JUDGE ANDERSEN
MAGISTRATE JUDGE KEYS

DEC 11 2008

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA	)	
	)	No. 08CR1024
v.	)	
	)	Violations: Title 18, United States
STEPHEN ANTHONY PAM and	)	Code, Section 1347
SHAVON KEYONA WILLIAMS	)	UNDER SEAL

INDICTMENT

The SPECIAL JUNE 2007 GRAND JURY charges:

COUNTS ONE THROUGH THIRTY-FOUR

1. At times material to this indictment:

The Defendants

a. STEPHEN ANTHONY PAM resided in Sugarland, Texas and controlled and was the operator of Alliance Healthcare Services & Medical Equipment, Inc. (Alliance), located at 800 Roosevelt Road, Building C, Suite 330, Glen Ellyn, Illinois 60137. PAM also controlled and was the operator of Medlinc Concepts, Inc. (Medlinc), located at 2021 Midwest Road, Suite 305, Oak Brook, Illinois 60523.

b. Alliance was a registered Illinois corporation that held itself out as being a supplier of durable medical equipment, including motorized wheelchairs, scooters and reclining lift chairs.

c. Medlinc was a registered Illinois corporation that held itself out as being a supplier of durable medical equipment (DME), including motorized wheelchairs, scooters

and orthoses, which are also called "orthotic devices."

d. SHAVON KEYONA WILLIAMS resided in the Chicago area and was hired and employed by PAM as Alliance's office manager from on or about February 2005 to on or about February 2007. WILLIAMS' duties at Alliance included making sales of DME to Medicare beneficiaries or customers, ordering office supplies and DME, assembling DME, supervising the delivery of DME to customers, assisting with payroll and hiring of delivery personnel, compiling and distributing information from customers and doctors in order to bill Medicare for DME, and caused claims to be submitted to Medicare, Medicaid and private insurance companies. From on or about August 2007 to on or about December 2007, WILLIAMS was hired and employed by PAM as a salesperson for Medlinc where her duties included selling DME to Medicare beneficiaries or customers.

The Medicare Program

e. The Medicare Program (Medicare) was a federally funded health insurance program that provided health care benefits to certain individuals, primarily the elderly, blind and disabled. Medicare was administered by the Centers for Medicare and Medicaid Services (CMS), an agency of the United States Department of Health and Human Services (HHS), formerly known as the Health Care Financing Administration (HCFA). Individuals who received benefits under Medicare were often referred to as Medicare "beneficiaries."

f. Medicare was a "health care benefit program" as defined by Title 18,

United States Code, Section 24(b).

g. HHS and CMS contracted with private insurance organizations, known as "carriers" or "intermediaries," to process and pay claims submitted by health care providers for reimbursement by the Medicare Trust Fund, a reserve of monies provided by the federal government. 42 U.S.C. § 1395u.

h. The program known as "Medicare Part B" paid for certain physician and outpatient services provided to beneficiaries, and for health services and supplies including the provision of durable medical equipment (DME). Medicare Part B only paid for DME items that were prescribed by a physician for a Medicare beneficiary and that were medically necessary for the beneficiary. DME equipment is designed for repeated use and for a medical purpose and includes electric or motorized wheelchairs, also known as "power wheelchairs," power operated vehicles, also known as "scooters," reclining lift chairs and orthotic devices.

i. From on or about January 1, 2005, to on or about June 30, 2006, the Medicare reimbursement rate for a power wheelchair and related accessories was approximately $4,800; the reimbursement rate for a scooter was approximately $1,500 to $1,800; and the reimbursement rate for a reclining lift chair was approximately $250 to $270.

j. From on or about September 1, 2007, to on or about January 30, 2008, the Medicare reimbursement rate for a set of ten orthotic devices, along with a heat lamp, was approximately $3,140.

k. In order to bill Medicare for DME items, a DME supplier had to be an

approved Medicare supplier. The DME supplier obtained this approval by submitting an application to Medicare. If the supplier met certain qualifications, Medicare approved the application. The DME supplier was issued a number called a "supplier number." The DME supplier was then able to submit bills, known as "claims," for payment to Medicare for the cost of DME supplied to beneficiaries.

