25-7628

ORIGINAL

No. 25A1079

IN THE SUPREME COURT OF THE UNITED STATES

OLIVER JENKINS, M.D. and SHERRY-ANN JENKINS, Ph.D.,

Petitioners,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition for a Writ of Certiorari to the

United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether the deliberate-ignorance doctrine may supersede the mens rea (willful knowledge) element for criminal intent in healthcare fraud and conspiracy offenses when the defendant acted throughout the entire alleged criminal period at the direction of and in reliance upon written authorizations from the designated institutional compliance and risk management director — who identified the legal and compliance guardrails, directed that services be billed as physician services under specific CPT codes, and installed the EMR computer credentials enabling the challenged services — a scenario structurally incompatible with the willful blindness the doctrine is designed to address.

This question is squarely presented by Ruan v. United States, 597 U.S. 450 (2022), which held that the government must prove a defendant knowingly or intentionally acted in an unauthorized manner — a standard the deliberate-ignorance instruction, as applied here, directly undermines by permitting an inference of knowledge from conduct that written institutional authorization expressly sanctioned.

II. Whether the good-faith reliance defense is defeated as a matter of law by post-investigation, years-later witness recollections contradicting full disclosure established by contemporaneous documentary evidence — where the institution's own COO initiated the billing arrangement in writing; the institution's own compliance and risk management director installed the EMR computer credentials enabling PET scan and laboratory test ordering six months before operations began; the government's own lead investigator testified the institution's administration knew the defendant's unlicensed status throughout; the institution's board of directors unanimously approved the Cognitive Center after viewing a PowerPoint presentation explicitly showing PET scans and laboratory referrals; the institution's own COO admitted he "made mistakes, clearly," that he "missed the flags," and that "it's obvious we screwed this up;" and the Court of Appeals resolved this conflict under sufficiency-review credibility-deference without first conducting Napue v. Illinois analysis of materially inconsistent government witness testimony.

III. Whether the Jackson v. Virginia sufficiency standard — as applied through the Sixth Circuit's requirement to resolve all credibility disputes in the government's favor under United States v. Hinojosa — may constitutionally operate as the complete framework for appellate review of a health-care fraud conviction when: the government's financial fraud witness testified on direct examination that the defendant received Medicare payments, then confirmed on cross-examination that she does not know who submitted the claims or who received those payments; the government's lead investigator testified that the timing of a supervising physician's co-signature for submission to Medicare "Doesn't matter" — a false statement as a matter of applicable Medicare regulation; and neither false statement was subjected to independent Napue v. Illinois, 360 U.S. 264 (1959), analysis before sufficiency deference was applied.

IV. Whether a district court violates the constitutional right to present a complete defense when it excludes all defense expert testimony on medical billing, neurocognitive testing, and the medical science underlying the diagnostic and treatment methodologies in cognitive impairment in a healthcare fraud prosecution — while permitting the government's fact witness to deliver unrebutted expert-level opinions over defense objections about diagnostic limitations of PET scan imaging — and while the government's own financial fraud witness misrepresented to the jury the three-component cumulative billing structure of the charged CPT codes, as confirmed by that same witness reading the CPT manual into the record on direct examination.

V. Whether Petitioner Sherry-Ann Jenkins is entitled to equitable tolling of the certiorari deadline under Holland v. Florida, 560 U.S. 631 (2010), where retained appellate counsel explicitly promised, following the court of appeals' affirmance, to file a petition for panel rehearing, failed to do so, failed to file a rebuttal brief during the direct appeal while remaining substantially unreachable, and affirmatively told Petitioner there was nothing to petition the Supreme Court about — thereby causing Petitioner to miss the deadline while reasonably relying on counsel's assurances — a pattern of abandonment consistent throughout the entirety of the appellate representation.

PARTIES TO THE PROCEEDING

Petitioners Oliver Jenkins, M.D. and Sherry-Ann Jenkins, Ph.D. were defendants-appellants in the proceedings below. They are husband and wife. They were jointly indicted, tried, convicted, and sentenced in the same proceeding before the United States District Court for the Northern District of Ohio. Their appeals were consolidated before the Sixth Circuit and decided in a single unpublished opinion. Respondent is the United States of America, represented by the United States Attorney's Office for the Northern District of Ohio.

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The opinion of the United States Court of Appeals for the Sixth Circuit is unpublished, File Name: 25a0473n.06, issued October 17, 2025, Nos. 23-3820/23-3821, panel Cole, White, Davis, authored by White. A petition for panel rehearing filed for Oliver Jenkins by counsel of record was denied by one-word order on December 8, 2025. A pro se supplemental petition for panel rehearing and rehearing en banc filed by Oliver Jenkins on November 7, 2025 was denied simultaneously without analysis. No petition for rehearing was filed on behalf of Sherry-Ann Jenkins due to counsel's abandonment as described herein. Judgment and sentence of the United States District Court for the Northern District of Ohio (Zouhary, J.) followed a jury trial in March 2023; sentencing was September 14, 2023.

JURISDICTION

The Sixth Circuit entered judgment on October 17, 2025. Panel rehearing for Oliver Jenkins was denied December 8, 2025. This petition is filed within 90 days of the extension to May 7, 2026, Application No. 25A1079, granted by Justice Kavanaugh on April 2, 2026. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

With respect to Petitioner Sherry-Ann Jenkins, whose retained appellate counsel Neil S. McElroy failed to file a petition for panel rehearing despite explicitly promising to do so, failed to file a rebuttal brief while remaining substantially unreachable, and affirmatively told Petitioner there was nothing to petition the Supreme Court about, this petition is accompanied by a request for equitable tolling. See Holland v. Florida, 560 U.S. 631 (2010); Evitts v. Lucey, 469 U.S. 387 (1985); Roe v. Flores-Ortega, 528 U.S. 470 (2000); Penson v. Ohio, 488 U.S. 75 (1988). In the alternative, this Court should treat the petition as timely for both Petitioners as it is filed within the extended deadline of May 7, 2026, Application No. 25A1079.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fifth Amendment provides that no person shall be deprived of liberty without due process of law. The Sixth Amendment guarantees the right to a speedy and public trial by an impartial jury and the assistance of counsel. 18 U.S.C. § 1347 prohibits health-care fraud and requires that the defendant knowingly and willfully execute a scheme to defraud a health-care benefit program. 18 U.S.C. § 1349 prohibits conspiracy to commit health-care fraud.

STATEMENT OF THE CASE

A. The Parties and the Toledo Clinic Cognitive Center

Petitioner Oliver Jenkins, M.D., is a board-certified otolaryngologist who served as Senior Otolaryngologist and Section Chief of ENT at a major Toledo hospital and as a shareholder-physician at the Toledo Clinic, a private multispecialty medical practice with approximately 200 physicians and revenues of approximately $250 million annually. He had functional knowledge of Medicare billing for ENT codes. He had no independent knowledge of the CPT codes used for neurocognitive testing, which is why he sought and relied upon the Toledo Clinic's designated compliance and risk management director, who was held out as the institutional expert for guidance.

