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:

PRELIMINARY STATEMENT

1. This case involves rampant fraud, avarice, financial loss to the taxpayer-funded New York Medicaid and federal Medicare programs, and repeated and persistent violation of laws

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.

related-party transactions, over $22.6 million from Cold Spring Hills that should have been spent on resident care. *See infra* ¶¶ 13, 394-446. They also engaged in repeated fraudulent and illegal acts to hide this conversion.

4. At all relevant times, New York law has imposed on Cold Spring Hills, as a nursing home, and those who own, operate, and control it, a "special obligation" to care for its residents and to ensure that they are provided with the "necessary care and services," including clinical care in accordance with each resident's individualized care plan, and sufficient staffing "to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 10 NYCRR § 415.1(a)(1)-(2); *id.* § 415.3(f); *id.* § 415.12; *id.* § 415.13; 42 CFR § 483.25; *see also* 42 § CFR 483.35; *id.* § 483.10(d)(2). Respondents repeatedly violated these regulations and other laws.

5. Furthermore, Respondents repeatedly committed countless acts of neglect against residents of Cold Spring Hills, in violation of Public Health Law ("PHL") § 2803-d (7), by failing 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" as required by 10 NYCRR § 81.1(c).

6. This Petition is accompanied and supported by witness affidavits of Andrea Parker ("A.P."), Carol Borrelli ("C.B."), Elsie Limage ("E.L."), Margaret Galeno ("M.G."), Melissa Heche ("M.H."), Satwattie Davi Singh ("S.D.S."), Wendy Shapiro ("W.S."), Chelsea Hansson ("C.H."), and Mary Ann Gagliardi ("M.A.G.") (collectively, "Witness Affidavits"), whose family members were or are residents of Cold Spring Hills, affidavits of Senior Auditor-Investigator Patrick Beltrani ("Auditor Aff."), Detective Ryan Ricker ("Detective Aff."), Medical Analyst Mary Conway, R.N. ("Medical Analyst Aff."), and the records of testimony and document

production attached to the Affirmation of Special Assistant Attorney General Christina Pinnola ("SAAG Aff.").

7. The COVID-19 pandemic was not a random inflection point for Respondents' management and ownership of Cold Spring Hills; rather, the pandemic merely exposed and exacerbated the total failure of Respondents' callous decisions to operate the nursing home by cutting staffing expenses and continue resident admissions to maximize revenue in order to prioritize up-front profit-taking by its owners and the owners of its related parties—all while disregarding the nursing home's duties to provide required care and staffing to its residents. When COVID-19 hit Long Island, Respondents' exploitative business model simply snapped under the poor working conditions they had created.

Cold Spring Hills Repeatedly Violated Its Duties to Many Residents

8. The interviews of residents, their family members, and employees of Cold Spring Hills, analysis of medical records of residents, and evidence in the accompanying Affidavits all support the Attorney General's findings showing that Respondents repeatedly and illegally prioritized their personal profit over Cold Spring Hills' legal duty to provide required resident care and necessary staffing to deliver that care, thereby causing physical and emotional harm to vulnerable residents and stripping them of their dignity. 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 ("Ventura") and Cold Spring Hills (collectively, the "Philipson Control Group") 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 related party schemes. As a result, Cold Spring Hills' residents suffered neglect and humiliation for years: from *before* the COVID-19 pandemic, through the peak

of its first wave, and continuing into 2022. The following are a few of many examples of Respondents' repeated and persistent pattern of illegality, and disregard of Cold Spring Hills' duty to provide necessary resident care:

a. **Resident Neglected, Not Showered for Months, Her Basic Needs Ignored.** S.H.[2] was admitted for short term rehabilitation to Cold Spring Hills in August 2019 after she had a stroke that affected her ability to walk, to use her right, dominant arm and hand, and to speak. She could not feed herself or make her needs known, and she was dependent on her caregivers at Cold Spring Hills. S.H.'s daughter, M.H., said that, during her mother's five-month residency at Cold Spring Hills, she only received a shower the first week she arrived, the week she left, and one more in between. Staff claimed they could not shower S.H. because the necessary bariatric chair was broken -- as was the only replacement chair they could find. Despite this, Cold Spring Hills nursing staff told S.H.'s daughter that staff was showering S.H. regularly and the showers were documented in her chart. Moreover, M.H. said that in August 2019, when her sister visited their mother, she asked an aide to change her mother's diaper, as she could smell an odor. The aide declined to do so, responding, "She is a 2 person assist, and I am the only one here—she will have to wait." Her mother waited approximately six hours in a soiled diaper until staff changed her. M.H. said that similar instances of her mom being left to sit in soiled diapers happened "more times than I can tell you." M.H. added that Cold Spring Hills staff ignored her requests to trim her mother's fingernails, which grew so long as to cause abrasions to her mother's paralyzed hand. *See infra* ¶¶ 145-54.

b. **Missing Teeth and Exposed Roots, Repeated Neglect of Hygiene and Care Needs, Filthy Room.** Resident C.P. has been living at Cold Spring Hills since 2018. According to her daughter, A.P., in the second half of 2019, Cold Spring Hills' staff said C.P. was refusing to take showers and so they were going to stop bathing her. A.P. had to go to Cold Spring Hills to shower her mother each week, stopping only because of the COVID-19 pandemic. During their weekly FaceTime video calls through the summer of 2020, her mother always looked dirty, as if staff, again, were not showering her. Cold Spring Hills also failed to provide dental care to her mother. C.P. lost her dental bridge after an "unwitnessed" fall in the Cold Spring Hills dining room, leaving her mouth such that her "upper front teeth were broken off and her root tips and metal posts were exposed." And while the Cold Spring Hills dentist recommended leaving her mouth as it was, claiming it was too difficult to make dentures for

[2] Current and former residents of Cold Spring Hills and their family members are referred to by initials rather than full names to protect their privacy. "Family" includes natural relatives, legal representatives, and friends of Cold Spring Hills residents.

a dementia patient,[3] an oral surgeon unconnected to Cold Spring Hills expressed disbelief at the state of C.P.'s teeth, based on the lack of oral care. She had to have several teeth extracted. Adding to her poor care, when A.P. visited her mother at Cold Spring Hills for the first time since the pandemic began, she was "very upset, angry, and infuriated" by the conditions in which her mother was living. Among the items under her mother's bed were food, a fork, clothing, a medication cup, shoes, a newspaper, and other garbage. The bathroom floor was filthy, there were feces on the walls, and there was no running water, among other issues. In recent years while living at Cold Spring Hills, C.P. has also suffered the COVID-19 virus, a bacterial skin infection from scratching herself, and hospitalization for a urinary tract infection—unsurprising, as she has been left to sit in diapers soaked with urine and feces. *See infra* ¶¶ 122-44, 336.

c. **"They tried to kill me at Cold Spring Hills…."** T.S. was admitted to Cold Spring Hills in April 2021 because he needed physical therapy to regain mobility after a car accident. He had a tracheostomy but was able to speak. His wife, W.S. visited her husband every weekday evening and on the weekends. She said that "he always looked like no one had taken care of him." Like others, T.S. had pressure injuries when admitted to Cold Spring Hills. While under the care of Cold Spring Hills, however, his sacral pressure injury increased in size and worsened from stage 3 to the most severe stage 4. T.S. lost a significant amount of weight during the four months he lived at Cold Spring Hills. He was on a feeding tube, and Cold Spring Hills records document that T.S. was seen disconnecting his feeding tube and sucking and swallowing the formula from it; he also gestured that he wanted water. Despite his serious pressure injuries and deep tissue injuries, W.S. invariably found T.S. "always lying on his back in his bed and his call bell was always on the floor, where he could not reach or use it." Being left in the same position for too long can worsen existing pressure injuries and lead to new ones. Like others, W.S. said that T.S. looked dirty and was not groomed. Additionally, T.S.'s room was "gross," including trash under his bed and constant dripping from his sink faucet. Yet, W.S. described T.S.'s nursing unit as a "ghost town," "hard to find a staff member to talk to." When T.S. went to Plainview Hospital in August 2021 to have his dialysis port and trach removed, a nurse at the hospital told W.S. that her husband was dehydrated,[4] and a dietitian "said that there was no way Cold Spring Hills was

[3] "Dementia" does not connote violence or dangerousness in any way. Per the U.S. Centers for Disease Control and Prevention ("CDC"), dementia is not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities, commonly seen in patients with Alzheimer's Disease and other diseases with significant cognitive impairments. Medical Analyst Aff., ¶ 35 n.9.

[4] Dehydration, or the lack of appropriate and sufficient fluids, can lead to a multitude of physical issues and ailments, including weakness, infections, delirium, and cardiac arrhythmia. It can impair a resident's ability to heal from injury and cause overall deterioration of their body and decline in health. This can be particularly serious for nursing home residents, who are often already in a

> feeding him four to six times a day." T.S. managed to regain weight in the hospital. He told his wife: "They tried to kill me at Cold Spring Hills . . . ." W.S. told the hospital staff "over my dead body" would she send her husband back to Cold Spring Hills. In September 2021, he was discharged from the hospital to another facility, where he finally received the care he was supposed to have received at Cold Spring Hills. *See infra* ¶¶ 177-84, 174-75, 329, 303.

9. While taking millions of dollars to increase their up-front profit while cutting nursing home staff necessary to provide required care, Respondents also shifted the cost and burden of such care to the families of many of the residents of Cold Spring Hills. Repeatedly, as shown below, family members had to step in to provide basic hygiene, grooming care, advocacy, and services that Respondents failed to provide while deliberately cutting staff—even though New York taxpayers were paying for such care. Sadly, many Cold Spring Hills residents did not have family to take on those burdens.

Respondents Engaged in Three Fraudulent Schemes Resulting in the Conversion of Over $22.6 Million from Cold Spring Hills

10. Respondents have persistently operated Cold Spring Hills to cause it to repeatedly violate its duties to provide required care to many of its residents, as well as its duty to provide sufficient staffing to provide that care—beginning long before the COVID-19 pandemic.

11. Respondents could have prevented much of the neglect and suffering of Cold Spring Hills' residents by permitting the nursing home to spend more of the Medicaid and Medicare funds it received on resident care and staffing. Instead, Respondents used a complex web of at least 13 related parties to hide how Respondents were exercising control over the nursing home, and to orchestrate multiple deceptive schemes to extract funds for their personal financial benefit. In so doing, Respondents created and controlled revenue streams flowing from the nursing

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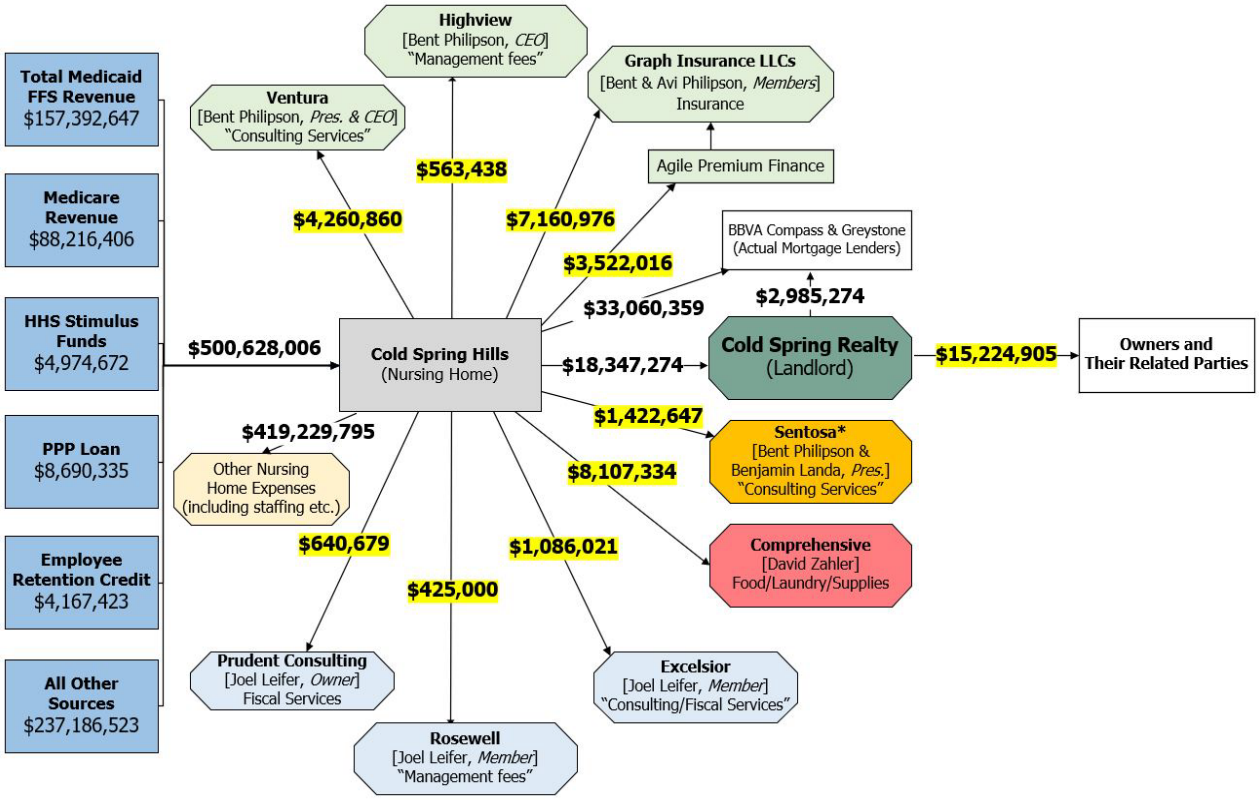
compromised state. Dehydration can also take an emotional and psychological toll on a resident, potentially causing a lack of motivation to participate in activities and lack of cooperation with his or her care plan. Medical Analyst Aff., ¶ 54.

home to owners of its related parties, through transactions that were disguised to appear bona fide but were fraudulent vehicles to deliver hidden "up-front" profit to the owners. Simultaneously, Respondents disregarded the nursing home's many legal obligations to provide required care and staffing for its residents, causing neglect, suffering and increased risk of harm.

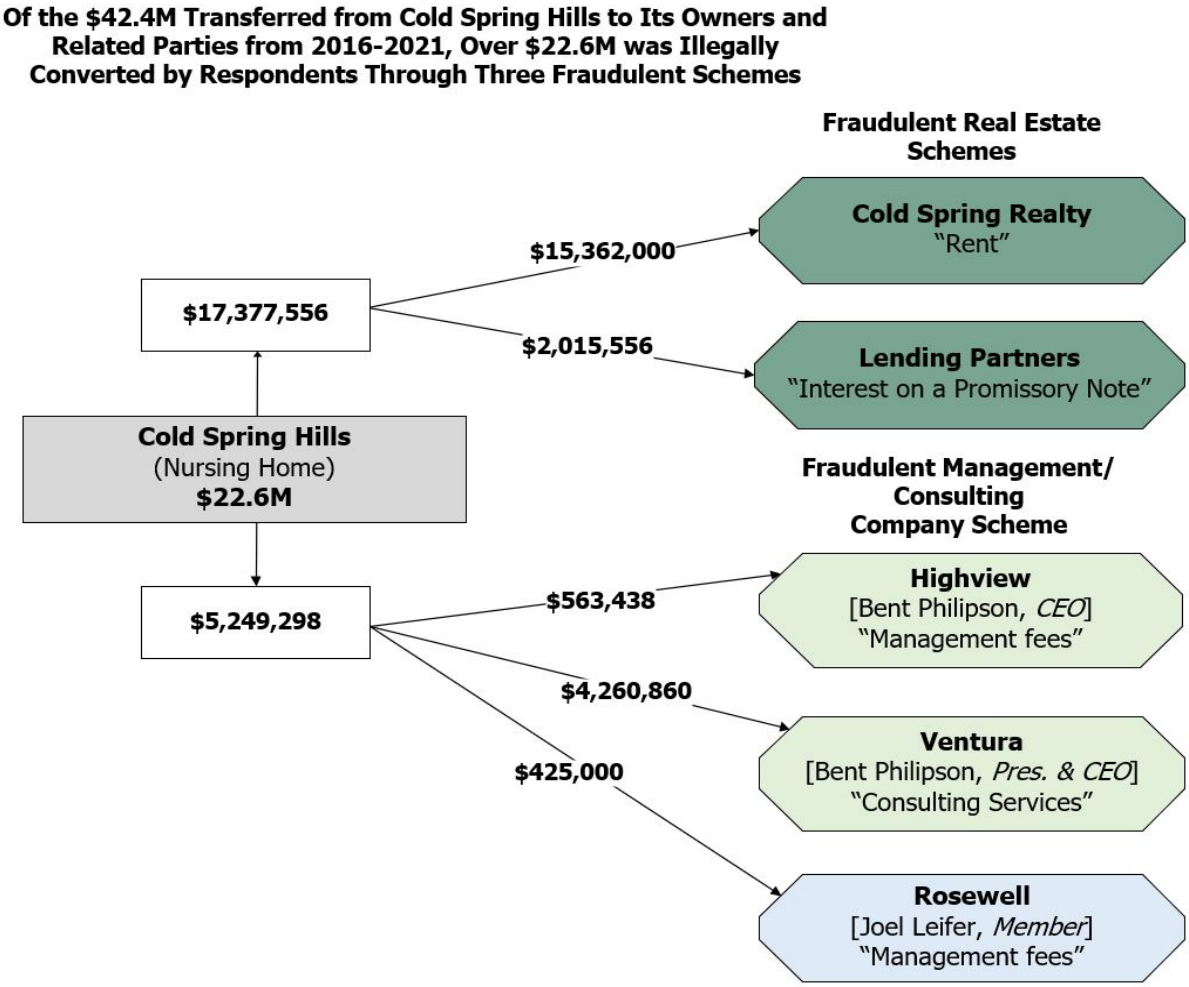
12. The Respondents' deceptive schemes depended in part on the confusion created by the myriad of transactions and related party arrangements they controlled and used to siphon out funds from Cold Spring Hills. As indicated in the cash flow chart below, from 2016 through 2021, over $42.4 million was transferred from Cold Spring Hills to its owners and related parties. The amount received by each related party is highlighted in yellow. The resulting cash flow from these related party financial transactions can be better understood with graphics. Therefore, in the charts below, entities controlled, directly or indirectly, by various Respondents are shown in consistent colors. For example, the entities controlled by Respondent Bent Philipson are shown in light green; entities controlled by Respondent Joel Leifer are shown in light blue; and entities controlled by Respondent Benjamin Landa are shown in orange.