l. Medicare permitted approved DME suppliers to submit Medicare claims on paper or electronically. To submit claims electronically, a supplier had to have a Electronic Data Interchange Agreement (EDI) with Medicare. Medicare required that the claims contain the following information: the beneficiary's name and Medicare identification number; the name and unique provider identification number (UPIN) of the doctor who ordered the item or service; the item or service that was provided by the supplier; the date of service; and the charge for the item or service.

m. In Illinois, Medicare Part B was administered by Palmetto Government Benefits Administrators (Palmetto GBA), located in South Carolina, which had entered into a contract with HHS and CMS to serve as the "entity" or "carrier" that received, processed and paid Medicare claims for DME, including those relating to power wheelchairs, scooters and orthoses.

n. Medicare, through Palmetto, would generally pay a substantial amount of the costs for medical services and DME that were medically necessary and ordered by licensed doctors or other qualified healthcare providers. Suppliers receiving electronic

reimbursement from Medicare had to complete an Electronic Funds Transfer (EFT) Authorization Agreement. Information required on an EFT included: the provider's name and tax identification number, the financial institution's routing transmit number, the provider's name, address and account number with the financial institution, and the type of account that Medicare monies would be deposited into. The EFT also required the name, signature and title of the individual authorizing Medicare to make electronic payments to the provider's account. By signing the EFT, the individual agreed to allow a CMS contractor to make credit entries to the listed account. The authorizing individual, by signing the EFT, certified that he or she had sole control over the referenced account. An EFT agreement was effective as of the signature date listed on the agreement.

o. Under Medicare rules, Medicare Part B would pay for the cost of DME provided to the beneficiary. In order for Medicare to pay for a beneficiary's DME, the equipment had to be ordered and/or prescribed by a physician. In addition, Medicare imposed other regulations and standards which DME suppliers needed to follow in order to obtain and retain their billing privileges.

Power Wheelchairs, Orthoses and Certificates of Medical Necessity

p. Under Medicare rules, Medicare Part B would pay for the cost of a power wheelchair and accessories supplied to a beneficiary only when the beneficiary's condition was such that without the use of a power wheelchair, the beneficiary would otherwise be bed or chair confined; the beneficiary's condition was such that a power

wheelchair was medically necessary and the beneficiary was unable to operate a wheelchair manually; and the beneficiary was capable of safely operating the controls for a power wheelchair. To be eligible to receive a power wheelchair, Medicare rules also required that a beneficiary exhibit severe weakness of the upper extremities and be unable to walk over long periods of time.

q. In order for a DME supplier to be paid for providing a power wheelchair and accessories to a beneficiary, Medicare required the supplier to obtain documentation that the wheelchair was medically necessary. Until on or about May 1, 2005, a specific document, called the HCFA Form 843, was required to establish medical necessity. On the HCFA Form 843, also known as a Certificate of Medical Necessity (CMN), the Medicare beneficiary's treating doctor was required to set forth the medical necessity for the power wheelchair. Among other things, the doctor was required to certify that the beneficiary required the wheelchair to move around in their residence; the beneficiary had severe weakness of the upper extremities due to a neurologic, muscular or cardiopulmonary disease or condition; and, that the beneficiary was unable to operate any type of manual wheelchair. The doctor was also required to sign the CMN after attesting that he or she was the beneficiary's treating physician and that the medical necessity information was true, accurate and complete.

r. The CMN included a section that described the power wheelchair and accessories that were ordered by the beneficiary's treating physician and contained the DME

supplier's charge for these items. This section of the CMN formed the basis for the bill that the DME supplier sent to Medicare in order to be paid for the cost of providing the power wheelchair and accessories.

