Carmi Insurance Investigation

Distribution List

- Federal Bureau of Investigation (FBI)
- U.S. Department of Justice - Health Care Fraud Section
- Illinois Attorney General
- White County State's Attorney
- Illinois State Police
- Illinois Department of Insurance
- City of Carmi - Mayor's Office
- City of Carmi - City Clerk's Office
- City of Carmi - Administrative / Economic Development Office
- Mutual Medical

TEN POINTS - FEDERAL INSURANCE QUESTIONS

City of Carmi | Lacey Bradshaw / Cynthia J. Attebury

- **Insurance-change form.** A January 2, 2024 City form names Lacey Bradshaw but shows "C. Attebury" on the employee-signature line. [Ex. E]
- **Authorization remains unresolved.** The extracted record does not establish who authorized that signature, what was submitted, or who approved the change. [Ex. E, H, I]
- **Council authority needs verification.** A signed October 2025 resolution and council minutes raise questions about prior authorization for alderman health coverage. [Ex. K, L]
- **Payroll is not the City premium.** Selected paychecks show $0.00 current deductions; other entries show $60.17. The January form lists $120.34. These amounts require reconciliation. [Ex. E, F, G]
- **The $26,000 figure is not Bradshaw's bill.** At the October 2025 meeting, Attebury gave an approximate annual family-of-four coverage cost; no exact City expenditure for Bradshaw has been established. [Ex. L, Q]
- **Two coverage-end dates appear.** A December 18, 2025 email refers to January 1, 2026; a separate membership form gives February 1, 2026. Carrier records are needed. [Ex. M, O]
- **Federal coverage can include private plans.** 18 U.S.C. § 24(b) can reach a public or private healthcare benefit program affecting commerce; an HHS payment is not automatically required.
- **Fraud and false-statement inquiries differ.** 18 U.S.C. §§ 1347 and 1035 require proof of a fraudulent scheme or a knowingly and willfully material false statement and the required healthcare nexus.
- **Theft provisions have distinct elements.** 18 U.S.C. § 669 concerns health-plan assets; § 666(a)(1)(A), (b) requires City-agent conduct, at least $5,000 in City property and more than $10,000 in qualifying federal benefits within one year. Section 666(c) excludes bona fide compensation.
- **Documents investigators should obtain.** Original authorization and processing logs; plan invoices and claims; City disbursements; council compensation authority; federal assistance receipts; and actual termination dates. [Ex. E–Q]

Exhibit letters refer to the separate full investigative report.

CARMI INSURANCE - THE FEDERAL PAPER TRAIL

Investigative Update

I've been going through the City of Carmi's insurance and payroll records, and the federal questions are now part of this investigation. A January 2, 2024 insurance-change form names Alderwoman Lacey Bradshaw, but the employee-signature line carries the name "C. Attebury." That's a real document with a real question attached to it: who gave permission for that signature, and what happened to the form after it was completed? The paperwork does not yet answer either question.

Then there is the money. Some payroll statements show a $60.17 insurance deduction, while selected checks show $0.00; the change form itself lists $120.34. City Clerk Cynthia Attebury estimated about $26,000 a year for family-of-four coverage during the October 2025 council meeting, but that is not a verified bill for Bradshaw. The amount actually paid by the City still needs a month-by-month accounting, not a guess based on a paycheck stub.

The council's signed resolution and meeting record also raise the issue of whether this elected-official benefit was properly authorized in the first place. And the end dates don't match neatly: one December email points to January 1, 2026, while a membership document points to February 1. I want to see the actual coverage ledger, insurer communications, and effective dates before anybody tells the public this is all settled. Those are records that should exist somewhere in the administrative trail.

Federal law has specific provisions for healthcare fraud, material false statements, misuse of healthcare-plan assets, and theft involving federally assisted local governments: 18 U.S.C. §§ 1347, 1035, 669, and 666. Those laws do not make every paperwork mistake a crime; intent, actual transactions, the plan's status, and—in some cases—dollar thresholds and federal assistance all matter. That's why the proper request is for independent investigators to obtain and examine the original records, not for the public to declare anyone guilty from a signature alone. I want the authorization, the accounting, and the truth about who approved and paid for this coverage.

Supporting federal-law excerpts, with relevant language highlighted, follow.

FEDERAL LAW - JURISDICTIONAL FRAMEWORK

Federal Review added November 2026

I request examination of the insurance transactions documented in my October investigative report under the federal statutes below. The supporting records identify a January 2, 2024 insurance-change request with Lacey Bradshaw's name and "C. Attebury" on the employee-signature line; municipal payroll deductions; a signed October 2025 resolution; and a December 2025 / February 2026 termination-date discrepancy. [Exhibits E, F, G, K, L, M, N and O]

Federal definition of a healthcare benefit program

18 U.S.C. § 24(b). Federal healthcare-fraud statutes cover a public or private plan or contract affecting commerce under which healthcare benefits, items, or services are provided. **Federal program funding is not required merely because I am raising 18 U.S.C. §§ 1347, 1035 or 669.** Investigators must still establish that the particular plan and transaction meet the statutory definitions and requirements.

