UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

FELONY

INDICTMENT FOR HEALTH CARE FRAUD AND AGGRAVATED IDENTITY THEFT

UNITED STATES OF AMERICA	*	**CRIMINAL NO.**
VERSUS	*	**SECTION:**
DAVID LEE KILLEN	*	**VIOLATIONS: 18 U.S.C. § 1347**
		18 U.S.C. § 1028A
	*	**18 U.S.C. § 2**

* * *

The Grand Jury charges that:

COUNTS 1 THROUGH 30

HEALTH CARE FRAUD

A. AT ALL TIMES MATERIAL HEREIN:

Medicare

1. The Medicare Program (Medicare) was a federal program that provided free or below-cost 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). Individuals who received benefits under Medicare were often referred to as "beneficiaries."

2. Medicare Part B helped pay for certain physician services, outpatient and other services, including manual chiropractic adjustments and durable medical equipment (DME) that was medically necessary and was ordered by licensed medical doctors or other qualified health care providers. Manual adjustments were the only services that Medicare would reimburse to a chiropractor. Medicare would also pay for all physical therapy services as long as they were performed by a licensed physical therapist or a physician.

3. CIGNA Government Services (CIGNA GS) received, adjudicated, and paid Medicare Part B claims for both a) medical and chiropractic services rendered by authorized providers; and b) DME and related health care benefits, items and services provided to Medicare beneficiaries (patients) pursuant to a contract with CMS.

Medicare and Services Provided

4. In order to participate in the Medicare program, physicians, chiropractors, and other suppliers of medical services were required to enter into a provider agreement with Medicare. Medicare issued a Provider Identification Number (PIN) to the applying provider, which enabled the provider to bill Medicare for services to qualified beneficiaries. The provider agreement required that any claims the provider submitted to Medicare were subject to the agreement and Medicare criteria, rules, regulations, and internal procedures.

Medicare and Equipment Supplied (DME)

5. Physicians, DME companies, and other health care providers that sought to participate in Medicare Part B and bill Medicare for the cost of DME and related benefits, items, and services were required to apply for and receive a "supplier number." CMS contracted with

Palmetto GBA (Palmetto) and the National Supplier Clearinghouse (NSC) to manage the processing of Medicare enrollment forms for all DME suppliers.

Claims Submission to Medicare

6. Both providers and suppliers submitted claims to Medicare Part B using a CMS Form 1500, the recognized standard claim form in the health insurance industry. The completed form contained the date of service, the place of service, a code that described the service rendered or the equipment, the name of the facility where the service was rendered, the physician and the supplier of the service.

7. Suppliers of DME submitted their CMS Form 1500 claims using the Healthcare Common Procedure Coding Systems (HCPCS) code. HCPCS L0631 was a back brace described as a "Lumbar-Sacral Orthosis" and was required to extend from the "Sacrococcygeal Junction to T-9 Vertebra." HCPCS L0627 was a back brace described as a "Lumbar Orthosis" and was required to extend from "L-1 to below L-5 Vertebra." Medicare reimbursements were higher for L0631 than for L0627 because the L0631 was required to cover a larger area of the back vertebra.

Medicare Reimbursements

8. Medicare, through CIGNA GS, generally paid a substantial portion of the cost of the DME or related health care benefit, item, or service if it was medically necessary and ordered by a licensed, qualified health care provider.

9. Payments under Medicare Part B were often made directly to the Medicare provider and supplier. For this to occur, the beneficiary would assign the right of payment to the provider and supplier. Once such an assignment took place, the provider and supplier assumed the responsibility for submitting claims to, and receiving payments from, Medicare.

10. Approved claims submitted to Medicare Part B were paid at 80% of the approved amount for each claim. Unless a Medicare beneficiary held supplemental or secondary insurance, Medicare required that the beneficiary be responsible for paying the remaining 20% of the claim, known as the co-pay. Waiver of this co-pay was not permitted under Medicare billing procedures.

Louisiana Medicaid

11. The Louisiana Medicaid Program (Medicaid) was a jointly funded cooperative venture between the federal and state governments, administered by the states that provided health care benefits for certain groups, primarily the poor and disabled.

Private Insurers

12. Blue Cross Blue Shield of Louisiana (BCBSLA), United Health Care (United), Cigna (Cigna), Humana (Humana) and Gilsbar (Gilsbar) are private insurance companies that have policies to reimburse authorized health care providers for chiropractic services and DME provided to eligible beneficiaries.