s. For claims filed before May 1, 2005, prior to submitting a claim to Medicare, the DME supplier was required to have a dispensing order on file (a detailed written order or prescription) and a completed and signed CMN. If the claim was submitted electronically, then all of the information from the CMN was required to be submitted electronically. Prior to submitting a claim to Medicare, the supplier had to obtain and include in the file a properly executed beneficiary authorization form and proof of delivery for the items. The supplier's date of service (DOS) is the date of delivery of equipment to the beneficiary's address.

t. Beginning on or about May 1, 2005, Medicare rules were modified with respect to DME orders for power wheelchairs and scooters. The new rules stated that any claim with a date of service on or after May 1, 2005, required a "face-to-face" examination between the Medicare beneficiary and his or her physician before the physician wrote a prescription or order for the equipment. The DME supplier had to obtain a report from this examination within thirty days after the examination was complete and maintain the report among its records. On the prescription or order for the power wheelchair or scooter, the physician had to include the following: beneficiary name, description of the item ordered, date of completion of the "face-to-face" examination, relevant diagnoses, length of need, and

the physician's signature. If those requirements were not met, Medicare would not cover the claim.

u. Medicare required all DME suppliers to maintain a copy of a CMN or physician order or prescription at their company's business for any and all claims submitted to Medicare for reimbursement.

v. Under Medicare rules, Medicare Part B would pay for the cost of an orthotic device if the device was eligible for a defined Medicare benefit category, the device was reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and the device met all other Medicare statutory and regulatory requirements. The device would only be covered by Medicare if it was a rigid or semi-rigid device which was used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. The device also had to provide support and counterforce on the limb or body part that it was being used to brace.

w. In order for a DME supplier to be paid for providing an orthotic device to a beneficiary, Medicare required the supplier to obtain documentation that the orthotic device was medically necessary. This documentation came in the form of an order or prescription from a doctor and had to be dated and signed by the doctor.

The Medicaid Program

x. The Medicaid program was a federally assisted grant program that

enabled the states to provide medical assistance and related services to needy individuals. CMS administered Medicaid on the federal level. Within broad federal rules, however, each state decided who was eligible for Medicaid, the services covered, payment levels for services and administrative procedures. The state directly paid providers of the services, with the state obtaining the federal share of the payment from accounts which drew on funds of the United States Treasury.

y. The State of Illinois, through the Illinois Department of Public Aid ("IDPA"), participated in the Medicaid program. IDPA received approximately fifty percent (50%) of its Medicaid funds from the federal government. The portion of the Medicaid program funded by the State of Illinois is also known as the "Illinois Medical Assistance Program."

z. In order to bill the Medicaid program for covered services, a medical provider had to first obtain a provider number with IDPA. Obtaining a provider number involved submitting a completed application signed by the individual provider, or, in the case of a company, by a corporate officer. In addition, the individual provider or corporate officer (or other authorized person acting on behalf of the company) had to sign an agreement of participation, also called a provider agreement, which listed the rules and regulations with which the provider had to comply.

aa. Once a provider obtained a provider number, the provider submitted billings (also called claims) to IDPA either on paper or electronically. At IDPA, the claims

were adjudicated, and vouchers were created. The vouchers were sent to the Illinois Comptroller's Office, and checks, called warrants, were written and sent to the provider, or alternatively, if the provider had requested direct deposit, IDPA electronically deposited the payments directly into the provider's account.

2. Beginning on or about August 3, 2004, and continuing through on or about March 14, 2008, at Glen Ellyn and Oak Brook, Illinois, in the Northern District of Illinois, Eastern Division, and elsewhere,

STEPHEN ANTHONY PAM and
SHAVON KEYONA WILLIAMS,

defendants herein, did knowingly and willfully execute a scheme to defraud health care benefit programs, including Medicare and Medicaid, and in the execution of said scheme to obtain by means of materially false and fraudulent pretenses and representations, money and property under the custody and control of health care benefit programs including Medicare and Medicaid, in connection with the delivery of and payment for health care benefits, items and services, namely power wheelchairs and orthotic devices.