Cold Spring Hills' Cash Flow Analysis Reflects Over $42.4M Transferred to Its Owners and Related Parties from 2016-2021



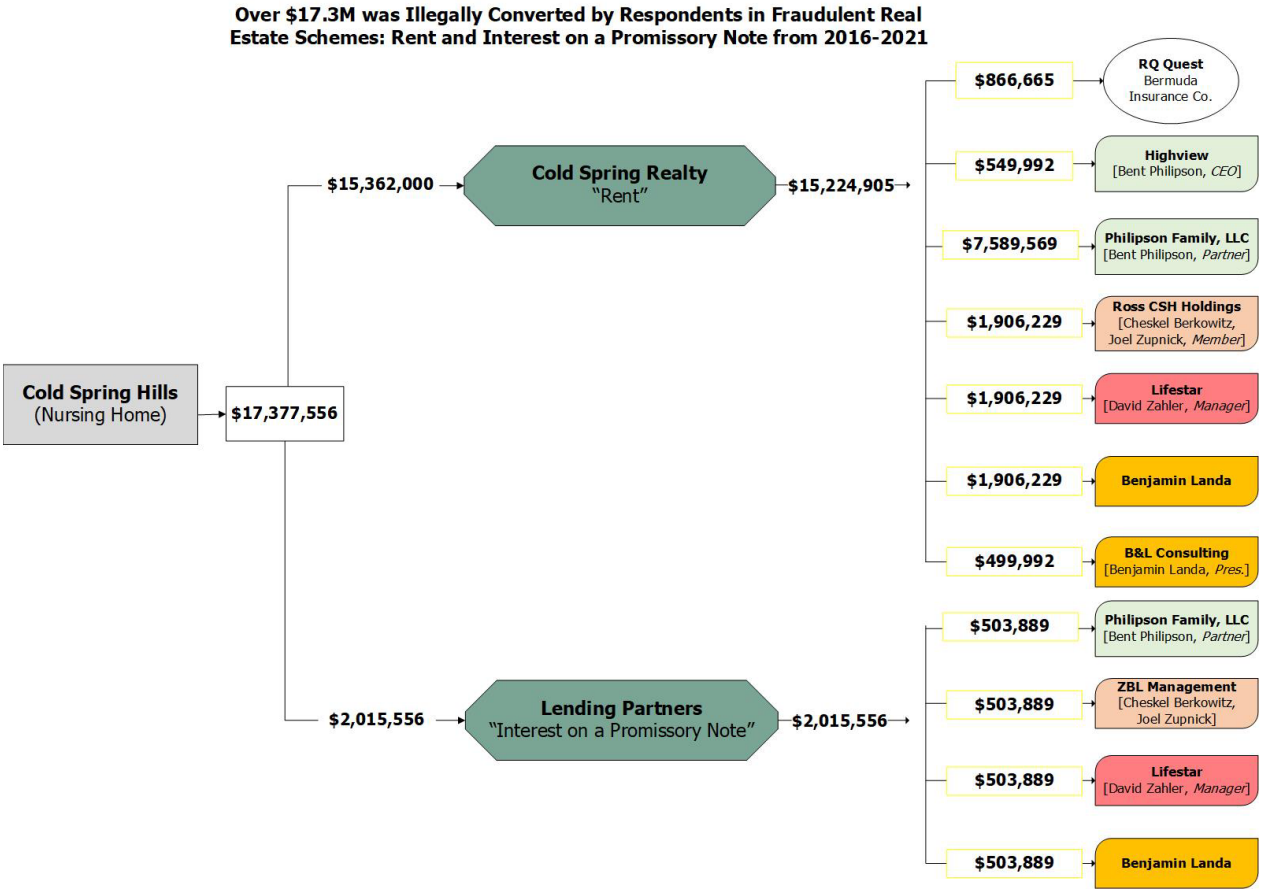
Note:
* The payments to Sentosa were divided evenly between Bent Philipson and Benjamin Landa.
The operating bank account balance as of 12/31/2021 for Cold Spring Hills was $2,801,607.00.

13. Of the $42.4 million transferred from Cold Spring Hills to its owners and related parties, Respondents illegally converted over $22.6 million. The chart below reflects the three primary fraudulent schemes through which Respondents converted over $22.6 million in Medicaid and Medicare funds from Cold Spring Hills from 2016 through 2021, including: (1) their fraudulent rent scheme through Cold Spring Realty Acquisition, LLC ("Cold Spring Realty"); (2) their fraudulent promissory note scheme through Lending Partners, LLC ("Lending Partners"); and (3) their fraudulent management/consulting company scheme through Ventura, Highview Management, Inc. ("Highview"), and Rosewell Associates, LLC ("Rosewell").



14. The next chart below depicts a more detailed analysis of the fraudulent rent and promissory note schemes that resulted in the Respondents conversion of $17,337,556. Through a collusive and predatory lease agreement between Cold Spring Hills and Cold Spring Realty, Cold Spring Realty illegally converted $15,362,000 from Cold Spring Hills. As explained in greater detail below, there is a familial relationship between most of the owners of Cold Spring Realty and the owners of Cold Spring Hills. Cold Spring Realty owns the real property on which Cold Spring Hills is located and, through this collusive lease agreement, charges Cold Spring Hills exorbitant rent. *See infra* ¶¶ 394-404. The chart below depicts the converted funds received by each owner of Cold Spring Realty as a result of this collusive lease agreement. Moreover, Respondents

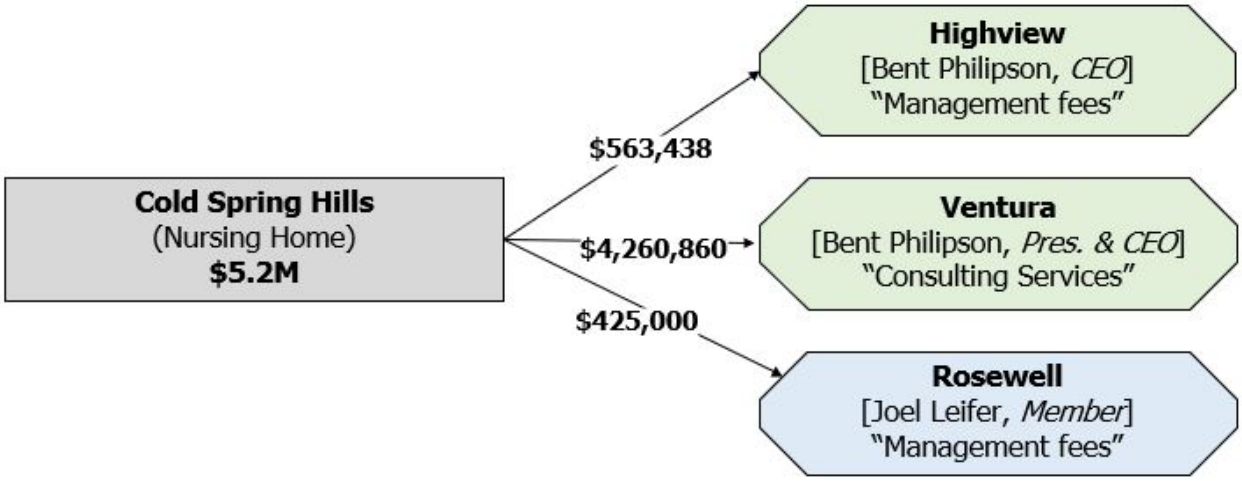
converted $2,015,556 from Cold Spring Hills through the issuance of a fraudulent promissory note with exorbitant 13% interest. Specifically, to facilitate the purchase of Cold Spring Hills' real estate, the owners of Cold Spring Realty created a corporate alter ego, Lending Partners, and executed a promissory note in which Lending Partners loaned the Cold Spring Realty owners $16 million at 13% interest. Respondent Bent Philipson and the other owners of Cold Spring Realty caused Cold Spring Hills to pay this fraudulent promissory note plus interest to themselves to increase their personal profit while depleting the amount of working capital it had to pay for staffing and care. *See infra* ¶¶ 382-389. As shown below, each owner of Lending Partners received $503,889 through this fraudulent promissory note scheme.



15. In addition to the real estate schemes discussed above, as depicted in the next chart below, from 2016 through 2021, Respondents further converted over $5.2 million through

fraudulent management and consulting company schemes. *See infra* ¶¶ 411-448. These management and consulting companies, owned by Bent Philipson and Joel Leifer, provided duplicative sham services, but nonetheless received funds from Cold Spring Hills at the expense of Cold Spring Hills' residents who were neglected due to the lack of available funds to employ sufficient staff.

Over $5.2M was Illegally Converted by Respondents in Fraudulent Management/Consulting Company Schemes from 2016-2021

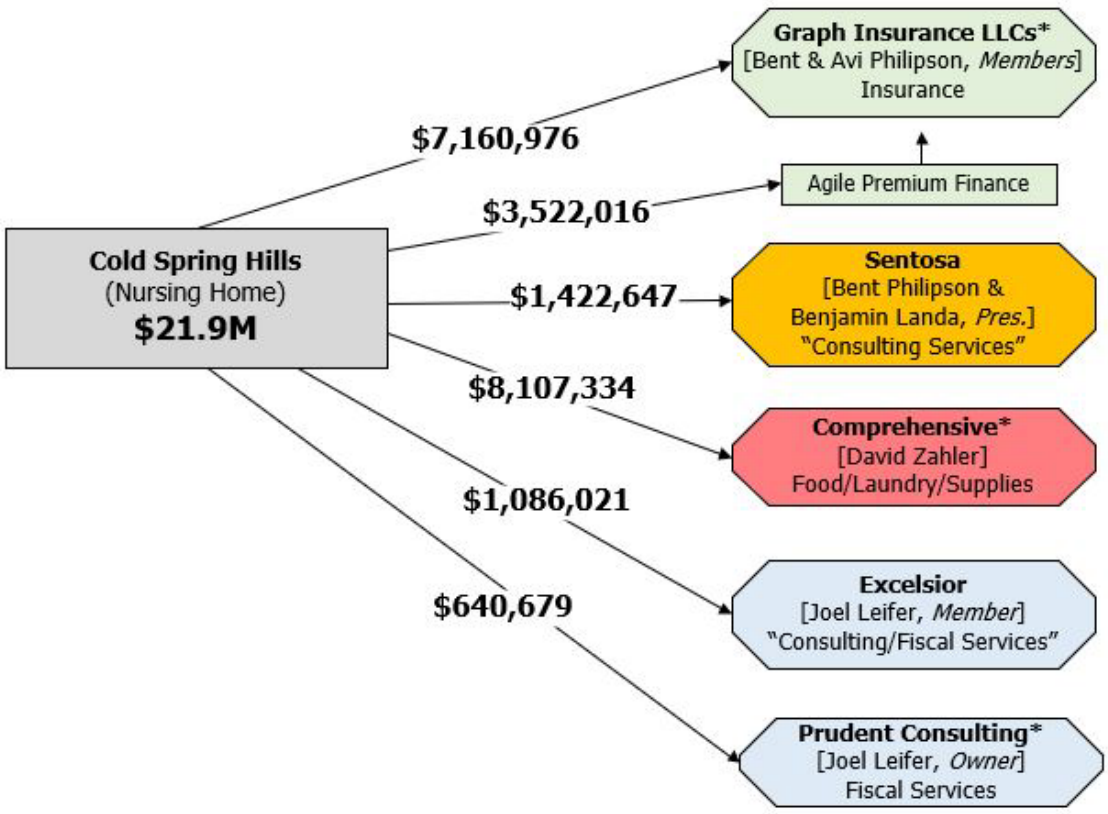


16. In order to conceal the disguised conversion of funds from Cold Spring Hills through these three fraudulent schemes, Respondents hid from the New York State Department of Health ("DOH") the true owners and operators of Cold Spring Hills by repeatedly filing false documents and certifications. *See infra* ¶¶ 90-107; 457-475.

17. But Respondents fraud was not limited to those three schemes. In addition to the over $22.6 million Respondents converted as outlined in the above charts, from 2016 through 2021, Respondents used various other related parties and shell entities to extract government funds from Cold Spring Hills for Respondents up-front profits. The chart below reflects the transfer of over $21.9 million more to other related parties. For example, and as shown below, Respondents

funneled an additional $10.6 million in concealed self-dealing transactions through Graph MGA, LLC ("Graph MGA"), Graph Management, LLC, Graph Insurance Company A Risk Retention Group, LLC (collectively, Graph Insurance LLCs), ostensibly insurance companies, and another $8.1 million through Comprehensive Care Solutions, LLC ("Comprehensive"), an entity that purportedly provided services and supplies to Cold Spring Hills. *See infra* ¶¶ 499-454. The asterisks that appear next to Graph Insurance LLCs, Comprehensive, and Prudent Consulting indicate that they were not properly disclosed in annual filings (Cost Reports) with DOH.

Of the $42.4M Transferred from Cold Spring Hills from 2016-2021, Over $21.9M was Transferred to Other Related Parties



Philipson Control Group Cuts Staff, Siphons Funds, Disregards DOH Direction to Prepare for Pandemic—And Bent Philipson Takes the Fifth

18. The Philipson Control Group implemented staffing cuts when it took command of Cold Spring Hills' operations in 2019. *See infra* ¶ 280-81. These staffing cuts allowed Respondents to continue to line their pockets and those of Favored Persons,[5] including by: (i) furthering the fraudulent "rent" scheme and (ii) engaging in the sham management/consulting company scheme through Ventura and other LLCs.[6] Through this, Bent Philipson used Cold Spring Hills to funnel money through extravagant salaries, bonuses, and luxury cars to himself and the Favored Persons. *See infra* ¶¶ 425-434. The Philipson Control Group cut the nursing home's direct care staffing expenses and levels again in 2020 — notably in February 2020, right ***after*** DOH issued a February 6, 2020 letter directing nursing homes to prepare for the pandemic and just ***before*** COVID-19 hit Long Island. Auditor Aff., ¶ 200.

