LETITIA JAMES
ATTORNEY GENERAL OF THE STATE OF NEW YORK

MEDICAID FRAUD CONTROL UNIT

NEW YORK ATTORNEY GENERAL'S 2022 NURSING HOME ENFORCEMENT ACTIONS

Amy Held
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Chief of Criminal Investigations
Medicaid Fraud Control Unit

February 21, 2023

The Medicaid Fraud Control Unit "MFCU"

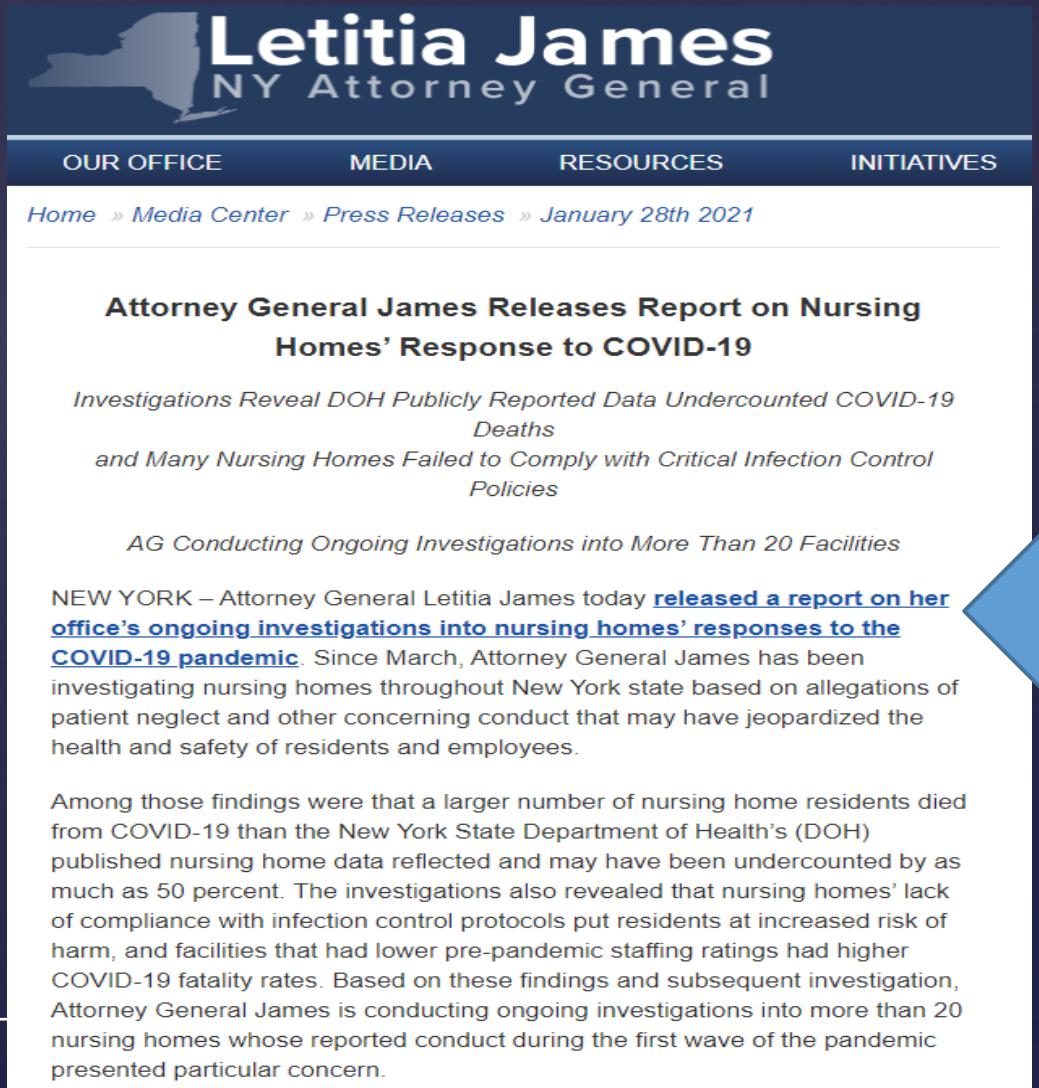
Part of the New York State Attorney General's Office - Criminal Justice Division

- Created in 1975 as a result of abuses in the nursing home industry
- Investigates Medicaid provider fraud and abuse, neglect and mistreatment of residents of nursing homes
- MFCU has Attorneys, Detectives, Auditor-Investigators, Medical Analysts and Data Analytics Specialists

Attorney General's Nursing Home Report January 2021

https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf

Nursing Home Report is Publicly Available Through the Link in the Attorney General's Press Release on the Report



Letitia James
NY Attorney General

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Attorney General James Releases Report on Nursing Homes' Response to COVID-19

Investigations Reveal DOH Publicly Reported Data Undercounted COVID-19 Deaths
and Many Nursing Homes Failed to Comply with Critical Infection Control Policies

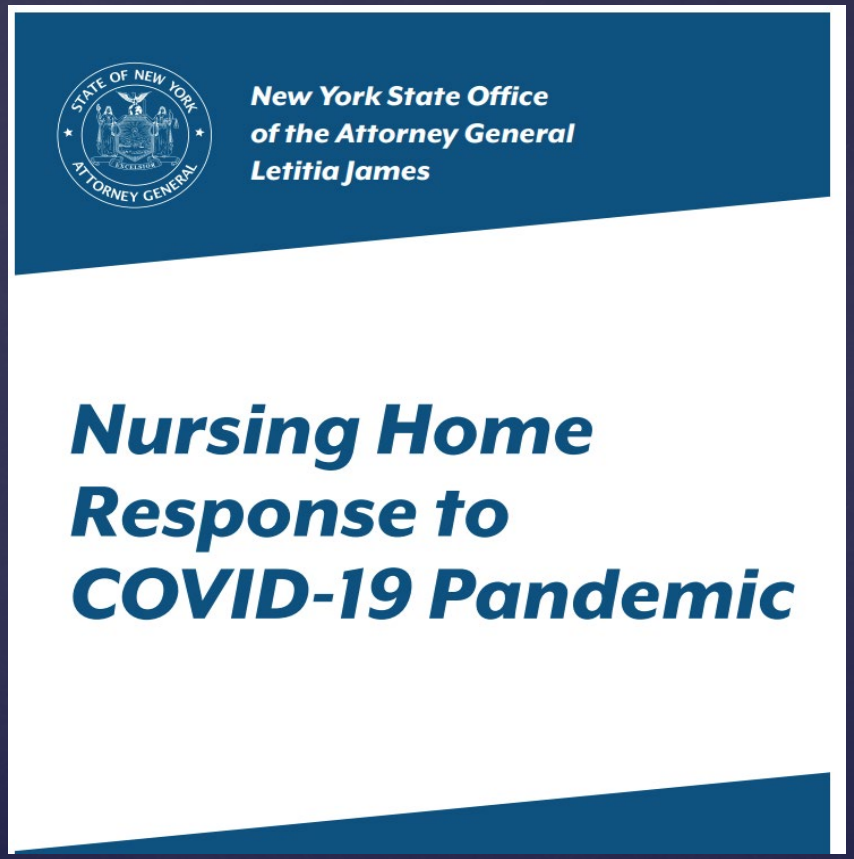
AG Conducting Ongoing Investigations into More Than 20 Facilities

NEW YORK – Attorney General Letitia James today **released a report on her office's ongoing investigations into nursing homes' responses to the COVID-19 pandemic**. Since March, Attorney General James has been investigating nursing homes throughout New York state based on allegations of patient neglect and other concerning conduct that may have jeopardized the health and safety of residents and employees.

Among those findings were that a larger number of nursing home residents died from COVID-19 than the New York State Department of Health's (DOH) published nursing home data reflected and may have been undercounted by as much as 50 percent. The investigations also revealed that nursing homes' lack of compliance with infection control protocols put residents at increased risk of harm, and facilities that had lower pre-pandemic staffing ratings had higher COVID-19 fatality rates. Based on these findings and subsequent investigation, Attorney General James is conducting ongoing investigations into more than 20 nursing homes whose reported conduct during the first wave of the pandemic presented particular concern.

Attorney General's Nursing Home Report January 2021

https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf



COVID-19 related neglect complaints began in early March 2020

774 hotline complaints from 4/23/20 to 8/3/20

Preliminary investigative findings and data analysis Published in the interest of increasing transparency and awareness, and encouraging collective action to protect residents

Attorney General's Nursing Home Report January 2021

https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf

Preliminary Findings, e.g.:

- Nursing homes that entered the pandemic with low CMS Staffing ratings had higher COVID-19 fatality rates. (pp. 22, 28)
- Nursing homes' lack of compliance with infection control protocols put residents at increased risk of harm (p. 17).
- State reimbursement model for nursing homes gives a financial incentive to owners of for-profit nursing homes to transfer funds to related parties (ultimately increasing their own profit) instead of investing in higher staffing levels and PPE. (p. 6)
- A larger number of nursing home residents died from COVID-19 than DOH data reflected. (p. 10)

13 Recommendations included: requiring quantitative minimum staffing and "additional and enforceable transparency in the operation of for-profit nursing homes, including financial transactions and financial relationships with related parties".

Attorney General's Nursing Home Report

Regulatory Framework Section sets forth New York and Federal law on Nursing Home Duties to Residents (pp. 43-47).

Contents

Attorney General's Nursing Home Report Appendix B

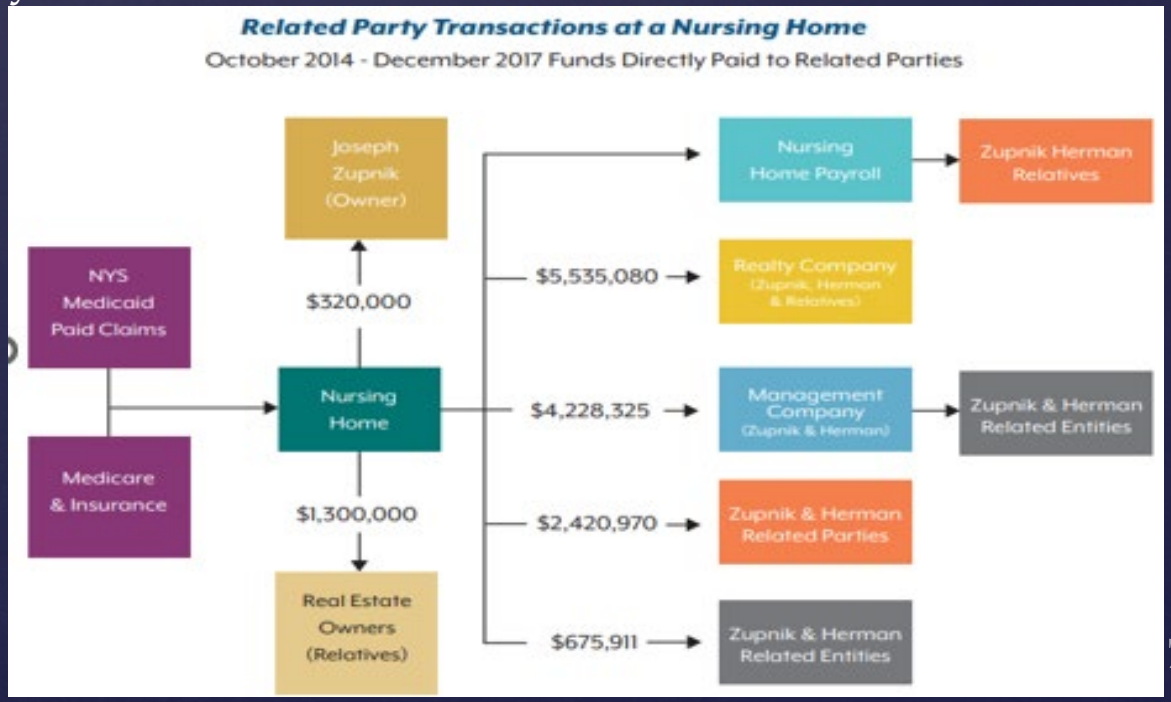
Prosecution in May 2018: Endangering the Welfare of an Incompetent or Physically Disabled Person, 3 Counts, 1st Deg., PL 260.25; and 2 Misdemeanor Counts (2nd Deg., PL 260.24)

Guilty Pleas, Sept 2018: Misdemeanor Endangering by Corporation, 99% owner and manager;

AOD: $1M Restitution and Exclusion from Medicaid.

3. Prosecution, Convictions, and Civil Remedies

Prosecution: Based on relevant aspects of these findings, in May 2018, OAG filed criminal charges against the entity that held the operator's license for, and controlled, Focus, an individual who was the 99 percent owner of Focus, and an individual who was the owner's business partner in other ventures while acting as a high level manager for Focus, for their conduct between October 14, 2014 to December 31, 2017. The charges included three felony counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, in violation of Penal Law § 260.25, a Class E felony: one count as to all residents of the facility from October 14, 2014 to November 29, 2016, and two counts as to two specific residents who each suffered injury. The charges against each defendant also included two misdemeanor counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the Second Degree in violation of Penal Law § 260.24 ("Misdemeanor Endangering") as: one count as to all residents of the home from May 26, 2016 to November 29, 2016, and one count as to a specific resident from May 28, 2016 to June 1, 2016; and, two misdemeanor counts of Willful Violation of Health Laws, in violation of Public Health Law §§ 12-b(2), 2803-d(7), and 10 NYCRR §§ 81.1, 415.11 and 415.12(c)(2): one count for the neglect of all the residents of the home from May 26, 2016 to November 29, 2016, and one count for the neglect of a specific resident from May 28 to 30, 2016.



Attorney General Filed 3 Executive Law § 63(12) Special Proceedings in 2022

- November 29, 2022: Orleans County: The Villages of Orleans, a for-profit 120-bed nursing home:
  - Verified Petition
  - 14 Affidavits, including Auditor Affidavit, Medical Analyst Affidavit, Detective Affidavit and Civilian Affidavits
  - Memorandum of Law
  - Notice of Petition
  - 17 Respondents

- December 13, 2022: Nassau County: Fulton Commons, a for-profit 280-bed nursing home, in East Meadow
  - Verified Petition
  - 13 Affidavits, including Auditor Affidavit, Medical Analyst Affidavit, Detective Affidavit and Civilian Affidavits
  - Memorandum of Law
  - Notice of Petition
  - 19 Respondents: Nursing Home, 14 individuals including 12 nursing home owners, 4 other corporate entities including related party landlord and management company

- December 15, 2022: Nassau County: Cold Spring Hills, a for-profit 588-bed nursing home in Oyster Bay
  - Verified Petition
  - 21 Affidavits, including Auditor Affidavit, Medical Analyst Affidavit, Detective Affidavit and Civilian Affidavits
  - Memorandum of Law
  - Notice of Petition
  - 27 Respondents: Nursing Home, 12 LLCs, 1 other corporate entity, 14 individuals, including owners of nursing home and related party landlord and management companies

Attorney General's 3 Executive Law § 63(12) Special Proceedings re: Nursing Homes in Late 2022

- **<u>These are ongoing civil special proceedings.</u>**

- **We will summarize the allegations, findings and causes of action in the Verified Petitions and supporting papers filed in the special proceedings. We will tell you how to find the public filings for yourselves, for your own review.**

- **We will not provide any nonpublic information about them.**

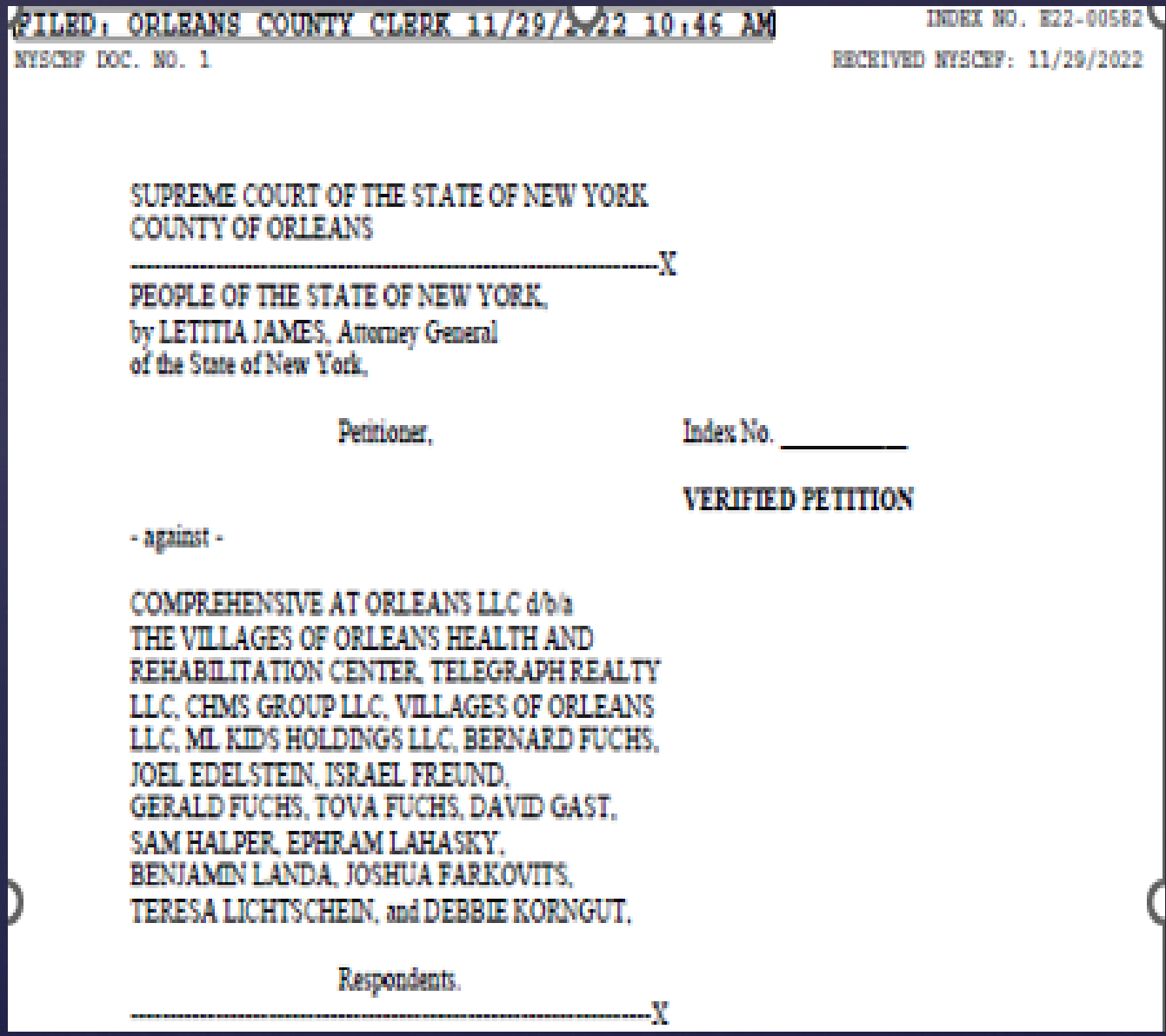
Attorney General's Executive Law § 63(12) Special Proceeding Against Villages of Orleans, et al.