3. It was part of the scheme that defendants falsely and fraudulently represented to Medicare and Medicaid that the conditions of Medicare and Medicaid beneficiaries were such that a power wheelchair or orthotic devices were medically necessary when in fact the defendants well knew that licensed medical doctors had not ordered or prescribed power wheelchairs or certain orthotic devices, and the beneficiaries did not qualify to receive a power wheelchair or orthotic devices under Medicare and Medicaid rules.

4. It was further part of the scheme that defendants falsely and fraudulently represented in Alliance and Medlinc's claims for reimbursement to Medicare and Medicaid that power wheelchairs and orthotic devices had been delivered to beneficiaries when in fact the defendants well knew that either (i) no equipment had been delivered to beneficiaries, (ii) beneficiaries instead received a scooter and/or reclining lift chair, or (iii) beneficiaries received orthotic devices that were either less in quantity or Medicare approved quality than what was billed.

5. It was further part of the scheme that on or about August 19, 2004, defendant PAM opened and caused to be opened a bank account in the name of Alliance at Harris Bank in Oak Brook Terrace, Illinois. Defendant PAM caused the signatory to be listed as Individual A, when in fact, as he well knew, PAM was the signatory and controlling party on the account.

6. It was further part of the scheme that on or about September 16, 2004, defendant PAM submitted and caused to be submitted a provider enrollment application for the purpose of obtaining a Medicare supplier number for Alliance. On the enrollment application, defendant PAM listed and caused to be listed the name of Individual A as the owner of Alliance even though Individual A was a nominee who exercised no control and realized no benefit from the operation and it was defendant PAM who controlled Alliance and received the proceeds generated from its operation. As part of the enrollment process, defendant PAM submitted and caused to be submitted an EDI with Medicare so that Alliance

could submit claims for reimbursement electronically. On or about October 27, 2004, Medicare assigned Alliance a Medicare supplier number, thereby authorizing it to submit claims for reimbursement for approved equipment and services.

7. It was further part of the scheme that on or about October 25, 2004, defendant PAM submitted and caused to be submitted a provider agreement for Alliance to be assigned a Medicaid supplier number; and on or about April 29, 2005, defendant WILLIAMS submitted additional materials to obtain this supplier number, including an updated provider agreement. On or about June 3, 2005, Medicaid assigned Alliance a Medicaid supplier number that authorized the submission of claims for reimbursement for approved equipment and services retroactively from on or about December 2, 2004.

8. It was further part of the scheme that defendant PAM hired defendant WILLIAMS as Alliance's office manager in approximately February 2005. Defendants PAM and WILLIAMS hired additional individuals as DME salespeople and delivery personnel.

9. It was further part of the scheme that defendant PAM wrote paychecks from the Alliance account at Harris Bank to defendant WILLIAMS and other employees and signed the checks with the name, Individual A.

10. It was further part of the scheme that defendants PAM and WILLIAMS obtained both directly and through salespeople hired and acting at the direction of defendant PAM, Medicare and Medicaid beneficiary information, including identification numbers of

Medicare and Medicaid beneficiaries and UPINs of doctors, which defendants used to prepare and cause to be prepared false and fraudulent Medicare and Medicaid claims.

11. It was further part of the scheme that to support the false and fraudulent Medicare and Medicaid claims, defendants PAM and WILLIAMS knowingly forged CMNs and prescriptions and caused the use of forged CMNs and prescriptions. Specifically, in furtherance of this scheme, defendant WILLIAMS instructed Individual B, an employee at Alliance, to copy doctors' signatures from existing CMNs to another CMN for a different beneficiary and/or claim on a photocopy machine at Alliance's office to falsely create the appearance that equipment and services for new claims were certified as medically necessary by a licensed doctor.

12. It was further part of the scheme that defendants PAM and WILLIAMS ordered and caused to be ordered DME from at least one wholesale supplier, Company A, located in Houston, Texas, that was materially different from the items billed to the health care benefit programs. Defendant PAM opened Alliance's account with Company A in person on approximately October 29, 2004. From approximately May 2005 to August 2006, defendants PAM and WILLIAMS ordered and caused to be ordered from Company A approximately 352 scooters, approximately 409 reclining lift chairs, and approximately 11 power wheelchairs. Defendant PAM, sometimes using accounts in the name of Alliance and Netsource Capital Investments, a company owned, registered to and controlled by defendant PAM, paid Company A approximately $405,445 for this equipment.