13. Medicare, Medicaid, BCBSLA, United, Cigna, Humana, and Gilsbar were each a "health care benefit program" as defined by Title 18, United States Code, Section 24(b).

14. Defendant **DAVID LEE KILLEN (KILLEN)** was a licensed chiropractor in Louisiana from on or about October 31, 2006, until on or about December 31, 2012.

15. As a licensed chiropractor, **KILLEN** was a Medicare and Medicaid provider authorized to submit bills for reimbursement for certain medical services to eligible Medicare and Medicaid beneficiaries. As a licensed chiropractor, he was also an authorized provider for private insurers: BCBSLA, Cigna, United, Humana, and Gilsbar. As such, **KILLEN** was authorized to

submit bills for reimbursement for certain medical services provided to eligible BCBSLA, Cigna, United, Humana, and Gilsbar beneficiaries.

16. **KILLEN** owned and operated Back On Track Clinic, LLC (BOTC), located at 528 Avenue F in Bogalusa, Louisiana. When he relocated his practice to 521 Ontario Avenue in Bogalusa on or about December 22, 2012, **KILLEN** operated BOTC under the name, "The Spine and Joint Center of Washington Parish" (S&JC).

17. Dr. A was a medical doctor employed by **KILLEN** for the time period January 24, 2012, until May 4, 2012. Dr. A worked for **KILLEN** on Mondays and Thursdays at S&JC. Dr. A was also a Medicare and BCBSLA provider authorized to submit bills for reimbursement for certain medical services provided to eligible Medicare and BCBSLA beneficiaries.

18. Dr. B was a medical doctor employed by **KILLEN** from on or about September 2010, until October 24, 2011. Dr. B worked for **KILLEN** approximately four hours per week. Dr. B was also a Medicare and BCBSLA provider authorized to submit bills for reimbursement for certain medical services provided to eligible Medicare and BCBSLA beneficiaries.

19. Dr. C became a licensed chiropractor in or about January, 2012, and received his Louisiana chiropractic license in or about February, 2012. Dr. C was employed on a full-time basis by **KILLEN** from in or about January, 2012, continuing until at least April 26, 2013. Dr. C was also a Medicare and BCBSLA provider authorized to submit bills for reimbursement for certain chiropractic services provided to eligible Medicare and BCBSLA beneficiaries.

20. Employee D was a licensed physical therapist (LPT) employed by **KILLEN** on a full-time basis from in or about May 2011, until at least April 26, 2013. Employee D was a

Medicare and BCBSLA provider authorized to submit bills for reimbursement for certain physical therapy services provided to eligible Medicare and BCBSLA beneficiaries.

21. Cell Science Systems Corporation (Cell Science), located in Deerfield Beach, Florida, was a laboratory that conducted antigen leukocyte antibody testing, otherwise known as ALCAT (ALCAT). Cell Science promoted this test as a way to identify cellular reactions to food, chemicals, and herbs. Providers drew blood from patients and mailed the specimens to Cell Science. The results were returned to the providers.

B. HEALTH CARE FRAUD:

Beginning on or about May 4, 2009, and continuing until on or about April 26, 2013, in the Eastern District of Louisiana and elsewhere, **DAVID LEE KILLEN** knowingly and willfully devised and intended to devise a scheme to defraud Medicare, Medicaid, BCBSLA, United, Humana, Cigna, and Gilsbar, and to obtain money and property by means of materially false and fraudulent pretenses, representations and promises.

1. It was part of the scheme and artifice to defraud that **KILLEN** falsely and fraudulently caused to be submitted claims to Medicare, Medicaid, and private insurance plans that he knew were for services and DME he had not ever rendered.

2. It was further part of the scheme and artifice to defraud that **KILLEN** falsely and fraudulently urged and bartered with his patients to accept medically unnecessary services and equipment in order to maximize his financial gain.

Chiropractic Manipulation Not Performed

3. It was further part of the scheme and artifice to defraud that **KILLEN** billed or caused to be billed to Medicare and BCBSLA chiropractic manipulation that he did not perform.

KILLEN used "travel cards" that documented in hard copy form the types of services patients received at his S&JC clinic. Patients signed in upon arrival at a kiosk at the front reception area, signaling technicians that the patient was present and ready for treatment. Technicians pulled arriving patients' travel cards and brought the patient to the treatment area. The technicians checked off on the travel card the procedures that were rendered for each patient appearing at the clinic. Once the patient treatment was completed, the office manager entered procedures checked off on the patient's travel card electronically into the office's computerized patient record. Upon finalization of the electronic entries, **KILLEN** had the final review for each electronic record prior to submitting it to his billing contractor for actual billing to the insurer of record.