Petitioner Sherry-Ann Jenkins holds a doctoral degree in neuroscience, with research focused on the auditory system and its termination in the temporal lobe of the brain — the primary neuroanatomical substrate of Alzheimer's pathology. The temporal lobe is the first brain region affected by Alzheimer's neurofibrillary tangles, making her neuroscience training directly relevant to the Cognitive Center's clinical model. Both Petitioners were W-2 employees of the Toledo Clinic throughout the operation of the Toledo Clinic Cognitive Center (TCCC). They operated within the Toledo Clinic's institutional infrastructure, under its compliance department's guidance, using its billing systems, subject to its administrative oversight, and pursuant to a Letter Agreement of November 10, 2014, signed by Toledo Clinic President Ian Elliot, M.D. The Letter Agreement was an amendment to Oliver's Employment Agreement dated January 14, 2009, establishing that the Toledo Clinic Cognitive Center operated under the auspices of Toledo Clinic, Inc. and that all future and subsequent Cognitive Centers would operate outside of Toledo Clinic ownership.

B. The Institutional Authorization Chain

The Cognitive Center did not originate with Oliver Jenkins's unilateral initiative. It began with a January 31, 2014 email from Sue Ann Lancaster — the Toledo Clinic's Director of Compliance, Quality, and

Risk Management — who had been researching the connection between dementia screenings and hearing loss, and proactively confirmed the Cognitive Center's feasibility before Oliver had formally proposed it:

> "I have read some articles in regards to the dementia screenings associated to hearing loss diagonal/cognitive function. Very interesting studies/information. Checked with Beth, she can credential a PH.D. It only gets messy when credentialing and billing for behavioral health/addiction issues. If you want to move forward on this, we don't see a problem."
> *Trial Exhibit 1006 (January 31, 2014)*

Oliver and Sherry-Ann Jenkins completed a comprehensive scientific review and structured a business plan under the guidance of Lancaster. Over the following ten months — nearly 100 meetings in total — Oliver met with either Lancaster, COO Scott Porterfield, or the Clinic's President approximately one to three times per week, with Lancaster identifying the legal and compliance guardrails used in its construction. Lancaster routinely provided Oliver with Medicare billing guidance on ENT and non-ENT services alike, as she confirmed under cross-examination: she sent CPT code regulations and information to Oliver "numerous times." (Lancaster Cross, Trial Tr. p. 743, PageID 2738.) On March 17, 2014, Lancaster sent a written directive specifically authorizing the use of CPT codes 96116 and 96118 — the physician-billed neurocognitive testing codes:

> "I have attached for your files of Medicare policy on billing for services when patients are nursing home residents. Your services for the dementia/Alzheimer assessment should be paid as a physician service."
> *Trial Exhibit 1013 (March 17, 2014)*

This written directive — issued eight months before the Center opened — establishes that the billing-as-physician decision and specifically the use of CPT codes 96116 and 96118 originated with Lancaster's institutional research, not with Oliver's independent recommendation. Lancaster also stated to law enforcement in December 2016 that "the CPT codes and billing information were provided to Lancaster by Oliver Jenkins" and that "Oliver Jenkins conducted all the research." On cross-examination she confirmed she made those statements — false statements directly contradicted by Trial Exhibit 1013 and her own research file (Trial Exhibit 1527). (Lancaster Cross, Trial Tr. p. 731, PageID 2726.) On January 6, 2015, Lancaster sent an additional email confirming: "We pulled all of the requirements and

regulations from CMS and EnCoder when we were developing the charge tickets and forms." (Trial Exhibit 1078.) Lancaster — not Oliver — developed the billing structure from CMS regulations.

Oliver presented the complete business plan to the Toledo Clinic's Executive Committee via PowerPoint presentation in April 2014. The slides presented to and unanimously approved by the board explicitly included:

PowerPoint Slide 27 — Business Plan:

- Perspective patients will undergo a comprehensive intake evaluation
- Patients will be scheduled for audiograms and laboratory testing
- Patients who fail (Medicare approved) cognitive screening tests will undergo diagnostic PET scans
- Referrals will be made to the appropriate specialist: Endo, ENT, Hem-Onc, Neurology, Pharmacy, (Radiology), Rheum, Vascular Surgery
- Marketing strategies implemented
- Annual testing of all patients with abnormalities
- Collect, analyze, publish and lecture on the cost savings in this treatment modality
- Develop the quality indicators for Alzheimer's management and National CDC's creation
- Create CME courses and institutional consulting services

PowerPoint Slide 28 — Business Benefits:

- Creation of multi-disciplinary service that would be difficult to reproduce
- Bypass health system internal referrals requirements
- Increase patient flow through TC physicians and services
- Off load the dementia/Alzheimer's workload from PCP's
- Drastically increase the number of Neuro-PET's
- CDC practices can be applied to ACO patients with resultant cost savings to TC and UT

The Cognitive Center's clinical model also recognized that patients with a higher clinical index of suspicion — including highly educated individuals who may score within normal limits on standardized testing despite significant underlying pathology — required additional evaluation including PET imaging, consistent with established clinical practice. The board voted unanimously to approve the Cognitive Center — with no dissenting vote. (EX 1548, ¶40; Porterfield Interview, EX 1548, ¶28.) Toledo Clinic President Ian Elliot personally emailed Oliver:

> "the EC approved your wife's application and I hope she has a great start."
> *Ian Elliot, M.D., President, Toledo Clinic (Email June 4, 2014, EX 1597)*

The FBI's lead investigator confirmed the presentation made clear PET scan referrals were part of the model:

> **Q. That was something that was made very clear by Dr. Jenkins in the presentation?**
>
> A. Yeah, that was it.
>
> **Q. And that actually occurred, didn't it?**
>
> A. Yes.
>
> *(Marciniak Cross, Trial Tr. p. 1314, 14-1315, 20)*

A board that voted unanimously to approve the creation of the Cognitive Center — naming it after the institution itself and designing it from its inception to use neurocognitive testing and PET scans as shown in the PowerPoint it unanimously approved — cannot later claim it did not know PET scans and laboratory referrals were part of the plan.

Toledo Clinic made multiple unsuccessful attempts to credential Sherry-Ann Jenkins. The COO personally contacted the Ohio Board of Psychology and received a response that the arrangement could not proceed as described, and forwarded that response to Oliver. (EX 1548, ¶31.) Following the failed credentialing effort, the decision to bill Sherry-Ann Jenkins's work under Oliver's NPI number originated with the institution. COO Porterfield emailed Oliver on June 6, 2014:

> "Medicare is balking at figuring out how to classify Sherry's degree. That is, she is not certified or licensed and they don't feel that she can bill anything under Medicare. We are trying to see if we can bill her out under your provider number."
> *Scott Porterfield, COO, Toledo Clinic (Trial Exhibit 1021, June 6, 2014)*

Three independent witnesses confirmed the NPI decision was Lancaster's institutional decision:

> **Q. And it was Sue Ann Lancaster that made the decision to use Oliver Jenkins' NPI number for work that would be performed by Sherry-Ann Jenkins, correct?**
>
> A. It was agreed-upon that the NPI would be Oliver's that they would bill through.
>
> *(Marciniak Cross, Trial Tr. p. 1318)*

Q. Were you directed to go ahead and input Dr. Jenkins' NPI number for the services that were being provided by the Cognitive Center?