Verified Petition re:
Villages of Orleans,
a 120-bed facility
(151 pages),
Filed 11/29/22

17 Respondents:

5 Corporate Persons:
Nursing Home, and 4
other corporate persons,
including related party
landlord and
management company, and

12 Individuals who are
their owners



FILED: ORLEANS COUNTY CLERK 11/29/2022 10:46 AM INDEX NO. E22-00582
NYSCEF DOC. NO. 1 RECEIVED NYSCEF: 11/29/2022

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORLEANS

----------X

PEOPLE OF THE STATE OF NEW YORK,
by LETITIA JAMES, Attorney General
of the State of New York,

Petitioner,

Index No. _____

VERIFIED PETITION

- against -

COMPREHENSIVE AT ORLEANS LLC d/b/a
THE VILLAGES OF ORLEANS HEALTH AND
REHABILITATION CENTER, TELEGRAPH REALTY
LLC, CHMS GROUP LLC, VILLAGES OF ORLEANS
LLC, ML KIDS HOLDINGS LLC, BERNARD FUCHS,
JOEL EDELSTEIN, ISRAEL FREUND,
GERALD FUCHS, TOVA FUCHS, DAVID GAST,
SAM HALPER, EPHRAM LAHASKY,
BENJAMIN LANDA, JOSHUA FARKOVITS,
TERESA LICHTSCHEIN, and DEBBIE KORNGUT,

Respondents.

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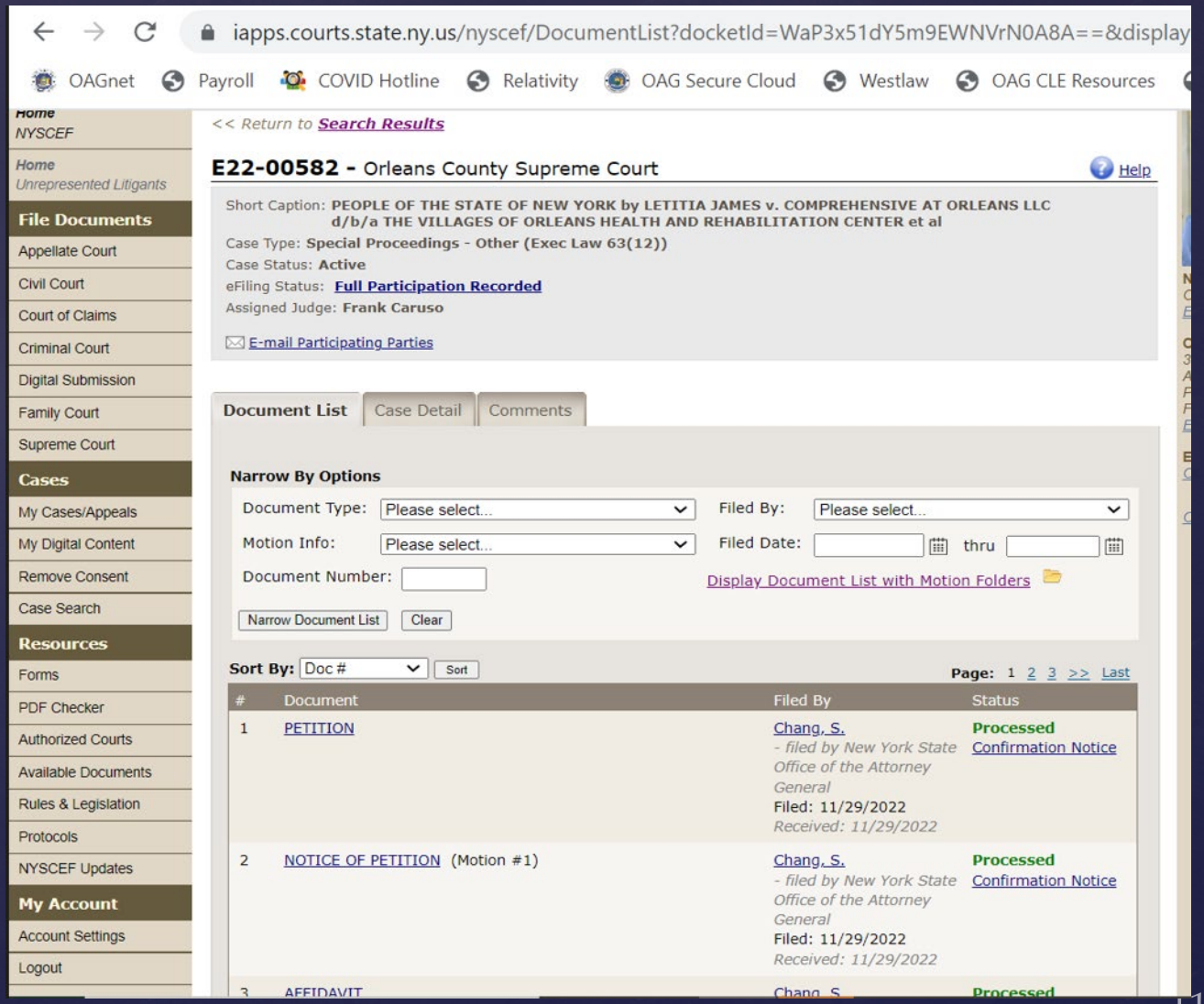
Attorney General's Executive Law § 63(12) Special Proceeding: Villages of Orleans, 11/29/22

All documents are free and publicly available on Court website and Attorney General's website in press release:

- Verified Petition
- 14 Affidavits:
  - Auditor Affidavit
  - Medical Analyst Affidavit
  - Detective Affidavit
  - Civilian Affidavits
- Memorandum of Law
- Notice of Petition

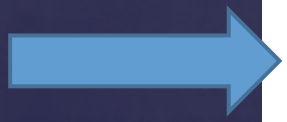
- 17 Respondents

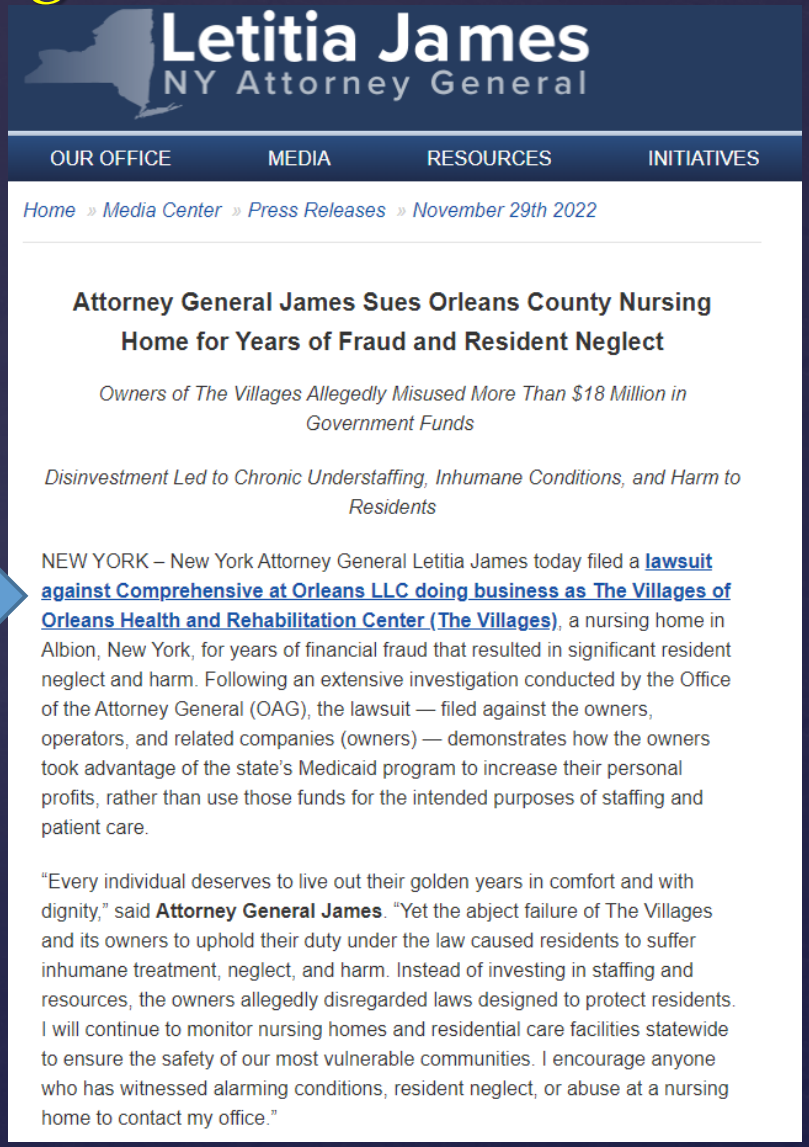


Attorney General's Executive Law § 63(12) Special Proceeding Against Villages of Orleans, et al.

- Verified Petition Against Villages of Orleans (151 pages), 11/29/22

Publicly available at link on press release





Letitia James
NY Attorney General

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Attorney General James Sues Orleans County Nursing Home for Years of Fraud and Resident Neglect

Owners of The Villages Allegedly Misused More Than $18 Million in Government Funds

Disinvestment Led to Chronic Understaffing, Inhumane Conditions, and Harm to Residents

NEW YORK – New York Attorney General Letitia James today filed a **lawsuit against Comprehensive at Orleans LLC doing business as The Villages of Orleans Health and Rehabilitation Center (The Villages)**, a nursing home in Albion, New York, for years of financial fraud that resulted in significant resident neglect and harm. Following an extensive investigation conducted by the Office of the Attorney General (OAG), the lawsuit — filed against the owners, operators, and related companies (owners) — demonstrates how the owners took advantage of the state's Medicaid program to increase their personal profits, rather than use those funds for the intended purposes of staffing and patient care.

"Every individual deserves to live out their golden years in comfort and with dignity," said **Attorney General James**. "Yet the abject failure of The Villages and its owners to uphold their duty under the law caused residents to suffer inhumane treatment, neglect, and harm. Instead of investing in staffing and resources, the owners allegedly disregarded laws designed to protect residents. I will continue to monitor nursing homes and residential care facilities statewide to ensure the safety of our most vulnerable communities. I encourage anyone who has witnessed alarming conditions, resident neglect, or abuse at a nursing home to contact my office."

New York Executive Law § 63(12):

"Whenever any person shall engage in repeated fraudulent or illegal acts or otherwise demonstrate persistent fraud or illegality in the carrying on, conducting or transaction of business, the attorney general may apply, in the name of the people of the state of New York, to the supreme court of the state of New York…for an order enjoining the continuance of such business activity or of any fraudulent or illegal acts, directing restitution and damages..."

Executive Law § 63(12) Special Proceedings

- Attorney General seeks injunction under Executive Law 63(12) to stop repeated fraud and illegality, to protect the residents from further neglect, suffering and humiliation, and to order Respondents to disgorge and return illegally converted Medicaid funds under Executive Law 63-c.
- NYS DOH Commissioner requested Attorney General to enjoin violations of Public Health Law or any regulations promulgated thereunder.

10. Public Health Law § 2801-c further provides that, "upon request of the [Commissioner of Health], the attorney general shall maintain an action in the supreme court in the name of the people of the state to enjoin any" violation or threatened violation of the provisions of Article 28 of the Public Health Law, or any DOH regulations promulgated thereunder.[7] Pursuant to Public Health Law § 2801-c, the Commissioner of Health has specifically requested that the Attorney General seek such injunctive relief in this action, in addition to any other remedies available by law. (*Id.* ¶ 6, Ex. 40.)

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans

Findings Supported by Affidavits and Exhibits: The Villages Neglected Residents While Respondents Operated It with Insufficient Staffing and Poor Quality of Care in Violation of Regulations:

2. Petitioner brings this proceeding pursuant to, *inter alia*, Executive Law § 63(12) against Respondents to seek injunctive relief to expose and stop the persistent fraud and illegality of the persons who have operated, owned, and controlled The Villages, and to seek restitution, disgorgement, rescission, civil penalties, and costs against any person that has engaged in or otherwise demonstrated repeated illegal and/or fraudulent acts, including: (1) repeated neglect and inhumane mistreatment of The Villages' residents who have suffered while in Respondents' charge; and (2) a long history of insufficient and unqualified staffing and poor quality of care in violation and in reckless disregard of numerous New York State rules, regulations, and laws, including the Tweed Law, Executive Law § 63-c, which authorizes the Attorney General to recover public monies "without right obtained, received, converted, or disposed of." Petitioner also brings this special proceeding to bring transparency to the reality that much of the human pain, actual harm, and humiliation experienced by the individuals who have lived at The Villages was preventable and can be prevented in the future. As detailed herein, Respondents did not provide The Villages' residents with even the most basic care and necessities, such as hygiene, prescribed medications, meals, phones, and hot water, and created conditions wherein those who lived at The Villages routinely sat unattended in dirty adult diapers for hours on end; suffered from unnecessary physical and mental decline; were deprived of essential medical treatment; suffered from pressure sores, infections, and other preventable ailments; and were forced to live in a dilapidated facility, despite receipt of tens of millions of dollars in government reimbursement.

3. The Villages' egregious history of insufficient and unqualified staffing and poor quality of care is directly traceable to Respondents' unconscionable conversion of millions of dollars in "up-front profit" taken from The Villages. In flagrant disregard of their legal duties, from January 1, 2015 to the present, Respondents took either directly or through related-party

Attorney General sued Respondents under Executive Law 63(12) to seek injunctive relief to expose and stop repeated and persistent fraud and illegality in Respondents' operation of the nursing home, including:

- "Repeated neglect and inhumane treatment of The Villages' residents"
- "Long history of insufficient and unqualified staffing and poor quality of care in violation of regulations,

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans

Findings Supported by Affidavits and Exhibits: Respondents Took $18.6M That Should Have Been Spent on Care:

-Directly traceable to Respondents' conversion of millions of dollars in up-front profit while nursing home disregarded its duties to provide required care and staffing;

-Verified Petition identifies many laws and regulations that Respondents repeatedly and persistently violated, that require nursing homes to provide required care

-Findings demonstrate Respondents repeatedly prioritized their personal profits over the nursing home's duty to provide required care and staffing, which caused neglect and harm.

transactions, over $18.6 million from The Villages that should have been spent on ensuring adequate resident care, but was instead used by Respondents to unnecessarily and unjustly enrich themselves at the expense of The Villages' residents.

4. At all relevant times, New York law has imposed on The Villages, as a nursing home facility, and those who own, operate, and control it, a "special obligation" to care for its residents; and to ensure that the facility has sufficient staffing "to assure the highest practicable quality of life" for each resident and to provide its residents with the necessary "care and services," including clinical care, in accordance with each resident's individualized care plan. (*See* 10 NYCRR § 415.1[a] [nursing homes – minimum standards]; 10 NYCRR § 415.3[f] [right to clinical care and treatment]; 10 NYCRR § 415.12 [quality of care]; 10 NYCRR § 415.13 [nursing services]; *see also* 42 CFR § 483.25 [quality of care]; 42 CFR § 483.35 [nursing services]; 42 CFR § 483.10 [resident rights]; PHL § 2803-c(3) ["Patient's Bill of Rights"].) Respondents repeatedly violated these regulations during the relevant time period.

5. Furthermore, Respondents repeatedly committed acts of neglect against residents of The Villages in violation of Public Health Law § 2803-d(7). (*See* 10 NYCRR § 81.1[c] [defining "neglect" as "failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living"].)

6. Through the interviews of residents and employees of The Villages, analysis of medical records of residents, and additional evidence as set forth in the accompanying affidavits, the Attorney General's findings demonstrate that Respondents repeatedly prioritized their personal profit over The Villages' duty to provide required resident care and required staffing, thereby causing physical and emotional harm to vulnerable people who lived at the nursing home, and stripping them of their dignity. Neglect and mistreatment at The Villages includes the following illustrative, but not exhaustive, examples:

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Examples of Neglect, Suffering & Humiliation (Verified Pet. pp. 4, 28-116)

Suicidal Patient Ignored to Death: A woman known as Resident 38[2] was admitted to The Villages in early 2020, for rehabilitation of a fractured left femur. Shortly after admission, Resident 38 began refusing medications and food, and spoke of wanting to die. An outside psychology consultant determined that Resident 38 was at high risk for self-harm and ordered checks on her condition every 30 minutes. Nonetheless, The Villages repeatedly failed to monitor Resident 38 and she was found dead 20 days later. The Villages failed to report Resident 38's death to the New York State Department of Health as required.

Delayed Wound Treatment, Unexplained Doping and Death: Resident 42 was admitted to The Villages on January 6, 2021, with a Stage II pressure sore near the base of her spine, but it was not treated for the first time until 18 days later.[3] By June 24, Resident 42 suffered from two Stage III pressure sores. A specialty wound care consultant recommended a treatment regime, yet The Villages did not order this new treatment until nearly a week later, and did not provide a new dressing until July 1. When the consultant re-assessed Resident 42's wounds on July 7, both wounds had deteriorated to "unstageable." Additionally, The Villages gave Resident 42 psychotropic medication, purportedly for "severe anxiety," a diagnosis which cannot be found in Resident 42's medical records. Resident 42 was also frequently given medications for nausea, cough, and pain, without documented clinical need. Resident 42 was found unresponsive on July 13, and her records are silent as to what care, if any, she was provided before being sent to the hospital, where she died on July 13, 2021, from acute cardiopulmonary arrest secondary to respiratory failure. Staff at The Villages failed to notify Resident 42's healthcare proxy that she was sent to the hospital. (Medical Analyst Aff. ¶¶ 72-82.)

D. The Villages Did Not Provide Even Basic Care to Residents Before, During, and After the COVID-19 Pandemic, Endangering Residents' Health, Dignity, and Well Being.