19. Bent Philipson refused to testify during the course of this investigation when asked questions about Cold Spring Hills' financial transactions, staffing levels and staffing cuts, his control over Cold Spring Hills and its related parties, its resident care, and New York laws designed to protect residents; during his Executive Law § 63(12) examination, he asserted protection against

[5] "Favored Persons" refers to those persons who acted as strawman managing members or nominal owners of Cold Spring Hills, who controlled its operations, and/or whom the Philipson Control Group directed money to through fraudulent machinations that include inflated amounts of purported "rent" or other "fees" that were designed to appear to be legitimate arms-length business transactions yet were actually disguised "up-front profit-taking" by these persons from Cold Spring Hills before it complied with its duties to provide required care to its residents, in exchange for providing little or no service of value to the nursing home or its residents, and in violation of multiple laws and regulations.

[6] For readability, this petition does not always use adjectives such as "purported" or "bogus" to modify Respondents' use of terms such as "rent," "management," or "consulting," but absence of the modifier does not signify the transaction to be bona fide.

self-incrimination approximately 685 times, on the grounds that his testimony would tend to incriminate him. SAAG Aff., Ex. 6.

166 Resident Deaths in 3 Months; Cold Spring Hills Under-Reports COVID Deaths By 52%; Additional Mortality among Residents

20. Respondents' persistent conversion of money from Cold Spring Hills for their own benefit at the expense of resident care started long before the pandemic, which meant that when the COVID-19 pandemic hit Long Island, the suffering and death experienced by Cold Spring Hills residents needlessly increased. From March 1, 2020 to June 4, 2020, 166 Cold Spring Hills residents died: 98 from COVID-19 and 68 from other causes. But Cold Spring Hills fraudulently failed to report 51 of those COVID-19 deaths to DOH through the New York State Health Emergency Response Data System ("HERDS"), an official portal that nursing homes are required to use to report accurate information to DOH. Auditor Aff., ¶¶ 241-42. And on top of Cold Spring Hills' failures to prevent unnecessary deaths from COVID-19, a comparison of data from 2019 to 2020 shows that 14 more residents died of non-COVID causes from March 1, 2020 through June 4, 2020 than had died during this same time period in 2019, supporting a finding that Respondents' overall poor operation of Cold Spring Hills led to increased mortality during COVID. *Id.* at ¶¶ 242, 253.

Respondents' Fraud Created Poor Working Conditions for Cold Spring Hills Staff

21. Respondents' practices of cutting staffing levels to funnel up-front profit to themselves and Favored Persons caused poor working conditions for staff at Cold Spring Hills, starting well before the pandemic and continuing through to today. *See infra* ¶¶ 255-267, 280-81, 287-348. Respondents cannot escape their actions by contending, as they might, that "Medicaid rates are too low" for the nursing homes to be profitable, or to hire sufficient staff to care for the residents, due to "staffing shortages." This investigation shows that such assertions are false and

an attempt to deflect attention from the profit-ensuring and regulation-disregarding practices of the Respondents and the poor working conditions their practices created for nursing home staff.

22. When COVID-19 hit, it more fully exposed and exacerbated these poor working conditions. Conditions worsened during the height of the pandemic, with many Cold Spring Hills staff working back-to-back shifts at risk to their own health, without sufficient Personal Protective Equipment ("PPE") or any COVID-19 vaccines, to provide care to the vulnerable residents. *See infra* ¶¶ 255-264. Respondents' failure to sufficiently staff Cold Spring Hills led to more burnout and turnover, increasing the burden on remaining staff to provide training, care, and supervision.

23. Cold Spring Hills residents and staff did not have to suffer as much as they did. If in 2020, Bent Philipson had extracted only $1.76 million less from the nursing home (i.e., less than half of the $3.9 million he diverted that year) Cold Spring Hills could have provided over 31,000 additional hours of direct care to its vulnerable residents. Auditor Aff., ¶¶ 255-56.

24. Respondents nevertheless continue to personally profit at the expense of residents' care and needs, while they have continued to disregard and repeatedly violate Cold Spring Hills' duties to comply with New York State and Federal law designed to protect residents.

Respondents Must be Enjoined in Order to Protect Residents, Disgorge Their Ill-Gotten Gains, and Implement Reforms

25. Judicial intervention is required now to enjoin Respondents' repeated persistent fraudulent and illegal conduct to protect Cold Spring Hills' vulnerable residents from ongoing and further neglect and harm. Despite being on notice of the importance of adequate staffing, Cold Spring Hills, as controlled by Respondents, has continued to neglect its residents, operate with insufficient staffing to provide the care required under many of its residents' Care Plans, transfer exorbitant amounts of its funds fraudulently to related parties to facilitate profiteering, and violate many State and federal regulations. For these reasons, it is especially important that hidden owner

Bent Philipson and straw-owner Avi Philipson be enjoined from participating in the operations of Cold Spring Hills in order to protect residents from their callous and illegal self-dealing.

26. In addition to enjoining Respondents' persistent fraud and illegality in their operations of Cold Spring Hills, Petitioner also seeks restitution and disgorgement of the illegally converted funds that Respondents fraudulently transferred to themselves from Cold Spring Hills, while disregarding its duty to provide required care and staffing for its residents. Respondents retained these funds without right, under Executive Law § 63-c. *See infra* ¶¶ 394-446.

27. Finally, Petitioner brings this special proceeding to bring transparency to the reality that much of the human pain and humiliation experienced by Cold Spring Hills' residents was preventable. Respondents can prevent more of the same resident suffering if Respondents stop converting such substantial amounts of Medicaid and Medicare funds from the nursing home as "up-front profit," and instead operate the nursing home properly and cause it to spend its revenue to improve care to its residents, to hire, train, supervise and retain qualified staff, and comply with applicable nursing home law. *See infra* ¶¶ 76-80.

Respondents Violated the Law and Must Be Held Accountable.

28. Respondents' fraudulent and illegal conduct is detailed throughout this Petition and the Affidavits. Cold Spring Hills' residents suffered harm, neglect, and risk of harm due to Respondents' repeated decisions to funnel many millions of dollars out of the facility rather than adequately fund resident care. Controlling persons of nursing homes, such as the Respondents, are directly liable under the PHL.[7]

[7] PHL § 2808-a provides that "Every person who is a controlling person of any residential health care facility liable under any provision of this article . . . to the state for any civil fine, penalty, assessment or damages, shall also be liable, jointly and severally, with and to the same extent as such residential health care facility, to such person or class of persons for damages or to the state for any such civil fine, penalty, assessment or damages" and provides that "controlling person" of a residential health care facility shall be deemed to mean any person who by reason of a direct or

29. Instances of harm and neglect included failure to: (1) meet basic care needs; (2) provide proper wound care; (3) provide proper feeding and weight monitoring (4) provide care required under resident care plans; and (5) communicate vital health information, all simultaneous with Respondents' operation of Cold Spring Hills with insufficient staffing to care for its existing residents needs and admission of new residents into the facility for more revenue.

30. Cold Spring Hills residents were further endangered by the Respondents' failure during the pandemic to ensure proper infection control, including, without limitation, failure to cohort residents and staff, failure to provide adequate health screening, and failure to provide sufficient protective gear. DOH surveys and citations underscored Cold Spring Hills' infection control violations and put Respondents on notice of regulatory violations and resident endangerment.[8]

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indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said facility."

[8] The Attorney General anticipates that the Respondents will cynically attempt to shield themselves by asserting a defense under the short-lived COVID-19 emergency immunity statute intended to protect the heroic healthcare workers who had to make difficult triage and treatment decisions under emergency circumstances. That law, PHL §§3081-82, was enacted on March 7, 2020, modified on August 3, 2020 to limit the scope to COVID-19 cases only, and repealed effective April 6, 2021. Respondents will fail to make out such a defense for the harms described herein during the COVID-19 crisis, for, among other reasons, in order for immunity to apply, they must show:

> [The] treatment of the individual was impacted by the health care facility's or health care professional's decisions or activities in response to or as a result of the COVID-19 outbreak and in support of New York State's directives; and the health care facility or health care professional arranged for or provided health care services in good faith.

Here, the harm occurring at Cold Spring Hills during COVID-19 was the result of financial decisions carried out as part of a pre-existing, unrelated scheme to siphon funds from the facility, putting at risk the delivery of care. Moreover, the acts and omissions of the Respondents pre-date the COVID-19 pandemic, and Respondents' looting continued after the expiration of the declaration of emergency. *See infra* ¶¶ 98-107, 382-404, 411-434.

31. Moreover, Cold Spring Hills intentionally maintained chronically inadequate staffing levels to increase its owners' profits, and pressured or forced staff to: (1) work without adequate support from other personnel; (2) be assigned more work to provide care than could be completed in their shift, predictably resulting in neglect of residents; (3) regularly prioritize nursing home cost savings over the residents' human dignity; (4) work without sufficient training and supervision; and (5) work under very poor conditions.

32. Respondents' fraudulent conduct also included their scheme to hide the facility's true owners and operators from DOH and their repeated filing of false documents and certifications in order to conceal their disguised conversion of funds. Respondents' scheme also included hiding their illegal promissory note with exorbitant 13% interest in connection with their acquisition of Cold Spring Hills which was another vehicle through which Respondents deceptively funneled money to themselves instead of permitting Cold Spring Hills to retain and expend sufficient funds on staffing and care. Respondents' model of directing payment from the nursing home first and foremost to themselves and the owners of related third parties prior to ensuring the nursing home delivered adequate care to its residents is referred to herein as taking "up-front profit."

33. Respondents likely will respond to this Petition by attempting to place blame on the individual employees and staff of Cold Spring Hills. But this Court should not be deceived by any attempt to deflect the effect of Respondents' mismanagement and fraud onto the very individuals that Respondents were responsible for properly paying, supervising, training, and providing with the necessary resources to enable them to satisfy their responsibilities. Respondents alone are responsible for their illegal and fraudulent conduct set forth in this Petition. To the extent this Petition identifies failures with respect to any staff or employees of Cold Spring Hills, it does

so only as evidence of Respondents' egregious misconduct. The Petition should not be read as pointing the finger at the staff or employees who Respondents set up to fail.

Structure of this Petition

34. This Petition has five Parts:

a. Part I sets out this Court's jurisdiction over the Petition.

b. Part II sets out the parties and details Respondents' relationships to Cold Spring Hills, each other, and the related parties—unraveling the complex web of overlapping ownership, hidden control, nepotism, and self-dealing that Respondents used to line their pockets at the expense of resident care.

c. Part III sets out the legal requirements in New York for providing nursing home care, which Respondents repeatedly and persistently violated.

d. Part IV sets out the Attorney General's findings of fact supporting this Petition, namely that: (i) Cold Spring Hills received government funds for medical care; (ii) Respondents hid the true ownership and control over Cold Spring Hills in order to benefit themselves financially at residents' expense; (iii) Respondents provided grossly substandard care at Cold Spring Hills, resulting in resident neglect and harm; (iv) Respondents failed to ensure proper infection control procedures that endangered the residents of Cold Spring Hills and contributed to 98 resident COVID-19 deaths in three months; (v) Respondents failed to provide sufficient levels of appropriately trained and supervised staff, also resulting in resident neglect and harm; and (vi) Respondents engaged in financial frauds that lined their own pockets to the detriment of Cold Spring Hills and its residents.

e. Part V sets out in greater detail the findings as to financial frauds that Respondents engaged in to line their own pockets to the detriment of Cold Spring Hills and its residents.

35. After demonstrating Respondents' persistent fraud and illegal conduct, this Petition requests relief from the Court to end Respondents' unlawfulness and hold them accountable. Petitioner seeks an order:

a. Declaring Respondents violated Executive Law § 63(12), Executive Law § 63(12), and other applicable laws and regulations, and that they were unjustly enriched by doing so;

b. Permanently enjoining Respondents from continuing to violate the law and from making any self-dealing payments, loans, and other transfers of excessive value to the Respondents and related entities;

c. Appointing a financial monitor to oversee Cold Spring Hills financial operations and ensure that Cold Spring Hills ceases collusive and self-dealing payments, loans, and other transfers of value to the Respondents;

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

e. Directing the Respondents to provide the healthcare monitor with real-time 24-hour/day remote access to all Cold Spring Hills' electronic medical records systems for its residents, with the highest-level permissions granted to the healthcare monitor, to enable viewing of all edits made to any records by any person and/or systems administrator;

f. Directing Respondents pay restitution to the State;

g. Directing that each Respondent fully account for and disgorge all monies wrongfully received;

h. Removing Respondents Bent Philipson and Avi Philipson immediately and permanently from any role at Cold Spring Hills or any related entity; and

i. Directing Respondents to pay civil penalties, costs, and post-judgment interest.

36. Accordingly, for the reasons stated herein, to protect Cold Spring Hills' vulnerable residents, the Attorney General respectfully asks the Court to promptly issue an order imposing injunctive relief to end Respondents' repeated, persistent, fraudulent, and illegal conduct that exploits the vulnerable residents at Cold Spring Hills, exploits the Medicaid and Medicare programs, and exploits the healthcare workers laboring under poor conditions that Respondents created at the nursing home. Further time lost for these residents cannot be replaced.

I. JURISDICTION AND VENUE

37. Venue is proper in this county pursuant to CPLR § 503.

38. The Medicaid Fraud Control Unit ("MFCU") in the Office of the Attorney General ("OAG") of the State of New York is responsible for investigating and prosecuting healthcare providers and associated persons engaged in civil and criminal fraud against the Medicaid and Medicare programs and for protecting the State's vulnerable nursing home residents from exploitation, abuse, and neglect by providers. The investigation leading to this proceeding was undertaken pursuant to the well-established authority vested in the OAG by the Executive Law, New York Medicaid rules and regulations, and MFCU's federal grant of authority under the Social Security Act and its Medicaid and Medicare program regulations to investigate and prosecute

provider fraud and nursing home resident abuse and neglect. *See* Executive Law § 63(12); 42 U.S.C. 1396b(q); 42 C.F.R. § 1007.11(a)(2).

39. Executive Law § 63(12) empowers the Attorney General to bring a special proceeding for permanent injunctive relief, restitution, and damages whenever a person or business engages in "repeated or persistent fraud or illegality." *See* Exec. Law § 63(12) ("[w]henever any person shall engage in repeated fraudulent or illegal acts . . . the attorney general may apply . . . on notice of five days" for relief). A special proceeding as authorized under Executive Law § 63(12) is "plenary as an action, culminating in a judgment, but is brought on with the ease, speed and economy of a mere motion." Siegel & Connors, N.Y. Practice § 547, at 1054 (6th ed. 2018).

40. A special proceeding goes directly to the merits. The Court is required to make a summary determination upon the pleadings, papers, and admissions to the extent that no triable issues of fact are raised. *See* CPLR 409. To the extent factual issues are raised, then they must be tried "forthwith." CPLR 410. It is the very purpose of a special proceeding to provide a summary remedy, "so summary, indeed, as to dispense with the need or occasion for the application of summary judgment." *Council of City of N.Y. v. Bloomberg*, 6 N.Y.3d 380, 401 (2006).

41. Further, the Attorney General is empowered under the Tweed Law to investigate the misappropriation and misuse of any government funds. *See* Exec. Law § 63-c; *see also Cuomo v. Ferran*, 77 A.D.3d 698, 909 N.Y.S.2d 521 (2nd Dept. 2010); *State of New York v. Franklin Nursing Home*, 65 A.D.2d 788, 410 N.Y.S.2d 321 (2nd Dept. 1978) (Attorney General on behalf of State may recover Medicaid overpayments).

42. And lastly, pursuant to PHL §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. SAAG Aff., Ex. 1.

II. PARTIES

A. Petitioner

43. Letitia James is the Attorney General of the State of New York, and as such, she is authorized on behalf of the People of the State of New York to enjoin and seek restitution for repeated or persistent fraudulent or illegal practices in the conduct of a business, pursuant to Executive Law § 63(12) and to recover government funds "without right obtained" pursuant to Executive Law § 63-c.

B. Corporate Respondents

Cold Spring Hills — The Nursing Home Facility

44. At all times relevant hereto, Cold Spring Acquisition, LLC d/b/a Cold Spring Hills Center for Nursing and Rehabilitation was a 588-bed for-profit nursing home and an LLC existing under the laws of the State of New York with a registered address in Nassau County, New York, and a physical location at 378 Syosset-Woodbury Road, Woodbury, New York. Cold Spring Hills' nominal owners are Avi Philipson (24%) and the Estate of Deborah Philipson (1%) (who are the son and deceased wife of Respondent Bent Philipson), Esther Farkovits (25%) (who is the daughter of Respondent Benjamin Landa), Rochel David (12.5%) and Leah Friedman (12.5%) (both of whom are the daughters of Respondent David Zahler), and Joel Leifer (25%).