4. It was further part of the scheme and artifice to defraud that **KILLEN** falsely and fraudulently added into the patient's computerized medical record services that were not actually provided to the patient, and that were not documented on the patient's travel card. **KILLEN** falsely and fraudulently added non-existent chiropractic manipulation services into the patient's electronic medical record that he well knew had not been rendered to the patient. After he added the fraudulent non-existent services into the patient's electronic medical records, **KILLEN** alone had the final review of all clinical procedures that were submitted to his billing contractor, well knowing that he was causing his billing contractor to bill insurers for services that were not provided to the patient.

5. It was further part of the scheme and artifice to defraud that **KILLEN** obtained insurance policy information for a friend of his, ScFo, and billed BCBSLA for chiropractic manipulation and other services purportedly rendered to ScFo when ScFo never went to BOTC or the S&JC, and never received any other services personally from **KILLEN.**

ALCATs Not Performed

6. It was further part of the scheme and artifice to defraud that **KILLEN** billed and caused ALCATs to be billed to BCBSLA and United, when he well knew that they had not been performed. **KILLEN** falsely and fraudulently caused BCBSLA and United to be billed for ALCATs for patients he knew had not had the necessary blood drawn to complete the test.

7. It was further part of the scheme and artifice to defraud that **KILLEN** fraudulently added and caused to be added ALCATs into the patient's electronic medical record that he well knew had not been rendered to the patient, causing insurers to be billed for medical tests that had not been performed.

ALCATS Not Medically Necessary

8. It was further part of the scheme and artifice to defraud that **KILLEN** also fraudulently billed and caused ALCATs to be billed to BCBSLA, Humana, and United that were not medically necessary. Cell Science charged **KILLEN** approximately $600 for each of the tests he submitted. Providers like **KILLEN** billing BCBSLA for ALCATs were reimbursed as much as $4,480 for each test provided the test was medically necessary.

9. It was further part of the scheme and artifice to defraud that **KILLEN** urged patients to have the ALCAT if their insurer reimbursed for it, and that he bartered with patients who agreed to have their blood drawn for the test, with no regard for medical necessity. **KILLEN** told patients he would halve their co-payment requirements or that he would wipe out their clinic balances if they would agree to have the test. **KILLEN** falsely and fraudulently marketed the test to patients telling them the results would help guide him in treating them both mentally and

physically. **KILLEN** also told Dr. C that he would give him a percentage of the insurance pay-out to the clinic for each patient he referred for the test.

10. It was further part of the scheme and artifice to defraud that **KILLEN** billed BCBSLA, Humana, and United almost exclusively for the most expensive test that Cell Science offered, the "Platinum Comprehensive" option, rather than cheaper options available to him. Depending on the test ordered, patients had between two and four vials of blood drawn. BCBSLA paid the provider $4,480 for each 320-panel test ordered and performed, which was approximately $14 per panel. Each panel was a different allergen that was tested, such as foods, additives, or antibiotics. Cell Science offered cheaper versions of the test, such as a "Pediatric Wellness" option that only required 71 panels for testing and would have reduced the amount of blood drawn from toddlers and children who had the test. The "Pediatric Wellness" option, if it had ever been used, would have been reimbursed by insurers at a much lower level, but **KILLEN** did not use this option for the four pediatric patients, ages 2 through 12 that he billed to BCBSLA, choosing instead the most expensive option that Cell Science offered and fraudulently maximizing his reimbursement from insurers.

Services Fraudulently Billed Using the Medical Doctor's Provider Number

11. It was further part of the scheme and artifice to defraud that **KILLEN** fraudulently billed and caused insurers to be billed using the medical doctor's provider number for services that were not provided, and for services that would not otherwise be reimbursed had the insurer known who actually provided the services. **KILLEN** falsely and fraudulently billed and caused BCBSLA to be billed for trigger point injections that were not performed. **KILLEN** falsely and fraudulently submitted and caused to be submitted fraudulent claims to BCBSLA for trigger point

injections purportedly performed by Dr. B when he well knew that they had not been provided at all.