A. Yes, yes.

Q. All right, you weren't asked who directed you to do that. That was Sue Ann Lancaster, wasn't it?

A. Yes.

Q. Because the Toledo Clinic could not obtain an NPI number for Sherry-Ann Jenkins, correct?

A. Correct.

(Duke Cross, Trial Tr. p. 879, 2-9 & 20-22; p. 880, 14-23)

CFO Kopitke confirmed: "The Compliance Department set the Cognitive Center to submit billings under Jenkins' NPI number." (Kopitke Interview, EX 1404, p. 3.) Kopitke further confirmed he "never told the Executive Committee he thought the operation of the Cognitive Center was illegal" and described the Executive Committee as "conservative" and as one that had "never done anything illegal." (EX 1404, p. 4.) Oliver told Kopitke during the investigation that "The Toledo Clinic improperly advised him and he doesn't think he should have to pay the money back." (EX 1404, p. 4.) This contemporaneous assertion to the institution's own CFO during the government's own pre-trial investigation is independent corroboration of Oliver's good-faith reliance defense.

Following the NPI decision, Lancaster researched Medicare billing regulations for approximately eight months — compiling a research file of approximately 500 pages (Trial Exhibit 1527) — before issuing written authorization in September 2014:

> "I have exhausted all reviews of Medicare regulation and feel you can move forward with the project. Essentially the services can be performed under the GENERAL SUPERVISION of the physician, meaning you do not have to be in the suite."
> *Trial Exhibit 1038 (September 19, 2014) — read into the trial record verbatim by the government's own lead FBI agent (Marciniak Cross, Trial Tr. p. 1332, 20-1333, 25)*

This authorization expressly stipulated that Sherry-Ann Jenkins could bill CPT codes 96116 and 96118 incident to Oliver Jenkins under his general supervision. In a moment of sheer bewilderment, Lancaster testified in 2023 that her incorrect 2014 understanding of the incident-to general supervision authorization for the applicable CPT codes remains correct, and that the issue was "not a problem." (Lancaster Cross, Trial Tr. p. 745, PageID 2740.)

Lancaster then created a cost center, practice ID, and EMR computer credentials — Trial Exhibit 1043 — and installed the Cognitive Center EMR profile. The full email reads:

> "I have set up a separate practice ID and provider number. I have added as an appt doctor, so we need to work on details of setting a schedule, charge tickets, etc. Currently I gave the current office phone number, but that can be changed if it is decided to set up a separate line for scheduling these patients outside of the ENT practice. Terri, you will need to load all of the current active insurance provider numbers for Dr. Jenkins to the 433-OT03 numbers. Practice ID-OT03. Provider #-433."
> *Sue Ann Lancaster, Director of Quality, Compliance and Risk Management (Trial Exhibit 1043, October 20, 2014)*

This institutional action gave Sherry-Ann system-level authority to order PET scans, laboratory tests, and make referrals — six months before the Center opened. Lancaster was personally managing scheduling infrastructure, phone lines, and insurance provider number loading for the Cognitive Center. It is a physical and administrative impossibility for Lancaster — and hence the Toledo Clinic — to have been unaware of PET scan and laboratory ordering while simultaneously installing the computer user profile making those exact orders possible. An institution cannot construct a mechanism for medical billing while claiming ignorance that any billing would occur. Lancaster later told law enforcement that Oliver "never talked about ordering PET scans for patients" — a statement directly contradicted by the PowerPoint she confirmed seeing, by Trial Exhibit 1043, and by her February 28, 2014 coordination with the Director of Radiology on PET scan coding. This false statement to law enforcement is precisely the demonstrably false testimony that required Napue analysis before sufficiency deference was applied.

Toledo Clinic's Director of Legal Services, Valerie Trudel, confirmed she and Lancaster discussed the billing codes and "knew it was okay for Sherry to bill" for the two CPT codes Lancaster had identified, "since Jenkins would be providing supervision to Sherry." In other words, Trudel understood — based

entirely on Lancaster's incorrect incident-to authorization — that Sherry-Ann could bill CPT codes 96116 and 96118 incident to Oliver Jenkins under general supervision. Lancaster's incorrect incident-to opinion had thus permeated every level of Toledo Clinic administration simultaneously: the compliance and risk management director who authorized it, the COO who initiated the NPI arrangement, the Medical Director who oversaw operations, and the Director of Legal Services who documented her understanding in her FBI interview.

The institution knew that Sue Ann Lancaster was a high school graduate, untrained and uncertified in compliance, billing, or risk management, but was designated Director of Compliance, Quality, and Risk Management for approximately 200 physicians. Dr. Ian Elliot, the Toledo Clinic's President, confirmed on cross-examination:

> **Q. Did you represent to the government that you had never been comfortable with Sue Ann Lancaster in the position as Director of Compliance?**
>
> A. I think that I represented to the government, the intent was that, at the time, we had a fairly explosive growth in the clinic, and we were a very small group practice, and the needs for a more robust and, what can I say modern compliance department was evident to me.
>
> *(Elliott Cross, Trial Tr. p. 582-584)*

Toledo Clinic's own President acknowledged that the institution's need for more robust compliance expertise was evident — yet kept Lancaster in the compliance director role, presented her as the authoritative compliance resource, and concealed her actual qualification deficiencies from the physicians depending on her opinions. Lancaster herself admitted at trial that her compliance department had no formal compliance plan, no program, and no policies and procedures. (Lancaster Cross, Trial Tr. p. 724-726.) COO Porterfield acknowledged in his government interview that Lancaster "only has a high school education" and that he "did not know if Lancaster was a certified Compliance Officer." (EX 1548, ¶12.) Lancaster obtained her first compliance certification in 2018 — four years after authorizing the Cognitive Center's billing structure. (Lancaster Direct, Trial Tr. p. 695-696.) Her misrepresentation of

her qualifications to colleagues — including to Porterfield who believed she was already certified — is consistent with her concealment of her December 2015 error from the Clinic's own attorney. Toledo Clinic paid Lancaster over $100,000 annually as Director of Compliance, Quality, and Risk Management — untrained and uncertified, with a high school diploma. She remains in that role at the Toledo Clinic today. The Jenkinses were not perpetrators of the institution's compliance failures — they were its victims.

C. Lancaster's Concealed Error and Its Consequences

In December 2015 — fifteen months after issuing her written authorization — Lancaster discovered she had misread the applicable Medicare regulations. Incident-to psychological services required direct supervision rather than general supervision, and the supervising physician was required to personally evaluate patients first. Lancaster acknowledged to law enforcement in December 2016 that it was not until December 2015 that Lancaster and Toledo Clinic realized portions they missed when reading and researching CPT codes. (Lancaster Cross, Trial Tr. p. 724-726.)