Cold Spring Realty — The Real Property Holding Company

45. At all times relevant hereto, Cold Spring Realty was an LLC existing under the laws of the State of New York with an address in Nassau County, New York. Cold Spring Realty owns the real property on which Cold Spring Hills is located. Benjamin Landa and Philipson Family, LLC each own 25% of Cold Spring Realty. Lifestar Family Holdings, LLC ("Lifestar") owns 25% of Cold Spring Realty; Lifestar in turn is owned by David Zahler and Chaya Zahler (together 60%),

Rochel David (10%), Leah Friedman (10%), Jacob Zahler (10%), and Chaim Zahler (10%). *See infra* ¶ 95. Cheskel Berkowitz owns the remaining 25% of Cold Spring Realty.

Ventura — The "Consulting" Company

46. At all times relevant hereto, Ventura was an LLC existing under the laws of the State of New York and located at the same residence as its owner Bent Philipson in Rockland County, New York. Avi Philipson, who also lives at that address with his father, Bent Philipson, is listed as a 50% beneficial owner of Ventura on Ventura's signature cards and bank account application. Ventura is controlled by Bent Philipson, and provides purported consulting services to nursing homes, including Cold Spring Hills, from which it received over $4.2 million from 2019 through 2021, as a result of Bent Philipson's control of Cold Spring Hills.

Highview Management Inc. — A "Management" Company

47. At all times relevant hereto, Highview was a domestic business corporation existing under the laws of the State of New York with an address in Rockland County, New York, which is the same address as its owner Bent Philipson and former owner Deborah Philipson, whose interest is now owned by her estate. Despite not being listed as a related party on Cold Spring Hills' 2019 Cost Report, Highview purportedly provides management services to Cold Spring Hills and received $563,438 in 2019. Moreover, from 2016 through 2019, Respondents also caused Cold Spring Realty to transfer $549,992 to Highview for purported management fees.

Graph Insurance LLCs — The Three Related-Party Insurance Brokers

48. At all times relevant hereto, Graph MGA, owned by Avi Philipson, Graph Insurance Company A Risk Retention Group, LLC, owned by Avi and Bent Philipson, and Graph Management, LLC, owned by Avi Philipson, are insurance brokerage LLCs existing under the laws of the State of New Jersey with an address in Rockland County, New York, at the same

address as their owners. Despite not being properly on Cold Spring Hills' Cost Reports from 2017 through 2021, the Graph Insurance LLCs purportedly provide insurance services to Cold Spring Hills, from which it received over $10.6 million from 2017 through 2021.

Philipson Family, LLC — The Philipson Pass-Through Entity

49. Philipson Family, LLC is owned by Bent Philipson, as General Partner. At all times relevant hereto, Philipson Family, LLC was an LLC existing under the laws of the State of New York with an address in Rockland County, New York, at the same address as Bent Philipson. Philipson Family, LLC is a 25% owner of Cold Spring Realty.

B&L Consulting, LLC — The Benjamin Landa Pass-Through Entity

50. At all times relevant here, B&L Consulting, LLC ("B&L Consulting") was an LLC operating under the laws of the State of New York with an address in Rockland County, New York. B&L Consulting is owned by Benjamin Landa and from 2016 through 2019 received $499,992.00 from Cold Spring Hills through Cold Spring Realty, purportedly for "consulting" services.

Lifestar Family Holdings, LLC — The Zahler Pass-Through Entity

51. At all times relevant hereto, Lifestar was an LLC existing under the laws of the State of New York with an address in Rockland County, New York. Lifestar is a 25% owner of Cold Spring Realty and is owned by David Zahler and Chaya Zahler (together 60%), Rochel David (10%), Leah Friedman (10%), Jacob Zahler (10%) and Chaim Zahler (10%).

Comprehensive Care Solutions, LLC — The Zahler Related Party

52. At all times relevant here, Comprehensive was an LLC operating under the laws of the State of New York with an address in Rockland County, New York. Comprehensive is affiliated with David Zahler. Between 2016 through 2021, Comprehensive received over $8.1

million from Cold Spring Hills, despite not being appropriately disclosed on Cold Spring Hills' Cost Reports from 2017 through 2021.

Ross CSH Holdings, LLC — The Berkowitz/Zupnick Pass-Through Entity

53. At all times relevant hereto, Ross CSH Holdings, LLC ("Ross CSH Holdings") was an LLC existing under the laws of the State of New York with an address in Kings County, New York. Ross CSH Holdings is owned by Cheskel Berkowitz and Joel Zupnick is its manager and organizer. Cheskel Berkowitz and Joel Zupnick are both listed as signatories on bank records for Ross CSH Holdings.

ZBL Management, LLC — Another Berkowitz/Zupnick Pass-Through Entity

54. At all times relevant hereto, ZBL Management, LLC ("ZBL Management") was an LLC existing under the laws of the State of New York with an address in Kings County, New York. ZBL Management is owned by Joel Zupnick and Cheskel Berkowitz, who is a 25% owner of Cold Spring Realty. Cheskel Berkowitz and Joel Zupnick are both listed as signatories on ZBL Management's bank account.

Rosewell Associates, LLC — The Leifer Pass-Through Entity

55. At all times relevant hereto, Rosewell was an LLC existing under the laws of the State of New York with an address in Kings County, New York. Rosewell is owned by Joel Leifer (99%) and his wife, Blima Leifer (1%). Joel Leifer is a 25% owner of Cold Spring Hills. Rosewell purportedly provides management services to Cold Spring Hills, from which it received $425,000.02 from 2016 through 2019.

C. <u>Individual Respondents — Straw Owners and Concealed Control</u>

56. The Individual Respondents named below operate the Corporate Respondents as their alter-egos, disregarding corporate form and creating fictitious ownership structures, fictitious lines of authority, and fictitious documentation that misstates the true nature of their arrangements.

The Individual Respondents named below have used the entities to engage in wrongful conduct, including using them: merely as vehicles to obtain government licensing and funds; to conceal their diversion of funds away from proper healthcare for residents of Cold Spring Hills and other nursing homes; and to commit and further their fraud. Most of the Individual Respondents, who nominally own small percentages of the Corporate Respondents, knew little about their ownership interest in Cold Spring Hills or how and by whom it was obtained. The *de facto* owners colluded to install them to conceal and obfuscate the control and misconduct of the other Individual Respondents.

The Philipson Family Respondents — Bent Philipson, Avi Philipson, and the Estate of Deborah Philipson

57. Respondent Bent Philipson resides in the same house in Rockland County, New York as his son, Avi Philipson, and was at all relevant times: (i) a *de facto* and undisclosed owner and operator of Cold Spring Hills in violation of PHL § 2801-a; (ii) the owner and President of Ventura; (iii) together with his late wife, Deborah Philipson, the owner of Highview, a purported management company that received funds from Cold Spring Hills and from Cold Spring Realty; (iv) a General Partner of Philipson Family, LLC which is a 25% owner of Cold Spring Realty; and (v) an owner of Standard & Preferred Insurance Company, LLC ("Standard and Preferred"), a company that received tens of millions of dollars directly from or passing through the Graph Insurance LLCs. Bent Philipson controls Cold Spring Hills and directs the management and policies of the facility and is therefore an operator. For example:

a. Emails and testimony show Bent Philipson exercising control over Cold Spring Hills' staffing decisions, including staffing cuts, and his regular receipt of reports of its expenses, revenue, and balance.

b. Letters produced by Cold Spring Hills' accountants dated from 2017 through 2021 regarding yearly financial audits of Cold Spring Hills identify Bent Philipson as the Executive Director of Cold Spring Hills. Auditor Aff., Ex. 26.

c. Testimony from staff referred to Ventura as "corporate" for Cold Spring Hills. SAAG Aff., Ex. 9 (pg. 112).

d. Testimony from Cold Spring Hills' nominal managing member Joel Leifer confirms that Bent Philipson and Benjamin Landa set the terms of a predatory purported "lease" between Cold Spring Hills and Cold Spring Realty in 2016. SAAG Aff., Ex. 5 (pg. 102).

e. Bent Philipson is identified as the "manager" of Cold Spring Hills in an agreement submitted to Agile Premium Finance for the purpose of advancing an entire premium for a general liability insurance policy on behalf of Cold Spring Hills. Auditor Aff., ¶ 118.

f. Beginning in May 2019, Bent Philipson signed checks on behalf of Cold Spring Hills to various vendors, despite not being an authorized signatory on the Cold Spring Hills' account.

58. Respondent Avi Philipson resides at the same house in Rockland County, New York as his father, Bent Philipson, and was at all times relevant: (i) a nominal managing member and straw 24% owner of Cold Spring Hills; (ii) an operator of Cold Spring Hills pursuant to PHL § 2801-a; and (iii) an owner of each of the Graph Insurance LLCs. The Graph Insurance LLCs each received significant monetary transfers from Cold Spring Hills despite not being properly disclosed on its cost reports as a related party, and then transferred tens of millions of dollars directly or as a pass through to Standard and Preferred, a company owned by Avi Philipson's

father, Bent Philipson. *See infra* ¶¶ 449-50. Avi Philipson had knowledge of and participated in the illegal, fraudulent, and deceptive practices alleged herein. For example:

a. The Attorney General's investigation established that Avi Philipson was a willing straw owner of Cold Spring Hills at all relevant times and was inserted in this position by the other Respondents, including his father Bent Philipson, to conceal Respondents' control of Cold Spring Hills and deceive DOH. Avi Philipson was identified as the proposed 24% owner and a managing member of Cold Spring Hills on its Certificate of Need ("CON")[9] application to DOH after Respondents or their agents removed the name of his father, Bent Philipson, from the application in the belief that the use of his name, rather than that of his father's, would favorably affect DOH's decision on whether to approve the application. *See infra* ¶¶ 90-91.

b. On behalf of Cold Spring Hills, Avi Philipson submitted false certifications to DOH. *See infra* ¶¶ 457-475.

c. Although Avi Philipson averred during an examination taken pursuant to Executive Law § 63(12) that as managing member his "duties and responsibilities were to put the correct people in place" to run the facility properly, at the time Cold Spring Hills was purchased in 2016 he was not directly involved in doing so. SAAG Aff., Ex. 8 (p. 85). Avi Philipson further testified that Joel Leifer took a more active role as managing member until

[9] Pursuant to PHL § 2801-a, a CON application must include, inter alia, "information as to the character, competence and standing in the community of every individual and entity of the applicant and specify the identity of every nursing home in which each of those individuals and entities is, or in the preceding seven years has held a controlling interest or has been a controlling person, principal stockholder or principal member; and the nature of that interest."

2019, when a business dispute resulted in a split between his father, Bent Philipson, and Benjamin Landa. At this time, Joel Leifer "stepped back" and Avi Philipson claimed that since "the facility itself was running smoothly . . . [he] just made some changes in who – who would be the consulting company at the facility, and that's – that's really it." *Id.* at 89-90, 114.

d. Despite his ownership interest in Cold Spring Hills, he testified under oath that he could not recall basic recent facts about "his" multi-million-dollar healthcare businesses. Avi Philipson repeatedly answered many questions by saying he did not remember or did not know and failed to explain what independent value any of the nursing home's related party consultants brought. With respect to his father, Bent Philipson's company Ventura becoming Cold Spring Hills' consulting company in 2019, Avi Philipson testified he simply "allowed [it] to happen." *Id.* at 172.

e. Avi Philipson is listed as a 50% beneficial owner of Ventura on Ventura's signature cards and a bank account application. Auditor Aff., ¶ 59.

f. Bank records reflect that Avi Philipson is an authorized signatory on Cold Spring Realty's bank account and on Cold Spring Hills' operating bank account. Auditor Aff., ¶ 97, n.14.

59. Respondent Deborah Philipson (by her estate) lived in the same residence in Rockland County, New York as her husband, Bent Philipson, and her son, Avi Philipson, until her death in March 2022. Until then, she was at all times relevant a 1% owner of Cold Spring Hills.

The Landa Family Respondents — Benjamin Landa and Esther Farkovits

60. Respondent Benjamin Landa resides in Nassau County, New York, and at all times relevant hereto was a 25% owner of Cold Spring Realty, which is the owner of the real estate property on which Cold Spring Hills is located. Benjamin Landa is also the father of Esther Farkovits, a 25% straw owner of Cold Spring Hills, to whom he gave that interest so that he could exercise control over it, and was at all times relevant through a point of time in 2019: (i) a *de facto* and undisclosed owner and operator of Cold Spring Hills in violation of PHL § 2801-a; (ii) the owner and a President of SentosaCare ("Sentosa"); and (iii) the owner of B&L Consulting which received monetary transfers from Cold Spring Realty from 2016 through 2019. From June 2016 through a point in time in 2019, Benjamin Landa exercised control over Cold Spring Hills with the ability to direct the management and policies of the facility; he was therefore an operator.

61. Respondent Esther Farkovits resided outside the United States during the relevant period and was a 25% straw owner of Cold Spring Hills. Esther Farkovits is the daughter of Benjamin Landa, who exercised control over Cold Spring Hills, including through his management company, Sentosa. In an examination pursuant to Executive Law § 63(12), Esther Farkovits testified that she "assumed" her father, Benjamin Landa, gave her a 25% ownership interest in Cold Spring Hills as a "gift," as she did not make an investment in exchange for her ownership interest. Esther Farkovits also testified that she was wholly unaware of her ownership interest in Cold Spring Hills until she was served with a subpoena in 2022, pursuant to this investigation. SAAG Aff., Ex. 4 (pgs. 21, 33). Respondents, including her father Benjamin Landa, installed Esther Farkovits as a straw owner of Cold Spring Hills to conceal their control of Cold Spring Hills and deceive DOH.

The Zahler Family Respondents — David Zahler, Chaya Zahler, Leah Friedman, Rochel David, Chaim Zahler, and Jacob Zahler

62. Respondent David Zahler resides in Rockland County, New York and at all times relevant hereto, together with his wife Chaya Zahler owns 60% of Lifestar, which is a 25% owner of Cold Spring Realty. David Zahler is also affiliated with the related party Comprehensive, which received over $8.1 million from Cold Spring Hills from 2016 to 2021 and was not disclosed as a related party on Cold Spring Hills' Cost Reports. *See infra* ¶ 462.

63. Respondent Chaya Zahler resides in Rockland County, New York and at all times relevant hereto, together with her husband David Zahler, owns 60% of Lifestar, which is a 25% owner of Cold Spring Realty.

64. Respondent Leah Friedman resides in Rockland County, New York, and is the daughter of Respondents David Zahler and Chaya Zahler. At all times relevant hereto she was a 12.5% owner of Cold Spring Hills, and a 10% owner of Lifestar, which is a 25% owner of Cold Spring Realty. Leah Friedman is the sibling of Rochel David, Chaim Zahler, and Jacob Zahler, each of whom are 10% owners of Lifestar. Respondents, including her father, David Zahler, installed Leah Friedman as a straw owner of Cold Spring Hills to conceal their control of Cold Spring Hills and deceive DOH.

65. Respondent Rochel David resides in Rockland County, New York, and is the daughter of Respondents David Zahler and Chaya Zahler. At all times relevant hereto she was a 12.5% owner of Cold Spring Hills, and a 10% owner of Lifestar, which is a 25% owner of Cold Spring Realty. Rochel David is the sibling of Leah Friedman, Chaim Zahler and Jacob Zahler, each of whom are 10% owners of Lifestar. Respondents, including her father, David Zahler, installed Rochel David as a straw owner of Cold Spring Hills to conceal their control of Cold Spring Hills and deceive DOH.

66. Respondent Chaim Zahler resides in Rockland County, New York, and at all times relevant hereto was a 10% owner of Lifestar, which is a 25% owner of Cold Spring Realty. Chaim Zahler is the son of David Zahler and Chaya Zahler and the sibling of Leah Friedman, Jacob Zahler and Rochel David, each of whom are 10% owners of Lifestar.

67. Respondent Jacob Zahler resides in Rockland County, New York, and at all times relevant hereto was a 10% owner of Lifestar, which is a 25% owner of Cold Spring Realty. Jacob Zahler is the son of David Zahler and Chaya Zahler and the sibling of Leah Friedman, Chaim Zahler and Rochel David, each of whom are 10% owners of Lifestar.

