, and is a calculated attack on programs meant to protect the vulnerable,” said Tyler Hatcher, Special Agent in Charge, IRS-CI Los Angeles Field Office. “The enforcement actions taken today demonstrate IRS-CI’s commitment to uncovering the financial lies behind these schemes and holding accountable those who profit at the expense of taxpayers and patients. Our agents will continue to work alongside our law-enforcement partners to protect the integrity of our healthcare system and ensure that those who abuse it are brought to justice.”

MEDICARE HOSPICE CARE FRAUD

- ***USA v. Miner***

Lolita Beronilla Miner, 65, a.k.a. “Lolita Beronilla Rice,” of Anaheim, a licensed vocational nurse, was arrested today on a federal criminal complaint charging her with health care fraud.

According to court documents, Miner owned and operated the Artesia-based Topanga Hospice Care Inc. From July 2020 to April 2025, Miner used this company to submit more than \$9,174,117 in fraudulent hospice claims to Medicare, which paid more than \$8,510,448 on these claims.

Through Topanga, MinerD billed Medicare for hospice services for beneficiaries who were not terminally ill. Numerous beneficiaries had common addresses and lived far from the facility, which is consistent with being recruited by marketers. The investigation further revealed that MinerD paid kickbacks to beneficiaries and marketers for the referral of purported hospice patients to her company.

One beneficiary couple was approached at a market about signing up and then were visited at home by MinerD and three other Topanga employees, who promised them if they signed up everything would be free, and they each would receive \$300 per month. The money was delivered in an envelope in cash: \$600 per month for six months. Neither beneficiary stated they had a terminal illness, which their physician confirmed. The couple also reported receiving unneeded items such as nutritional shakes, non-prescription vitamins, and wheelchairs.

Topanga had a non-death discharge rate of approximately 85%, nearly five times the national average of 17.2% from 2021.

The FBI is investigating this matter along with the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).

Assistant United States Attorney Alexandra M. Michael of the Major Frauds Section is prosecuting this case.

- ***USA v. Gill, et al.***

Gladwin Gill, a 66-year-old psychologist, and his wife, Amelou Gill, a 70-year-old registered nurse, both of Covina, were arrested today on a federal criminal complaint charging them with health care fraud.

According to an affidavit filed with the complaint, the Gills owned and operated the Glendale-based 626 Hospice Inc., which did business as St. Francis Palliative Care.

The Gills allegedly schemed to defraud Medicare by paying illegal kickbacks for the referral of patients who were not dying. The Gills also submitted more than \$5.2 million in fraudulent claims to Medicare for hospice services that either were not medically necessary or were not provided. Medicare paid the Gills more than \$4 million on these fraudulent claims.

They then laundered the scheme's proceeds and spent their ill-gotten gains on personal expenses such as mortgage payments, car payments, international flights, restaurants, and personal bills.

The Gills are expected to make their initial appearance this afternoon in U.S. District Court in downtown Los Angeles.

HHS-OIG, the FBI, IRS Criminal Investigation, and the Food and Drug Administration are investigating this matter.

Assistant United States Attorney David Y. Pi of the Major Frauds Section is prosecuting this case.

- ***USA v. Palma, et al.***

Nita Almuete Paddit Palma, 76, a [thrice-convicted](#) health care fraudster now incarcerated at a federal prison in Seattle, and her husband, Adolfo Catbagan, 68, of Glendale, are charged in an 11-count indictment with operating at least three fraudulent hospice care facilities – including while Palma was free on bond awaiting a hospice fraud trial. Law enforcement arrested Catbagan this morning.

Palma, who is a lawful permanent resident from the Philippines, and Catbagan are charged in an indictment with one count of conspiracy to commit wire fraud and health care fraud and 10 counts of health care fraud.

According to the indictment, from June 2022 to April 2024, Palma and Catbagan opened three Glendale-based hospice care facilities despite Palma being legally barred from doing so: One Up Hospice Care Inc., Rosewood Hospice and Palliative Care Inc., and Advance Hospice and Palliative Care Inc.

Catbagan was named as the nominal owner and CEO of the three hospices when Palma in fact owned and exercised operating control of them – despite her exclusion – so Medicare would not deny the companies' claims. The defendants submitted false claims to Medicare for beneficiaries who were not terminally ill and the physicians supposedly providing hospice services did not treat the patients.

Palma and Catbagan submitted at least \$4.8 million in fraudulent claims through these companies, resulting in Medicare payments of at least \$4.2 million.

HHS-OIG and the FBI are investigating this matter.