13. It was further part of the scheme that defendants PAM and WILLIAMS leased and used storage units at Public Storage, 1110 E. Roosevelt Road, Lombard, Illinois 60148 to store DME received from Company A.

14. It was further part of the scheme that from approximately February 2005 to approximately May 2006, defendants PAM and WILLIAMS electronically billed and caused Medicare and Medicaid to be electronically billed for DME provided to beneficiaries that was not medically necessary. Defendants PAM and WILLIAMS, knowing that a power wheelchair was reimbursed at a higher rate than a scooter or reclining lift chair, electronically billed and caused Medicare and Medicaid to be electronically billed for power wheelchairs when in fact as they well knew beneficiaries were often provided with a scooter and/or reclining lift chair.

15. It was further part of the scheme that from approximately February 2005 to approximately May 2006, defendants PAM and WILLIAMS submitted and caused to be submitted electronically under Alliance's Medicare supplier number approximately 539 claims for reimbursement to Medicare totaling approximately $3,849,628. During this same time period, defendants PAM and WILLIAMS submitted and caused to be submitted electronically under Alliance's Medicaid supplier number, both directly and through contract billers approximately 299 claims for reimbursement to Medicaid totaling approximately $867,010. Approximately 99 percent of the Alliance claims submitted to Medicare and Medicaid were for power wheelchairs and related accessories, although defendants well

knew that no such equipment or items had been supplied. Based on the submitted claims, defendant PAM, through Alliance, received reimbursements from Medicare totaling approximately $1,684,663, and Medicaid totaling approximately $175,799, which reimbursements were paid by checks later deposited into Alliance's account at Harris Bank.

16. It was further part of the scheme that from approximately April 6, 2005 to August 2, 2006, approximately $1,196,723 was transferred from Alliance's bank account to an account in the name of Netsource Capital Investments, a company owned and controlled by defendant PAM. It was further part of the scheme that from on or about December 31, 2004 through on or about July 31, 2007, approximately $176,460 was transferred from Alliance's bank account to defendant WILLIAMS.

17. It was further part of the scheme that after receiving a letter from Medicare dated on or about April 6, 2006, requesting proof of delivery for equipment provided to approximately 25 Medicare beneficiaries for whom defendants had submitted fraudulent claims and received reimbursement from Medicare, defendants PAM and WILLIAMS prepared and sent and caused to be prepared and sent to Medicare false and fraudulent documents indicating that the beneficiaries had been provided with power wheelchairs, when defendants well knew that the beneficiaries had only received a scooter and/or a reclining lift chair.

18. It was further part of the scheme that on or about November 29, 2006, defendant PAM opened and caused to be opened a bank account in the name of Medlinc at

MB Financial Bank at Oak Brook, Illinois. Defendant PAM caused the signatory on the account to be listed as Individual C. From this account, defendant PAM wrote payroll checks to Individual D and also wrote checks for Medlinc's business expenses.

19. It was further part of the scheme that in approximately mid-February 2007, defendant PAM submitted or caused to be submitted a provider enrollment application for Medlinc to be assigned a Medicare supplier number. On the enrollment application, defendant PAM listed and caused to be listed Individual C as the owner of Medlinc even though Individual C was a mere nominee who exercised no control and realized no benefit from the operation, and it was defendant PAM who controlled Medlinc and received the proceeds generated from its operation. As part of the enrollment process, defendant PAM submitted and caused to be submitted an EFT and EDI to Medicare, allowing Medlinc to submit claims to Medicare for reimbursement electronically and allowing Medicare to credit those reimbursements to Medlinc's bank account electronically. On or about July 17, 2007, Medlinc was assigned a Medicare supplier number, thereby authorizing Medlinc to submit claims for reimbursement for approved equipment and services.