Respondent Cheskel Berkowitz

68. Cheskel Berkowitz resides in Kings County, New York, and at all times relevant hereto is a 25% owner of Cold Spring Realty and owner of Ross CSH Holdings.

Respondent Joel Leifer

69. Respondent Joel Leifer resides in Kings County, New York, and at all times relevant hereto was a nominal Managing Member and 25% owner of Cold Spring Hills, and an owner of Rosewell, Excelsior Care Group, LLC ("Excelsior"), and Prudent Consulting, LLC ("Prudent Consulting"), three separate purported consulting and fiscal companies, which together received over $2 million from Cold Spring Hills from 2016 to 2021.

Respondent Joel Zupnick

70. Joel Zupnick resides in Kings County, New York, and at all times relevant hereto was a member and organizer of Ross CSH Holdings, was a signatory on its bank account, and was identified as the sole member of Ross CSH Holdings in the 2018 K-1 that Cold Spring Realty issued to Ross CSH Holdings.

D. Non-Respondent Related Parties

Prudent Consulting and Excelsior: Leifer Related Parties

71. Prudent Consulting is a related party owned entirely by Joel Leifer that purportedly provided fiscal services to Cold Spring Hills. From 2016 through 2021, Respondents caused Cold Spring Hills to transfer $640,679.00 to Prudent Consulting for such services. Auditor Aff., ¶¶ 54, 56. Yet, Cold Spring Hills failed to fully disclose Prudent Consulting on Cost Reports from 2017 through 2021. *See infra* ¶ 463.

72. Excelsior, owned by Joel Leifer (99%) and his wife, Blima Leifer (1%), is a related party that provided purported management or consulting services to Cold Spring Hills. Respondents required Cold Spring Hills to transfer $1,086,021.30 to Excelsior for such services. Auditor Aff., ¶ 54.

Sentosa: Bent Philipson and Benjamin Landa's Management Company

73. Sentosa is a purported management and fiscal services LLC that was jointly owned by Respondents Bent Philipson and Benjamin Landa. From 2017 through 2019, Cold Spring Hills paid Sentosa $1,422,646.89 for purported management and fiscal services. Auditor Aff., ¶ 58.

III. NEW YORK AND FEDERAL LAW PROTECTS NURSING HOME RESIDENTS FROM NEGLECT AND PROHIBITS MISUSE OF HEALTHCARE FUNDS

74. Petitioner brings this proceeding pursuant to Executive Law § 63(12) to seek injunctive relief, restitution, disgorgement, and costs against any person that has engaged in or otherwise demonstrates repeated illegal and/or fraudulent acts in the conduct of business, and under the Tweed Law, Executive Law 63-c, which authorizes the Attorney General to recover public monies "without right obtained, received, converted, or disposed of." The Attorney General's MFCU investigates and brings proceedings to address abuse and neglect of nursing home residents and Medicaid provider fraud, and to recover Medicare funds diverted in connection

with schemes to defraud the New York State Medicaid program, for which it has received authorization to recover Medicare funds in this proceeding by the United States Department of Health and Human Services ("HHS"), Office of the Inspector General, pursuant to 42 USC § 1396b(q)(3).

75. The state and federal statutes and regulations relevant to this special proceeding are contained within the Findings of Facts below describing Respondents' illegal conduct and are also set forth in the Auditor Affidavit and Medical Analyst Affidavit. These statutes and regulations are contained in the PHL and related regulations with regard to nursing home care, nursing home ownership, and nursing home financial disclosures, the Social Services Law and related regulations governing claims under the Medicaid Program, and title 42 of the United States Code and related regulations, which provide federal requirements for nursing homes, and place clear requirements on Respondents to deliver quality healthcare to the residents of Cold Spring Hills.

76. Specifically, Article 28 of the PHL sets forth requirements imposed on nursing homes, their owners, their operators, and their managers. Among the many statutory provisions of Article 28 of the PHL violated by the conduct of Respondents as found herein are:

> **PHL § 2801-a** requiring a Certificate of Need application to include, inter alia, "information as to the character, competence and standing in the community of every individual and entity of the applicant and specify the identity of every nursing home in which each of those individuals and entities is, or in the preceding seven years has held a controlling interest or has been a controlling person, principal stockholder or principal member; and the nature of that interest.
>
> **PHL § 2803-c** establishing rights of patients in certain medical facilities, aka the "Patient's Bill of Rights," which include the following rights violated by Respondents: (1) Every patient shall have the right to receive adequate and appropriate medical care; (2) Every patient shall have the right to receive courteous, fair, and respectful care and treatment; and (3) Every patient shall be free from mental and physical abuse and from physical and chemical restraints.

PHL § 2803-d establishing the duty of reporting to the Department of Health both by the facility and almost all staffers whenever there is "reasonable cause to believe that a person receiving care or services in a residential health care facility has been abused, mistreated, neglected or subjected to the misappropriation of property by other than a person receiving care or services in the facility."

PHL § 2803-x establishing disclosure requirements related to nursing homes and related assets and operations.

PHL § 2805-e establishing disclosure requirements related to nursing homes and related assets and operations.

PHL § 2808(5) establishing limitations on the withdrawal of funds from nursing homes in excess of 3% of its most recent annual revenue, without the approval of DOH, also known as the 3% equity withdrawal rule.

77. Regulations of DOH adopted under the foregoing statutes, and repeatedly and persistently violated by Respondents, include:

10 NYCRR § 415.3 – requiring that each resident's right to adequate and appropriate medical care be fulfilled.

10 NYCRR § 415.3(f) – requiring that each resident be provided with clinical care in resident's care plan.

10 NYCRR § 415.4(a) – setting limits to ensure resident free from medically unnecessary physical and chemical Restraints.

10 NYCRR § 415.4(b) – defining and prohibiting resident neglect.

10 NYCRR § 415.5 – requiring maintenance or enhancement of quality of life and each resident's dignity.

10 NYCRR § 415.11 – requiring creation of comprehensive and timely care plans, provision of services in accordance with comprehensive care plans and revision of care plans as necessary to assure the continued accuracy of a resident's health assessment.

10 NYCRR §§ 415.12-(a)(1): requiring the necessary quality of care and services to attain and maintain the "highest practicable physical, mental, and psychosocial well-being," of each resident be

provided, including but not limited to failing to ensure that the residents' activities of daily living "do not diminish."

10 NYCRR§ 415.12(a)(3): requiring facility to ensure that 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.

10 NYCRR§ 415.12(c): requiring facility to 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.

10 NYCRR § 415.12(h)(2): requiring that adequate assistance and supervision to residents to prevent accidents be provided.

10 NYCRR § 415.12(i): requiring facility to 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.

10 NYCRR § 415.13 – requiring the provision of nursing services, also reflected in federal law at CFR 483.35 – i.e., facility is required to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident; facility must ensure that a resident is offered sufficient fluid intake to maintain proper hydration and health.

10 NYCRR § 415.13(a) – requiring that facility 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 nursing facility is required to develop.

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

10 NYCRR § 415.15 – requiring the development and implementation of medical services to meet the needs of facility's residents.

10 NYCRR § 415.16 – requiring the development and implementation of rehabilitation services to meet the needs of facility's residents.

10 NYCRR § 415.17 – requiring the development and implementation of dental services to meet the needs of facility's residents.

10 NYCRR § 415.19 – requiring facility to maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment, including as reflected in federal law at CFR 483.80.

10 NYCRR § 415.22 – requiring facility to maintain clinical records for each resident in accordance with accepted professional standards.

10 NYCRR § 415.26(h)(7) – restricting withdrawal of funds without DOH approval.

10 NYCRR § 415.26(h)(3)(iii) – prohibiting kickbacks and accepting gifts from vendors or suppliers.

10 NYCRR § 400.4 –requiring written contracts containing required information with vendors, management companies and others.

10 NYCRR § 702.4 – setting forth infection control reporting requirement to report data to DOH via HERDS.

10 NYCRR § 86-2.5 – requiring facility to file complete and accurate annual financial and statistical reports (Medicaid Cost Reports) to DOH.

78. Respondents repeatedly and persistently violated the following Medicaid financial regulations, as promulgated under the Social Services Law, and subject to injunctive relief under Article 63 of the CPLR and Executive Law § 63(12):

18 NYCRR § 521.3 – Mandatory Compliance Program; false certification for failures in compliance

18 NYCRR § 515.2(b) – Unacceptable Practices constituting fraud and abuse, including:

(1) – False claims
(4) – Conversion
(5) – Bribes and kickbacks
(8) – Receiving additional payments
(10) – Conspiracy
(12) – Failure to meet recognized standards

18 NYCRR § 504.6(d) – requirement that a provider submit Medicaid claims for reimbursement only for services provided in compliance with Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State.

79. Respondents violated the following federal regulations promulgated by HHS for the protection of nursing home residents under title 42 of the United States Code and title 42 of the Code of Federal Regulations:

42 CFR § 483.1 – requiring that nursing homes must comply with federal statutes and regulations to participate in Medicaid and Medicare

42 CFR § 483.10 – requiring that nursing homes must treat residents with respect and dignity, provide all services in care plan, and keep residents free from restraints

42 CFR § 483.12 – requiring that residents must be free from neglect, abuse, misappropriation of property and exploitation

42 CFR § 483.20 – requiring that nursing homes must develop personalized care plans and assess and review them periodically

42 CFR § 483.24 – requiring that nursing homes must provide necessary care and service to attain or maintain highest practicable physical, mental and psychosocial well-being… and ensure residents' abilities to do activities of daily living do not diminish unnecessarily; requiring that nursing homes must provide grooming, good nutrition, and hygiene

42 CFR § 483.25 – requiring that nursing homes must ensure residents receive treatment and care in accordance with professional standards, care plan, and resident choice

42 CFR § 483.35 – requiring that nursing homes must have sufficient nursing staff with appropriate skills sets and competencies to assure resident safety

42 CFR § 483.40 – requiring that nursing homes must provide physical therapy, and occupational and rehabilitative services

42 CFR § 483.50 – requiring that nursing homes must provide dental, laboratory, radiology and other diagnostic services

42 CFR § 483.60 – requiring that nursing homes must employ sufficient staff for food and nutrition services, and staff must possess appropriate competencies for care plans

42 CFR § 483.70 – requiring that nursing homes must do an annual update to assessment of resources needed to care for residents competently, daily and in emergencies

42 CFR § 483.80 – requiring that nursing home infection control and prevention must include a system for preventing, identifying, reporting, investigating and controlling infection

80. In addition, at all relevant times, New York law imposed on Cold Spring Hills, as a nursing home, a "special obligation" to care for its residents, including by ensuring that it provides each resident with the care, treatment, diet, and health services that they need to attain their "highest practical level of well-being" pursuant to 10 NYCRR § 415.1(a)(1)-(2) and sufficient staffing to provide required care, pursuant to 10 NYCRR § 415.13(a-d). Cold Spring Hills violated each of the above regulations repeatedly during the relevant time period.

IV. FACTS DETERMINED BY THE ATTORNEY GENERAL

81. As the result of an investigation conducted pursuant to Executive Law § 63(12), the Attorney General has taken proof and made a determination of the relevant facts concerning persistent fraud and illegality by Respondents, and violations of the laws described above, harming the residents of Cold Spring Hills and wrongfully converting millions in Medicaid and Medicare

and other healthcare payments. The Attorney General finds that Respondents have violated New York State and Federal law as follows:

82. As demonstrated in the Witness Affidavits, the analytical affidavits, and records of testimony and documentary evidence, Respondents repeatedly and persistently violated the law and prioritized up-front profit-taking by the owners of Cold Spring Hills and its related parties, resulting in tragic human consequences, including the neglect and mistreatment of many of its residents who suffered injury, infection, pain, humiliation, and loss of dignity.

83. As demonstrated by the examination pursuant to Executive Law § 63(12) of Respondent Bent Philipson, who invoked his privilege against self-incrimination in response over 600 questions relating to the operation of Cold Spring Hills, the Attorney General finds that Respondent Philipson knew that his answers would lead to a finding that Respondents violated the laws, rules and regulations applicable to the operation of Cold Spring Hills, or that he intended unlawfully to disrupt and impede this investigation because of his knowledge that Respondents violated the laws, rules and regulations applicable to the operation of Cold Spring Hills. The Attorney General finds, therefore, that Respondent Bent Philipson has conceded liability for the acts and omissions described herein.

84. The Attorney General finds that Respondent Avi Philipson testified pursuant to Executive Law §63(12) in an intentionally evasive and contemptuous manner, knowing that his answers would lead to a finding that Respondents violated the laws, rules and regulations applicable to the operation of Cold Spring Hills, or that he intended unlawfully to disrupt and impede this investigation because of his knowledge that Respondents violated the laws, rules and regulations applicable to the operation of Cold Spring Hills. The Attorney General finds, therefore, that Respondent Avi Philipson has conceded liability for the acts and omissions described herein.

Medicaid and Medicare Funding of Cold Spring Hills

85. Medicaid is a joint state and federal program designed to provide medical care to those who would not otherwise be able to afford it. It is funded by New York State and Federal monies. The Medicaid Program provides no-cost medical services and goods to eligible needy persons who must meet defined income thresholds to be eligible for Medicaid.

86. In New York State, Medicaid service providers such as nursing homes are reimbursed either directly, on a fee-for-service basis wherein healthcare providers and pharmacies bill New York State directly for Medicaid services, or through claims submitted to Managed Care Organizations.

87. Cold Spring Hills, a Medicaid and Medicare provider, is a 588-bed for-profit nursing home, comprised of five separate residential buildings in close proximity to each other on the same campus, located in the Town of Oyster Bay, Nassau County, New York.

88. All Cold Spring Hills' residents are vulnerable, elderly, and/or disabled individuals. The majority of its residents are Medicaid recipients, and the full cost of their care is provided by the Medicaid program. Many of its residents are also Medicare beneficiaries, and most of the cost of their care is provided by Medicare, a health care program for elderly individuals which is funded by the federal government.

89. From 2017 through 2021, Cold Spring Hills received over $157 million from New York State's Medicaid Program and over $88 million from Medicare, to provide critical care to its elderly and/or disabled residents.[10] Auditor Aff., ¶¶ 23, 68.

[10] As further discussed below, Cold Spring Hills also received federal healthcare stimulus payments as a result of the COVID-19 pandemic. *See infra* ¶¶ 405-06.

Respondents Hid Their True Ownership and Control of Cold Spring Hills, Lied to DOH, and Funneled Money to Shell Companies and Other Related Parties

90. In violation of and in disregard for dozens of New York State nursing home laws and regulations, Respondents lied to DOH about the true ownership and control of Cold Spring Hills, putting forward the names of straw owners for DOH approval on the CON application, and hiding the names of those individuals who truly control the management and financial decisions of the facility. Ultimately, Respondents Bent Philipson, Benjamin Landa, and David Zahler installed their children, Avi Philipson, Esther Farkovits, and 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.

91. Bent Philipson put up his son, Avi Philipson, who was only 22 years old at the time and was studying abroad, as 25% owner of Cold Spring Hills. Auditor Aff., ¶ 49, Ex. 6.[11] As per a new CON application filed for the "Assignment of Membership Interest," on September 27, 2016, Bent Philipson's wife, Deborah Philipson, then received a 1% ownership interest from their son, Avi Philipson. Avi Philipson ultimately became a 24% straw owner of the 588-bed nursing home, which enabled Bent Philipson to exercise control over Cold Spring Hills. Auditor Aff., ¶ 43, Ex. 2.

92. Similarly, Benjamin Landa put up his daughter, Esther Farkovits, as a 25% straw owner of Cold Spring Hills, which enabled Benjamin Landa to exercise control over Cold Spring Hills, aided by his control and ownership of Sentosa, with Bent Philipson.

[11] As part of the purchase process for Cold Spring Hills, through his agents, Bent Philipson sought a CON from DOH and provided DOH with financial disclosure documents. Initially, Bent Philipson listed himself on the Cold Spring Hills CON as a 5% proposed member of Cold Spring Hills, and later removed his name and increased his son, Avi Philipson's ownership interest to 25% on the CON application. Auditor Aff., ¶ 43, Ex. 2.