Assistant United States Attorneys Andrew M. Roach and Roger A. Hsieh of the Major Frauds Section are prosecuting this case. Assistant United States Attorney Alexander Su of the Asset Forfeiture and Recovery Section is handling asset forfeiture matters for this case.

- **USA v. Tindimobuna**

Evelyn Tindimobuna, 51, a licensed vocational nurse from Chatsworth, is charged in a federal criminal complaint with health care fraud. According to an affidavit filed with the complaint, from January 2022 to September 2025, Tindimobuna used the Tarzana-based Comfort Choice Hospice Inc. to submit to Medicare hundreds of fraudulent claims for purported hospice services to dozens of beneficiaries. For those claims, Comfort Choice sought more than \$3.8 million, of which Medicare paid approximately \$3.4 million.

For example, in November 2022, Comfort Choice submitted a claim to Medicare in the amount of \$7,021, for reimbursement of hospice services for a beneficiary. Law enforcement later interviewed this beneficiary and other Comfort Choice patients who said they were not terminally ill, a requirement to qualify for hospice care.

Tindimobuna allegedly also paid kickbacks to marketers for their referral of hospice patients to Comfort Choice in violation of the Anti-Kickback Statute.

HHS-OIG is investigating this matter.

Special Assistant United States Attorney Yervant P. Hagopian of the Major Frauds Section is prosecuting this case.

- **USA v. Lauritzen**

Ivan Verne Lauritzen, 50, of Simi Valley, was arrested Tuesday on a federal criminal complaint charging him with health care fraud. According to court documents, Lauritzen was the CEO and CFO of the Simi Valley-based Valley Pacific Hospice Inc., whose Medicare enrollment was revoked in August 2024.

In 2022, the live discharge rate of Valley Pacific patients was more than 75%, vastly higher than the national average that year of approximately 17%. Based on an audit examining 18 Valley Pacific Medicare claims from August 2023 to March 2024, CMS determined the company had a pattern and practice of submitting claims that failed to meet Medicare's hospice standards and requirements. To facilitate this fraud, Lauritzen forged the signature of at least one physician on the Medicare enrollment forms.

During the alleged scheme, Valley Pacific billed Medicare more than \$580,000 and was paid more than \$526,000.

Lauritzen made his initial appearance Tuesday and was ordered released on \$10,000 bond.

HHS-OIG is investigating this matter.

Assistant United States Attorney Neil P. Thakor of the Major Crimes Section is prosecuting this case.

PRIVATE HEALTH CARE PLAN FRAUD

• ***USA v. Aulava-Moala, et al.***

Four defendants with South Bay ties – one of them a licensed chiropractor – have been charged in a two-count information with conspiracy to commit health care fraud and wire fraud in connection with a \$19 million scheme to defraud a labor union’s health plan via false claims for chiropractic services and physical therapy that weren’t needed or never provided.

The defendants charged are:

- Tolu Aulava-Moala, 51, of Carson, who was the director of the facilities;
 - John Nicola, 77, of El Segundo, a licensed chiropractor;
 - Crysta Richter, 40, of Torrance, who owned a medical billing company; and
 - John Keohulua, 49, of Long Beach.

These defendants will be summonsed into Los Angeles federal court and are expected to make their initial appearances in the coming weeks.

According to court documents, from January 2010 to September 2023, they fraudulently submitted at least \$19,005,463 in claims to International Longshore and Warehouse Union Pacific Maritime Association and other private health insurers on behalf of several chiropractic and physical therapy service companies: Ohana Wellness Center, Ohana Management Corp., and R3New Wellness – all based in Carson – and the Huntington Beach-based One Life Acupuncture APC.

Aulava-Moala and Keohulua induced beneficiaries to visit clinics to receive medically unnecessary services, such as massages or endoscopies, in exchange for kickback payments. Nicola knowingly created fake client notes for beneficiaries, and Aulava-Moala, Nicola, and Richter submitted false and fraudulent claims to health insurers for reimbursement for medical services.

In August 2022, the former owner of the Ohana companies testified under oath at a civil trial that the companies falsified patient chart notes and billed claims under

chiropractors' names and insurance numbers without their knowledge. A state court later that month found the Ohana companies liable for the fraud scheme.

In addition, from March 2016 to June 2023, Aulava-Moala and Keohulua conspired to submit approximately \$700,000 in fraudulent receipts for a charity donation program operated by a Los Angeles-based oil refinery for which the company paid at least \$500,000.