20. It was further part of the scheme that from on or about September 5, 2007 to on or about November 2, 2007, defendant WILLIAMS, in her capacity as a salesperson for Medlinc, submitted and caused to be submitted information regarding approximately 12 Medicare beneficiaries to defendant PAM and Individual D, an employee of Medlinc. The information submitted by defendant WILLIAMS purported to show that defendant

WILLIAMS had met with these beneficiaries, and that each beneficiary provided a unique Medicare identification number and had requested a series of orthotic devices. In fact, as defendant WILLIAMS well knew, none had requested or even discussed orthotic devices with defendant WILLIAMS. Eight of the 12 beneficiaries were individuals whose identities and Medicare information were previously obtained by defendants and used to generate fraudulent claims by Alliance seeking reimbursement from Medicare for motorized wheelchairs as set forth above. However, on or about September 8, 2007, defendants WILLIAMS and PAM caused Medicare claims to be submitted electronically for these 12 beneficiaries, falsely and fraudulently representing that each beneficiary had received the same set of 10 orthotic devices and a heat lamp, when, in fact, none of these beneficiaries received any orthotic device from defendants PAM or WILLIAMS or from Medlinc, and one of the beneficiaries had died approximately one year before the service date claimed on the Medicare claims form. The amount submitted for each beneficiary was approximately $4,850, totaling approximately $58,200.

21. It was further part of the scheme that from on or about September 8, 2007, through on or about November 14, 2007, on behalf of Medlinc, defendant PAM billed and caused Medicare to be billed electronically for DME provided to beneficiaries he well knew was not medically necessary and that was not in fact delivered. Specifically, defendant PAM billed and caused Medicare to be billed electronically for a series of 10 orthotic devices and a heat lamp for approximately 59 beneficiaries, when in fact, beneficiaries were often

provided with no orthotic devices, less than 10 orthotic devices and/or devices that did not meet the requirements of orthotic devices which would be reimbursed by Medicare.

22. It was further part of the scheme that from on or about September 8, 2007 through on or about November 14, 2007, defendant PAM, operating under the name Medlinc, submitted and caused to be submitted electronically a total of approximately 128 claims to Medicare for approximately $291,610, and Medicare reimbursed Medlinc for approximately $24,158 through electronic wire transmissions of funds to Medlinc's bank account at MB Financial.

23. On or about the dates set forth below, at Glen Ellyn and Oak Brook, Illinois, in the Northern District of Illinois, Eastern Division, and elsewhere,

STEPHEN ANTHONY PAM and
SHAVON KEYONA WILLIAMS,

defendants herein, did knowingly and willfully execute and attempt to execute the above-described scheme by causing to be submitted materially false and fraudulent claims to Medicare and Medicaid for services in connection with the authorization and approval of beneficiaries to receive a power wheelchair and orthotics in the amounts indicated below:

Count	Medicare Receipt Date	Medicare Paid Date	Claimed Date of Service/ Delivery	Amount Paid	Patient
1	4/7/2005	4/13/2005	4/4/2005	$4,795.91	AV
2	6/17/2005	6/30/2005	6/3/2005	$4,854.50	MG
3	9/13/2005	9/17/2005	9/2/2005	$4,795.91	GB