She did not disclose this discovery to Trudel, the Toledo Clinic's own Director of Legal Services and in-house counsel. Trudel testified she first learned of Lancaster's error when asked about it on cross-examination:

> **Q. Are you aware that in December 2015, Sue Ann Lancaster realized that she had made mistakes in the way that she was interpreting and reading certain compliance issues related to the Cognitive Center?**
>
> A. I'm not aware of that.
>
> **Q. You're not aware of that? Is that the first time you're hearing of this?**
>
> A. That she made mistakes?
>
> **Q. Yes.**
>
> A. Yes, it is the first time I'm hearing of it.

Q. That she got it wrong, that she misread certain codes and had given the wrong information to the Jenkinses, is that the first time you're hearing of this?

A. Yes.

(Trudel Cross, Trial Tr. p. 1209, 24-1210, 17)

Lancaster concealed her mistake from her own institution's attorney while co-leading the Toledo Clinic's peer review investigation into the Cognitive Center's operations. (Trudel Cross, Trial Tr. p. 1190, 10-25.) A root cause analysis leads to a single point of origin: Lancaster's incorrect and unqualified incident-to billing opinion, issued by a high school graduate held out as the compliance and risk management authority for 200 physicians, initiated the cascade of institutional decisions the government recharacterized as criminal fraud — and her subsequent concealment of that error from the Clinic's own in-house counsel corrupted every investigative and judicial proceeding that followed.

D. The Billing Structure and the FBI's Investigative Failures

The Cognitive Center paid the Toledo Clinic $26,150 in 2015 for institutional services inclusive of billing, collections, compliance, HR, and legal services — 8% of gross revenues. The Jenkinses never received the billing, collections, and compliance services they paid for. Toledo Clinic's COO confirmed the Clinic controlled all billing without physician discretion:

Q. Okay, that was really my question, so there is no discretion, if you are at the Clinic, the Clinic is doing the billing?

A. Correct.

(Porterfield Cross, Trial Tr. p. 691, 5-8)

The Toledo Clinic's billing office — not the Jenkinses — electronically submitted unsigned claims under Oliver's NPI number, independently violating CMS requirements and institutional workflow rules without first routing the charts to Oliver for electronic co-signature. These unsigned charts were

submitted without Oliver Jenkins' knowledge or consent. The FBI's lead agent confirmed there is no evidence Oliver ever saw the charts submitted in his name:

Q. The way it would work for the Cognitive Center is that Sherry-Ann Jenkins would write a note, and she would sign it, correct?

A. Correct.

Q. Then an electronic record, or electronic message, would be sent to Oliver Jenkins to review that note because she's performing the services incident to and under his general supervision, correct?

A. That's how it was supposed to work.

Q. So explain to me how is it that if Oliver Jenkins is required to sign off on a note, how is it that a bill can be issued by the Business Services Department?

A. I think the electronic record can be signed off later than. I think that bill gets sent electronically. It doesn't matter. At some point the signature goes on. You'll see in certain notes that they're dated after billed for.

Q. You think, correct?

A. Correct.

(Marciniak Cross, Trial Tr. p. 1350, 2-18)

This testimony is categorically false as a matter of Medicare billing rules. Under 42 C.F.R. § 410.26(b) and Medicare Claims Processing Manual, Chapter 12, § 30.6.1, the supervising physician's electronic co-signature is a condition precedent to billing submission. Submitting a claim without a prior electronic co-signature is itself a regulatory violation — committed here by the Toledo Clinic's own billing office.

Q. Okay. And then the same issue, Oliver Jenkins, no signature, next to service provided by Sherry-Ann Jenkins, yet the billing department was issued a bill, despite the fact that there was no sign off?

A. Yes, they were billed for services.

Q. So you would agree with me that there's no evidence that Oliver Jenkins ever saw the notes that are represented in Exhibits 800 and 801?

A. But they were billed for services, correct.

Q. They were billed for, but there's no evidence that he actually saw what was written in that note, correct?

A. I would agree with you.

(Marciniak Cross, Trial Tr. p. 1351, 10-22)

Porterfield confirmed in his government interview: "whoever billed and collected on the services provided by Sherry-Ann Jenkins is the most culpable in this whole investigation because they were the ones who benefited." (EX 1548, ¶53.) Toledo Clinic's own COO identified Toledo Clinic's billing office — not the Jenkinses — as most culpable.

The government's financial gain evidence consisted of a $45,405.70 year-end check that Agent Marciniak assumed was a Cognitive Center bonus without speaking to the CFO:

Q. Did you talk to Mr. Kopitke (CFO) about what that $45,405.70 represented?

A. I did not.

Q. Did you look to determine whether that $45,405 was related to payments from the Outpatient Surgery Center and a dividend issued by the Toledo Clinic?

A. I did not.

Q. You assumed that it was money from the Cognitive Center, correct?

A. Correct.

Q. But the year end financial statement for 2015 for the Cognitive Center shows its net profit is less than $1,000.00, correct?

A. I didn't take into account all the salary and whatnot.

(Marciniak Cross, Trial Tr. p. 1359, 13-1361, 23)

An Independent Auditor's Report by Gilmore Jasion Mahler, Ltd. (November 17, 2017) — commissioned by Toledo Clinic's own external counsel — established complete repayment:

Category	Payments Received	Refunds Issued
Patient Services	$367,754.91	$346,356.85
Radiology (PET Scans)	$132,062.74	$132,062.74
Laboratory	$18,787.28	$18,787.28
Additional Patient Visits	—	$21,398.06
TOTAL	**$518,604.93**	**$518,604.93**
Unissued Refunds		**$0.00**

Toledo Clinic subrogated the entire $518,604.93 refund obligation to Oliver's ENT practice accounts receivable in two transactions: "Monies used to refund payments were taken from Oliver Jenkins ENT practice." (Kopitke Interview, EX 1404, p. 4.) Additionally, Toledo Clinic retained $407,569.59 of Oliver's ENT practice accounts receivable upon his departure in April 2017, never paying those funds for ENT services he had already performed. Toledo Clinic's combined financial extraction from Oliver Jenkins totals approximately $926,174.52. Toledo Clinic was named as a defendant in the qui-tam civil proceeding months prior to the criminal case and in the settlement documents was mandated to cooperate in future proceedings. The Jenkinses were named but never served notice of the proceeding and consequently are not signatories to the settlement agreement, which was not revealed to the defense until after the discovery deadline. The institution characterized as an innocent victim extracted nearly one million dollars from the defendants it was testifying against under a mandatory cooperation clause.

E. The External Radiology Validation

The Toledo Clinic understood that the entirety of Cognitive Center operations revolved around accurate neuro-PET reports from its own neuroradiologists. The Clinic understood that once the PET scans were completed and reports finalized, the results would be conveyed to patients — not diagnosed — at the next visit by Sherry-Ann Jenkins. Therefore, to verify the accuracy of its own neuroradiologists' reports, in August 2015, Toledo Clinic commissioned ProScan Reading Services, an independent outside

radiology firm, to review eight random brain PET scans. Seven of the eight received "Agree with original interpretation as written." All eight received "Excellent" image quality ratings. This oversight, resulting in an 87.5% agreement rate with Excellent image quality ratings across all eight scans, demonstrates the full operational control of the Toledo Clinic over the Cognitive Center and radiology, and is a major reason the Clinic left the Cognitive Center operational for approximately five additional months following the completion of the peer review — closing it only on January 29, 2016, after the FBI investigation became known.