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Examples of Neglect, Suffering and Humiliation (pp. 5, 32, 62-127):

Amputee Sits in Urine, Awaiting Medication: Resident 43 was admitted to The Villages in late 2020 after a leg amputation in order to regain enough strength to use a prosthetic leg and live independently. During his three-month stay at The Villages, Resident 43 had few physical therapy sessions, which he described as "laughable." In the Physical Therapy room, he was left to sit without exercise. Due to his amputation, Resident 43's care plan called for two staffers to assist him with cleaning himself, but staff frequently failed to timely change his adult diaper and, as a result, he often sat in a puddle of his own urine for hours. When interviewed in March 2022, Resident 43 was living at a different facility and reported he was "making great progress." He stated that if he had received proper treatment and care at The Villages, he "would be back home by now." (Detective Aff. ¶¶ 175-194; Medical Analyst Aff. ¶¶ 33-37.)

"Wouldn't put a dog in Villages": Resident 50 arrived at The Villages in December 2020 for rehabilitation after knee surgery. During a video call, Resident 50's wife saw he was lying in bed with only a diaper on, atop a rubber mat, without sheets or blankets. Resident 50's wife found bruises on his head, face, and arms, yet The Villages did not notify her about or explain these injuries. At The Villages, Resident 50 became "a stranger" to his wife, and "could not communicate verbally." After his wife transferred Resident 50 to a different facility, he was able to eat, talk, and laugh again. Resident 50's wife now holds that she "wouldn't put a dog in Villages." Resident 50 passed away in November 2021 from COVID-19. (Affidavit of Margarette Volkmar ["Volkmar Aff."] ¶¶ 7-

B. The Villages Does Not Create, Follow, and Update Residents' Care Plans, Leading to Resident Harm, Accidents, and Injuries.

G. Respondents Continued to Pressure Staff to Admit New Residents Despite Knowing The Villages Did Not Provide for Residents' Basic Needs.

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

More Examples of Neglect, Suffering & Illegality:

Failure to follow Care Plans, Manage Medications, Provide nutritional support and wound care.

Leaving residents Unattended in soiled diapers.

Failing to follow infection control protocols, and maintain accurate medical records

All simultaneous with Respondents' constant drive to admit new residents.

Yet, while these objective metrics provide insight into The Villages' functioning, they cannot tell the whole story. Other instances of harm and neglect included failure to: (1) follow resident care plans, meaning that The Villages failed to appropriately monitor residents at risk for suicide and safely supervise and assist residents to prevent falls (*see* pp. 33-40); (2) manage physician-ordered medications and monitor medical conditions, for example failing to obtain one resident's seizure medications and schedule a biopsy for another (*see* pp. 40-44); (3) provide proper nutritional support and weight monitoring, leading one resident to lose 60 pounds in three months (*see* pp. 44-48); (4) provide proper wound care, causing residents to develop gangrene and other dangerous infections (*see* pp. 49-53); (5) meet basic care needs, leaving residents unattended in dirty adult diapers (*see* pp. 53-59); (6) complete and maintain accurate medical records (*see* pp. 59-61); and (7) communicate vital health information to families and loved ones, all simultaneous with Respondents' constant drive to admit new residents into The Villages for more revenue (*see* pp. 61-72). The Villages' residents were further endangered by Respondents' failure during the pandemic to ensure proper infection control, including The Villages' delayed and secretive response to COVID-19 infections, pressure on staff to work while sick, and failure to provide adequate health screening (*see* pp. 72-80). DOH surveys and citations, along with third-party consultant evaluations, further echoed these findings and put Respondents on notice of regulatory violations and resident endangerment (*see* pp. 80-93).

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

- "The Villages intentionally maintained chronically inadequate staffing levels in order to maximize Respondents' profits"…"deprive[d] healthcare workers of the resources and supervision needed to succeed" and "pressured or forced staff to . . . "

12. Moreover, The Villages intentionally maintained chronically inadequate staffing levels in order to maximize Respondents' profits, and pressured or forced staff to: (1) perform work outside the scope of their qualifications; (2) work without adequate support from other personnel; and (3) work under substandard conditions, all while being paid low wages (*see* pp. 93-106). Indeed, Petitioner recognizes that Respondents will likely argue that the allegations herein are the result of negligent and lazy direct care staff. To the contrary, however, Petitioner's extensive investigation found that the Respondents themselves are responsible for egregious conditions at The Villages, including through their intentional and reckless decision to deprive healthcare workers of the resources and supervision needed to succeed.

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Findings: -Staffing Cuts After Purchase in 2015,

-Followed by Decreases in all CMS ratings, to lowest levels,

-Immediate Jeopardy May 2020; March 2021 CMS Designated Special Focus Facility

-Repeated and persistent fraud and illegality through Illegal Conversion of $18.6 million in up-front profit through self-dealing lease with related party landlord, and management fees, including $10M before 2020

7. Respondents' persistent violations of their duty to care for The Villages' residents began long before the COVID-19 pandemic, and continue to the present.[4] Almost immediately after Respondents took control of The Villages in January 2015, The Villages' Five Star quality ratings plummeted, becoming among the worst in the State. In May 2020, the New York State Department of Health ("DOH") declared The Villages to be in "Immediate Jeopardy" for violating COVID-19 protocols, causing or likely causing, "serious injury, harm, impairment, or death to a resident."[5] (*See* 42 CFR § 488.301 [defining "Immediate Jeopardy"].) Less than a year later, in March 2021, the U.S. Centers for Medicare and Medicaid Services ("CMS") designated The Villages as a Special Focus Facility, a designation reserved for the poorest performing nursing homes in the country.[6] As shown below, the Attorney General's Medicaid Fraud Control Unit ("MFCU") has determined that The Villages' egregious mistreatment of residents continues to date and has seemingly not been deterred by Petitioner's investigation, and other repeated notifications of deficiencies, including DOH surveys, consultant reports, news media reports, and resident family complaints.

8. Neglect and mistreatment of The Villages' residents could have been prevented by Respondents' appropriate investment in resident care and staffing. Instead, as the below cash flow chart illustrates, the funds paid to The Villages and Respondents' real property holding company, Telegraph Realty LLC ("Telegraph"), including tens of millions of dollars in taxpayer funds to provide healthcare to vulnerable residents, flowed from The Villages' and Telegraph's bank accounts to Respondents' bank accounts, resulting in over $18.6 million in "up-front profit." Critically, Respondents did not re-invest these funds to improve the building, operations or quality of life and care for residents at The Villages. Respondents' looting of The Villages began well before the onset of the COVID-19 pandemic. Of the over $18.6 million in "up-front profit" shown below, Respondents took over $10 million before 2020 – leaving the facility in a precarious position to face the COVID-19 pandemic. Respondents achieved this through, among other things, causing The Villages to pay an outsized portion of its annual revenue to Telegraph in the form of inflated "rent" payments, dwarfing the percentage of revenue allocated to rent at similarly situated [illegible]. Moreover, this looting of The Villages' funds continues to the present day, while residents at The Villages continue to suffer.

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Respondents' Fraudulent Conduct included Hiding the facility's True Owners and Operators from DOH (p. 11);

I. Respondents Gast, Halper, and Lahasky Are De-Facto Owners of The Villages and Abdicated Their Responsibility to Provide Adequate Care; Other Respondents Contributed Nothing and Made Millions.

49. Respondents falsely listed Bernard Fuchs as 100% owner of The Villages in submissions to DOH and on corporate organizing documents in an intentional scheme to mislead DOH about the identities of the individuals who planned to, and did in fact, exercise control over The Villages from day one – all in an effort to evade DOH scrutiny and fast track licensing. In

-Respondent Bernard Fuchs agreed to put his name on the CON application to induce DOH to approve it quickly. Respondents also misled DOH about the collusive lease (pp. 121-127);

-Respondents Sam Halper, Ephram Lahasky and David Gast controlled The Village's finances, staffing, budgeting and high-level decision-making, (pp. 23-27),
-They controlled and were signatories on its bank accounts, and payments for rent and management services; Gast entered into contracts for laboratory testing; Lahasky signed its Purchase & Sale Agreement, held himself out to the IRS as its sole member, and signed its Medicaid billing certification.

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Though Respondent Bernard Fuchs was the 100% owner on the CON application to DOH, Respondent Halper exercised control, executed cost report certifications, and decided in April 2020 not to offer hazard pay for its staff (pp. 23-27).

For example, Fuchs testified that Halper "was on the ground. He was the one that was in the facility, operating the facility, resident care, all that." (*Id.*, Ex. 2 at 96:13-16.) Administrator Jason Teitelbaum testified that if there was an issue at The Villages on "an operational level," he would contact Sam Halper. (*Id.*, Ex. 5 at 32:15-18; *see also id.* at 39:16 – 40:6 [testifying that he would contact Sam Halper if there was a question, problem, concern or complaint with "the building or anything in the facility" and "in the event there were issues with the operation day-to-day"] and 284:13-17 [referring to Halper, Gast, and Lahasky as "operators" of The Villages].) Administrator Teitelbaum also testified that Halper personally asked him to become the Administrator at The Villages. (*Id.*, Ex. 5 at 75:3-13.)

- Respondent Sam Halper was indicted in 2022 for health care fraud by the United States for his conduct in Pennsylvania nursing home. Halper repeatedly asserted his 5th Amendment rights against self-incrimination when asked, under oath, questions about the operation of The Villages, in the Attorney General's 63(12) examination.

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Respondents' repeated fraudulent conduct included:

-Hiding the true nature of the nursing home's lease with its related party landlord, Telegraph
-Using Telegraph to funnel millions in "Up-Front Profit" to themselves while operating the nursing home with insufficient staff and disregarding its legal duties to provide required care (pp. 11; 123-128).

Telegraph. The lease agreement is the vehicle through which Respondents funnel money from The Villages to themselves to create automatic profits, prior to ensuring that The Villages expends sufficient funds on staffing and resident care to meet its legal duties (*see* pp. 123-28). The practice of making payments from the nursing home to Respondents in the guise of pre-determined and self-negotiated "expenses" and other transfers of funds as a priority over, and without regard to, ensuring that the nursing home uses the public funds it receives to meet the nursing home's duty to provide required care, with sufficient staffing to render such care, to its residents is referred to herein as "Up-Front Profit."

Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Respondents' repeated fraudulent conduct included:

-Causing The Villages to pay Telegraph millions in "rent" well in excess of fair market value;

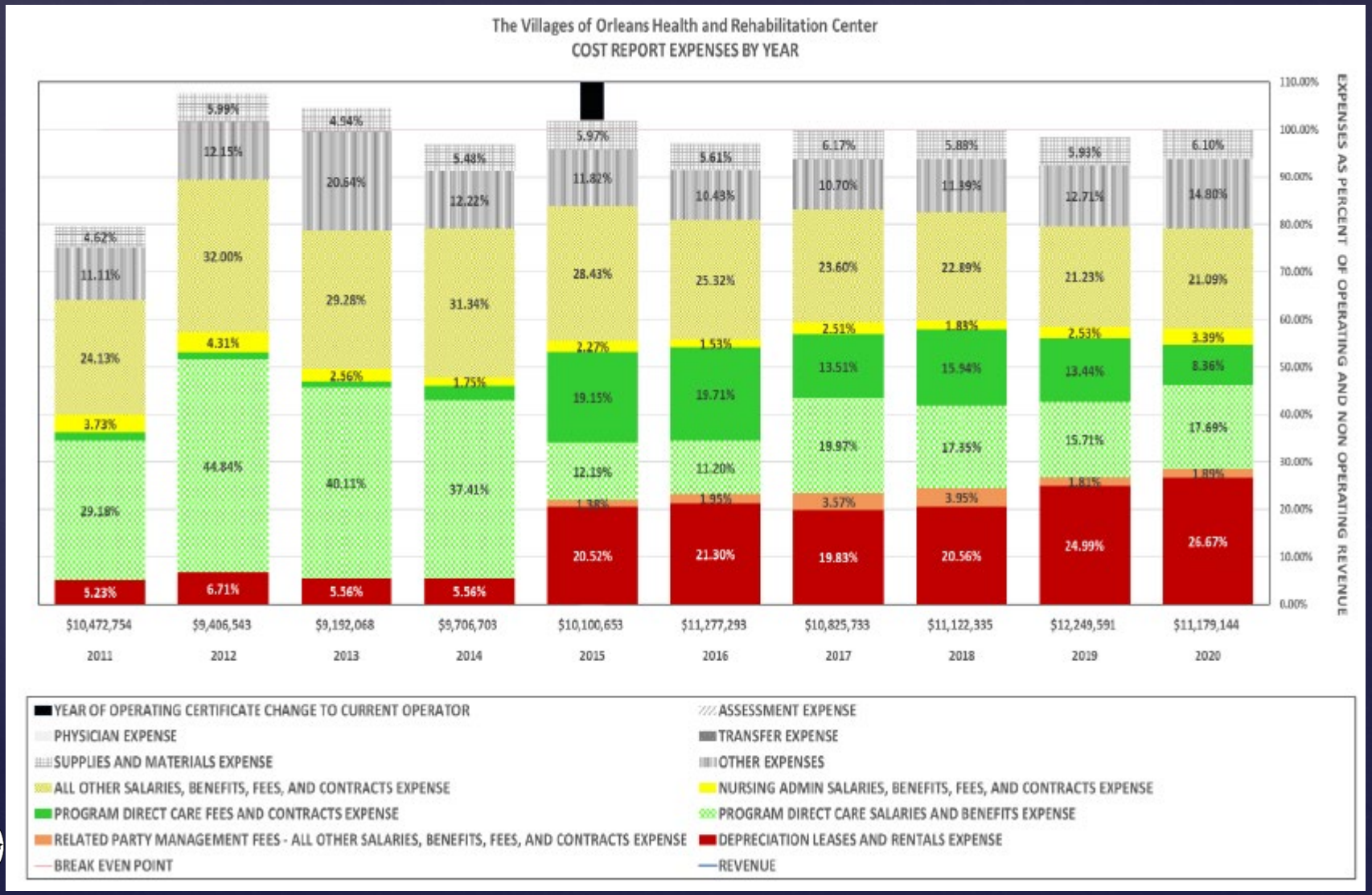
-Causing The Villages to pay over $2M in purported "management" fees;

-Using the facility as collateral to secure and cash in on multi-million dollar loans that provided no benefit to the residents (par. 179-199).

> netted out to almost even in 2015 through 2020. This careful orchestration of its financial operations creates the false impression that The Villages is an unprofitable investment. To the contrary, those who control it have extracted millions of dollars each year in "up-front profit" through related-party transactions – principally causing The Villages to pay "rent" to Telegraph well in-excess of fair market value, causing The Villages to pay over $2 million in purported "management" fees and other payments to related parties, and using the facility as collateral to secure and cash in on multi-million dollar loans that provided no benefit for the residents. (*See id.* ¶¶ 179-99.)

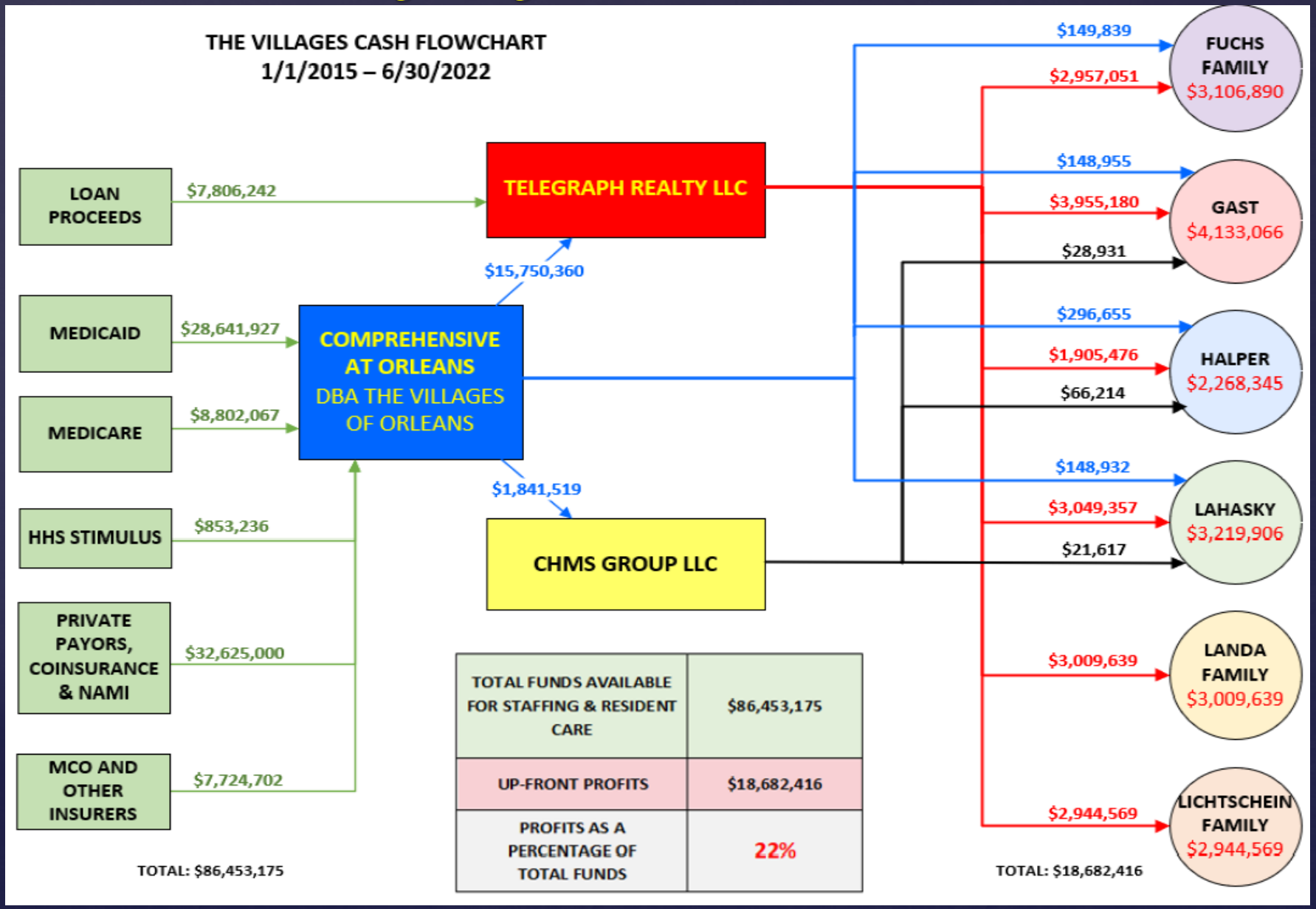
Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Respondents' fraudulent conduct gave the false impression The Villages was not a profitable investment for Respondents: - red is the increase in "rent" expenses
- light green shows decrease in direct care staffing expenses



Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

Financial Findings: Illegal Conversion of $18.6 Million:



Executive Law § 63(12) Special Proceeding re: The Villages of Orleans, Filed 11/29/22

7 Individual Respondents Edelstein, Freund, G. Fuchs, T. Fuchs, Farkovits, Lichtenstein, and Korngut Got Money for Nothing from The Villages and Telegraph, in varying amounts:

$589,000, $1.49M, $1.5M, $1.36M, $1.58M

D. Respondents Edelstein, Freund, G. Fuchs, T. Fuchs, Landa, Farkovits, Lichtschein, and Korngut Get Money for Nothing.

63. Respondents Edelstein, Freund, G. Fuchs, T. Fuchs, Landa, Farkovits, Lichtschein, and Korngut made money while abdicating their duties to the residents of The Villages. During the period January 2015 through June 2022:

- Respondent Edelstein made over $589,000 from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Freund made over $598,000 from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent G. Fuchs made over $589,000 from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent T. Fuchs made over $589,000 from The Villages and Telegraph, although she contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Landa made over $1.49 million from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Farkovits made over $1.5 million from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Lichtschein made over $1.36 million from The Villages and Telegraph, although she contributed nothing and failed to prevent the abuse and neglect described herein; and
- Respondent Korngut made over $1.58 million from The Villages and Telegraph, although she contributed nothing and failed to prevent the abuse and neglect described herein.