Federal provisions to evaluate

• **18 U.S.C. § 1347 - Health care fraud:** Knowing and willful execution or attempted execution of a scheme to defraud a health benefit program or obtain its money or property by false representations in connection with healthcare benefits.

> **Penalty:** Up to **10 years** imprisonment; up to **20 years** if serious bodily injury results; **any term of years or life** if death results. Federal fine also authorized. [18 U.S.C. § 1347(a)]

• **18 U.S.C. § 1035 - False statements relating to health care matters:** Knowing and willful material false statements or documents in matters involving a health benefit program and connected to healthcare delivery or payment.

> **Penalty:** Up to **5 years** imprisonment and/or a federal fine. [18 U.S.C. § 1035(a)]

• **18 U.S.C. § 669 - Theft or embezzlement in connection with health care:** Knowing and willful diversion of healthcare benefit program assets, including premiums or credits.

> **Penalty:** Up to **10 years** imprisonment; if the property value does not exceed $100, up to **1 year**. Federal fine also authorized. [18 U.S.C. § 669(a)]

• **18 U.S.C. § 666(a)(1)(A), (b) - Theft or bribery concerning programs receiving Federal funds:** Knowing unauthorized taking or misapplication of municipal property valued at least $5,000, subject to qualifying federal-assistance and other requirements.

> **Penalty:** Up to **10 years** imprisonment and/or a federal fine. Qualifying federal-program benefits must exceed $10,000 in an applicable one-year period; the bona fide compensation exception in § 666(c) must be considered. [18 U.S.C. § 666(a)-(c)]

Federal fine framework (18 U.S.C. § 3571): For an individual, the ordinary maximum is $250,000 for a felony, or $100,000 for a nonfatal Class A misdemeanor. An alternative fine up to twice gross gain or gross loss may apply under § 3571(d). These are maximum statutory penalties, not automatic sentences.

These are issues to investigate, not completed statutory counts. I do not infer a federal scheme from a questioned signature alone.

FEDERAL REVIEW I - HEALTHCARE FRAUD

18 U.S.C. §§ 1347 and 1035 | source exhibits and unmet elements

18 U.S.C. § 1347 - healthcare fraud (ordinary maximum: 10 years)

The government must establish a knowingly and willfully executed or attempted scheme to defraud a qualifying healthcare benefit program, or to obtain program money or property using materially false or fraudulent representations, connected with delivery or payment for healthcare benefits, items or services. [18 U.S.C. §§ 1347(a), 24(b)]

Documentary connection: I obtained a 2024 City insurance-change form naming Lacey Bradshaw and a line signed "C. Attebury." City payroll records show several $60.17 deductions and selected $0.00 deduction periods. [E, F, G] These documents raise questions about who requested or authorized enrollment and what the plan paid; they do not establish a fraudulent scheme or a payment trace.

Missing: The plan's governing documents and federal statutory status, original enrollment approval, insurer transaction logs, actual claim or benefit payment, the precise false representation (if any), a participant/administrator communication trail, and the required knowing and willful scheme.

18 U.S.C. § 1035 - false healthcare statements (maximum: 5 years)

This statute addresses knowingly and willfully material false statements or writings in a matter involving a healthcare benefit program, in connection with delivery of or payment for healthcare benefits, items or services. It is not enough simply to show a form signed by someone other than the named participant. [18 U.S.C. § 1035(a)]

Documentary connection: The January 2 form is a concrete transaction for verification. [E] I have not established that Lacey Bradshaw withheld consent, that the employee-signature field represented a statement legally required to be personal, or that the form contained a materially false fact knowingly used for payment. I request preservation and review of its processing history.