F. The Szczesniak Patient: Spoliation and Distortion

The government's most emotionally powerful patient evidence concerned the daughter of Dr. Szczesniak, a radiologist employed at the Toledo Clinic who was a source of peer review complaints. His daughter came to the Cognitive Center voluntarily, of her own volition, seeking neurocognitive evaluation. The underlying PET scan was read by Dr. D'Souza — the radiologist chosen by Dr. Szczesniak himself specifically for an unbiased independent opinion. Dr. D'Souza found the scan abnormal. Sherry-Ann's assessment, based on Dr. D'Souza's radiological finding, noted the possibility of mild cognitive impairment in the future — a probabilistic, qualified, forward-looking statement grounded in a licensed radiologist's interpretation. Sherry-Ann did not diagnose this patient with Alzheimer's disease. She conveyed the neuroradiologist's findings — which is precisely what the Toledo Clinic's compliance infrastructure authorized her to do. Any representation to the contrary is without any supporting evidence or merit, and provides the basis of inference stacked upon inference.

Dr. Szczesniak testified that he found the assessment [by Dr. D'Souza] ridiculous and caused the Toledo Clinic to expunge his daughter's Cognitive Center and radiology records from the EMR — motivated by his desire to ensure "no one ever saw that" given his daughter's medical school plans. The government's inference at trial — that the Cognitive Center diagnosed a 21-year-old with Alzheimer's disease — was made with no documentary basis because Szczesniak destroyed that basis. Both Porterfield and Elliot believed this inference, demonstrating how an unverified administrative narrative — built on records

destroyed by the complaining witness himself — propagated through the institution and into the prosecution theory. Toledo Clinic's Director of Radiology, Richard Gray, was personally aware of and approved the Szczesniak patient encounter in March 2015. (EX 1096.)

G. Proceedings Below

A grand jury returned an indictment in May 2020 — approximately five years after the Cognitive Center closed. Following a jury trial in March 2023, both Petitioners were convicted on all counts. Sherry-Ann Jenkins was sentenced to 71 months of imprisonment. Oliver Jenkins was sentenced to 41 months — 30 months less than his wife for conduct arising from the same institutional authorization, in the same proceeding, under the same theory.

The Sixth Circuit affirmed on October 17, 2025. The panel made three concessions revealing the closeness of the case: (1) "Although a reasonable juror might instead have concluded that the Jenkinses' misrepresentations and billing practices were mistakes, not the product of a criminal conspiracy, that is not the standard under which we must review the Jenkinses' claim." (Op. p. 14.) (2) "If these misunderstandings about the application of the general-supervision and incident-to rules to Sherry-Ann's memory-testing practice were the sole bases for the Jenkinses' fraud charges, they might have a strong claim of good-faith reliance." (Op. p. 17.) (3) "The trial testimony is less straightforward than both parties suggest regarding whether Oliver's presentation led individuals to understand that Sherry-Ann would be diagnosing patients and ordering laboratory and radiology work." (Op. Fn. 2, p. 3.)

The panel's Footnote 12 contains an irreconcilable internal contradiction: "Although some Clinic leadership, such as Dr. Elliot and Trudel, knew that Sherry-Ann was not credentialed, they also understood from their discussions with Oliver that Sherry-Ann would not be diagnosing patients for that very reason." (Op. Fn. 12, p. 13.) If leadership knew she was not credentialed and understood from Oliver that she would not be diagnosing patients but conveying the results of the neuro-radiology reports, then Oliver disclosed her status and described her role consistent with Lancaster's incident-to

authorization. The panel simultaneously held that Oliver misrepresented her clinical role — a holding irreconcilable with its own footnote.

Two central government witnesses — Deborah Schmidt and Mary Kay Smith — were the qui-tam relators who originated the False Claims Act civil case, No. 3:15CV2288, received $70,334.45 from the settlement funds, and testified at trial without the jury knowing of their financial stake. Mary Kay Smith was an employee of Toledo Clinic's radiology department — the department that received $132,062.74 in PET scan revenue. The settlement agreement's cooperation clause (¶12) obligated Toledo Clinic to deliver its employees as witnesses while Paragraph 5(f) reserved individual criminal liability. The Jenkinses remained unaware and were not served notice of the proceeding.

Lancaster's false statement to law enforcement that Oliver "never talked about ordering PET scans for patients" — directly contradicted by the PowerPoint she confirmed seeing, by Trial Exhibit 1043, and by her February 28, 2014 coordination with the Director of Radiology on PET scan coding — produced three false factual holdings in the Sixth Circuit opinion:

> (1) Page 9: "Lancaster did not believe — either in September 2014 or thereafter — that the incident-to and general-supervision rules permitted Sherry-Ann to...order brain PET scans." — refuted by Trial Exhibit 1043, Lancaster's installation of the EMR profile enabling PET scan ordering.
>
> (2) Page 14: "Lancaster did not advise the Jenkinses that Sherry-Ann could...order brain PET scans under such supervision." — refuted by Trial Exhibits 1038 and 1043, both authored by Lancaster, and confirmed false by her own cross-examination.
>
> (3) Page 17: "The Jenkinses do not point to any evidence suggesting that Lancaster (or anyone else) advised them that Sherry-Ann...could bill under Oliver's NPI for...ordering brain PET scans." — refuted by Trial Exhibits 1021, 1038, and 1043, and confirmed by three independent witnesses.

These three false factual holdings illustrate precisely why Napue analysis was constitutionally required before Hinojosa sufficiency deference was applied. When a court "must resolve any evidentiary conflicts or credibility disputes in a manner that favors the government's version of facts," United States v. Hinojosa, without first verifying that those facts are true, it invites conviction on uncorroborated accusation and transforms sufficiency review into a mechanism for insulating false testimony from constitutional scrutiny — a direct conflict with Glossip v. Oklahoma, 604 U.S. ___ (2025).

The government's own pretrial filing makes the institutional contradiction explicit. In Doc. 57 (PageID 670), filed August 5, 2022, the government represented to the district court: "It is undisputed that the Toledo Clinic was the conduit by which Defendants billed their victim patients and insurance companies." The government simultaneously possessed — and had obtained through its own pre-trial investigation — interview reports from Toledo Clinic's COO confirming he "made mistakes, clearly" and that he did not pay attention to the business the way he should have, and from Toledo Clinic's CFO confirming "The Compliance Department set the Cognitive Center to submit billings under Jenkins' NPI number." (EX 1548, ¶49; EX 1404, p. 3.) A government that characterizes an institution as a passive billing conduit to the district court while possessing its own investigative record establishing that institution's COO initiated the NPI arrangement in writing, its compliance and risk management director installed the EMR credentials enabling PET scan ordering six months before operations began, and its CFO confirmed the compliance department set up the billing — has made a representation to the court that its own record refutes. The government further referenced the qui tam settlement in Doc. 57, describing it as occurring "following defendants' fraud" while simultaneously moving to exclude evidence about it under Rules 402 and 403 — preventing the jury from learning that the government had paid the relators who would testify at trial. This is precisely the disclosure the government was required to make under Giglio v. United States, 405 U.S. 150 (1972), and the false and misleading testimony pattern that Glossip v. Oklahoma, 604 U.S. ___ (2025), reaffirms must be corrected.