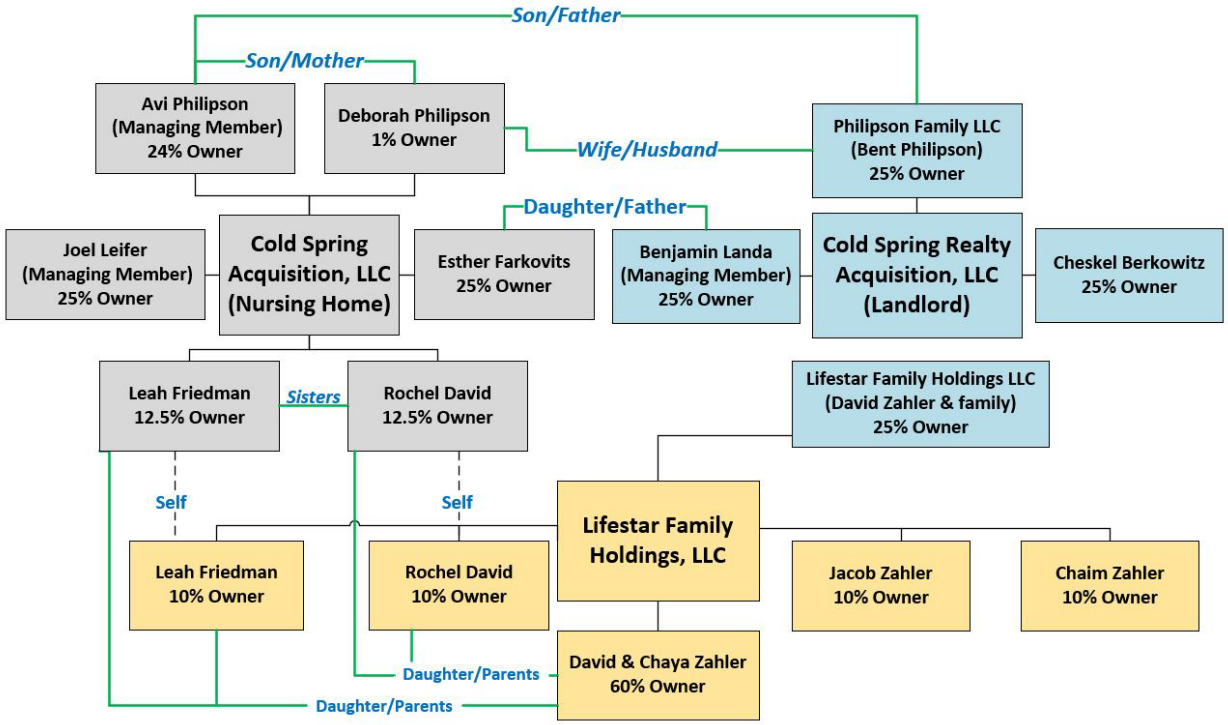
93. Likewise, David Zahler installed his two daughters, Rochel David and Leah Friedman, as 12.5% straw owners of Cold Spring Hills to effectuate his hidden ownership of its operations.

94. Respondents Bent Philipson, Benjamin Landa, and David Zahler then created and used a complex web of related party LLCs in order to control the finances, management, and operations of Cold Spring Hills, and its real estate. They structured the Cold Spring Hills real property into a real estate holding company,[12] and used it as a corporate vehicle through which they siphoned and shared exorbitant profits disguised as "rent." *See infra* ¶¶ 394-404.

95. As shown in the chart below, Cold Spring Realty is owned in nominally equal portions by the Philipson Family, LLC, Benjamin Landa, Cheskel Berkowitz, and Lifestar, which is owned by David Zahler and Chaya Zahler (60%), Rochel David (10%), and Leah Friedman (10%), Jacob Zahler (10%), and Chaim Zahler (10%).

[12] In June 2016, Cold Spring Realty purchased the real property where Cold Spring Hills is located. Auditor Aff., ¶ 42.

Ownership Interests and Familial Relationships of Cold Spring Realty, Cold Spring Hills, and Lifestar



96. Respondents Bent Philipson, Benjamin Landa, and Joel Leifer also caused Cold Spring Hills to pay them purported management, consulting and/or fiscal service fees through self-dealing, related party transactions with entities such as Sentosa, Excelsior, Rosewell, Prudent Consulting, Highview, and Ventura. Moreover, Respondents Bent Philipson and Benjamin Landa structured additional transactions through Cold Spring Realty to pass-through shell companies, such as B&L Consulting, Philipson Family, LLC, and Highview.

97. When a business dispute resulted in a split between Bent Philipson and Benjamin Landa in 2019, Bent Philipson took sole control of the operations, finances, and management of Cold Spring Hills. Cold Spring Hills ceased doing business with Sentosa and Excelsior, and Bent Philipson formed Ventura, which became Cold Spring Hills' "consulting company." Auditor Aff., ¶¶ 59, 139. Respondent Joel Leifer testified in an examination taken pursuant to Executive Law

§ 63(12) that prior to 2019 he monitored operations of Cold Spring Hills and in July of 2019, "backed out of Cold Spring Hills" because "the partners I mean, Landa and Philipson were fighting." SAAG Aff., Ex. 5 (pg. 154).

Respondents Intentionally Deceived DOH to Get CON Approval, Using Straw Owners

98. A CON application submitted to DOH requires a proposed owner to make specific representations of fact and, in some instances, provide an affirmative statement explaining why he or she is qualified to operate the proposed facility. As part of the scheme to make its ownership appear to be a diversified group, when in fact control rested with a centralized few, Respondents Rochel David, Leah Friedman, Esther Farkovits, and Avi Philipson made false and/or misleading statements on their CON applications submitted to DOH to disguise the true ownership and control of Cold Spring Hills from DOH.

99. Indeed, Respondents Esther Farkovits, Rochel David, and Leah Friedman plainly admit that, despite their collective 50% ownership, they played no role in management and operations of Cold Spring Hills and were brought the "investment" by their fathers. SAAG Aff., Ex. 4 (pgs. 52, 105); SAAG Aff., Ex. 3 (pg. 137); SAAG Aff., Ex. 2 (pg. 51). Respondent Avi Philipson, with his 24% share, admitted that until 2019 he played no part in management of the facility beyond "observing" Respondent Joel Leifer, and answered evasively about any time he spent at the facility after that. SAAG Aff., Ex. 8 (pg. 87).

100. Specifically, in 2016, Respondent Rochel David wrote in her CON application to DOH that she was employed at Confidence Management Systems, her father's company in Linden, New Jersey, but during this investigation in 2022, she testified that she had not worked there since about 2004. SAAG Aff., Ex. 3 (pg. 29). Further, despite working at Confidence Management Systems for only 13 years, she wrote in her CON application, "I believe my 25 years' experience in the payroll and human resource departments [at Confidence Management Systems] will be an

asset to this residential healthcare facility. Additionally, I plan to learn from the experiences of other members who have more nursing home operating experience." Auditor Aff., Ex. 5. Yet she testified during this investigation in 2022, "I am a passive owner. I don't have anything to do with the day-to-day running of the facility. There is an owner that's the managing member and it would be his responsibility, I would think." SAAG Aff., Ex. 3 (pg. 41).

101. Rochel David testified during her examination in 2022 in this investigation that she became an owner of Cold Spring Hills as an investment on the advice of her father, David Zahler, and that the purpose of her investment in nursing homes is to make money. SAAG Aff., Ex. 3 (pgs. 20-21, 48-50). Despite signing her application for the CON in 2016, she testified in 2022 during this investigation that she was unaware that there was an application for approval submitted to DOH for her ownership of Cold Spring Hills and that she did not submit any documentation to DOH. *Id.* at 37-38. She testified that she did not know the name of Cold Spring Hills and did not know the names of other nursing homes she owns. *Id.* at 18, 20-21. She testified that she did not know the location of Cold Spring Hills, how many buildings it has, or the number of resident beds. She testified that she had never visited the facility. *Id.* at 48-50.

102. Rochel David testified she had not thought about her ownership in Cold Spring Hills until she received the Attorney General's subpoena in May 2022, when she did some "research" and determined she "could be liable for whatever." She explained: "I could be liable for, I guess anything in the facility. I don't know." *Id.* at 37-38, 40-41.

103. Similarly, in 2016 when her sister, Respondent Leah Friedman, submitted her CON application, Ms. Friedman wrote that she was presently employed at Confidence Management Systems. Auditor Aff., Ex. 4. Yet during her examination in 2022 in this investigation, she testified that she had not worked for Confidence Management Systems since approximately 2004 or 2005.

SAAG Aff., Ex. 2 (pg. 29). She wrote on the CON application in 2016 that she intended to assist in the operation of Cold Spring Hills to learn from the experiences of other members who had more experience in the nursing home industry; however, she testified in 2022 that she is a "silent" partner who has no obligation regarding the care of the residents at Cold Spring Hills and knows nothing about their care. Auditor Aff., Ex. 4; SAAG Aff., Ex. 2 (pgs. 24-25). She testified that she does not know "how Medicaid operates with respect to a nursing home." SAAG Aff., Ex. 2 (pgs. 25-26). She is not familiar with New York or federal nursing home regulations and has "nothing to do with the running of the facility" and is "just an investor." *Id.* at 86-87. She repeated: "Like I said, I just invested and I have nothing to do with the runnings [sic] of the facility at all." *Id.* at 89. Like her sister, she testified that she does not know the location of Cold Spring Hills, how many buildings it has, the number of resident beds, and has never visited the facility. *Id.* at 40-41. She testified that her father, David Zahler, brought her Cold Spring Hills as an "investment." *Id.* at 16-18. She does not know what investments she has, and does not know how many nursing homes she owns or invests in. *Id.* at 16, 22.

104. Esther Farkovits testified she did not know that her name was submitted as part of the approval process for Cold Spring Hills. SAAG Aff., Ex. 4 (p. 22). She did not know she owned part of Cold Spring Hills until she was subpoenaed to testify in connection with the Attorney General's investigation, in May 2022; she said that her father invested in Cold Spring Hills for her "almost as a gift." *Id.* at 17-18, 20-22, 24. She testified she is a "silent investor" who has no responsibilities as an owner of the nursing home. When asked what being a "silent investor" in a nursing home means to her, she testified: "[I]t actually means not much because there is someone there who's managing and doing day-to-day operations. That's certainly not me. A, I'm not trained in it; B, I live overseas; and C, I'm a mother of five." *Id.* at 20-22. She testified that she does not

know who the other owners of Cold Spring Hills are and does not know how many nursing homes she has an ownership interest in. *Id.* at 16, 31. Esther Farkovits has resided outside the United States since at least 2014.

105. Moreover, Esther Farkovits falsely conveyed in her CON application that she had the required management experience to be an owner of Cold Springs Hills. Specifically, Esther Farkovits left blank the portion of the CON that requires an individual who has not served as a director/officer and lacks managerial experience to provide an affirmative statement explaining his or her qualifications to operate the facility. The omission of this section implies that she had the appropriate managerial experience to operate a skilled nursing facility. *See* Auditor Aff., ¶ 46, Ex. 3. Esther Farkovits testified under oath that she has no relevant managerial experience in the nursing home industry, and at the time this application was submitted, had only worked as a yoga instructor and a brochures designer. SAAG Aff., Ex. 4 (pgs. 15, 72-75, 79, 89-90).

106. Avi Philipson was 22 years old and studying abroad at the time that his 2015 CON application was filed with his name as an owner. Indeed, Joel Leifer testified that from January 2016 to May or June of 2019, Avi Philipson "wasn't much involved" in Cold Spring Hills. SAAG Aff., Ex. 5 (pgs. 90-92). In 2019, when his father split his business from Respondent Benjamin Landa, Avi Philipson purportedly took over Cold Spring Hills, yet was evasive when asked under oath how frequently he performed work for Cold Spring Hills after switching to Bent Philipson's company, Ventura. *See generally* SAAG Aff., Ex. 8 (pgs. 114-127).

107. Respondents Leah Friedman, Rochel David, Esther Farkovits, and Avi Philipson thus, as nominal owners, made false and misleading statements in their communications with DOH to induce the approval of their CON application and enabled Respondents' scheme of taking

significant "up-front profit" from Cold Spring Hills through disclosed and undisclosed related party transactions orchestrated by their fathers.

Bent Philipson and Benjamin Landa Exerted Ownership and Control Over Cold Spring Hills Until Philipson/Landa Business Split, Leaving Bent Philipson in Complete Control

108. Respondents Bent Philipson and Benjamin Landa jointly exercised actual, continued management and control over Cold Spring Hills' finances—including the expenses and related party distributions—until these "partners" split in 2019.

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.

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.

111. When a business dispute resulted in a split between Bent Philipson and Benjamin Landa in 2019, Bent Philipson, through his company Ventura, took exclusive control over Cold Spring Hills' operations and management, and exercised daily decision and policymaking over the nursing home, in addition to his control of its finances.

112. In February 2020, Bent Philipson orchestrated a plan to cut $1.6 million from the nursing home's expenses by eliminating staff at Cold Spring Hills, while pushing it to keep admission numbers up by admitting new residents. He consistently reviewed daily census information and Weekly Reports from Cold Spring Hills' payroll vendor, via email. Auditor Aff. ¶ 157. In addition, Helena Bernstein, Chief Financial Officer of Ventura, testified that she meets

with Bent Philipson at the end of each month and discusses incoming revenue as well as expenses. SAAG Aff., Ex. 16 (pg. 38).

113. Staff considered Bent Philipson's company, Ventura, to be the "corporate" entity of Cold Spring Hills. Budget documents refer to Cold Spring Hills' employees as being "moved to corporate payroll" when they became employees of Ventura. Auditor Aff. ¶¶ 145-56; Ex. 27. Stella Vilardi, the Executive Director of Ventura, testified that the term "corporate" was synonymous with Ventura. SAAG Aff., Ex. 9 (p. 12).

114. When asked under oath if Ventura is the corporate entity of Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

Ventura and Bent Philipson Illegally Act as Governing Body of Cold Spring Hills

115. In place of the approved owners of record, since 2019 Bent Philipson and Ventura have acted as the *de facto* governing body for Cold Spring Hills, and continue to do so, despite not being named as proprietors on the operating certificate.[13,14] *See* Auditor Aff., ¶ 139.

116. Illegally acting as the governing body of Cold Spring Hills, Ventura and Bent Philipson controlled policies and protocols. Documents produced by Cold Spring Hills include an

[13] According to 10 NYCRR § 415.2(g), a "governing body shall mean the policy-making body of a government agency, the board of directors or trustees of a corporation or *the proprietor or proprietors of a proprietary nursing home to which the department has issued an operating certificate*" (emphasis added). Pursuant to 10 NYCRR 415.26(b), a nursing home "shall 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. Moreover, 10 NYCRR 415.26(b) provided, in pertinent part, that the governing body shall appoint and administrator, determine and establish written policies, be responsible for the operation of the facility, and assure that a method is implemented to promptly deal with complaints and recommendations.

[14] Changes in nursing home ownership must be reported to DOH as amendments to the nursing home's initial CON application. To date, no amendments for a change in ownership have been submitted to DOH by Cold Spring Hills to indicate Bent Philipson as its owner, or proprietor.

email dated March 19, 2020, in which Daniel Schaffer, the Executive Vice President of Ventura, referred to Ventura multiple times as "corporate," and instructed staff at Ventura, along with other nursing home staff, to "try to keep all the Administrators in the loop when we [Ventura] are making changes to the protocols or everyday functions of the departments." Auditor Aff., ¶ 148, Ex. 28.

117. Moreover, despite not being the proprietor of Cold Spring Hills to whom DOH issued an operating certificate and therefore not eligible to be the governing body of Cold Spring Hills, Bent Philipson was involved in appointing Yossi Emanuel as Cold Spring Hills' Administrator and later Deborah Flack as the successor Administrator. In an examination taken pursuant to Executive Law § 63(12), Yossi Emanuel testified that he became the Administrator at Cold Spring Hills when Bent Philipson, along with Daniel Schafer, "called [him] up and said we'd like to move you to Cold Spring Hills." SAAG Aff., Ex. 15 (pgs. 30-31). And, when Yossi Emanuel left his employment at Cold Spring Hills, Bent Philipson was involved in the decision to replace Yossi Emanuel as Administrator with Deborah Flack. SAAG Aff., Ex. 7 (February 10, 2021 at pg. 216).

118. And lastly, illegally acting as the governing body, Ventura received complaints via email regarding Cold Spring Hills. Until approximately September 2021, the Cold Spring Hills website directed complaints to the email address of Ventura's d/b/a, Philosophy Care Centers: "info@philosophycare.com." Auditor Aff. ¶ 150, Ex. 29.