The FBI, the U.S. Department of Labor Office of Inspector General (DOL-OIG), and the U.S. Department of Labor – Employee Benefits Security Administration are investigating this matter with assistance from Homeland Security Investigations (HSI) and the United States Secret Service.

Assistant United States Attorney Jason C. Pang of the Transnational Organized Crime Section is prosecuting this case.

- ***USA v. Cartmell; USA v. Surace***

Gregory Cartmell, 62, of Coeur D'Alene, Idaho, a licensed chiropractor, was arrested today on a four-count indictment charging him with two counts of health care fraud and two counts of aggravated identity theft. He is expected to make his initial appearance today in U.S. District Court for the District of Idaho. He will be arraigned in Los Angeles in the coming weeks.

According to the indictment, from December 2018 to November 2022, Cartmell submitted approximately \$9.14 million in fraudulent claims to the ILWU-PMA health plan for chiropractic services – including for services not rendered – and received approximately \$6.43 million in payment from the union's health plan, which had terminated him from the plan in December 2020.

To circumvent his termination, Cartmell arranged with a co-conspirator – Vincent Surace, 87, of McKinney, Texas – to bill ILWU-PMA's health plan under the co-conspirator's name and identification number. In exchange for allowing his name and ID number to be used in the scheme, Cartmell paid Surace a portion of the proceeds the union's plan paid for the fraudulent claims.

Surace is charged via information with one count of conspiracy to commit health care fraud. He will be summonsed to Los Angeles federal court in the coming weeks.

The FBI, the U.S. Department of Labor Office of Inspector General (DOL-OIG), and the U.S. Department of Labor Employee Benefits Security Administration (DOL-EBSA) are investigating this matter.

Assistant United States Attorneys Jason C. Pang of the Transnational Organized Crime Section and William M. Larsen of the Criminal Appeals Section are prosecuting this case with assistance from Assistant United States Attorney Christopher C. Kendall of the Transnational Organized Crime Section.

- **USA v. Griffen**

Sonia Griffen, 51, of Lakewood, was arrested today on a five-count indictment charging her with health care fraud. From April 2019 to May 2024, Griffen allegedly submitted nearly \$5 million in fraudulent claims to ILWU-PMA's health care plan through her wellness company, Bee Well Holistic Wellness Center, for purported chiropractic services given to union members, even though the plan had previously terminated Bee Well and barred it from submitting claims.

According to the indictment, to circumvent Bee Well's termination from the ILWU-PMA plan and obtain payments, Griffen concealed Bee Well's identity and involvement by arranging with two chiropractors to bill the plan under their names and at fictitious addresses. She also submitted false claims billing the plan for chiropractic services that were never rendered.

In total, Griffen submitted approximately \$4.9 million in fraudulent claims to the ILWU-PMA plan, resulting in payments of approximately \$2.5 million.

The FBI, the United States Department of Labor Office of Inspector General (DOL-OIG), and the Department of Labor – Employee Benefits Security Administration (DOL-EBSA) are investigating this matter.

Assistant United States Attorney Jing Yan of the General Crimes Section is prosecuting this case.

IMMIGRATION HEALTH CARE FRAUD

- **USA v. Ko**

Young Joo Ko, 59, of East Hollywood and a lawful permanent resident from South Korea, was arrested today on a federal criminal complaint charging her with fraud and misuse of visas, permits, and other documents.

According to an affidavit filed with the complaint, Ko engaged in a medical fraud scheme exploiting the green card application process by creating fraudulent immigration documents. Civil surgeons designated by U.S. Citizenship and Immigration Services (USCIS) and operating in the Los Angeles area did not examine green card applicants as required by law.

Instead, Ko – for a fee – fraudulently prepared the required forms by presenting herself as a nurse or doctor and indicating false compliance with medical examination requirements necessary for immigration applicants to register permanent residence or adjust their immigration status.

If convicted, Ko would face a statutory maximum sentence of 10 years in federal prison.

HSI, IRS Criminal Investigation, and USCIS are investigating this matter.

Assistant United States Attorney Brenda N. Galván of the General Crimes Section is prosecuting this case.

Health care fraud-related charges in these cases carry a statutory maximum sentence of 10 years in federal prison. Wire fraud is punishable by up to 20 years in federal prison. Aggravated identity theft carries a mandatory two-year consecutive prison sentence.

Complaints and indictments contain allegations that a defendant has committed a crime. Every defendant is presumed to be innocent until and unless proven guilty in court.

Contact

Ciaran McEvoy

Public Information Officer

ciaran.mcevoy@usdoj.gov

(213) 894-4465

Updated April 2, 2026