12. It was further part of the scheme and artifice to defraud that **KILLEN** falsely billed and caused BCBSLA to be billed for trigger point injections that he performed himself, but billed under Dr. B's provider number, well knowing that trigger point injections performed by a chiropractor were not reimbursable by BCBSLA.

13. It was further part of the scheme and artifice to defraud that **KILLEN** submitted and caused to be submitted claims for office visits using the physician's provider number, well knowing that chiropractors were not reimbursed for office visits and also knowing that the physicians had not been in his office to conduct the office visit.

14. It was further part of the scheme and artifice to defraud that **KILLEN** falsely and fraudulently used the provider numbers of Drs. A and B, who were both medical doctors, to support billings for chiropractic and physical therapy services that the doctors did not provide, when **KILLEN** well knew that, had he submitted the billings under the chiropractor's or physical therapist's provider numbers, he would not have been reimbursed for the services. **KILLEN** falsely and fraudulently used or caused to be used the provider numbers of Drs. A and B who were in his employ to inflate his reimbursements from Medicare, Medicaid, and BCBSLA, well knowing that the physicians had not been in his office the day the services were purportedly rendered, and that the services were actually rendered by a provider who would not receive reimbursement from Medicare, Medicaid, or BCBSLA.

X-Rays Not Performed

15. It was further part of the scheme and artifice to defraud that **KILLEN** falsely and fraudulently billed and caused Medicare, BCBSLA, Gilsbar, Humana, and United to be billed for patient X-rays that he well knew had not been performed or provided.

Back Braces Not Provided

16. It was further part of the scheme and artifice to defraud that **KILLEN** falsely and fraudulently billed and caused BCBSLA and United to be billed for back braces that he well knew had never been provided to the patient. **KILLEN** billed and caused to be billed a back brace described as HCPCS L0631 to BCBSLA on behalf of patients usually in the amount of $999, well knowing that braces had not been provided to the patients.

Back Brace Substitutions

17. It was further part of the scheme and artifice to defraud that **KILLEN** falsely and fraudulently billed and caused Medicare, Medicaid, BCBSLA, United, Humana, and Gilsbar to be billed for L0631 back braces when he well knew he did not provide a back brace that met the description of an L0631. When **KILLEN** actually provided a back brace to his patients, he provided a cheaper substitution and one for which he would have been reimbursed at a lower rate had he accurately described what he was providing to the patient.

18. It was further part of the scheme and artifice to defraud that **KILLEN** provided patients with a back brace that met the qualifications of a HCPCS L0627, and one that was clearly marked from the manufacturer with a description "L0627." Instead, **KILLEN** falsely and fraudulently billed and caused Medicare, Medicaid, BCBSLA, United, Humana, and Gilsbar to be billed for an L0631, one he well knew would be reimbursed at a much higher rate than the L0627.

C. EXECUTIONS OF THE SCHEME TO DEFRAUD:

COUNTS 1 THROUGH 6

Chiropractic Manipulation Not Performed

1. Beneficiary EmBl had Medicare as his/her primary insurance and BCBSLA as a secondary insurance. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused Medicare and BCBSLA to be billed for manual adjustments for beneficiary EmBl that he did not perform as listed below.

COUNT	DATE	PATIENT	INSURER	BILLED AMOUNT
1	02/16/2012	EmBl	Medicare/BCBSLA	$75
2	07/18/2012	EmBl	Medicare/BCBSLA	$75
3	11/13/2012	EmBl	Medicare/BCBSLA	$75

2. Beneficiary ScFo had BCBSLA as his/her primary insurance. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused BCBSLA to be billed for services, including chiropractic manipulation, for beneficiary ScFo that he did not perform as listed below.

COUNT	DATE	PATIENT	INSURER	BILLED AMOUNT
4	06/01/2009	ScFo	BCBSLA	$75
5	08/24/2009	ScFo	BCBSLA	$75
6	11/18/2009	ScFo	BCBSLA	$75

3. **KILLEN** falsely and fraudulently billed and caused Medicare to be billed for approximately $10,425 and BCBSLA to be billed for $10,817 for approximately 137 manual adjustments for beneficiary EmBl that he did not perform.

4. **KILLEN** falsely and fraudulently billed and caused to be billed BCBSLA for approximately $3,100 for approximately 40 services, including chiropractic manipulation, for beneficiary ScFo that he did not perform.