(*See* Auditor Aff. ¶¶ 183, 186, 190.)

Executive Law § 63(12) Causes of Action: Villages of Orleans:

- 1st Cause of Action Under Executive Law 63(12) Against All Respondents for repeatedly and persistently committing fraud by engaging in scheme to convert millions of dollars from Medicaid that the nursing home received as reimbursement for services purportedly rendered that did not conform with applicable laws and regulations, and engaging in unacceptable practices under 18 NYCRR 515.2;

- 2nd Cause of Action Under Executive Law 63(12) Against All Respondents, for repeatedly and persistent fraudulent conduct by:
  - entering into collusive and self-dealing lease agreement causing the nursing home to pay exorbitant rent in addition to mortgage expenses;
  - Engaging in a mortgage scheme to saddle the nursing home with debt while bolstering their profits and equity holdings at no benefit to the residents; and
  - engaging in unacceptable practices under 18 NYCRR 515.2

- 3rd Cause of Action Under Executive Law 63(12) Against Respondents Nursing Home Operator, CHMS Group LLC, The Villages LLC, ML Kids Holdings LLC, Bernard Fuchs, Sam Halper, David Gast, Ephram Lahasky for repeatedly and persistent fraudulent conduct by:
  - Failing to seek approval from DOH for transfers from the nursing home in excess of limits set by Public Health Law 2808(5)(c).
  - Filing false cost reports with DOH that misrepresented amounts certified to have been spent on resident care, in violation of 10 NYCRR 86-2.2
  - Filing false documents with DOH concerning the application for the nursing home's Certificate of Need

Executive Law § 63(12) Causes of Action: Villages of Orleans (par. 373):

- 4th Cause of Action Under Executive Law 63(12) Against Respondents Nursing Home Operator, CHMS Group LLC, The Villages LLC, Bernard Fuchs, Sam Halper, David Gast, Ephram Lahasky for repeated and persistent illegality by causing the nursing home to fail to deliver required care under 34 regulations:

a. Fulfill each resident's right to adequate and appropriate medical care, as required by 10 NYCRR § 415.3 and PHL § 2803-c;

b. Provide regular access to the private use of a telephone, as required by 10 NYCRR § 415.3(e);

c. Consult with the resident immediately if the resident is competent, and notify the resident's physician and designated representative within 24 hours when there is an accident involving the resident which results in injury requiring professional intervention; a significant improvement or decline in the resident's physical, mental, or psychosocial status in accordance with generally accepted standards of care and services and a need to alter treatment significantly as required by 10 NYCRR § 415.3(f)(2)(ii);

d. Assure that the resident is free from any psychotropic drug administered for purposes of discipline or convenience, and not required to treat the resident's medical conditions or symptoms, as required by 10 NYCRR § 415.4(a)(1);

Provide a safe, clean, comfortable and homelike environment, housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior and comfortable and safe temperature levels, as required by 10 NYCRR § 415.5(h);

Create comprehensive and timely care plans, provide services in accordance with comprehensive care plans, revise care plans as necessary to assure the continued accuracy of a resident's health assessment, and prepare a discharge summary as required by 10 NYCRR § 415.11(a)-(d) and 42 CFR § 483.70(e);

Provide the necessary quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being, of each resident, including but not limited to failing to ensure that the residents' activities of daily living "do not diminish," as required by 10 NYCRR §§ 415.12-(a)(1);

Ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, as required by 10 NYCRR § 415.12(a)(3);

Ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, as required by 10 NYCRR § 415.12(c) and 42 CFR § 483.25(b);

Provide adequate assistance and supervision to residents to prevent accidents, as required by 10 NYCRR § 415.12(h)(2);

Executive Law § 63(12) Causes of Action: Villages of Orleans (par. 373):

4th Cause of Action Under Executive Law 63(12) Against Respondents Nursing Home Operator, CHMS Group LLC, The Villages LLC, Bernard Fuchs, Sam Halper, David Gast, Ephram Lahasky for repeatedly and persistent illegality by causing the nursing home to fail to deliver required care:

k. Ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels and receives a therapeutic diet when there is a nutritional problem, as required by 10 NYCRR § 415.12(i);

l. Timely administer treatments, medications, diets, and other health services, as required by 10 NYCRR § 415.13;

m. Maintain sufficient personnel on a 24-hour basis to provide nursing care to all residents in accordance with each resident's needs as set forth in a comprehensive care plan that The Villages is required to develop, as required by 10 NYCRR § 415.13(a);

n. Provide each resident with a nourishing, palatable, well-balanced and medically appropriate diet that meets residents' daily nutritional and special dietary needs, employ sufficient competent staff to carry out the functions of the dietary service, provide assistance with eating and special eating equipment and utensils for residents who need them and store, prepare, distribute and serve food under sanitary conditions, as required by 10 NYCRR § 415.14;

o. Develop and implement medical services to meet the needs of its residents, as required by 10 NYCRR § 415.15;

p. Maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment, as required by 10 NYCRR § 415.19 and 42 CFR § 483.80;

q. Ensure that laboratory services meet the needs of the nursing home residents, including by failing to ensure the quality and timeliness of such services, as required by 10 NYCRR § 415.20;

r. Maintain clinical records for each resident in accordance with accepted professional standards, as required by 10 NYCRR § 415.22;

s. Have an administrator that reports to the facility's governing body at regular intervals, as required by 10 NYCRR § 415.26(a)(4)(i) and 42 CFR § 483.70(d)(2)(iii);

t. Have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, as required by 10 NYCRR § 415.26(b);

u. Employ on a full-time, part-time or consultant basis a sufficient number of professional staff members who are educated, oriented and qualified, as required by 10 NYCRR § 415.26(c);

v. Limit resident admissions, and accept and retain only those nursing home residents for whom they can provide adequate care, as required by 10 NYCRR § 415.26(i)(1)(ii);

w. Maintain a quality assessment and assurance committee consisting of at least the administrator or his or her designee, the director of nursing services, a physician designated by the facility, one member of the governing body who is not otherwise affiliated with the nursing home in an employment or contractual capacity, and three other members of the facility's staff, as required by 10 NYCRR § 415.27(b);

x. Maintain a safe, healthy, functional, sanitary, and comfortable environment for residents, as required by 10 NYCRR § 415.29;

Executive Law § 63(12) Causes of Action: Villages of Orleans (par. 373):

4th Cause of Action Under Executive Law 63(12) Against Respondents Nursing Home Operator, CHMS Group LLC, The Villages LLC, Bernard Fuchs, Sam Halper, David Gast, Ephram Lahasky for repeatedly and persistent illegality by causing the nursing home to fail to deliver required care:

y. Maintain accident and incident records necessary to permit the production of such records immediately upon request, as required by 10 NYCRR § 415.30(f);

Protect and promote the rights of the resident, treat each resident in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality, and provide equal access to quality care regardless of diagnosis, severity of condition, or payment source, as required by 42 CFR § 483.10(a);

aa. Inform the resident, consult with the resident's physician, and notify the resident representative(s) when there is a change in condition, including accident, discharge, change of room, etc., as required by 42 CFR § 483.10(g)(14)(i);

bb. Provide care and services relating to a resident's activities of daily living, including bathing, dressing, grooming, oral care, transfer and ambulation, walking, toileting, eating and communication, as required by 42 CFR § 483.24(b);

cc. Ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, as required by 42 CFR § 483.25;

Maintain sufficient numbers of nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure the well-being of each resident, as required by 42 CFR § 483.35;

ee. Ensure that an ongoing QAPI program is defined, implemented, and maintained, including during transitions in leadership and staffing; and that the QAPI program is adequately resourced, identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents, takes corrective actions to address gaps in systems, and sets clear expectations around safety, quality, rights, choice, and respect, as required by 42 CFR § 483.75(f);

ff. Maintain a quality assessment and assurance committee, as required by 42 CFR § 483.75(g);

g. Provide adequate and appropriate medical care to each resident, as required by PHL § 2803-c(3)(e);

n. Provide courteous, fair, and respectful care and treatment to each resident, as required by PHL § 2803-c(3)(g); and

Prevent and report abuses of persons receiving care or services in The Villages, as required by PHL § 2803-d.

Additional Causes of Action: Villages of Orleans:

- 5th Cause of Action Under Executive Law 63(12) Against Respondents Nursing Home Operator, CHMS Group LLC, The Villages LLC, ML Kids Holdings LLC, Bernard Fuchs, Sam Halper, David Gast, Ephram Lahasky for repeatedly and persistent illegality by:
  - Engaging in unacceptable practices under 18 NYCRR 515.2;
  - Failing to seek DOH approval for transfers from the nursing home in violation of 10 NYCRR 400.19(b)(1) and PHL 2808(5)(c);
  - Submitting incorrect and improper claims in violation of 18 NYCRR 518(3)(a)
  - Failing to file complete and accurate cost reports with DOH in violation of 10 NYCRR 86-2.2

6th Cause of Action: Misappropriation of Public Property Under The Tweed Law, Executive Law 63-c, Against All Respondents

7th Cause of Action: Unjust Enrichment:

385. Respondents are not entitled to receive or retain payment from the Medicaid and Medicare Programs for the services purportedly rendered by The Villages, as they were not in conformance with applicable laws and regulations.

386. By reason of the foregoing, Respondents have been unjustly enriched to the detriment of the Medicaid and Medicare Programs and it is against equity and good conscience to permit them to retain the payments they received under the Programs.

Attorney General's Executive Law § 63(12) Special Proceeding re: The Villages of Orleans

Declaratory Relief Sought: declaring Respondents engaged in repeated and persistent fraud and illegality, and received funds to which they were not entitled, and were unjustly enriched

REQUEST FOR RELIEF

WHEREFORE, Petitioner respectfully requests that this Court grant relief pursuant to Executive Law § 63(12), Executive Law § 63-c, Public Health Law § 2801-c, and 42 USC § 1396b(q)(3) against Respondents as set forth below by issuing an Order and Judgment immediately:

A. Declaring that:

1. Respondents engaged in repeated and persistent fraud in their up-front conversion of The Villages' Medicaid and Medicare reimbursement payments for their own use, in violation of Executive Law § 63(12);
2. Respondents engaged in repeated and persistent fraud through the use of self-dealing lease agreements with The Villages and through a scheme to use a mortgage loan to further profit off of The Villages, and by engaging in other unacceptable practices, in violation of Executive Law § 63(12);
3. Respondents engaged in repeated and persistent fraud by failing to seek DOH approval for withdrawals and transfers from The Villages, preparing, filing, and/or causing to be filed with DOH false cost reports and false and/or misleading documents concerning an application for a Certificate of Need, and by engaging in other unacceptable practices, in violation of Executive Law § 63(12);
4. Respondents repeatedly and persistently engaged in illegality in the operation of The Villages in its failure to deliver adequate care to residents

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of The Villages, contrary to the regulations set forth in paragraphs 373a-373ii above, all in violation of Executive Law § 63(12);

5. Respondents repeatedly and persistently engaged in illegality in the operation of The Villages in its failures to refrain from engaging in unacceptable practices and failures to adhere to the laws and regulations set forth in paragraphs378a-d, all in violation of Executive Law § 63(12);
6. Respondents obtained, received, converted, or disposed of funds, either directly or indirectly, from the Medicaid and Medicare Programs to which they were not entitled, in violation of the Tweed Law, Executive Law § 63-c; and
7. Respondents were unjustly enriched to the detriment of the Medicaid and Medicare Programs by receiving and retaining payments from said Programs for services which were purportedly rendered by The Villages, but which were not performed in conformance with applicable laws and regulations.

Attorney General's Executive Law § 63(12) Special Proceedings Against 3 Nursing Homes in 2022

Injunctive Relief Sought:

Permanently enjoining:

1. Respondents from engaging in the illegal, fraudulent, and deceptive practices alleged herein;

2. Respondents from making self-dealing payments, loans, and other transfers of excessive value to the Respondents and related entities;

3. Respondents from further violation of state and federal regulation to nursing home services;

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4. Respondents from further engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program;

5. Respondent The Villages from accepting any admissions of new residents unless and until Respondent Fuchs provides a signed certification, endorsed by a qualified licensed clinician, to the Attorney General certifying that Fuchs has met his obligation to operate The Villages by ensuring sufficient care and staffing for all existing residents and for any potential new residents; and

6. Respondents Halper, Gast, and Lahasky from further serving or having any role at The Villages and any related entity;

C. Directing all Respondents to pay restitution to the State;

D. Directing that each Respondent fully account for and disgorge all monies wrongfully received as a result of Respondents' fraudulent and illegal conversion and retention of substantial public funds paid as Medicaid and Medicare reimbursement to The Villages for resident care that The Villages failed to provide, and to return said monies within 15 days to the Attorney General's Medicaid Fraud Control Unit, for return to the Medicaid and Medicare Programs;

E. Appointing a receiver and financial monitor to oversee The Villages' financial operations, with plenary powers of visitation and inspection, and specific authority to approve and withhold payments, including any payments to any Respondent or related person or entity;

Attorney General's Executive Law § 63(12) Special Proceeding re Villages of Orleans

Injunctive Relief Sought:

F. Appointing an independent healthcare monitor to oversee The Villages' healthcare operations and ensure that The Villages improves healthcare outcomes for the residents;

G. Directing the Respondents to provide the independent healthcare monitor with real-time 24-hour/day remote access, every day of each year, to all of The Villages' Electronic Medical Records ("EMR") systems for its residents, and to grant the highest level network permissions and credentials for all such EMR systems to the independent healthcare monitor in order to enable viewing of all edits made at any time to any records by any user, person, and/or systems administrator;

H. Directing all Respondents except The Villages to pay for the expenses of the receivers and monitors appointed hereunder;

I. Directing Respondents to pay civil penalties to the State, including in accordance with CPLR 8303(a)(6), for violations of the Public Health Law, Social Services Law, and Medicaid payment rules;

J. Directing all Respondents except The Villages to reimburse the State and the United States for the costs of this investigation;

K. Directing each Respondent to notify Petitioner of any change of Respondents' addresses within five days of such change;

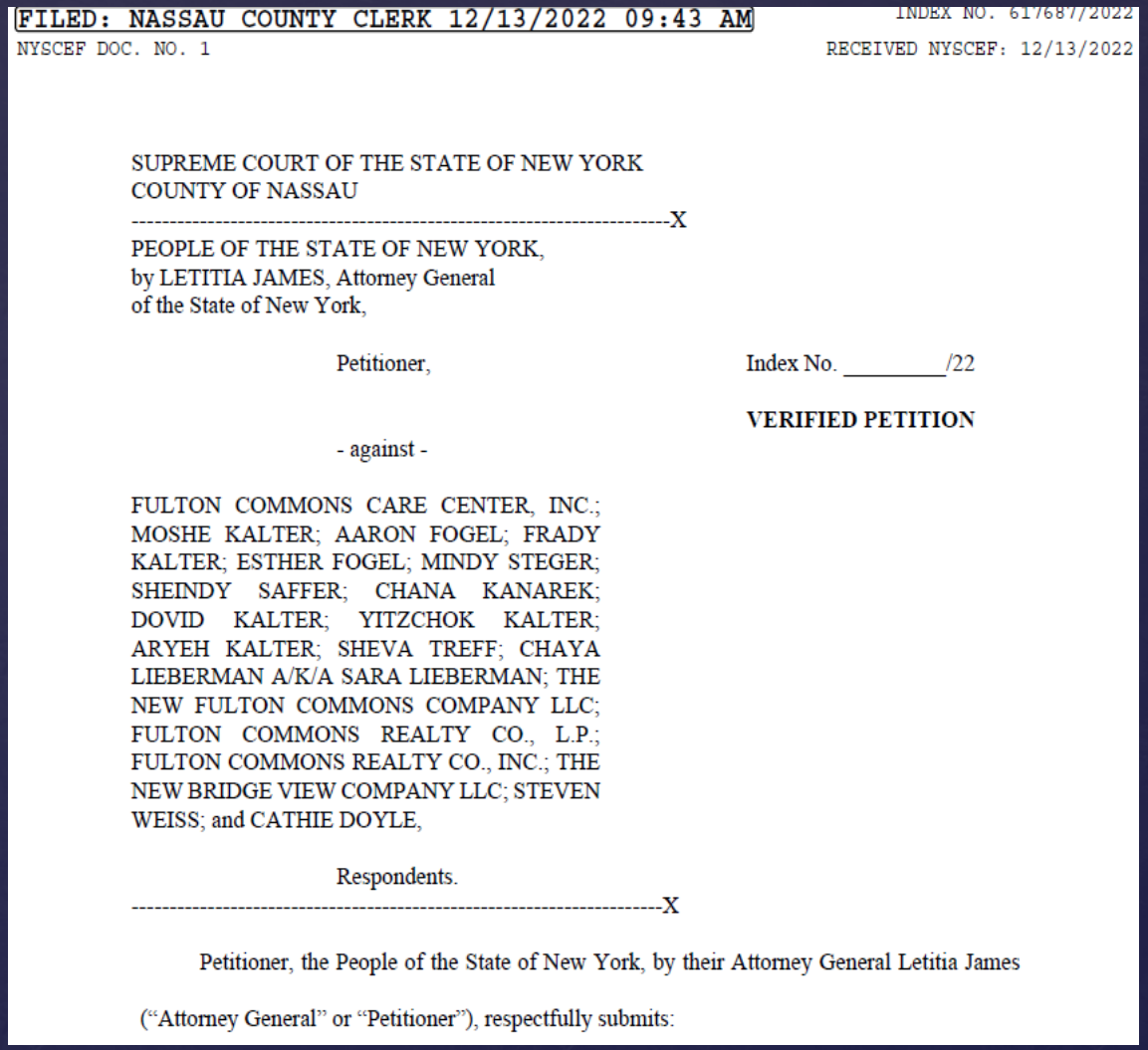
L. Directing each Respondent to pay post-judgment interest at the statutory rate of 9% per annum pursuant to CPLR §§ 5003-5004; and

M. Granting Petitioner such other and further relief as this Court deems just and proper.

Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons, Filed 12/13/22

Verified Petition re:
Fulton Commons
(155 pages),
12/13/22

19 Respondents:
Nursing Home,
14 individuals
including 12 nursing home owners, 4 more corporate Entities including related party landlord & management company



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NYSCEF DOC. NO. 1 RECEIVED NYSCEF: 12/13/2022

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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PEOPLE OF THE STATE OF NEW YORK,
by LETITIA JAMES, Attorney General
of the State of New York,

Petitioner,

Index No. _____/22

VERIFIED PETITION

- against -

FULTON COMMONS CARE CENTER, INC.; MOSHE KALTER; AARON FOGEL; FRADY KALTER; ESTHER FOGEL; MINDY STEGER; SHEINDY SAFFER; CHANA KANAREK; DOVID KALTER; YITZCHOK KALTER; ARYEH KALTER; SHEVA TREFF; CHAYA LIEBERMAN A/K/A SARA LIEBERMAN; THE NEW FULTON COMMONS COMPANY LLC; FULTON COMMONS REALTY CO., L.P.; FULTON COMMONS REALTY CO., INC.; THE NEW BRIDGE VIEW COMPANY LLC; STEVEN WEISS; and CATHIE DOYLE,

Respondents.