119. When asked under oath about whether Ventura determines policy and makes decisions on behalf of Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

Grossly Substandard Care at Cold Spring Hills—Resident Neglect and Harm

120. After Respondents took control of Cold Spring Hills in June 2016, its Centers for Medicare and Medicaid Services ("CMS") Nursing Home Health Inspection Rating[15] dropped to the lowest possible rating, "one star" ("MUCH BELOW AVERAGE"), where it remained until the third quarter of 2022, the most recently available data. Auditor Aff., ¶ 162. Moreover, through cost-cutting and predatory up-front profit-taking, Respondents caused Cold Spring Hills' Overall Ratings to drop from "three stars" ("AVERAGE") to "two stars" ("BELOW AVERAGE") in the third quarter of 2016, where those ratings remained through the third quarter of 2022, the most recently available data. *Id.* Meanwhile, Cold Spring Hills' in-house resident death rate rose in 2018 and 2019 when compared to 2017. *Id.* ¶ 254.

Cold Spring Hills Failed to Provide Even Basic Care to Residents Before, During, and After the Height of the COVID-19 Pandemic, Endangering Residents' Health

121. While Cold Spring Hills violated its duties of care to its residents, Respondents' callous disregard and looting of Cold Spring Hills caused neglect and harm. Below are some of the heart-wrenching illustrations of Cold Spring Hills' neglect of its residents,[16] which Respondents failed to prevent or stop.

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[15] CMS publishes nursing home ratings for every nursing home in the country, in the following categories: 1) Health Inspections; 2) Staffing; 3) Quality Measures; and 4) Overall ratings. These ratings are published on the CMS "Care Compare" website. CMS created the Five Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. The ratings are based on data required to be reported by the facility and on official inspections; the ratings are not matters of consumer opinion. CMS designates a "one star" rating to mean "MUCH BELOW AVERAGE," a "two star" rating to mean "BELOW AVERAGE," a "three star" rating to mean "AVERAGE," a "four star" rating to mean "ABOVE AVERAGE," and a "five star" rating to mean "MUCH ABOVE AVERAGE." Auditor Aff., ¶ 162.

[16] Several of the witnesses in the Attorney General's investigation expressed strong fear of retaliation from Cold Spring Hills for cooperating in this investigation. One witness refused to talk with an OAG Detective after expressing a concern that if they cooperated in this investigation, their family member, who resides at Cold Spring Hills and is dependent on it for all of their needs, would face retaliation from Cold Spring Hills. The family member reported a lack of care for their

122. **Pre-Pandemic Neglect Continuing into 2022—Failure to Provide Basic Humane Care, Unexplained Injury, Infection Followed by Social Withdrawal:** C.P. has been a resident at Cold Spring Hills since 2018, with diagnoses including dementia. Before living there, she enjoyed riding horses and spending time with friends and family. A.P. is C.P.'s daughter and health care proxy, as is her sister. A.P. also holds power of attorney for C.P. According to A.P., in approximately September 2019, Cold Spring Hills' staff said C.P. was refusing to take showers and they were not going to even try to bathe her anymore. A.P. stated that, as a result, she went to Cold Spring Hills and showered her mother each week until March 2020. The COVID-19 pandemic impacted visits. In the summer of 2020, during the COVID-19 pandemic, A.P had weekly FaceTime video calls with her mother, during which she observed "mom always looked dirty, as if she was not receiving any showers." Affidavit of A.P. ("A.P. Aff."), ¶¶ 3-6, 8, 12.

123. Cold Spring Hills records reveal that in January 2020, C.P. was diagnosed with the bacterial skin infection cellulitis from scratching her ankle. Medical Analyst Aff. ¶ 98. *See also id.* at ¶ 75 & n.18 (bathing removes dirt and bacteria and promotes blood circulation, and good hygiene including meticulous skin and nail care is imperative in preventing bacterial skin infections; when there is insufficient staffing to provide required care to residents based on their needs and acuity, their direct caregivers are more likely to fail to properly groom residents, thereby negatively impacting the residents' physical and psychosocial health).

124. Nursing homes must provide services that ensure residents maintain good personal hygiene, such as regular bathing, grooming including nail care, dental hygiene, and dressing, as crucial to resident health, dignity, and well-being. Every activity of daily living,

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loved one, a lack of responsiveness from an Administrator regarding expressed concerns about care, and a fear that the care provided to their loved one would further decline in retaliation if they cooperated with this investigation. Detective Aff., ¶ 8.

including hygiene, is critical to a resident's achievement or maintenance of her highest practicable physical, mental, and psychosocial well-being – including the avoidance of infections such as cellulitis, as well as tooth decay and the need for extractions. *See* Medical Analyst Aff., ¶¶ 68-69, 75.

125. In early June 2021, A.P. visited her mother at Cold Spring Hills for the first time since the COVID-19 pandemic began. When A.P. entered and observed her mother's room, she felt "very upset, angry, and infuriated" at its condition. She observed there was clothing, food, stuffed animals, a medication cup, a fork, shoes, a newspaper, and other garbage under her bed. She described the bathroom floor as filthy, with feces on the walls, no running water, the hot water handle missing on the sink, and a wide ring of dark brown rust around the drain. A.P. Aff., ¶ 13. A.P took photographs of the conditions of her mother's room and bathroom. *See* A.P. Aff., Ex. 1; *see also infra* ¶¶ 330-31.

126. The poor conditions of C.P.'s room and bathroom unquestionably contributed to her lack of hygiene.

127. A.P. also recounted that her mother was not provided adequate dental care, and her discovery of that basic fact also shows the lack of overall supervision of staff and a failure of supervisors to monitor the condition of the residents at Cold Spring Hills.

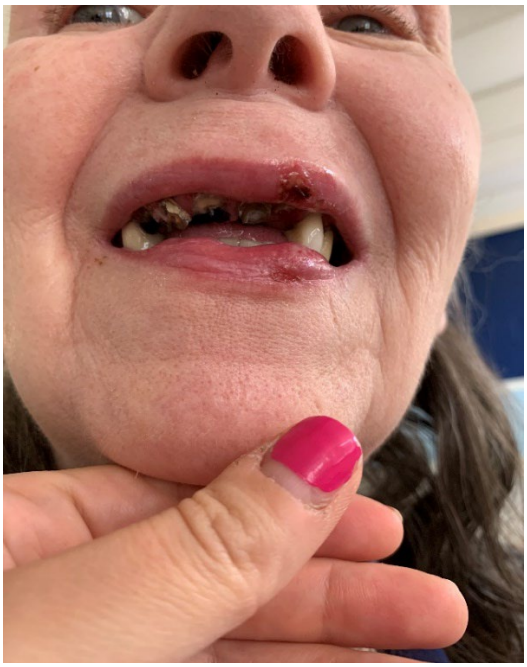
128. Nursing homes are required to screen residents for risk of falling and ensure that there is sufficient staff to implement the care plan to ensure the resident's safety. Insufficient staffing to adequately monitor residents increases a resident's risk of falls. Nursing homes must operate with sufficient staffing in all areas of the building in order to prevent resident accidents and incidents that result from inadequate staffing, and to prevent the resulting adverse events and outcomes, such as injuries. Medical Analyst Aff., ¶¶ 34, 36; *see also id.* at ¶¶ 33, 35, 37 (accidents,

incidents and insufficient staffing; consideration of risk of falls from medical conditions, medications and restraints as part of resident's care plan; ensure sufficient staffing to implement care plan to ensure resident's safety; falls from unanswered call bells by residents who need assistance).

129. Yet, around June 6, 2021, a Cold Spring Hills nurse notified A.P. that her mother had fallen in the dining room the night before and had a swollen lip. Shortly thereafter, a different nurse notified A.P. that her mother's dental bridge, i.e., her mother's front teeth, had fallen out of her mouth. A.P. told the Cold Spring Hills Administrator that she wanted a dentist to see her mother as soon as possible. A.P. Aff., ¶¶ 17-18.

130. The day after that, a Cold Spring Hills nurse practitioner called A.P. and told A.P. that she was not sure if her mother had actually fallen on June 5 because, although she was "found" on the floor of the dining room, the fall was not witnessed, and Cold Spring Hills was categorizing it as an unwitnessed injury. A.P. Aff., ¶ 21. However, there is a discrepancy in the Cold Spring Hills records as to whether the incident was actually witnessed or unwitnessed. Medical Analyst Aff., ¶ 96. Cold Spring Hills denied A.P.'s request for a copy of the Cold Spring Hills incident/accident report, although A.P. was her mother's health care proxy and holds power of attorney for her. A.P. Aff., ¶¶ 23, 4.

131. While these events were unfolding, A.P.'s sister and brother-in-law visited their mother. The sister told A.P. that "she was upset and shocked" by their mother's mouth— "mom's upper front teeth were broken off and her root tips and metal posts were exposed." A.P. Aff., ¶ 19. A.P.'s sister took photographs of C.P.'s mouth and teeth at the time of her visit, which are attached as Exhibit 3 to the Affidavit of A.P., one of which is copied below:



132. The Cold Spring Hills dentist recommended leaving C.P.'s mouth as it was, however, claiming that making dentures would be difficult due to her dementia. A.P. Aff., ¶ 20.

133. Despite no one knowing if C.P.—who was already cognitively impaired—had hit her head, since it was categorized as an unwitnessed injury, and despite her cut lip and missing teeth, A.P. explained that Cold Spring Hills did not send C.P. to the hospital for evaluation and to rule out a head injury until her family insisted the facility do so. A.P. Aff., ¶¶ 17-21.

134. Because of Cold Spring Hills' lack of dental care, C.P.'s family had an oral surgeon unconnected to Cold Spring Hills examine her. The oral surgeon expressed disbelief at the state of C.P.'s teeth—A.P. noted, "There was extreme tarter buildup in her gumlines, her gums were bleeding," and she had to have numerous teeth extracted. A.P. Aff., ¶¶ 24-25; *see also id.* at ¶ 20.

135. Dental hygiene is incredibly important to the overall health of a nursing home resident. Failure to maintain good dental hygiene has been linked to heart disease and other conditions, as well as overall mouth health. Nursing homes must assist residents with routine dental care and provide emergency dental services to meet the needs of each resident. Nursing

homes that operate with insufficient staffing increase the likelihood that their staff will fail to regularly brush their residents' teeth and/or otherwise provide good dental hygiene, thereby increasing the risk that their residents' teeth will decay, rot, develop infection, need to be extracted, and cause the residents to experience preventable pain, suffering and bad breath. Medical Analyst Aff., ¶ 75 (dental hygiene); *see also id.* at ¶¶ 68-69. Decay, rot, infection, and extraction would also affect a resident's ability to eat food of normal consistency and obtain sufficient nutrition.

136. A.P. also noticed in early June 2021 that her mom's toenails were very long and her feet were very dry. She took photographs of her mother's feet at that time. *See* A.P. Aff., Ex. 2. Although A.P. discussed the condition of her mother's feet with members of Cold Spring Hills administration, nursing and a social worker, they ignored her complaint and continued to fail to provide the care. Instead, A.P. resorted to cutting her mother's toenails and fingernails and bringing her own cream to Cold Spring Hills to tend to her mother's feet. A.P. Aff., ¶¶ 13-16.

137. Additionally, A.P. said that she visited her mother every day for a week in August 2021, and every day upon her arrival, her mother's adult diaper was "wet through to her pants" with urine and/or feces A.P. did not know for how long her mother had been left like that before she arrived. A.P. Aff., ¶ 26.

138. Failure to promptly change a resident's soiled diaper can cause severe health problems for the resident. Additionally, proper toileting, including prompt changing of adult diapers, personal grooming, and foot care are types of care and services relating to a resident's activities of daily living ("ADLs") and are crucial to resident health, dignity, and well-being. Medical Analyst Aff., ¶¶ 71-72, 68-69.

139. C.P.'s care at Cold Spring Hills continued to suffer. In mid-March 2022, a nursing staff member called A.P. to tell her that "mom was found unresponsive, in a chair" and that she

had syncope.[17] When A.P. said she didn't know what syncope is, the nursing staff member replied tersely, "Google it." She then assured A.P. her mother was "fine." But the next day, a member of nursing staff said C.P. was lethargic, and she was unresponsive when A.P. tried to FaceTime with her. Soon after, A.P. spoke with a doctor for Cold Spring Hills, who could not explain why C.P. had fainted. The doctor told A.P. it could have been an infection and that it would take a long time to identify the problem. A.P. Aff., ¶¶ 30-34.

140. The Cold Spring Hills doctor, however, determined that C.P.'s stomach was distended, her bladder was not functioning, and her kidneys were blocked. During their call, Cold Spring Hills inserted a urinary catheter. At A.P.'s request, C.P. was sent to the hospital. A.P. Aff., ¶¶ 34-36.

141. C.P. was diagnosed with a urinary tract infection at the hospital. A nurse also advised that she had a fever. A hospital doctor advised that C.P.'s urinary tract infection was likely due to her diapers not being changed frequently enough. C.P. was treated at the hospital for an entire week. A.P. Aff., ¶ 36.

142. Since her urinary tract infection, C.P. has been more withdrawn and has been talking less. Cold Spring Hills staff notified A.P. in early April 2022, that her mother was also participating less in recreational activities. A.P. Aff., ¶ 37.

143. During a May 2022 care plan meeting, A.P. expressed concern to Cold Spring Hills about the frequency with which her mother's diapers were being checked and changed, as she did not want her mother to contract any more urinary tract infections. The participating social worker said he would get back to her, but as of September 26, 2022, he still had not. A.P. Aff., ¶ 38.

[17] Syncope involves fainting, passing out, or feeling dizzy or light-headed and it is caused by a lack of blood flow to the brain, secondary to multiple conditions or illnesses. Medical Analyst Aff., ¶ 35, & n. 8.

144. A.P. has been trying to transfer her mother to a different facility. A.P. Aff., ¶ 7.

145. **Pre-Pandemic Neglect—Failure to Provide Basic Humane Care:** S.H. was admitted to Cold Spring Hills in early August 2019 for short term rehabilitation after she had a stroke that affected her ability to walk, to use her right, dominant arm and hand, and to speak. She could not feed herself or make her needs known, and she was dependent on her caregivers at Cold Spring Hills. Before her stroke, S.H. enjoyed doing word puzzles, reading, and listening to music. According to S.H.'s daughter and health care proxy, M.H., at least one of S.H.'s daughters or her husband visited her daily throughout her residency at Cold Spring Hills through early 2020. Affidavit of M.H. ("M.H. Aff."), ¶¶ 3-6, 8.

146. M.H. recounted that during her mother's five months living at Cold Spring Hills, she received only three showers, including one the first week she arrived and one the week she left. M.H. visited her mother on one of her two weekly scheduled shower days but did not see her being taken to the shower room. She noted her mother "always had bad body odor due to the lack of bathing." She reported that in September 2019, an aide told her that staff was providing her mother with sponge baths instead of showers because the bariatric chair that she needed for a shower was broken. The aide showed M.H. a broken bariatric chair in the shower room. M.H. Aff., ¶¶ 9, 12.

147. During an October 2019 care plan meeting, M.H. confronted the nursing staff about her mother not being showered. Despite staff having previously told her that they were not showering her mother, the nursing staff claimed that staff was showering her mother regularly and they said the showers were documented in her chart. When M.H. told them the chart was inaccurate because they did not have the correct chair to shower her mother, nursing staff said they would try to borrow a chair from another wing. M.H. Aff., ¶ 10.