COUNTS 7 THROUGH 9

ALCATs Not Performed

5. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused BCBSLA and United to be billed on or about the dates listed for the below-listed ALCATs that he knew had not been performed for the beneficiaries:

COUNT	DATE	PATIENT	INSURER	AMOUNT BILLED
7	06/14/2012	StMa	BCBSLA	$4,480.00
8	07/21/2011	FrRi	BCBSLA	$4,480.00
9	06/28/2012	JaPa	United	$4,480.00

6. **KILLEN** falsely and fraudulently billed and caused BCBSLA to be billed approximately $8,960 and United $4,480 for ALCATs he knew had not been performed.

COUNTS 10 THROUGH 14

ALCATs Not Medically Necessary

7. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused ALCATs to be billed to BCBSLA, Humana and United that were not medically necessary, being urged to the beneficiaries as a way to halve their future co-payments or fraudulently misrepresented to beneficiaries as a way for **KILLEN** to better treat them mentally and physically, including the below-listed billings:

COUNT	DATE	PATIENT	INSURER	AMOUNT BILLED
10	02/07/2012	HuMa	BCBSLA	$4,480.00
11	02/07/2012	JeMa	BCBSLA	$4,480.00
12	02/09/2012	RoPi	BCBSLA	$4,480.00
13	05/16/2011	KaGa	BCBSLA	$4,480.00
14	03/16/2012	RuGa	BCBSLA	$4,480.00

8. **KILLEN** fraudulently billed and caused BCBSLA, Humana, and United to be billed for medically unnecessary allergy testing codes in the amount of $403,844, including the below-listed billings. Of the approximately $403,844 in medically unnecessary ALCAT billings, **KILLEN** billed and caused BCBSLA to be billed for approximately $366,586, United was billed for approximately $35,550, and Humana was billed for approximately $1,708.

COUNTS 15 THROUGH 19

Services Fraudulently Billed Using the Medical Doctor's Provider Number

9. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused Medicare, Medicaid, and BCBSLA to be billed for the below-listed services as though they were rendered by a physician, well knowing that the physician did not render the service and was not in the office to perform the service:

COUNT	DATE	PATIENT	SERVICE	INSURER	AMOUNT BILLED
15	10/29/2010	KiBe	Trigger Point Injection	BCBSLA	$150.72
16	12/20/2010	KiBe	Trigger Point Injection	BCBSLA	$150.72
17	11/4/2011	BaGu	Therapeutic Procedure	Medicare	$165.00
18	3/14/2012	ArSt	Office Visit	Medicaid	$150.00
19	3/28/2011	SuKi	Office Visit	BCBSLA	$150.00

10. **KILLEN** fraudulently billed and caused to be billed services using Dr. A's provider number in the amount of approximately $19,176: approximately $18,241 to BCBSLA and approximately $935 to Medicare. **KILLEN** fraudulently billed and caused to be billed services using Dr. B's provider number in the amount of approximately $42,155: approximately $11,230 to BCBSLA and approximately $30,925 to Medicare.

COUNTS 20 THROUGH 24

X-Rays Not Performed

11. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused BCBSLA, United, Gilsbar, and Humana to be billed for X-rays that he well knew had not been performed for the below-listed beneficiaries:

COUNT	DATE	PATIENT	INSURER	AMOUNT BILLED
20	05/06/2009	JoMo	United	$455
21	10/08/2009	JoMo	BCBSLA	$565
22	10/12/2009	JoMo	BCBSLA	$820
23	06/09/2010	DiEa	Humana	$745
24	05/04/2009	ChWa	United	$945

12. **KILLEN** fraudulently billed and caused to be billed X-ray services for $13,080 that had not been performed to the following insurers: approximately $9,450 to BCBSLA, approximately $1,400 to United, approximately $1,080 to Gilsbar, and approximately $1,150 to Humana.

COUNTS 25 THROUGH 27

Back Braces Not Provided

13. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused BCBSLA and United to be billed for the below-listed expensive back braces that he well knew he had never provided the beneficiaries:

COUNT	DATE	PATIENT	INSURER	AMOUNT BILLED
25	07/20/2010	TePi	BCBSLA	$999.00
26	06/10/2011	TePi	BCBSLA	$999.00
27	05/13/2010	JoMo	United	$999.00

14. **KILLEN** fraudulently billed and caused to be billed BCBSLA for a total of $1,998, and Humana for approximately $999, totaling approximately $2,997 for back braces he had not provided to the beneficiaries.