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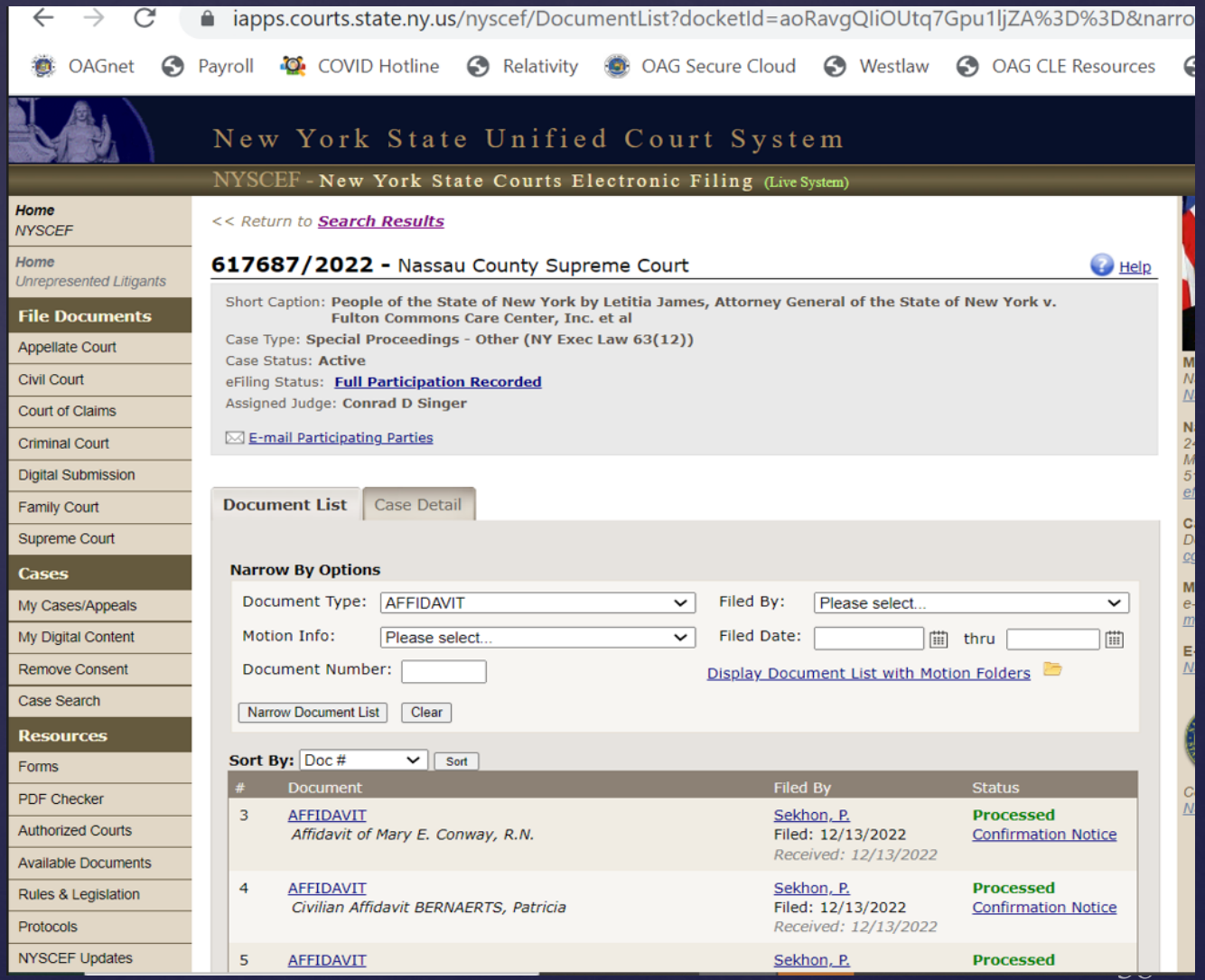
Petitioner, the People of the State of New York, by their Attorney General Letitia James ("Attorney General" or "Petitioner"), respectfully submits:

All documents are free and publicly available on Court website and Attorney General's website in press release:

- Verified Petition
- 13 Affidavits:
  - Auditor Affidavit
  - Medical Analyst Affidavit
  - Detective Affidavit
  - Civilian Affidavits
- Memorandum of Law
- Notice of Petition

- 19 Respondents



Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons, Filed 12/13/22, Based on Findings of Repeated and Persistent Fraud and Illegality in Respondents' Operation of Fulton Commons:

- Repeated incidents of Fulton Commons' resident abuse and neglect occurred from 2018 to 2022, (see pp. 9-12; 43-72), including neglect from insufficient staffing, failure to provide medical care and rehabilitation, lack of supervision resulting in falls, violations of infection control protocols that increased risks to residents.

- Fulton Commons violated 10 NYCRR 702-4 by intentionally underreporting by 45% is COVID-19 deaths as part of its fraudulent scheme to conceal its poor performance (p. 73-74): Fulton Commons reported 40 COVID deaths to DOH, yet its records reflected 74 COVID resident deaths.

- In March 2020, Fulton Commons sent misleading robocalls to family members, falsely denying existence of COVID-19 in facility, even after residents had died from presumed COVID (pp. 74-75), and directed staff not to discuss COVID-19 with anyone outside of the facility (p. 76), and delayed testing (pp. 77-78)

Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons, Filed 12/13/22, Verified Petition's allegations and findings of:

Repeated Fraud and Illegality including:

- In January 2022, DOH determined that Fulton Commons failed to report a resident's allegation of sexual abuse by a nursing staff member. Fulton failed to investigate the allegation and permitted the staff member to continue working. DOH also found that Fulton Commons had an unlawful policy under which allegations of sexual abuse would not be reported to law enforcement, in violation of PHL 2803-d(7) and federal law, and instead would be treated as "grievances". DOH found Fulton Commons in Immediate Jeopardy.

- In April 2022, CMS lowered Fulton Commons overall rating to 2 stars – "BELOW AVERAGE" and identified it as a candidate for the Special Focus Facility Program.

Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons, Filed 12/13/22, Based on Findings of Repeated and Persistent Fraud and Illegality in Respondents' Operation of Fulton Commons

Preliminary Statement alleges: "egregious failures in resident care…often the direct result of insufficient staffing and supervision and are directly traceable to Respondents' repeated and persistent fraud and illegality in operating Fulton Commons with disregard for their legal duties"

- Illegal actions to conceal pervasive neglect and abuse;
- Fraudulent conversion of $16M that should have been spent on

resident care but was extracted through "salaries" for no-show jobs & fraudulent inflated "rent" schemes (pp. 16-21; 111-133)

Conversion	2018	2019	2020	2021	January 2022	Total
Excess Rent	$3,526,494.00	$4,422,281.00	$4,566,918.00	$2,397,710.00	Unable to determine	$14,913,403.00
Kalter-1% Owners' Salaries	$60,500.00	$170,295.03	$410,875.96	$415,319.80	$34,689.80	$1,091,680.59
Total	$3,586,994.00	$4,592,576.03	$4,977,793.96	$2,813,029.80	$34,689.80	$16,005,083.59

Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons, Filed 12/13/22, Based on Findings of Repeated and Persistent Fraud and Illegality in Respondents' Operation of Fulton Commons

Fraudulent conversion of millions that should have been spent on resident care but was extracted through fraudulent inflated "rent" scheme (pp. 16-21; 111-133)

Respondent Moshe Kalter caused Fulton to pay 21.66% rent to revenue ratio in 2018, and 30.65% in 2020, when NY state average rent to revenue ratio was 8.65% 10.62%;

Fulton Commons' rent was 13% and 20% higher than NY State average, and the Highest of Medicaid-certified nursing homes in Long Island (p. 114)

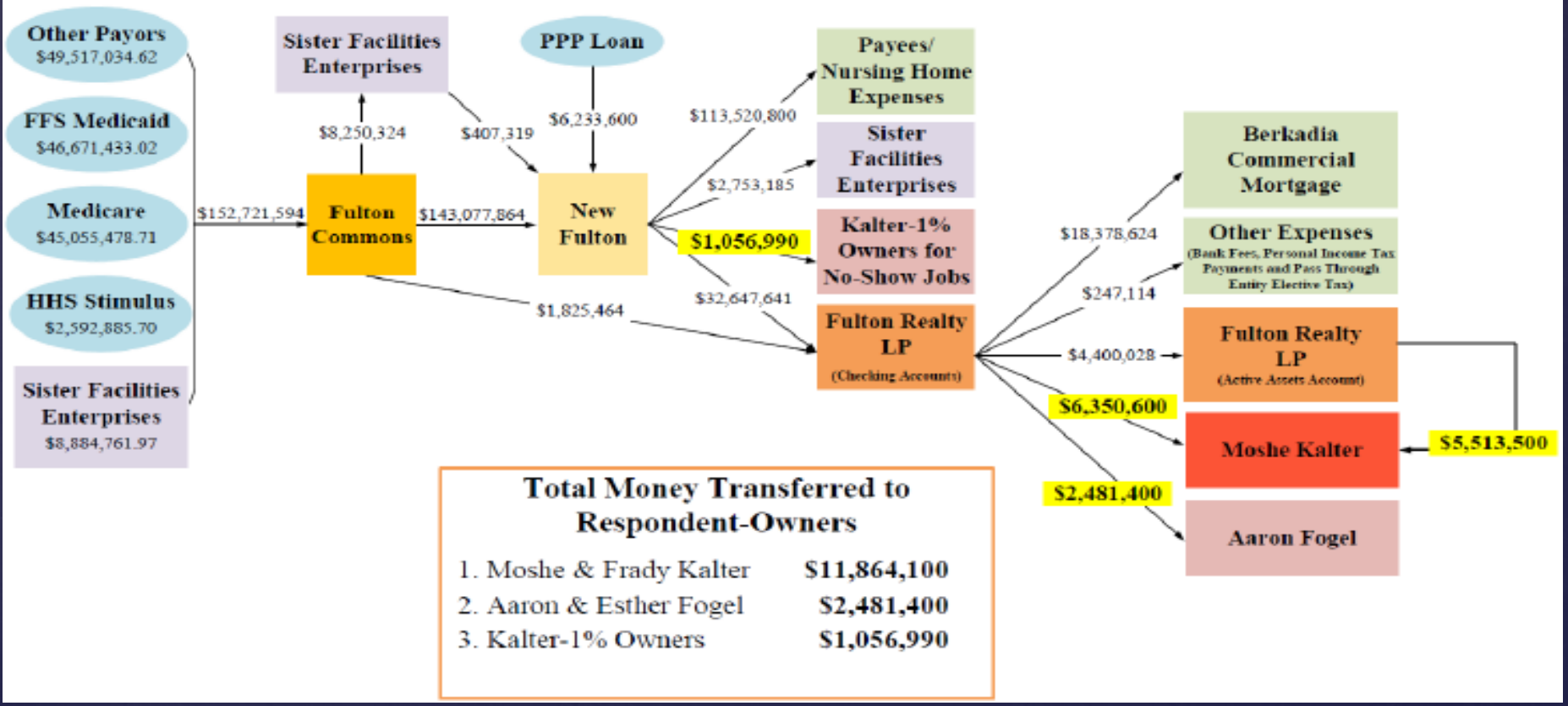
Fulton Commons' Rent to Revenue Ratio vs. NYS Average Rent to Revenue Ratio

Fulton Commons	2018	2019	2020	2021
Rent	$8,368,098	$9,096,302	$9,851,796	$7,156,909
Total Operating Revenue	$38,619,853	$40,638,641	$32,134,075	$29,953,410
Fulton Commons Rent to Revenue Ratio	21.66%	22.38%	30.65%	23.89%
NYS Average Total Rent to Revenue Ratio	8.65%	See Footnote[43]	10.62%	See Footnote[43]

212. As illustrated in the chart above, Kalter caused Fulton Commons' rent to revenue ratio, 21.66% in 2018 and 30.65% in 2020, to significantly exceed the corresponding NYS nursing home average rent to revenue ratios of 8.65% and 10.62%, respectively. This means that Fulton Commons' rent to revenue ratio surpassed the state average by over 13% in 2018 and 20% in 2020 and was the highest out of all Medicaid and Medicare-certified nursing homes on Long Island that reported a rental expense on their Cost Report. (*See* Ronan Aff. at ¶ 50.) In fact, Fulton Commons rent to revenue ratio in 2018 was the tenth highest out of all 351 such nursing homes in the state, and fourth highest out of all 379 such nursing homes in 2020. (*Id.*) This is particularly disturbing

Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons, Filed 12/13/22; Verified Petition at p. 19

Fulton Commons Cash Flow Chart: Transfer of $15,402,490 to Respondent-Owners from Fulton Commons from 2018–2021



Total Money Transferred to Respondent-Owners

1. Moshe & Frady Kalter	**$11,864,100**
2. Aaron & Esther Fogel	**$2,481,400**
3. Kalter-1% Owners	**$1,056,990**

Respondents' repeated and persistent fraudulent conduct continued through at least Jan. 2022 – when the Kalter 1% Owners illegally converted $34,689.80 for "salaries for no-show jobs" and Fulton Realty LLP transferred $300,000 to Moshe Kalter and $200,000 to Aaron Fogel. (Verified Petition, p. 19)

Executive Law § 63(12) Causes of Action: Fulton Commons:

- 1st Cause of Action Under Executive Law 63(12) Against Corporate Respondents, Respondent-Owners and Weiss for repeated and persistently committing fraud by engaging in fraudulent acts and/or demonstrated persistent fraud by converting $16M in up-front profit from Medicaid and Medicare funds that Fulton Commons received for resident care;

- 2nd Cause of Action Under Executive Law 63(12) Against Corporate Respondents, Respondents Kalter, Fogel and Weiss All Respondents, for engaging in repeated fraudulent acts by:
  - entering into collusive and self-dealing lease agreement causing the nursing home to pay artificially high rent to related-party Fulton Realty LLP

S

- 3rd Cause of Action Under Executive Law 63(12) Against Respondents Fulton Commons and Moshe Kalter for repeatedly and persistent fraudulent conduct by:
  - Failing to seek approval from DOH for transfers from the nursing home in excess of limits set by Public Health Law 2808(5)(c).
  - Filing false cost reports with DOH that falsely designated equity withdrawals and/or asset transfers to Respondent Kalter-1% Owners for no-show jobs as salaries and falsely asserted that such purported salaries were incurred to provide patient care at Fulton Commons;
  - Filing false certification statements for provider Billing Medicaid to DOH in which Kalter falsely attested that the Medicaid claims were for care and services furnished in accordance with applicable laws.