FEDERAL REVIEW II - PLAN AND CITY ASSETS

18 U.S.C. §§ 669 and 666 | program property and threshold requirements

18 U.S.C. § 669 - health-program property

Section 669 addresses knowing and willful embezzlement, theft, unauthorized conversion, or intentional misapplication of healthcare benefit program money, premiums, credits, or other assets. The ordinary maximum penalty is 10 years; when the value does not exceed $100, the maximum is one year. [18 U.S.C. § 669(a)]

Documentary connection: The records establish insurance-related enrollment and payroll events, but not a verified transfer of program assets to an unauthorized person. City-paid payroll or insurer premiums are not automatically proof that anyone unlawfully took property belonging to the healthcare plan. [E, F, G, M, N, O, Q]

18 U.S.C. § 666 - federally assisted municipal funds

For a possible municipal-property offense under § 666(a)(1)(A), investigators must establish an agent of the City, intentional unauthorized taking, conversion or misapplication of property owned or controlled by the City worth **$5,000 or more**, and a government that received **over $10,000 in federal-program benefits** within the relevant one-year period. Section 666(c) also excludes bona fide compensation paid in the usual course of business. The ordinary maximum is 10 years. [18 U.S.C. § 666(a)-(c)]

Documentary connection: Cynthia Attebury reportedly estimated approximately $26,000 annually to insure a family of four at the October 7, 2025 council meeting. That is **not** a verified total paid for Bradshaw, nor evidence that the $5,000 property element was met. The actual annual City premium contributions and federal grant-benefit thresholds are not established by my exhibits. [L, Q]

Missing: Certified City assistance receipts by relevant twelve-month period, source and value of actual municipal transactions, the applicable compensation authority, and evidence distinguishing bona fide lawful benefits from intentionally unauthorized ones.

FEDERAL ELEMENTS - EVIDENCE CROSSWALK

Statutory Elements and Supporting Exhibits

Federal provision	Exhibits	Unproved statutory requirements
1347 - health fraud	E; F-G; Q	Plan affecting commerce; false scheme; benefit/payment nexus; intent
1035 - false statement	E; H-I	Material false writing; knowing/willful act; delivery or payment connection
669 - plan assets	E; F-G; O; Q	Program-owned premiums, credits or assets; unauthorized conversion
666 - municipal funds	A-B; F-G; K-L; Q	City agent; $5,000 property; >$10,000 qualifying aid; §666(c) review

Original records I ask federal investigators to preserve and obtain

• Original January 2024 insurance-change form, the preparer's instruction, Lacey Bradshaw's authorization (if any), all related Holly Healy correspondence, and enrollment-platform transaction metadata. [E, H, I]

• Mutual Medical and any insurer/claims administrator enrollment history, plan ownership and funding structure, coverage tier and dependent records, premium invoices, claims or benefit payments, reversals, refunds and credits for each month. [B, E, O]

• City accounts-payable ledgers, bank disbursements, payroll contribution registers, council compensation ordinances, plan amendments, and federal-program benefit receipts for each relevant year. [A, F, G, K, L, Q]

• Council minutes and original recording of October 7, 2025; December 18, 2025 termination instruction; actual carrier effective and cancellation dates for January-February 2026. [K, L, M, N, O]

I specifically ask investigators to **reconcile the City's spending**; a $0.00 employee deduction is not an insurer invoice, and the general $26,000 family-plan estimate is not a verified individual expenditure.

FEDERAL STATUTORY VERIFICATION

Primary Federal Sources

18 U.S.C. § 24(b) - Public or private healthcare benefit program affecting commerce.
Official U.S. Code: uscode.house.gov - title 18, section 24

18 U.S.C. § 1347 - Healthcare fraud and knowing, willful scheme.
Official U.S. Code: uscode.house.gov - title 18, section 1347

18 U.S.C. § 1035 - Material false statements regarding healthcare benefit payments.
Official U.S. Code: uscode.house.gov - title 18, section 1035

18 U.S.C. § 669 - Theft or misapplication of healthcare benefit program assets.
Official U.S. Code: uscode.house.gov - title 18, section 669

18 U.S.C. § 666 - Municipal-property threshold, federal assistance and usual-compensation exception.
Official U.S. Code: uscode.house.gov - title 18, section 666

Statutes I am not asserting from this record

I have not separately alleged federal wire fraud (18 U.S.C. § 1343), false statements to a federal agency (18 U.S.C. § 1001), or theft from an ERISA-covered employee benefit plan (18 U.S.C. § 664). My exhibits do not establish the additional predicates for those theories. In particular, a purely municipal plan is generally excluded from ERISA Title I coverage, and § 664 applies to plans covered by that title.

Illinois law continues immediately after this section

My underlying Illinois analyses remain part of this report: official misconduct (720 ILCS 5/33-3), forgery (720 ILCS 5/17-3), theft (720 ILCS 5/16-1), public-records tampering (720 ILCS 5/32-8 and 50 ILCS 205/4), municipal compensation (65 ILCS 5/3.1-50-5 and -10; 50 ILCS 145/2) and FOIA (5 ILCS 140). The October 2026 source exhibits and original narrative have not been reinterpreted as adjudicated findings.

Legal-status note: I verified the federal statutory language and ordinary maximum penalties against the current published U.S. Code. Whether the plan, funds, transactions and conduct satisfy each offense remains unproved.