4	9/13/2005	9/17/2005	9/2/2005	$4,791.77	EB
5	9/13/2005	9/17/2005	8/29/2005	$4,795.91	VC
6	9/13/2005	9/21/2005	9/2/2005	$4,795.91	JH
7	9/13/2005	9/21/2005	8/30/2005	$4,795.91	DR
8	9/13/2005	9/21/2005	8/29/2005	$4,795.91	ST
9	9/13/2005	9/21/2005	8/30/2005	$4,795.91	Mam. W
10	9/13/2005	9/21/2005	8/29/2005	$4,795.91	Mar. W
11	9/13/2005	9/17/2005	9/6/2005	$4,795.91	MB
12	9/13/2005	9/22/2005	9/7/2005	$4755.13	LJ
13	11/11/2005	11/20/2005	10/24/2005	$4,795.91	LQJ
14	12/7/2005	12/15/2005	11/4/2005	$4,795.91	JF
15	12/7/2005	12/14/2005	10/29/2005	$4,795.91	SJ
16	12/7/2005	12/16/2005	11/17/2005	$4,795.91	MEM
17	12/7/2005	12/14/2005	10/28/2005	$4,795.91	MSM
18	1/13/2006	1/25/2006	12/27/2005	$4,795.91	PP
19	1/13/2006	1/26/2006	12/26/2005	$4,795.91	MR
20	1/23/2006	1/28/2006	1/17/2006	$4,488.08	IO
21	9/7/2007	12/29/2007 and 1/9/2008	9/5/2007	$3,139.99	HB
22	9/7/2007	9/21/2007	9/5/2007	$2,141.82	GM
23	9/7/2007	9/14/2007	9/5/2007	$3,139.99	JAB
24	9/7/2007	10/24/2007	9/5/2007	$3,139.99	MG
25	9/7/2007	N/A	9/5/2007	N/A	BB
26	9/7/2007	N/A	9/5/2007	N/A	WB

27	9/7/2007	N/A	9/5/2007	N/A	LJ
28	9/7/2007	N/A	9/5/2007	N/A	GC
29	9/7/2007	N/A	9/5/2007	N/A	JOB
30	9/7/2007	N/A	9/5/2007	N/A	BH
31	9/7/2007	N/A	9/5/2007	N/A	MB
32	10/12/2007	10/20/2007	9/27/2008	$3,139.99	CJ
33	10/12/2007	10/20/2007	9/28/2008	$2,699.99	CM
34	11/7/2007	1/18/2008 and 1/19/2008	10/26/2007	$2,800.26	LH

All in violation of Title 18, United States Code, Section 1347.

FORFEITURE ALLEGATION

The SPECIAL JUNE 2007 GRAND JURY further charges:

1. The allegations in Counts One through Thirty-Four of this indictment are hereby realleged and incorporated herein by reference for the purpose of alleging forfeiture pursuant to Title 18, United States Code, Section 982(a)(7).

2. As a result of his violations of Title 18, United States Code, Section 1347 as alleged in Counts One through Thirty-Four,

STEPHEN ANTHONY PAM,

defendant herein, shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any and all right, title, and interest he may have in any property constituting, and derived from, proceeds he obtained directly and indirectly as the result of such violations.

3. The interests and property of defendant PAM subject to forfeiture pursuant to Title 18, United States Code, Section 982(a)(7), include all money and other property that was the subject of; constituted and was derived from the proceeds of; and was obtained, directly or indirectly as a result of those violations, including but not limited to approximately $1,840,979.

4. If any of the forfeitable property described above, as a result of any act or omission by defendant PAM:

(a) cannot be located upon the exercise of due diligence;

(b) has been transferred or sold to, or deposited with, a third party;

(c) has been placed beyond the jurisdiction of the court;

(d) has been substantially diminished in value; or

(e) has been commingled with other property which cannot be divided without difficulty,

the United States of America shall be entitled to forfeiture of substitute property under the provisions of Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1), such property to include real property commonly known as 14314 Jaubert Court, Sugar Land, Texas and legally described as follows:

LOT SEVENTY-SEVEN (77), IN BLOCK FOUR (4), OF CHELSEA HARBOUR, SECTION ONE (1), A SUBDIVISION IN FORT BEND COUNTY, TEXAS ACCORDING TO THE MAP OR PLAT THEREOF RECORDED IN SLIDE NO 2218/B, 2219/A, AND 2219/B OF THE PLAT RECORDS OF FORT BEND COUNTY, TEXAS; Tax Identification Number: 2221-01-004-0770-907.

All pursuant to Title 18, United States Code, Section 982(a)(7).

A TRUE BILL:

_____

FOREPERSON

_____

UNITED STATES ATTORNEY