Executive Law § 63(12) Causes of Action: Fulton Commons:

- 4th Cause of Action Under Executive Law 63(12) Against Fulton Commons, Weiss, Kalter and Doyle for repeated and persistent fraud by deceiving DOH, current and prospective residents and their families as to conditions of Fulton Commons and the quality of care delivered;
- 5th Cause of Action Under Executive Law 63(12) Against Fulton Commons, Weiss, Kalter and Doyle for repeated illegality for violating over 38 regulations (pp. 138-140)

1. Maintain sufficient numbers of nursing staff with the appropriate competencies and skill sets to provide nursing and related services "to assure . . . the well-being of each resident," in violation of 42 CFR § 483.35.
2. Maintain sufficient personnel on a 24-hour basis to provide nursing care to all residents in accordance with each resident's needs as set forth in the care plan that Fulton Commons is required to develop, in violation of 10 NYCRR § 415.13(a);
3. Limit resident admissions, and "accept and retain only those nursing home residents for whom [they] can provide adequate care . . . ," in violation of 10 NYCRR § 415.26;
4. Timely administer treatments, medications, diets, and other health services, in violation of 10 NYCRR § 415.13;
5. Fulfill each resident's right to "adequate and appropriate medical care," in violation of 10 NYCRR § 415.3 and Public Health Law §§ 2803-c(2) and (3)(e);
6. Ensure that "all residents are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration, and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside the facility," as required by 10 NYCRR § 415.3(a) and 42 CFR § 483.10(a);
7. Fully inform each resident "in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being," as required by 10 NYCRR § 415.3(f)(1)(iv);
8. Consult with the resident immediately if the resident is competent, and notify the resident's physician and designated representative within 24 hours when there is an accident involving the resident that results in injury requiring professional intervention; a significant improvement or decline in the resident's physical, mental, or psychosocial status in accordance with generally accepted standards of care and services, or a need to alter treatment significantly, as required by 10 NYCRR § 415.3(f)(2)(ii) and 42 CFR § 483.10(g)(14)(i);
9. Assure that each resident is free from any psychotropic drug administered for purposes of discipline or convenience, and not required to treat the resident's medical conditions or symptoms, as required by 10 NYCRR § 415.4(a)(1), Public Health Law § 2803-c(h), and 42 CFR § 483.10(e)(1);
10. Develop and implement written policies and procedures prohibiting neglect, abuse, or mistreatment of Fulton Commons residents, and report any alleged violations of the same to DOH, as required by 10 NYCRR § 415.4(b), Public Health Law §§ 12-b and 2803-d, 42 USC § 1320b-25, and 42 CFR § 483.12;
11. Care for Fulton Commons' residents in a manner and environment promoting quality of life and dignity, as required by 10 NYCRR § 415.5;
12. Offer activities that meet the physical, mental, and psychosocial well-being of each resident and "promote and maintain the resident's sense of usefulness . . . , make his or her life more meaningful, stimulate and support the desire to use his or her physical and mental capabilities to the fullest extent and enable the resident to maintain a sense of usefulness and self-respect," as required by 10 NYCRR § 415.5(f)(1);
13. Maintain a safe, healthy, functional, sanitary, and comfortable environment for residents, as required by 10 NYCRR §§ 415.5(h) and 415.29;
14. Create comprehensive and timely care plans, provide services in accordance with comprehensive care plans and revise care plans as necessary to assure the continued accuracy of a resident's health assessment, as required by 10 NYCRR §§ 415.11(a)–(c) and 42 CFR § 483.20;
15. Acquire, receive, dispense, and administer "all drugs and biologicals required to meet the needs of each resident," as required by 10 NYCRR § 415.18 and 42 CFR § 483.45;
16. Maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment, in violation of 10 NYCRR § 415.19 and 42 CFR § 483.80;

Executive Law § 63(12) Causes of Action: Fulton Commons:

- 5th Cause of Action Under Executive Law 63(12) Against Fulton Commons, Weiss, Kalter and Doyle for repeated illegality in repeatedly violating over 38 regulations (pp. 138-140)

17. Have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, as required by 10 NYCRR § 415.26(b) and 42 CFR § 483.70(d);
18. Ensure that at least one member of the governing body of Fulton Commons participates in the quality assessment and assurance committee, as required by 10 NYCRR § 415.27;
19. Provide the necessary quality of care and services to attain and maintain the "highest practicable physical, mental, and psychosocial well-being," of each resident, including but not limited to failing to ensure that the residents' activities of daily living "do not diminish," as required by 10 NYCRR § 415.12;
20. Ensure that "a resident who is incontinent of bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible," as required by 10 NYCRR § 415.12(d)(1);
21. Provide "appropriate treatment and services to maintain or improve [residents'] abilities," as required by 10 NYCRR § 415.12(a)(2);
22. Ensure "a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene," as required by 10 NYCRR § 415.12(a)(3) and 42 CFR §§ 483.24(b) and 483.55;

23. Ensure that (1) any resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them; and (2) any resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, as required by 10 NYCRR § 415.12(c) and 42 CFR § 483.25(b);
24. Ensure that residents receive proper treatment and care to maintain good foot health, including providing foot care and treatment to prevent complications from the resident's medical condition, as required by 42 CFR § 483.25(b)(2);
25. Ensure that each "resident maintains acceptable parameters of nutritional status, such as body and weight and protein levels . . . and receives a therapeutic diet when there is a nutritional problem," as required by 10 NYCRR § 415.12(i);
26. Provide "each resident with sufficient fluid intake to maintain proper hydration and health," as required by 10 NYCRR § 415.12(j);
27. Provide "each resident with a nourishing, palatable, well-balanced and medically appropriate diet that meets residents' daily nutritional and special dietary needs[,] . . . employ sufficient competent staff to carry out the functions of the dietary service[,] . . . provide assistance with eating and special eating equipment and utensils for residents who need them[,] . . . [and] store, prepare, distribute and serve food under sanitary conditions," as required by 10 NYCRR § 415.14 and 42 CFR § 483.60;
28. Ensure that all "residents are free of any significant medication errors," as required by 10 NYCRR § 415.12(m)(2);
29. Ensure that "each resident receives adequate supervision . . . to prevent accidents," as required by 10 NYCRR § 415.12(h)(2);
30. Develop and implement medical services to meet the needs of its residents, as required by 10 NYCRR § 415.15;
31. Employ a sufficient number of professional staff members who are educated, oriented and qualified, as required by 10 NYCRR § 415.26(c);
32. Retain responsibility of the operation of the nursing home as the governing body or operator, as required by 10 NYCRR § 600.9;
33. Report accurate infection control data to DOH, as required by 10 NYCRR § 702.4;
34. Protect and promote the rights of each resident; treat each resident in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality; and provide equal access to quality care regardless of diagnosis, severity of condition, or payment source, as required by 42 CFR § 483.10(a);
35. Ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, as required by 42 CFR § 483.25;

36. Develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life, as required by 42 CFR § 483.75;
37. Provide courteous, fair, and respectful care and treatment to each resident, in violation of Public Health Law §§ 2803-c(2) and (3)(g); and
38. Ensure that only licensed individuals within a profession in which a license is a prerequisite practice in such profession, in violation of Education Law § 6512.

Additional Causes of Action: Fulton Commons:

- 6th Cause of Action Under Executive Law 63(12) Against All Respondents for repeatedly and persistent illegality by, e.g.,:
  - Committing in unacceptable practices under 18 NYCRR 515.2;
  - Failing to seek DOH approval for transfers from the nursing home in violation of 10 NYCRR 400.19(b)(1) and PHL 2808(5)(c);
  - Submitting incorrect and improper claims in violation of 18 NYCRR 518.3(a)
  - Failing to file complete and accurate cost reports with DOH in violation of 10 NYCRR 86-2.2

7th Cause of Action: Misappropriation of Public Funds Under The Tweed Law, Executive Law 63-c, Against Corporate Respondents, Respondent-Owners and Weiss

8th Cause of Action:
Unjust Enrichment Against
Fulton Commons, Fulton Realty LP, Fulton Realty, Inc.
and Respondent-Owners

292. By reason of the foregoing, Respondents Fulton Commons, Fulton Realty LP, Fulton Realty Inc., and Respondent-owners have been unjustly enriched to the detriment of the Medicaid and Medicare Programs and it is against equity and good conscience to permit them to retain the payments they received under these Programs.

293. Respondents Fulton Commons, Fulton Realty LP, Fulton Realty Inc., and Respondent-owners are therefore liable to the State in an amount to be determined by the Court at a hearing, but no less than $11,565,447, which is the amount identified to date that Respondent-owners unlawfully received from Medicaid and Medicare funds between January 1, 2018 and December 31, 2021, in violation of Public Health Law § 2808(5)(c).

Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons

- Injunctive Relief Sought:

Permanently enjoining:

1. Respondents from engaging in the illegal, fraudulent, and deceptive practices alleged herein;
2. Respondents from making self-dealing payments, loans, and other transfers of excessive value to themselves and related entities;
3. Respondents Fulton Commons, Kalter, Weiss, and Doyle from further violation of state and federal healthcare laws and regulations relating to nursing home services in New York State;
3. Respondents Fulton Commons, Respondent-owners, Weiss, and Doyle from further engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program; and

Respondent Fulton Commons from accepting any admissions of new residents unless and until Fulton Commons' operator provides a signed certification, endorsed by a qualified independent licensed clinician, to the Attorney General certifying that the operator has met their obligation to operate Fulton Commons with sufficient staffing to provide necessary care for all existing residents, and that Fulton Commons' staffing levels after any admissions of new residents will continue to meet the levels deemed necessary by the qualified independent licensed clinician, but no less than the 3.5 HPRD required by Public Health Law § 2895-b(3).

Directing Respondent-owners and Corporate Respondents, except Fulton Commons, to pay restitution to the State;

Appointing a financial monitor to oversee Respondent Fulton Commons' financial operations, with plenary powers of visitation and inspection, and specific authority to: (i) approve and withhold payments, including any payments to any Respondent or related person or entity; and (ii) ensure that Fulton Commons ceases collusive and self-dealing payments, loans, and other transfers of value to other Respondents;

E. Appointing an independent healthcare monitor to oversee Fulton Commons' healthcare operations and ensure that Fulton Commons improves healthcare outcomes for its residents;

F. Directing Respondents Fulton Commons, Respondent-owners, and Weiss to provide the independent healthcare monitor with real-time 24-hour per day remote access, every day of each year, to all of Fulton Commons' Electronic Medical Records ("EMR") systems for its residents, and to grant the highest level network permissions and credentials for all such EMR systems to the independent healthcare monitor in order to enable viewing of all edits made at any time to any records by any user, person, and/or system administrator;

G. Directing that Respondents Fulton Realty LP, Fulton Realty Inc., and Respondent-owners fully account for and disgorge all monies wrongfully received, as identified in the Ronan Aff. at ¶ 72 and enumerated in ¶ 18 *supra*, as a result of their fraudulent and illegal conversion and retention of substantial public funds paid as Medicaid and Medicare reimbursement to Respondent Fulton Commons for resident care that Fulton Commons failed to provide, and directing those Respondents to return said monies within 15 days to the Attorney General's Medicaid Fraud Control Unit, for return to the Medicaid and Medicare Programs;

Attorney General's Executive Law § 63(12) Special Proceeding re: Fulton Commons

Injunctive Relief Sought:

Declaratory Relief Sought:

Declaring Respondents engaged in repeated and persistent fraud and illegality, and received funds to which they were not entitled, and were unjustly enriched

Requiring the establishment of a governing body for Fulton Commons, comprised of multiple members, including the operator or their agent, the independent healthcare monitor, and the independent financial monitor; and requiring that the majority of the members of the governing body are not owners of Fulton Commons or their related persons;

Requiring the operator and the independent healthcare monitor, as members of the governing body, to participate in QAPI meetings;

J. Directing Corporate Respondents, except Fulton Commons, and Respondent-owners to pay for the expenses of the monitors appointed hereunder;

K. Directing Respondent Fulton Commons to remove Dr. Olaf Butchma from the position of Medical Director and to replace him with a qualified physician, approved by the independent healthcare monitor;

L. Directing all Respondents, except Fulton Commons, to pay civil penalties to the State;

M. Directing all Respondents, except Fulton Commons, to pay statutory penalties in the amount of $2,000 pursuant to CPLR 8303(a)(6) for violations of the Public Health Law, Social Services Law, and Medicaid Program rules;

N. Directing all Respondents, except Fulton Commons, to reimburse the State for the costs of this investigation;

O. Directing all Respondents, except Fulton Commons, to pay pre- and post-judgment interest at the rate of 9% pursuant to CPLR 5001, 5003, and 5004;

P. Directing each Respondent to notify Petitioner of any change to Respondents' addresses within five days of such change; and

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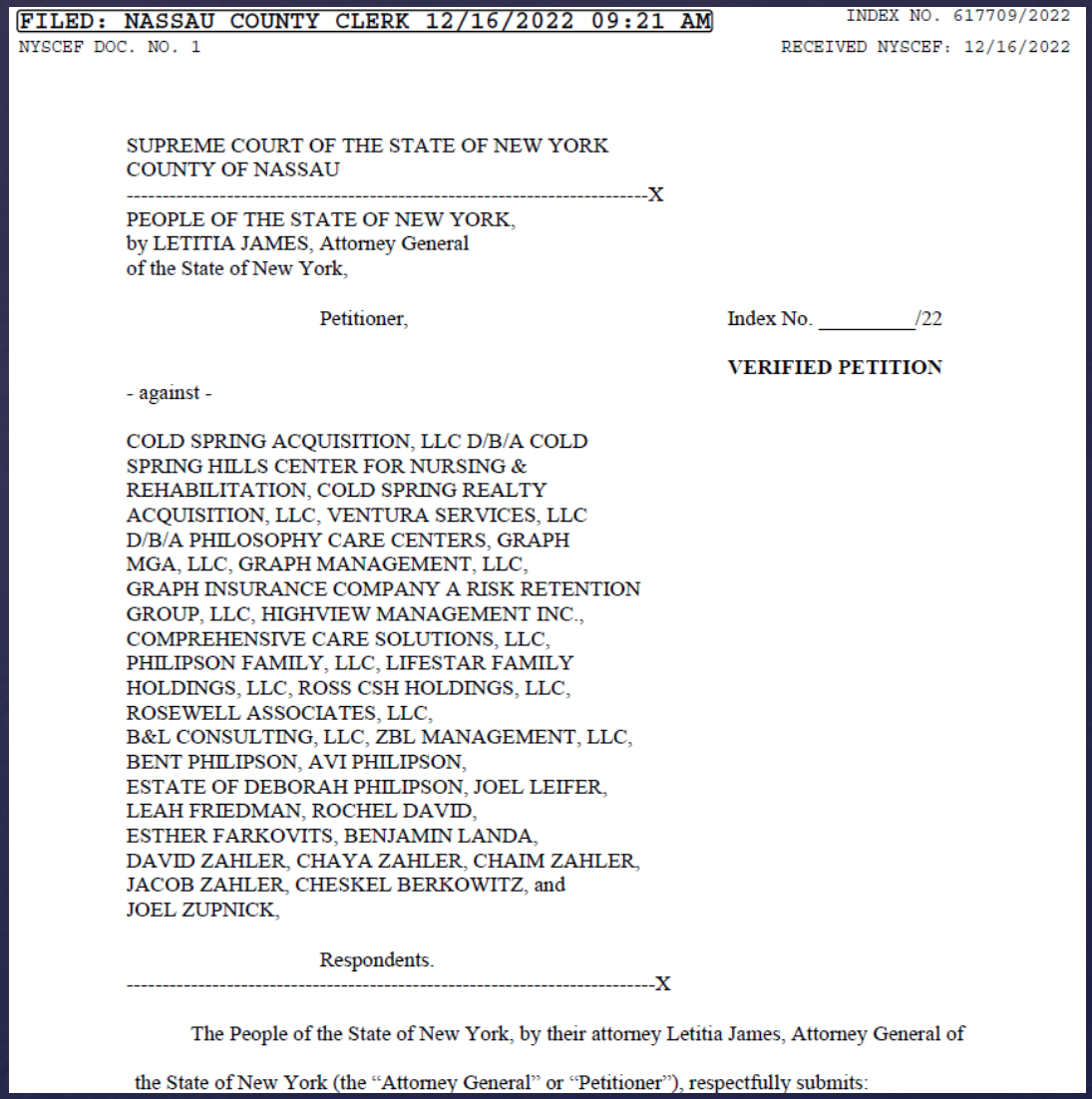
Attorney General's Executive Law § 63(12) Special Proceeding re: Cold Spring Hills, Filed 12/15/22

Verified Petition re: Cold Spring Hills (186 pages), filed 12/15/22

21 Affidavits

27 Respondents: Nursing Home, 12 LLCs, 1 other corporate entity, 14 individuals, including owners of nursing home and related party landlord and management companies



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NYSCEF DOC. NO. 1 RECEIVED NYSCEF: 12/16/2022

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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PEOPLE OF THE STATE OF NEW YORK,
by LETITIA JAMES, Attorney General
of the State of New York,

Petitioner,

Index No. _____/22

VERIFIED PETITION

- against -

COLD SPRING ACQUISITION, LLC D/B/A COLD SPRING HILLS CENTER FOR NURSING & REHABILITATION, COLD SPRING REALTY ACQUISITION, LLC, VENTURA SERVICES, LLC D/B/A PHILOSOPHY CARE CENTERS, GRAPH MGA, LLC, GRAPH MANAGEMENT, LLC, GRAPH INSURANCE COMPANY A RISK RETENTION GROUP, LLC, HIGHVIEW MANAGEMENT INC., COMPREHENSIVE CARE SOLUTIONS, LLC, PHILIPSON FAMILY, LLC, LIFESTAR FAMILY HOLDINGS, LLC, ROSS CSH HOLDINGS, LLC, ROSEWELL ASSOCIATES, LLC, B&L CONSULTING, LLC, ZBL MANAGEMENT, LLC, BENT PHILIPSON, AVI PHILIPSON, ESTATE OF DEBORAH PHILIPSON, JOEL LEIFER, LEAH FRIEDMAN, ROCHEL DAVID, ESTHER FARKOVITS, BENJAMIN LANDA, DAVID ZAHLER, CHAYA ZAHLER, CHAIM ZAHLER, JACOB ZAHLER, CHESKEL BERKOWITZ, and JOEL ZUPNICK,

Respondents.