COUNTS 28 THROUGH 30

Back Brace Substitutions

15. On or about the dates listed below, **KILLEN** falsely and fraudulently billed and caused to be billed Medicare, Medicaid, BCBSLA, United, Humana, and Gilsbar for expensive back braces as detailed below when he well knew that he was providing cheaper versions of the back braces to the beneficiaries. **KILLEN** well knew that the back braces he was actually giving the beneficiaries would not have been reimbursed had the insurer known the back brace did not meet the description provided to the insurer under the code billed.

COUNT	DATE	PATIENT	INSURER	AMOUNT BILLED
28	04/07/2011	HuMa	BCBSLA	$999.00
29	02/01/2010	RuGa	BCBSLA	$999.00
30	07/14/2010	DiEa	BCBSLA	$749.00

16. **KILLEN** billed and caused to be billed approximately $71,933 in back braces coded as L0631 when he well knew he had provided a back brace coded as L0627. **KILLEN** billed and caused to be billed Medicare for approximately $1,998, Medicaid for approximately $5,994, BCBSLA for approximately $49,428, United for approximately $8,991, Humana for approximately $4,495, and Gilsbar for approximately $1,027.

17. **KILLEN** billed and caused to be billed a total of approximately $590,967 for the above referenced schemes detailed in Counts 1 through 30. Of the approximately $590,967, Medicare was billed approximately $44,283, Medicaid was billed approximately $5,994, BCBSLA was billed approximately $479,810, United was billed approximately $50,421, Humana was billed approximately $8,352, and Gilsbar was billed approximately $2,107.

All in violation of Title 18, United States Code, Sections 1347 and 2.

COUNTS 31 THROUGH 34

AGGRAVATED IDENTITY THEFT IN CONJUNCTION WITH HEALTH CARE FRAUD

1. The allegations contained in parts A and B of Counts 1 through 30 are hereby realleged and incorporated herein by reference.

2. From on or about December 6, 2010, until on about July 12, 2012, in the Eastern District of Louisiana, the defendant, **DAVID LEE KILLEN**, did knowingly use, without lawful authority, a means of identification of another person during and in relation to the felony offense of health care fraud, in violation of Title 18, United States Code, Section 1347, that is, he knowingly used the names and provider numbers of Drs. A and B without authorization to bill or cause

billings for medical services that he knew had not been provided by Drs. A and B as described below:

COUNT	DATE	PATIENT/PHYSICIAN	INSURER	AMOUNT BILLED
31	12/06/2010	EmBl/Dr. B	BCBSLA	$130.36
32	08/22/2011	SuKi/Dr. B	BCBSLA	$84.00
33	06/08/2012	JoMo/Dr. A	BCBSLA	$4,480.00
34	07/12/2012	JaMc/Dr. A	BCBSLA	$84.00

All in violation of Title 18, United States Code, Sections 1028A(a)(1) and (c)(5).

NOTICE OF HEALTH CARE FRAUD FORFEITURE

1. The allegations contained in Counts 1 through 30 of this Indictment are hereby realleged and incorporated by reference for the purpose of alleging forfeiture to the United States pursuant to the provisions of Title 18, United States Code, Sections 1347 and 982(a)(7).

2. As a result of the offenses alleged in Counts 1 through 30 of this Indictment, defendant **DAVID LEE KILLEN,** shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any and all property, real and personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offenses, including but not limited to:

a. At least $590,967 in United States Currency and all interest and proceeds traceable thereto.

b. The government specifically provides notice of its intent to seek a personal money judgment against the defendant in the amount of the fraudulently-obtained proceeds.

3. If any of the property described above as being subject to forfeiture, as a result of any act or omission of the defendant:

a. cannot be located upon the exercise of due diligence;

b. has been transferred, sold to, or deposited with, a third person;

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 subdivided without difficulty;

it is the intent of the United States, pursuant to Title 21, United States Code, Section 853(p) to seek forfeiture of any other property of said defendant up to the value of the above forfeitable property;

All in violation of Title 18, United States Code, Section 982(a)(7).

A TRUE BILL:

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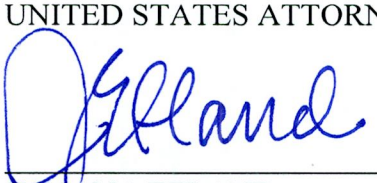
FOREPERSON

KENNETH ALLEN POLITE, JR.
UNITED STATES ATTORNEY



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New Orleans, Louisiana
February 13, 2014