REASONS FOR GRANTING THE PETITION

I. The Deliberate-Ignorance Doctrine Cannot Coexist With Written Institutional Authorization

The deliberate-ignorance doctrine permits a jury to find knowledge where a defendant consciously avoided learning facts that would have established guilt. Global-Tech Appliances, Inc. v. SEB S.A., 563 U.S. 754, 769 (2011). Oliver Jenkins did not avoid learning about the billing regulatory framework. He actively engaged his institution's designated compliance and risk management director over nearly 100 meetings spanning ten months, received Lancaster's written authorization, and paid $26,150 for comprehensive billing and compliance oversight that never identified the model as noncompliant. That is not deliberate ignorance. It is a written record of affirmative compliance inquiry resulting in written professional authorization, as well as a pattern of negligence by multiple Toledo Clinic administrators.

The Sixth Circuit approved a deliberate-ignorance instruction — read twice to the jury — permitting it to find that Oliver's authorized absence from the Cognitive Center suite constituted deliberate ignorance of billing falsity. The panel applied Hinojosa credibility deference to credit the deliberate-ignorance inference over documentary evidence of written authorization. Hinojosa deference has three critical limitations: it applies to genuine credibility disputes between competing witness accounts, not conflicts between testimony and documentary evidence; it presupposes testimony has survived Napue scrutiny; and it cannot be used to stack inference upon inference in violation of United States v. Ouedraogo, 531 F. App'x 731, 739-40 (6th Cir. 2013). Trial Exhibit 1038 is not a credibility contest. It is a document. Ruan v. United States, 597 U.S. 450 (2022), confirmed that the government must prove subjective knowledge in regulatory criminal offenses — yet this Court has not resolved whether a deliberate-ignorance instruction may supply that knowledge when the defendant acted throughout on affirmative written compliance authorization — a question recurring in every regulatory fraud prosecution.

II. The Good-Faith Defense Cannot Be Defeated By Post-FBI Recollections Contradicting Six Categories of Contemporaneous Documentary Evidence

The Sixth Circuit rejected the good-faith reliance defense on the ground that Oliver failed to disclose to Toledo Clinic administration that Sherry-Ann would be ordering PET scans. This holding is directly contradicted by six categories of contemporaneous documentary evidence. The good-faith reliance standard under United States v. Rozin, 664 F.3d 1052, 1060 (6th Cir. 2012), requires "(1) full disclosure of all pertinent facts, and (2) good faith reliance on the advice." The six categories below establish full disclosure at every level of Toledo Clinic simultaneously.

A. January 2014 Written Communications With Lancaster

Oliver's written exchanges beginning January 31, 2014 documented the business model from inception. Written communications with the designated compliance and risk management director over ten months are full disclosure to the institution, not concealment from it.

B. The PowerPoint Presentation Unanimously Approved by the Board

The PowerPoint presented to and unanimously approved by the board explicitly stated patients would undergo PET scans and laboratory testing, and identified increasing neuroPETs as an explicit business objective. A board that voted unanimously to approve this presentation — naming the center after the institution itself — cannot later claim it did not know PET scans and laboratory referrals were part of the plan.

C. The Risk Management and Compliance Director's Computer Credential Installation — The Dispositive Evidence

The risk management and compliance director installed the EMR user profile making PET scan and laboratory test orders possible six months before the Center opened — while personally managing scheduling infrastructure and insurance provider number loading for the Center. The act of installing

computer credentials that enable PET scan ordering is institutional knowledge of PET scan ordering expressed through administrative action. An institution cannot construct a mechanism for medical billing while claiming ignorance that any billing would occur. Trial Exhibit 1043 proves the opposite of the panel's disclosure holding. This is not testimony subject to Hinojosa credibility analysis. It is a documentary exhibit.

D. The COO's Written Initiation of the NPI Billing Arrangement

The COO's June 6, 2014 email initiated the NPI billing directive to his staff, which was later answered by the September 2014 Lancaster email that incorrectly authorizes the use of general supervision for Cognitive Center charges. Lancaster — not Oliver — made the compliance determination that became the billing structure.

E. The Administration's Own Failed Licensing Effort

Porterfield personally led the failed licensing effort and concluded there was no path forward for licensing Sherry-Ann Jenkins in the State of Ohio. The government's own FBI agent confirmed she believed the administration knew Sherry-Ann was unlicensed throughout. (Marciniak Cross, Trial Tr. p. 1318, 8-21.)

F. The COO's Institutional Admissions

COO Porterfield stated in his government interview the following admissions establishing institutional failure:

"I made mistakes, clearly." (EX 1548, ¶49.)

"I take responsibility. It happened on my shift. I missed the flags." (EX 1548, ¶53.)

"I don't know what to tell you. It's obvious we screwed this up. I don't think there was a deliberate reason to look away." (EX 1548, ¶59.)

"No one at the Toledo Clinic would deliberately break the law because they are trained not to do that." (EX 1548, ¶59.)

"I did not pay attention to Dr. Oliver Jenkins' new business idea the way I should have...I was distracted by personal issues at the time and was not 100%." (EX 1548, ¶49.)

The government interviewed Toledo Clinic's COO, documented these admissions, and prosecuted the Jenkinses for the institutional failures the COO admitted were Toledo Clinic's responsibility. The CFO independently confirmed he "never told the Executive Committee he thought the operation of the Cognitive Center was illegal" and that Oliver told him directly that "The Toledo Clinic improperly advised him." (EX 1404, p. 4.)

III. The Sufficiency Standard Cannot Insulate a Conviction Built on Demonstrably False Government Testimony Without Prior Napue Analysis

A. The Napue-Sufficiency Sequencing Error

The sufficiency standard under Jackson v. Virginia, 443 U.S. 307 (1979), asks whether any rational trier of fact could have found the essential elements beyond a reasonable doubt. Napue asks whether the government knowingly used false testimony to obtain the conviction. These standards operate on different axes — sufficiency addresses the quantum of evidence; Napue addresses its truth. The correct constitutional sequence is Napue first, then Jackson sufficiency. The panel reversed this sequence, applying Hinojosa as the complete analytical structure without separately analyzing whether the evidence it was crediting was the product of false government testimony. The panel's failure to conduct Napue analysis before applying Hinojosa credibility deference is not a discretionary omission — it is a constitutional sequencing error that independently warrants this Court's review regardless of how the sufficiency question would ultimately be resolved. Every Napue violation involves a jury that credited the false testimony, meaning false testimony always satisfies sufficiency review. If sufficiency review absorbs the Napue inquiry, Napue can never provide relief. This Court's decision in Glossip v. Oklahoma, 604 U.S. ___ (2025), reaffirmed that the prosecution bears an affirmative constitutional

obligation to correct materially false or misleading testimony — an obligation that cannot be discharged by pointing to sufficiency of remaining evidence.