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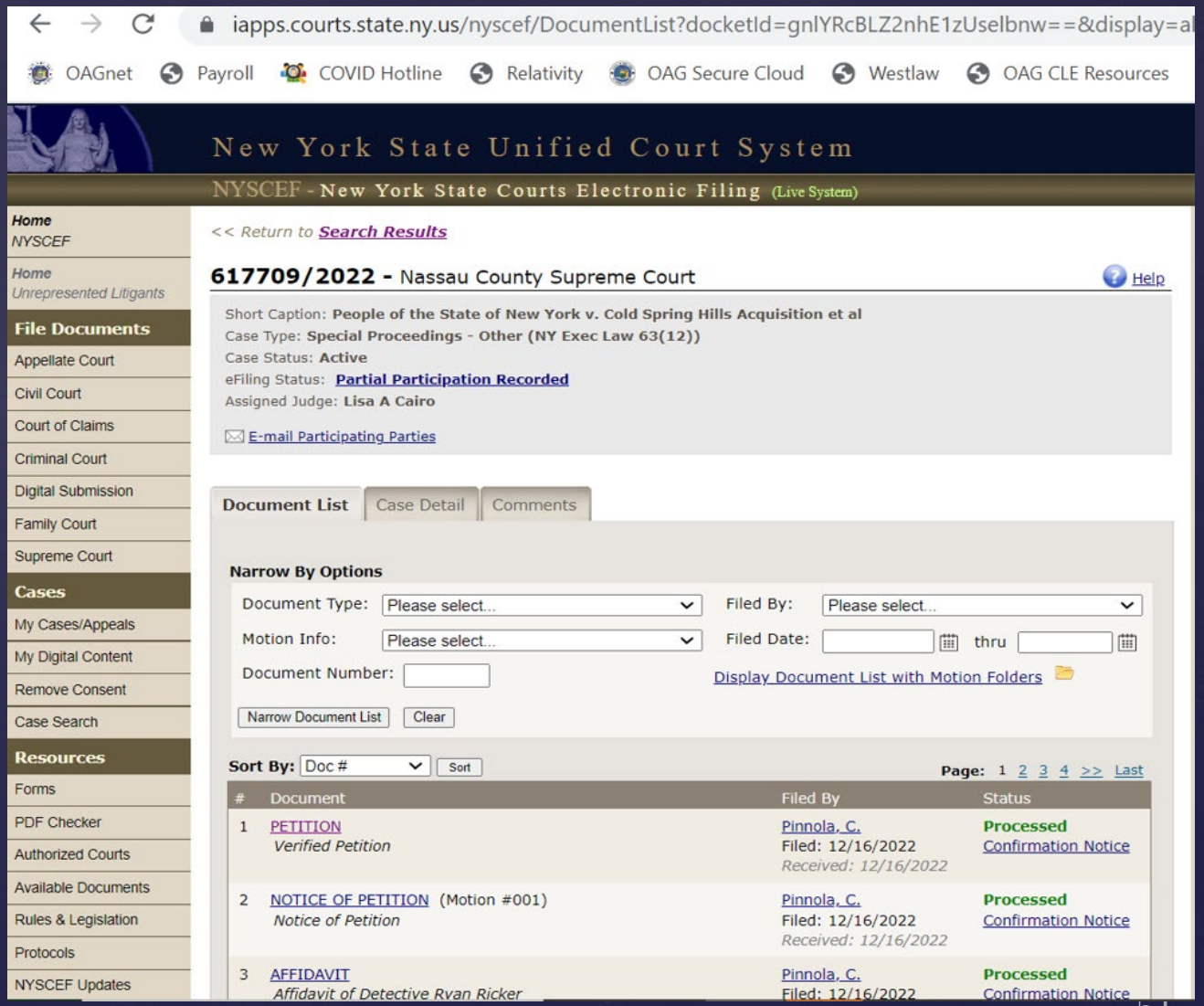
The People of the State of New York, by their attorney Letitia James, Attorney General of the State of New York (the "Attorney General" or "Petitioner"), respectfully submits:

All documents are free and publicly available on Court website and Attorney General's website in press release:

- Verified Petition
- 21 Affidavits:
  - Auditor Affidavit
  - Medical Analyst Affidavit
  - Detective Affidavit
  - Civilian Affidavits
- Memorandum of Law
- Notice of Petition

- 27 Respondents



Executive Law § 63(12) Special Proceeding re: Cold Spring Hills

Findings Supported by Affidavits and Exhibits: Cold Spring Hills Neglected Residents While Respondents Operated It with Insufficient Staffing and Poor Quality of Care in Violation of Regulations:

designed to protect vulnerable people who live in New York nursing homes, resulting in harm to the residents of a Long Island nursing home, Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"). Although this Petition is lengthy, the harrowing breadth and depth of the findings of resident neglect, harm and suffering, and the persistent fraud and illegality in Respondents' operation of Cold Spring Hills is appalling and warrants due exposure and redress.

2. Cold Spring Hills operates a 588-bed nursing home, located at 378 Syosset-Woodbury Road, Woodbury, in the Town of Oyster Bay, Nassau County, whose residents are all vulnerable, frail, elderly or disabled individuals, and primarily Medicaid and Medicare beneficiaries whose care is funded by taxpayers.

3. This special proceeding under New York Executive Law § 63(12) seeks restitution, disgorgement, and injunctive relief to expose and stop repeated and persistent fraud and illegality by the persons who have operated, owned, and controlled Cold Spring Hills, including (1) repeated neglect and inhumane treatment of Cold Spring Hills residents who have suffered while in Respondents' charge and (2) a long history of insufficient staffing and poor quality of care that began well before the COVID-19 pandemic, in violation and in reckless disregard of numerous New York State and federal laws, rules, and regulations. This egregious situation is directly traceable to Respondents' unconscionable fraudulent conversion of many millions of dollars in "up-front profit"[1] taken from Cold Spring Hills. Enriching themselves at the expense of Cold Spring Hills' residents, Respondents flagrantly disregarded their legal duties and diverted, through

[1] "Up-front profit" refers to the practice of making payments from the nursing home to Respondents under the guise of pre-determined and self-negotiated "expenses" and other transfers of funds, as a priority over, and without regard to, ensuring that the nursing home has used the public funds it received to meet the nursing home's duty to provide required care, with sufficient staffing to render such care, to its residents is referred to herein as "up-front profit." *See infra*, ¶¶ 7-8.

Attorney General sued Respondents under Executive Law 63(12) to seek injunctive relief to expose and stop repeated and persistent fraud and illegality in Respondents' operation of the nursing home, including:

- "Repeated neglect and inhumane treatment of Cold Spring Hills residents" (pp. 21-93)

- "Long history of insufficient staffing and poor quality of care in violation of regulations" (pp. 97-132)

- Directly traceable to Respondents' conversion of millions of dollars in "up-front profit" while nursing home disregarded its duties to provide required care and staffing and converted $22M (pp.21-169)

Executive Law § 63(12) Special Proceeding re: Cold Spring Hills

Findings in Verified Petition Supported by Affidavits and Exhibits: Respondents Took $22M That Should Have Been Spent on Care:

-Verified Petition identifies many laws and regulations that Respondents repeatedly and persistently violated that require nursing homes to provide required care. Cold Spring Hills Neglected Residents, Failed to Shower a Resident for Months, Failed to Provide Medical Care, Wound Care, and Dental Care, Nutrition Care, Failed to Provide Care in Care Plan, Basic Hygiene, Nail Care, Grooming, Dressing, Toileting (pp. 21-132)

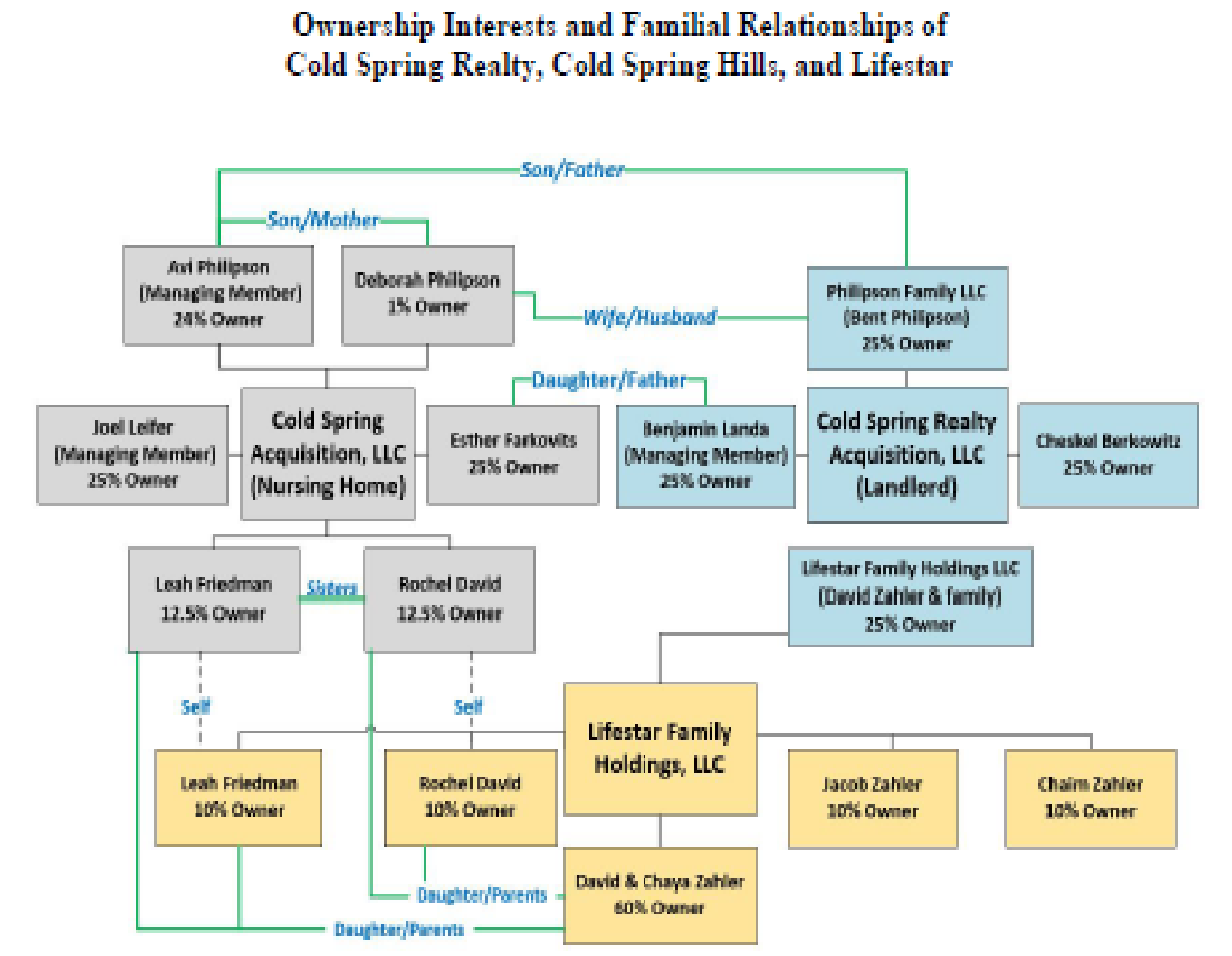
-Respondents failed to follow many infection control protocols during the pandemic. (pp. 86-97)

-Respondents fraudulently failed to report to DOH 52% of Cold Spring Hills COVID-19 resident deaths; specifically failing to report 51 COVID resident deaths from 3/1/20 to 6/4/20. During that time, 166 Cold Spring Hills residents died, 98 from COVID-19 and 68 from other causes. (pp. 15)

-Respondents also Filed False Cost Reports to DOH, Submitted False Documents to DOH for the CON application to Hide Undisclosed Operators, and Violated Asset Transfers Disclosure Laws. (pp. 161-168)

Executive Law § 63(12) Special Proceeding re: Cold Spring Hills Findings in Verified Petition (p. 46) Supported by Affidavits and Exhibits: Respondents Intentionally Deceived DOH to Get CON Approval, Filing False and Misleading Documents with DOH, "to Disguise the True Ownership and control of Cold Spring Hills from DOH,"(p. 44-51)

"Respondents Bent Philipson, Benjamin Landa, and David Zahler installed their children, Avi Philipson, Esther Farkovits, Rochel David and Leah Friedman, respectively, as straw owners, and Joel Leifer as the remaining 25% owner of Cold Spring Hills and the experienced figurehead and Managing Member." (pp. 44-45)



Executive Law § 63(12) Special Proceeding re: Cold Spring Hills; Findings in Verified Petition Supported by Affidavits and Exhibits:

Cold Spring Hills' Staffing Ratings Dropped Almost Immediately After Respondents Took Control, Then the Philipson Control Group Cut Staffing Again Before the Pandemic in Disregard of DOH Directives, Leading to Disastrous Pandemic Death Figures

275. Soon after Respondents purchased Cold Spring Hills, in the fourth quarter of 2016, the CMS RN Staffing rating dropped from a "four star" rating ("ABOVE AVERAGE") to a "three star" rating ("AVERAGE").[51] Under prior ownership, Cold Spring Hills' RN Staffing rating had been consistently "four stars" ("ABOVE AVERAGE") for each quarter of 2015 and the first three quarters of 2016. Auditor Aff., ¶ 165. Moreover, immediately prior to Respondents' ownership of Cold Spring Hills in 2016, the CMS Overall Staffing Rating was "three stars" ("AVERAGE."). Auditor Aff., ¶ 165.

- After a business dispute with Respondent Benjamin Landa, Respondent Bent Philipson took control of Cold Spring Hills, and cut staffing again in 2019.

Executive Law § 63(12) Special Proceeding re: Cold Spring Hills Findings in Verified Petition Supported by Affidavits and Exhibits:

-In June 2016, Cold Spring Realty purchased the real property where Cold Spring Hill is located. (p. 45);

-Respondents used complex web of 13 LLCs and 3 deceptive schemes to fraudulently extract $22M from the nursing home (pp. 9-13);

- $15.2M in inflated "rent" in collusive lease;

- $2M in fraudulent promissory note with 13% interest; and

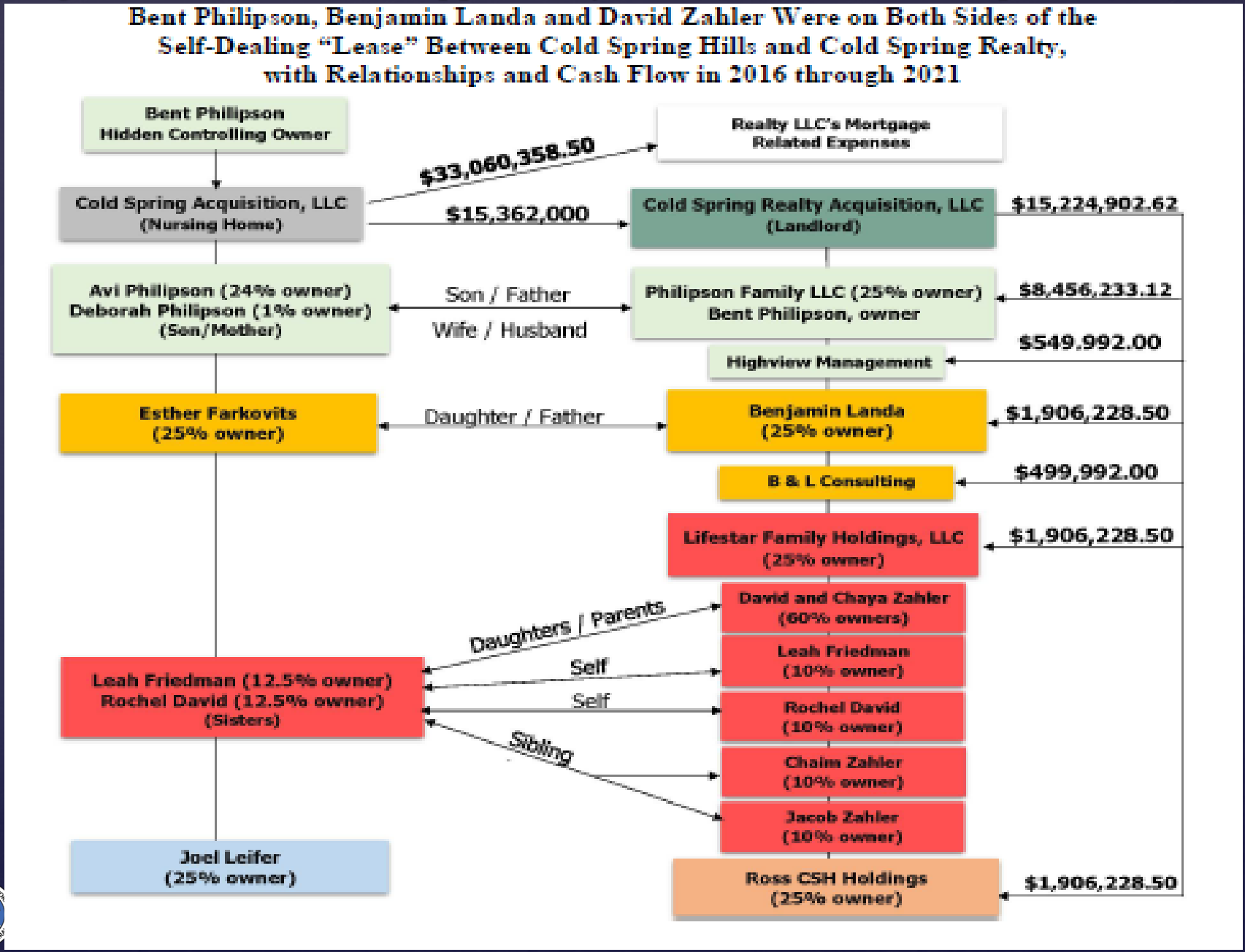
- $5M in sham "management" fees paid to 3 related party management or consulting entities, all while CMS ratings dropped.

110. Joel Leifer testified that Bent Philipson and Benjamin Landa set the terms of the "lease" between Cold Spring Hills and Cold Spring Realty in 2016 and Bent Philipson is an authorized signatory on Cold Spring Realty's bank account. SAAG Aff., Ex. 5 (pg. 102); Auditor Aff. ¶ 97, n.14.