B. The Demonstrably False Testimony in This Record

The record contains at least three instances of demonstrably false government testimony, none of which received independent Napue analysis. First — Lancaster's false statement to law enforcement that Oliver "never talked about ordering PET scans," directly contradicted by Trial Exhibit 1043 and the PowerPoint she confirmed seeing, produced three false factual holdings at pages 9, 14, and 17 of the Sixth Circuit opinion, each refuted by the documentary record. Second — Hartman testified on direct that "Dr. Jenkins would have received payment" for $96,387.41; on cross she confirmed she does not know who submitted the claims or who received the payments. The Toledo Clinic billed and received those payments under its universal billing number — not Oliver's NPI number. Third — Marciniak testified the electronic co-signature timing "doesn't matter," which is false under 42 C.F.R. § 410.26(b): the co-signature is a condition precedent to billing submission.

C. Ouedraogo's Anti-Stacking Caution Was Cited But Not Applied

The panel cited Ouedraogo's rule against piling inference upon inference — United States v. Ouedraogo, 531 F. App'x 731, 739-40 (6th Cir. 2013) — at page 11, then affirmed without applying it. Four sequential inferences, each contradicted by record evidence: Oliver knew the billing was wrong — inferred from authorized absence; his absence was deliberate ignorance — inferred despite written authorization; billing submissions were his act — inferred despite three witnesses confirming Lancaster's NPI decision; Oliver financially benefited — inferred from Hartman's attribution despite her cross-examination concession.

D. The Burks Sufficiency Argument

Under Burks v. United States, 437 U.S. 1 (1978), reversal on insufficiency grounds bars retrial. Hartman's direct-to-cross collapse eliminates the financial benefit element. Marciniak's false co-

signature testimony eliminates the evidence Oliver knowingly caused false claims to be submitted. Trial Exhibit 1038, read into the record by the government's own agent, affirmatively negates the knowledge element as a matter of law. The independent CPA audit confirming $0 net financial result — a satisfied court order totaling $200 in restitution — combined with $518,604.93 in subrogated refund obligations, $407,569.59 in retained accounts receivable, and complete pre-criminal repayment of all insurance companies — establishes a net negative financial position directly negating the financial benefit element the government was required to prove.

E. The Due Process Clause Requires Disclosure of Qui-Tam Relator Payments

Whether the Due Process Clause and Giglio v. United States, 405 U.S. 150 (1972), require disclosure to a criminal trial jury of a witness's financial interest as a qui-tam relator in a False Claims Act proceeding arising from the same conduct is a recurring and unresolved constitutional question. Schmidt and Smith received $70,334.45 as their relator share and testified at trial without jury knowledge of their financial stake. The structural due process violation extends beyond the individual Giglio issue: the government sealed the proceedings, paid the relators, aligned institutional cooperation under the settlement cooperation clause, and unsealed only shortly before trial — while the Jenkinses remained unaware and were not served notice of the proceeding.

IV. The Asymmetric Exclusion of Expert Testimony and Science Deprived Petitioners of a Complete Defense

A district court's decision to exclude expert testimony is reviewed for abuse of discretion, and exclusion that deprives a defendant of a complete defense is constitutional error subject to de novo review. Crane v. Kentucky, 476 U.S. 683, 690 (1986). The district court excluded all defense expert testimony on medical billing, neurocognitive testing, and the medical science underlying the diagnostic and treatment methodologies in cognitive impairment. In Doc. 69 (PageID 860), the court ruled "expert testimony is not required" for the government's patient fraud theory — then excluded all defense expert testimony that would have rebutted it. The result was constitutionally indefensible: the government prosecuted a

medical and billing fraud theory without experts while the defense was denied the experts needed to rebut it.

The government charged federal healthcare fraud requiring proof of knowing and willful execution of a scheme to defraud. It tried a state unlicensed practice case. These are fundamentally different legal standards. Without expert testimony on the CPT code structure, the rules for incident-to billing framework, and the medical science underlying the diagnosis and treatment of cognitive impairment, the jury had no basis to evaluate whether the regulatory framework Lancaster misread transformed a good-faith compliance failure into willful fraud. That distinction — between regulatory non-compliance and criminal fraud — is precisely what the excluded expert testimony would have addressed.

Sherry-Ann Jenkins, Ph.D., whose doctoral research in neuroscience focused on the auditory system's termination in the temporal lobe of the brain — the primary neuroanatomical substrate of Alzheimer's pathology, where neurofibrillary tangles first appear — possessed specific scientific training directly relevant to the Cognitive Center's clinical model. The government characterized her as an unqualified fraud; the jury had no expert to explain that her doctoral training was specifically relevant to the neuroanatomical substrate of the disease she was screening for.

Szczesniak's categorical statement that "you can't" diagnose Alzheimer's from PET scan imaging contradicts peer-reviewed medical literature and FDA-approved protocols — including the meta-analysis CMS relied upon when approving Medicare coverage for neuro-PET scans, reporting approximately 86% sensitivity and specificity for Alzheimer's diagnosis via FDG-PET (Patwardhan et al., Radiology, 2004). It was delivered as authoritative fact by a government fact witness without expert qualification, over defense objections, without any reliability screening. The defense had no expert to rebut it.

The exclusion of defense expert testimony deprived the jury of the scientific framework needed to evaluate the Cognitive Center's clinical model — and the prejudice was not harmless error, but denial of a constitutional complete defense. The excluded science would have established: that FDG-PET imaging

achieves approximately 86% sensitivity and specificity for Alzheimer's diagnosis (Patwardhan et al., Radiology, 2004); that multidomain intervention combining dietary modification, physical exercise, and cognitive training produces measurably superior cognitive outcomes (FINGER study, Ngandu et al., Lancet, 2015); that medium-chain triglycerides (MCT) found in coconut oil — the specific dietary supplement the government characterized as fraudulent quackery — improve memory in Alzheimer's patients via ketone body metabolism, leading to FDA approval of a medical food based on this mechanism (Henderson et al., Nutrition & Metabolism, 2009); that hearing loss is now identified as the single largest modifiable risk factor for dementia (Lancet Commission on Dementia Prevention, 2020); and that Sherry-Ann Jenkins' doctoral research in the auditory system's termination in the temporal lobe gave her specific scientific training in the exact cortical region where Alzheimer's pathology originates. Intervening science has further vindicated the Cognitive Center's clinical approach: FDA approval of blood-based amyloid biomarker testing, Medicare coverage expansion for amyloid PET scans, and current Alzheimer's Association clinical practice guidelines now recommend precisely the combination of neurocognitive testing, PET scan evaluation, laboratory blood work, and dietary and lifestyle intervention that the Cognitive Center employed in 2014-2015.