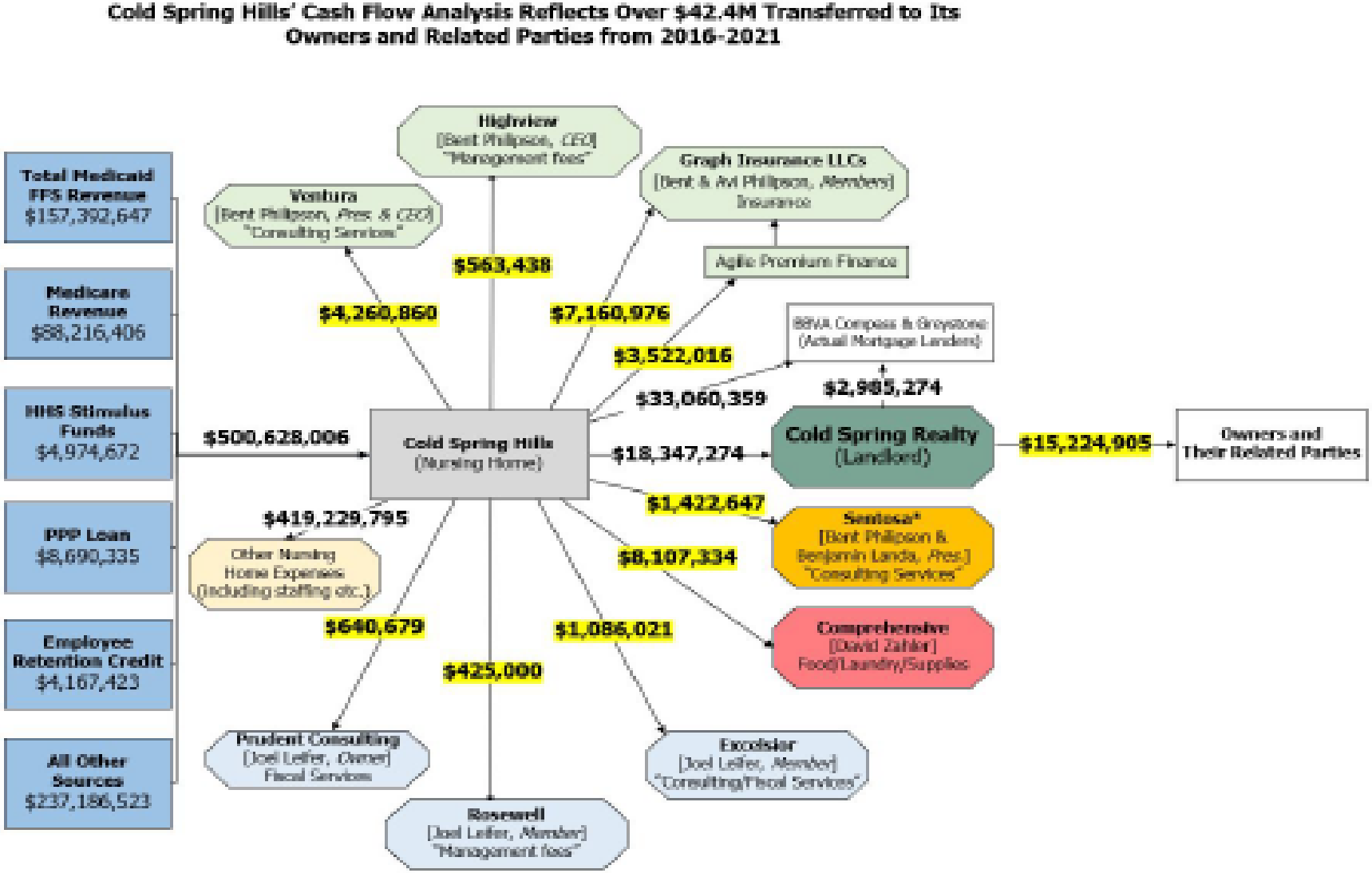
-Respondents' repeated fraud and illegality created poor working conditions for staff (pp. 15-16)

Executive Law § 63(12) Special Proceeding re: Cold Spring Hills

Findings in Verified Petition Supported by Affidavits and Exhibits (p. 137):



Executive Law § 63(12) Special Proceeding re: Cold Spring Hills: Findings in Verified Petition Supported by Affidavits and Exhibits: Respondents used complex web of 13 LLCs to fraudulently extract $22M in public funds from the nursing home



Executive Law § 63(12) Special Proceeding re: Cold Spring Hills; Findings in Verified Petition Supported by Affidavits and Exhibits:

-After Respondent Bent Philipson took control of Cold Spring Hills and cut staffing in 2019, he cut staffing again in February 2020 – right after DOH issued a Feb. 6, 2020 letter directing nursing homes to prepare for the pandemic. He did this "while pushing it to keep admission numbers up by admitting new residents." The cuts allowed Respondents to continue to line their pockets through the fraudulent inflated rent and management schemes. (pp. 50-53; 132-169)

> 109. Bent Philipson held himself out as the Executive Director of Cold Spring Hills in legal confirmation letters to Cold Spring Hills' accountants, dated from 2017 through 2021, regarding yearly financial audits of Cold Spring Hills. Auditor Aff., Ex. 26.

-Bent Philipson and Ventura illegally acted as Cold Spring Hills Governing Body.

-Bent Philipson used Cold Spring Hills to funnel money through extravagant salaries, bonuses and luxury cars to himself and the Favored Persons. (p. 14,52-52, pars. 97, 108-109, 425-434).

-Respondent Bent Philipson exercised his Fifth Amendment right against Self-Incrimination 685 times when asked questions, under oath, relating to the operation of Cold Spring Hills in the Attorney General's Executive Law 63(12) investigation. (p. 14)

Executive Law § 63(12) Special Proceeding re: Cold Spring Hills

Findings in Verified Petition Supported by Affidavits and Exhibits:

-Respondents used web of LLCs and predatory lease to fraudulently extract $15.2M in inflated "rent" to Respondent family members of Cold Spring Hills' straw owners (p. 141)

Conversion Through Fraudulent Cash Flow Rental Scheme of Over $15.2 Million by Bent Philipson, Benjamin Landa, Cheskel Berkowitz, and David Zahler from 2016 through 2020

Owner of Cold Spring Realty	2016	2017	2018	2019	2020	Total
Bent Philipson (Philipson Family)	$218,724.00	$833,334.31	$1,041,667.31	$2,937,499.50	$3,975,000.00	$9,006,225.12
Benjamin Landa	$218,724.00	$833,332.00	$1,041,665.00	$312,499.50	$0.00	$2,406,220.50
Cheskel Berkowitz (Ross)	$156,225.00	$666,668.00	$833,335.00	$250,000.50	$0.00	$1,906,228.50
David Zahler (Lifestar)	$156,225.00	$666,668.00	$833,335.00	$250,000.50	$0.00	$1,906,228.50
Total:	$749,898.00	$3,000,002.31	$3,750,002.31	$3,750,000.00	$3,975,000.00	$15,224,902.62

405 As shown above, in 2019, Bent Philipson controlled Cold Spring Hills and caused

Executive Law § 63(12) Special Proceeding re: Cold Spring Hills Findings in Verified Petition Supported by Affidavits and Exhibits: Respondents Engaged in Repeated and Persistent Fraud and Illegality, Converting $22M While Disregarding and Violating Many Laws and Regulations:

"When they obtained control of Cold Spring Hills in 2019, Respondents Bent Philipson, Avi Philipson, and Ventura Services, LLC d/b/a Philosophy Care Centers and Cold Spring Hills violated the law by cutting staffing levels, disregarding the nursing home's duties to provide required care and sufficient staffing to deliver it, and continued to extract up-front profit through multiple fraudulent schemes." (p. 4)

As Cold Spring Hills neglected residents in 2020, Bent Philipson extracted $4 Million from it through his control, in violation of laws and regulations. (pp. 76-83)

Special Proceeding Causes of Action re: Cold Spring Hills

- Five Causes of Action Under Executive Law 63(12) Against Respondents for repeated and persistent fraud and illegality in the operation of Cold Spring Hills in violation of numerous laws and regulations, and fraudulent conversion from Medicaid of funds that the nursing home received as reimbursement for services purportedly rendered that did not conform with applicable laws and regulations

- 6th Cause of Action Misappropriation of Public Funds Under The Tweed Law, Executive Law 63-c, Against All Respondents

7th Cause of Action: Unjust Enrichment: Against All Respondents

> 506. By reason of the foregoing, Respondents have been unjustly enriched to the detriment of the Medicaid and Medicare Programs and it is against equity and good conscience to permit them to retain the payments they received under the Programs.

Attorney General's Executive Law § 63(12) Special Proceeding re: Cold Spring Hills

- Injunctive Relief Sought:

Permanently enjoining:

1. Respondents from engaging in the illegal, fraudulent, and deceptive practices alleged herein;
2. Respondents from making self-dealing payments, loans, and other transfers of excessive value to the Respondents and related entities;
3. Respondents from further violation of state and federal regulations relating to nursing home services;
4. Respondents from further engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program;
5. Respondent Cold Spring Hills from accepting any admissions of new residents unless and until Respondent Cold Spring Hills provides a signed certification, endorsed by a qualified licensed clinician, to the Attorney General certifying that the facility has met his obligation to operate Cold Spring Hills by ensuring sufficient care and staffing for all existing residents and for any new residents; and
6. Removing Respondents Bent Philipson and Avi Philipson immediately and permanently from any role at Cold Spring Hills or any related entity.

C. Directing all Respondents to pay restitution to the State;

D. Directing that each Respondent fully account for and disgorge all monies wrongfully received as a result of Respondents' fraudulent and illegal conversion and retention of substantial public funds paid as Medicaid and Medicare reimbursement to Cold Spring Hills for resident care that Cold Spring Hills failed to provide, and to return said monies within 15 days to the Attorney General's Medicaid Fraud Control Unit, for return to the Medicaid and Medicare Programs;

E. Appointing a financial monitor to oversee Cold Spring Hills' financial operations, with plenary powers of visitation and inspection, and specific authority to withhold any payments to any Respondent or related person and decide any order of payments;

Attorney General's Executive Law § 63(12) Special Proceeding re: Cold Spring Hills

Injunctive Relief Sought:

Declaratory Relief Sought:

Declaring Respondents engaged in repeated and persistent fraud and illegality, and received funds to which they were not entitled, and were unjustly enriched

F. Appointing an independent healthcare monitor to oversee Cold Spring Hills' healthcare operations and ensure that Cold Spring Hills improves healthcare outcomes for the residents;

G. Directing the Respondents to provide the independent healthcare monitor with real-time 24-hour/day remote access to all Cold Spring Hills' Electronic Medical Records ("EMR") systems for its residents, and to grant the highest level permissions to the independent healthcare monitor for all such EMR systems in order to enable viewing of all edits made at any time to any records by any user, person and/or systems administrator;

H. Directing all Respondents except Cold Spring Hills to pay for the expenses of the monitors appointed hereunder;

I. Directing Respondents to pay civil penalties to the State, including in accordance with CPLR § 8303(a)(6), for violations of the PHL, Social Services law and Medicaid payment rules;

J. Directing all Respondents except Cold Spring Hills to reimburse the State and the United States for the costs of this Investigation;

K. Directing each Respondent to notify Petitioner of any change of Respondents' addresses within five days of such change;

L. Directing each Respondent to pay post-judgement interest at the statutory rate of 9% pursuant to CPLR §§ 5003; 5004; and

M. Granting Petitioner such other and further relief as this Court deems just and proper.

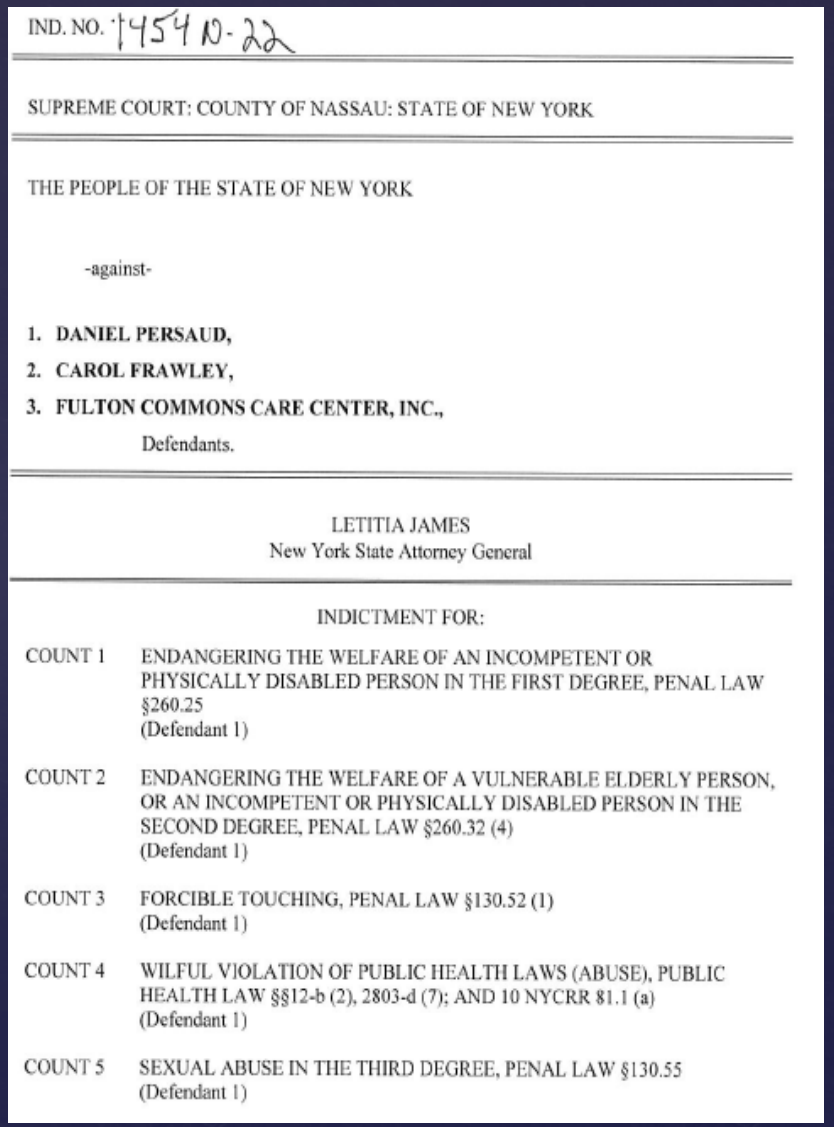
Indictment of Fulton Commons Care Center, Inc., Its Former DON and Former LPN, Announced 11/30/22

Charges in 13 Count Indictment:

In the indictment, a Nassau County Grand Jury charged Daniel Persaud with Sexual Abuse in the Third Degree, Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, Endangering the Welfare of a Vulnerable Elderly Person, or an Incompetent or Physically Disabled Person in the Second Degree, Willful Violation of Public Health Laws, and Forcible Touching for an act committed against a female resident at Fulton Commons between October 1, 2020, and November 26, 2020.

The Grand Jury also charged Carol Frawley and Fulton Commons Care Center, Inc. with two counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, multiple counts of Falsifying Business Records in the First Degree, and Willful Violation of Public Health Laws.

The charges filed in this case are merely accusations. The defendants are presumed innocent unless and until proven guilty in a court of law.



IND. NO. 1454 10-22

SUPREME COURT: COUNTY OF NASSAU: STATE OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK

-against-

1. **DANIEL PERSAUD,**
2. **CAROL FRAWLEY,**
3. **FULTON COMMONS CARE CENTER, INC.,**

Defendants.

LETITIA JAMES
New York State Attorney General

INDICTMENT FOR:

COUNT 1	ENDANGERING THE WELFARE OF AN INCOMPETENT OR PHYSICALLY DISABLED PERSON IN THE FIRST DEGREE, PENAL LAW §260.25 (Defendant 1)
COUNT 2	ENDANGERING THE WELFARE OF A VULNERABLE ELDERLY PERSON, OR AN INCOMPETENT OR PHYSICALLY DISABLED PERSON IN THE SECOND DEGREE, PENAL LAW §260.32 (4) (Defendant 1)
COUNT 3	FORCIBLE TOUCHING, PENAL LAW §130.52 (1) (Defendant 1)
COUNT 4	WILFUL VIOLATION OF PUBLIC HEALTH LAWS (ABUSE), PUBLIC HEALTH LAW §§12-b (2), 2803-d (7); AND 10 NYCRR 81.1 (a) (Defendant 1)
COUNT 5	SEXUAL ABUSE IN THE THIRD DEGREE, PENAL LAW §130.55 (Defendant 1)

Attorney General's Indictment of Fulton Commons, Its Former DON and Former LPN, Announced 11/30/22

As Alleged in the Indictment:

- The Indictment charges Daniel Persaud, a former LPN at Fulton Commons, with sexually assaulting a resident at the facility in the fall of 2020.

- The Indictment charges Carol Frawley, a former DON and a high managerial agent acting on behalf of Fulton Commons, with multiple counts of falsifying business records for covering up sexual assault and failing to report it.

- The Indictment alleges that Carol Frawley, acting on behalf of Fulton Commons, intentionally lied on internal records that should have accurately reported complaints regarding Daniel Persaud's conduct from residents and staff.

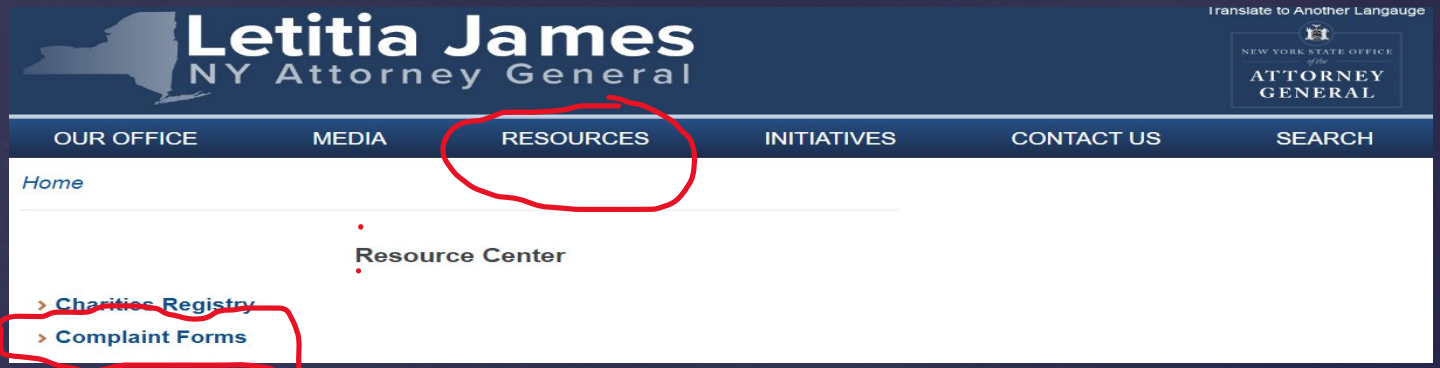
- The Indictment alleges that Carol Frawley failed to report complaints to DOH as required by law whenever staff have reasonable cause to believe a resident has been abused, mistreated, or neglected.

- The Indictment alleges that by failing to take disciplinary action against Daniel Persaud or report his conduct to DOH, Carol Frawley and Fulton Commons endangered the residents in their care.

The charges filed in this case are merely accusations. The defendants are presumed innocent unless and until proven guilty in a court of law.

How Do You Report Medicaid Provider Fraud, or Abuse, Neglect or Mistreatment?

Anyone with information about nursing home allegations of neglect, abuse or fraud, can file a confidential complaint at on the Attorney General's website: **www.AG.NY.Gov**



Go to **RESOURCES** Tab, then **COMPLAINT FORMS**

then click on:

or Call the Attorney General's Hotline: **(833) 249-8499**, or
NYS Attorney General MFCU Hotline: **212 417 5397**