The record contains direct patient testimony that the Cognitive Center's clinical model produced measurable results. Dr. Jonathan Rohrs, a Toledo Clinic physician and Cognitive Center patient, received a PET scan read by Dr. Gustine showing findings consistent with early Alzheimer's Disease. He retired but continued the regimen Sherry-Ann recommended — and testified at trial:

> **Q. And did you find your interaction with Sherry-Ann Jenkins to be helpful?**
>
> A. Very.
>
> **Q. And do you feel like it had a positive effect on your memory?**
>
> A. Absolutely. Over time I would say the — let me collect my thoughts there. I would — of the things that were tested, I do believe the — it was actually better — I do feel like I'm better today than I was back then.
>
> *(Rohrs Direct, Trial Tr. p. 1562-1563)*

A Toledo Clinic physician whose PET scan showed findings consistent with early Alzheimer's Disease continued the Cognitive Center's protocol and testified a decade later that his cognition is better today than when he started. His PET scan finding directly contradicts Szczesniak's claim that "you can't" diagnose Alzheimer's from PET imaging — a Toledo Clinic radiologist made exactly that finding in a patient who then benefited from the precise intervention the government characterized as snake oil.

The clinical significance of Dr. Rohrs' outcome cannot be overstated. Alzheimer's disease is a progressive neurodegenerative disorder whose natural history is unidirectional decline. Slowing that decline — not reversing it — is the primary endpoint in FDA-approved Alzheimer's drug trials. A patient with PET scan findings consistent with early Alzheimer's Disease who is cognitively better ten years later has achieved an outcome that exceeds what existing pharmaceutical interventions produce in controlled clinical trials. Dr. Rohrs' testimony is not merely evidence of patient satisfaction — it is proof of concept that the Cognitive Center's multidomain intervention protocol, grounded in the same peer-reviewed science the government's excluded expert testimony would have addressed, produced a clinically meaningful result that is inconsistent with the natural history of the disease he was screened for. The jury had no expert to explain the natural history of Alzheimer's disease, what a PET scan finding consistent with early Alzheimer's means prognostically, or why cognitive improvement a decade later is scientifically remarkable. Without expert testimony, the jury could not evaluate whether the Cognitive Center was promoting science or fraud — and that failure of proof, imposed by the district court's asymmetric exclusion ruling, deprived both Petitioners of a complete defense. The record contains no Daubert analysis of the excluded defense expert testimony. A district court that excludes defense expert testimony without gatekeeping analysis, while simultaneously admitting unrebutted expert-level opinions from a government fact witness over defense objections without any reliability screening, has violated Federal Rule of Evidence 702 and the constitutional guarantee of a complete defense under Crane v. Kentucky, 476 U.S. 683 (1986).

V. Sherry-Ann Jenkins: Equitable Tolling and Ineffective Assistance of Appellate Counsel

Sherry-Ann Jenkins was represented on appeal by Neil S. McElroy, retained and paid in full before the appeal commenced. McElroy's representation was characterized by a pattern of failures constituting abandonment under Holland v. Florida, 560 U.S. 631 (2010), and ineffective assistance under Evitts v. Lucey, 469 U.S. 387 (1985).

A. The Pattern of Abandonment

McElroy allowed CorrLinks invitations to go to spam, requiring communication through Sherry-Ann's son Bradley as intermediary. He filed an opening brief incorporating Oliver's arguments rather than developing independent arguments for Sherry-Ann, whose 71-month sentence was 30 months greater than Oliver's for conduct arising from the same institutional authorization. He failed to file a rebuttal brief — not as a strategic decision, but as a unilateral failure made without Sherry-Ann's knowledge or consent. He responded to Sherry-Ann's transmittal of detailed transcript excerpts and Napue arguments with two sentences: "Received and reviewed. Thank you." He failed to raise the Napue false evidence theory Sherry-Ann specifically identified with case citations. Following the October 17, 2025 affirmance, he explicitly promised to file a rehearing petition — and did not. He affirmatively told Sherry-Ann there was nothing to petition the Supreme Court about — demonstrably false given this record. An attorney who affirmatively misleads his client about the viability of Supreme Court review, having already failed to file a promised rehearing petition, has actively deprived his client of the ability to seek timely relief.

B. Equitable Tolling

Under Holland v. Florida, equitable tolling requires extraordinary circumstances beyond the petitioner's control and diligent pursuit of rights. McElroy's explicit promise to file a rehearing petition — followed by complete failure and affirmative misrepresentation about Supreme Court review — satisfies both elements. Under Roe v. Flores-Ortega, 528 U.S. 470 (2000), counsel's failure to pursue an appeal

without consulting the client constitutes deficient performance per se. Under Penson v. Ohio, 488 U.S. 75 (1988), complete denial of appellate counsel is presumptively prejudicial. Under Florida v. Nixon, 543 U.S. 175 (2004), fundamental decisions cannot be made without client consent. This petition is filed within the extended Supreme Court deadline of May 7, 2026, Application No. 25A1079, which independently renders it timely for both Petitioners.

C. Prejudice

The prejudice from McElroy's failures is demonstrated by the gap between the record available and the arguments presented. Lancaster's unqualified opinions and her concealment of her error from the Clinic's own in-house counsel, Porterfield's institutional admissions, the computer credential installation argument, the Hartman financial collapse, and the Napue sequencing argument — all were in the trial record available to McElroy. The panel's three concessions confirm the case was close enough that fully developed independent representation creates a reasonable probability of a different outcome — satisfying the Strickland v. Washington, 466 U.S. 668 (1984), prejudice standard.

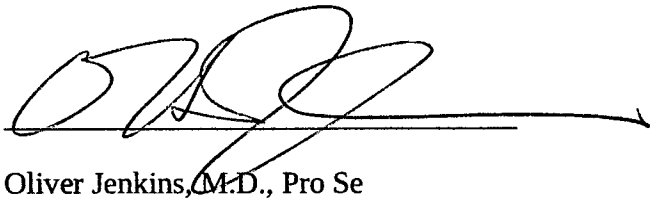
CONCLUSION

The record presents a compelling vehicle. The Sixth Circuit panel acknowledged the case was close on three grounds. The institution's unqualified compliance and risk management director — a high school graduate paid over $100,000 annually who obtained her first compliance certification four years after authorizing the Cognitive Center billing structure — installed the computer user profile making PET scan and laboratory test orders possible six months before operations began: institutional knowledge expressed in administrative action, irrefutable on its face. The institution's own COO admitted that he made mistakes, that he missed the flags, and that it is obvious the institution screwed this up — admissions documented in the government's own pre-trial investigation never presented to the jury. The government's financial fraud witness confirmed she does not know who submitted the claims or who received the payments. The lead investigator testified falsely about a fundamental billing requirement. Toledo Clinic extracted approximately $926,174.52 from the defendants it was testifying against under a

mandatory cooperation clause. Every institutional actor deferred to the same compliance authority whose incorrect opinion resulted in actions the government characterized as fraudulent — a high school graduate who admitted her department had no formal compliance plan, and who remains Director of Compliance, Quality, and Risk Management at the Toledo Clinic today.

The petition should be granted and the judgment of the Sixth Circuit reversed. In the alternative, because Oliver Jenkins has completed his sentence and Sherry-Ann Jenkins remains imprisoned, this Court should grant the additional relief of directing entry of judgments of acquittal and order Sherry-Ann's immediate release. Under Burks v. United States, 437 U.S. 1 (1978), reversal on insufficiency grounds bars retrial — and remand under these circumstances would serve only to extend Sherry-Ann Jenkins's incarceration while resolving nothing the trial record left open.

Respectfully submitted,



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