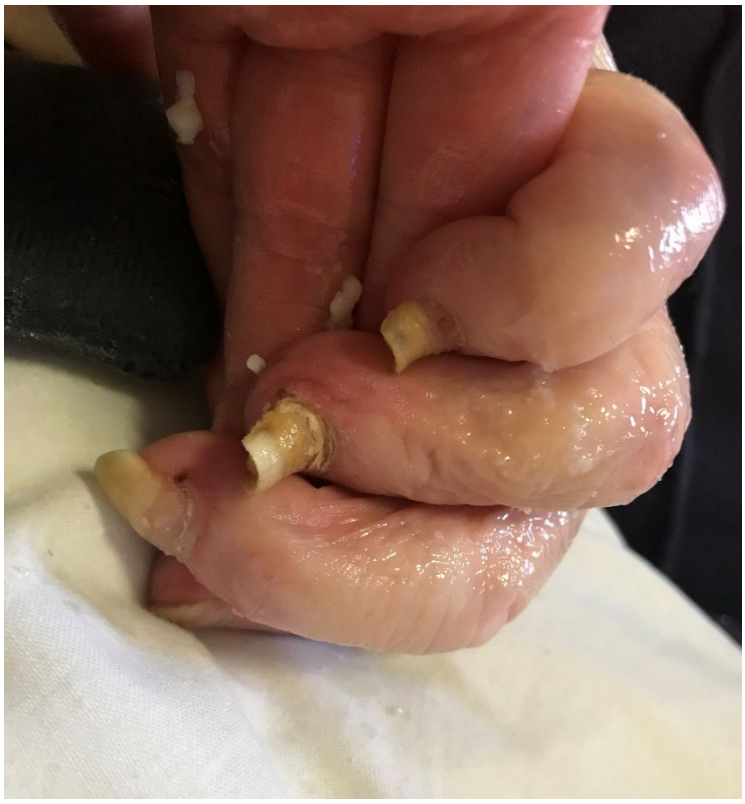
148. When M.H. informed staff that she had found a bariatric chair for her mother at a supplier, staff brought a chair to her mother's room, but that, too, was broken. M.H. Aff., ¶ 11. A bariatric shower chair can be purchased at retail for $600 or less. Medical Analyst Aff., ¶ 75 & n.17.

149. Despite her family's advocacy, S.H. waited throughout November and December for a shower. Staff finally provided her with one in January 2020, the same week she was discharged home. M.H. Aff., ¶ 12.

150. M.H. also said that in mid-August 2019, when her sister visited their mother right after lunch, at about 12:30 p.m., she smelled an odor in their mother's room and asked an aide to change her mother's diaper. According to M.H., the aide declined, responding, "She is a 2 person assist, and I am the only one here—she will have to wait." S.H. waited and sat in a soiled adult diaper for approximately six hours, until it was changed at about 6:30 p.m. This was not an isolated incident—M.H. said her mother sat in soiled diapers for extended periods of time, waiting for someone at Cold Spring Hills to change her "more times than I can tell you." M.H. Aff., ¶ 14.

151. During M.H.'s frequent visits with her mother at Cold Spring Hills, she saw that her mother's nails on her right, paralyzed hand were too long— "so long that they caused abrasions on the inside of her hand." M.H. complained to the Cold Spring Hills Administrator and the Director of Nursing ("DON") about her mother's nails and the abrasions they were causing to her hand. They ignored her complaints. M.H. Aff., ¶ 13.

152. M.H. took photographs of S.H.'s neglected right hand, which are attached as Exhibit 1 to the Affidavit of M.H., and one of which is also copied below:



153. Proper personal hygiene, including showers and nail care, and proper toileting are crucial to resident health, dignity, and well-being. *See* Medical Analyst Aff., ¶¶ 68-69, 72, 75; *see also id.* at ¶¶ 8, 11. Moreover, equipment in disrepair can endanger residents. *Id.* at ¶ 38

154. When asked under oath questions about whether he or anyone else at Cold Spring Hills made any effort to purchase a bariatric shower chair so S.H. could take a shower, Bent Philipson asserted his privilege against self-incrimination six times. In 2019, the year that S.H. could not be showered, Bent Philipson took over $3.5 million from Cold Spring Hills for himself. *See infra* ¶¶ 403, 440-43.

155. **Denied Wheelchair Footrests, Suffered Foot Injury from Dragging Feet on Floor, Infection, Amputation:** P.L. was admitted to the Brookville building of Cold Spring Hills in 2017, when he was in his early 70s. He had diagnoses including Type 2 diabetes, dementia, and

Alzheimer's disease.[18] E.L., who is a registered nurse ("RN") and was P.L.'s cousin and co-guardian,[19] visited P.L. at Cold Spring Hills once or twice a week. During P.L.'s first year there, he could walk without a problem, and he would read the bible out loud in French and sing for other residents on Sundays. However, when her cousin was moved to the second floor of the Brookville building, she said he always smelled of urine, and the second floor of the Brookville building also always smelled of urine. She described how the floor of her cousin's room was dirty, as were the curtains and toilet. Her cousin was rarely, if ever, groomed. He was never clean shaven and E.L. had to cut his fingernails because no one at Cold Spring Hills did it for him. Affidavit of E.L. ("E.L. Aff."), ¶¶ 2-5, 7-8, 15-17.

156. According to E.L., at the end of 2019, her cousin started using a wheelchair at Cold Spring Hills because he was having difficulty walking.[20] She said Cold Spring Hills provided him with a wheelchair but failed to attach needed footrests, so that over about the first six weeks, P.L. dragged both of his feet on the floor when using the wheelchair.[21] E.L. Aff., ¶ 9. Wheelchair footrests are relatively inexpensive products, readily available even at online retailers. Medical Analyst Aff., ¶ 88.[22]

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[18] *See* Medical Analyst Aff., ¶ 93.

[19] *See also* Medical Analyst Aff., ¶ 92.

[20] E.L. said the nurse practitioner told her that the nurses claimed P.L. was too confused and forgetful to participate in physical therapy to help him walk—but P.L. was cognitively impaired from dementia. E.L. Aff. ¶ 9.

[21] Similarly, the family member of Resident 47 said that Cold Spring Hills provided Resident 47 a wheelchair that did not have needed footrests. Unsurprisingly, her parent's feet also dragged on the ground, as a consequence. Detective Aff., ¶ 52.

[22] In addition, paragraph 38 of the Medical Analyst Affidavit discusses the danger that broken equipment poses to nursing home residents.

157. E.L. said that during that same time, P.L. developed sores on the toes of his right foot. In January 2020, E.L. made multiple requests for consultations with the nurse practitioner because she was worried about her cousin's toes, which were red and had sores on them. P.L. had diabetes, a disease that occurs when a person's blood glucose, also known as blood sugar, is too high or too low. It causes poor circulation in feet, making them less able to fight infection and to heal when injured.[23] In late January 2020, E.L. insisted P.L. be sent to the hospital because she could see the infection on his toes was red and "getting bad." P.L. had to have part of his toe amputated because the infection was so serious. E.L. Aff., ¶¶ 9-12.

158. After P.L. returned to Cold Spring Hills from the hospital, E.L. called Cold Spring Hills nearly every day from March to April 2, 2020, to see how he was doing, but staff always told her that he was sleeping and could not speak to her. The staff nevertheless assured E.L. that he was "fine." E.L. Aff., ¶¶ 12-13.

159. Her cousin was not fine: P.L. died on April 3, 2020. Despite being P.L.'s co-guardian, on April 3, 2020, E.L. learned of P.L.'s death not from Cold Spring Hills, but from P.L.'s son. E.L. was shocked, asking herself, "[H]ow can this be? He was fine yesterday, and now he's in heaven?" E.L. Aff., ¶ 14.[24]

160. In 2019, the year that P.L. developed the infection that cost his toe from lack of footrests, and also the year that the Philipson Control Group began exercising sole control over Cold Spring Hills, Bent Philipson took over $3 million from Cold Spring Hills for himself. *See infra* ¶¶ 403, 440-43.

[23] Medical Analyst Aff., ¶ 93 n.19.

[24] *See also* Medical Analyst Aff., ¶ 94.

161. **Humiliated, Ignored, Frightened and Disturbed by Treatment at Cold Spring Hills:** Resident J.D., a resident at Cold Spring Hills from the end of July 2020 to October 2020, suffers from ALS.[25] His son, C.H., testified by affidavit that J.D. had complained to C.H. that Cold Spring Hills staff were not answering his call bell and there were times during the day shift on the weekends that no one came to his room to check on him. C.H. said that J.D. used his call bell when he needed assistance with walking to the bathroom and moving between his bed and chair, and when he needed to receive his medication to relieve the gas buildup in his stomach from his gastroparesis, which was very painful. C.H. also said Cold Spring Hills put J.D. in adult diapers, to his embarrassment, even though he was continent, "because they consistently took too long to answer his call bell." J.D. told C.H. that he often waited at least 30 minutes and sometimes up to an hour for staff to answer his call bell to assist him with going to the bathroom. But because C.H. was not properly attended to, "after waiting too long for someone to answer, he would go in the diaper because he could not hold it any longer." Then he would have to sit in his dirty diaper waiting to be changed, which caused him further humiliation. Affidavit of C.H. ("C.H. Aff.") ¶¶ 3-5, 9, 12-14, 18.

162. Proper toileting is critical to the overall health of a nursing home resident, as failure to toilet is linked to serious health outcomes. It is, of course, also central to an individual's sense of dignity and control. *See* Medical Analyst Aff., ¶¶ 71-72. By putting otherwise continent residents in adult diapers, a nursing home avoids short-term need to have enough staff to respond timely to those same residents when they request assistance with getting to and from the toilet. *See infra* ¶ 318.

[25] ALS stands for amyotrophic lateral sclerosis, also known as Lou Gehrig's disease. It is a progressive neuro degenerative disease that affects the nerve cells in the brain and spinal cord, affecting muscles of movement, speaking, eating, and breathing. Medical Analyst Aff., ¶ 78.

163. C.H. described J.D. as appearing on video calls as dirty with greasy hair and unshaven—and, eventually, scared. J.D. asked C.H. to send him somewhere else. When J.D. was sent to the hospital for pneumonia in October 2020, C.H. visited him—J.D. looked "filthy," with overgrown hair and yellow toenails. C.H. Aff., ¶¶ 5, 11, 20-21, 23-24. Indeed, Cold Spring Hills records reflect that staff failed to provide J.D. with about eight of the approximately 18 baths required by his care plan. Medical Analyst Aff., ¶ 128.

164. Residents suffer when a nursing home operator fails to operate a nursing home with sufficient staff to provide the required care and services to assist residents with all of their ADLs, including bathing, nail and hair care, and toileting, consistent with state and federal law. The level of assistance needed for bathing varies from one resident to the next—some may only require assistance in getting to and from the bathroom, whereas others may be wholly dependent on their caregivers for bathing. Medical Analyst Aff., ¶¶ 69, 75; *see also id.*, ¶¶ 68, 71-72.

165. After his hospital stay, J.D.'s family moved him to a new facility because of his bad experience at Cold Spring Hills. At the other facility, J.D. regained strength and eventually returned home. Yet even afterwards, J.D. became visibly upset when speaking about Cold Spring Hills. C.H. Aff., ¶¶ 25-28. In 2020, the year that J.D. voided into his clothing because no staff were available to take him to the toilet, Bent Philipson took close to $4 million from Cold Spring Hills for himself.

166. **"After [Respondents] bought Cold Spring Hills, I noticed a decline in my mother's care. This was because there were never enough supplies or staff to take care of the residents."** M.A.G. described the neglect her mother, F.G., suffered while she was a resident at Cold Spring Hills from approximately May 2004 through December 2019. M.A.G.'s mother

suffered from dementia and she was unable to make her needs known. M.A.G. was her mother's health care proxy and visited her weekly. Affidavit of M.A.G. ("M.A.G. Aff."), ¶¶ 3-5, 8-10.

167. M.A.G. detailed the lack of enough Certified Nurse Aides ("CNAs") at Cold Spring Hills. For example, during a visit in early June 2018, M.A.G. explained that "one of the five CNAs assigned to my mother's unit was transferred to another unit because someone called in sick. This left only four CNAs" for the residents during the evening shift. M.A.G observed: "Without enough staff and enough supplies, they were not able to take care of the residents. I visited my mother regularly but wonder what kind of care she received when I was not there." M.A.G. Aff., ¶¶ 6, 14, 18.

168. M.A.G.'s concerns were substantiated. She said that "[r]ight after Sentosa took over, staff alerted me that Cold Spring Hills would only supply each shift with one diaper for my mother. My mother would sit in a dirty diaper until each shift changed." Indeed, M.A.G found her mother sitting in a dirty diaper almost every time she visited, with no idea for how long. During a visit in May 2018, an aide told M.A.G. that there were no diapers on the unit, so the aide had to take a diaper from another resident's room in order to change F.G.—after F.G. had waited for nearly an hour to be changed. M.A.G. Aff., ¶¶ 11-12.

169. After Sentosa took over, M.A.G. had to cut and file her mother's fingernails herself because there wasn't enough staff to do it and they failed to do it. Her mother's toenails grew over her toes, leading M.A.G. to believe no one provided toenail care. M.A.G. Aff., ¶ 19.

170. The repeated failure to provide nail care to residents of Cold Spring Hills is an example of Respondents having shifted the cost of care from themselves to residents' families or external care givers. Nursing homes are required to provide care and services relating to a resident's ADLs, such as nail care. Regular nail care prevents residents from accidentally injuring

themselves by scratching themselves, or from getting dirt and/or bacteria stuck under their nails, in addition to helping residents to present a neat appearance. Direct caregivers' failure to properly groom residents negatively impacts the residents' physical and psychosocial health. When a nursing home operates with insufficient staffing, it puts residents' families in the position of filling the void of care, forcing families to provide fundamental care to the residents themselves—while the nursing home is paid to provide the care and treatment to its residents. Medical Analyst Aff., ¶¶ 29, 68-69, 75 (grooming); *see also id.* at ¶ 30.

171. During a visit with her mother on a hot, 95-degree Saturday in July 2019, M.A.G. discovered that the air conditioning was broken in the dining room and other common areas in F.G.'s unit. Hot air was coming out of the air conditioning vents— "it was hotter inside than it was outside." She described that all of the residents were in the dining room, and they, as well as the nursing staff, "were not in good shape. Everyone was sweating." M.A.G. brought her mother to her room, where the air conditioning was working. When M.A.G. spoke with someone responsible for building operations, they told her the air conditioning would not be fixed for about another two days. Only after M.A.G.'s visit and complaint to DOH did Cold Spring Hills set up fans and a hydration station on the unit—and did Cold Spring Hills Administrator Yossi Emanuel[26] go to the nursing home to learn what was happening with the air conditioning. M.A.G. Aff., ¶¶ 15-17.

172. Properly functioning equipment, like air conditioning during the summer, is necessary to provide resident care, and failure to maintain this equipment function poses a danger to residents. *See* Medical Analyst Aff., ¶ 38. In 2019, as M.A.G.'s mother and many others sweltered without air conditioning, Bent Philipson took out over $3.5 million from Cold Spring Hills for himself. *See infra* ¶¶ 403, 440-43.

[26] *See infra* ¶¶ 117, 415.

Cold Spring Hills Failed to Provide Proper Wound Care to Residents, Endangering Residents' Health During and After COVID-19

173. Pressure injuries are serious medical conditions and according to the CDC, they are a major concern for nursing home residents and a key indicator of the quality of clinical care in nursing homes. Pressure injuries are wounds that develop on skin covering bony areas of the body when pressure on that area of the skin cuts off blood supply for more than a couple of hours. They may present as an open ulcer. Nursing homes are responsible for preventing pressure injuries, including performing comprehensive assessments on each resident, and they are required to take precautions and provide care to prevent pressure injuries from developing in the resident population. *See* 10 NYCRR § 415.12(c)(1); CFR § 483.25(b)(1)(i). Nursing homes are additionally required to ensure that a resident with a pressure injury receives the necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing. CFR § 483.25(b)(1)(ii); 10 NYCRR § 415.12(c)(2); *see also* Medical Analyst Aff., ¶¶ 47, 52 (severity of pressure injuries; risk factors include certain medical conditions and care failures).

174. Failure to provide proper care can result in new and worsened wounds. Turning and positioning, nutrition, hydration, proper hygiene, and prompt changing of soiled adult diapers, the appropriate use of assistive devices, and performance of regular skin integrity checks are critical to preventing the development of new pressure injuries and promoting healing of existing ones. *See* Medical Analyst Aff., ¶¶ 50-53, 72.

175. "Turning and positioning" refers to changing the position of those residents who lack sufficient ability to move their own bodies independently, e.g., to turn from their backs to their sides or from one side to the other in bed, to lift their heels, or to sit up, to relieve pressure from skin that was in contact with the bed or chair. Turning and positioning helps to increase the blood flow to pressure prone areas and supports the wound healing process. It is necessary and

well-understood preventative care, critical in preventing the development and worsening of pressure injuries. Turning and positioning is also important for residents who lack mobility and are susceptible to pneumonia because it improves oxygenation, breaks up congestion and reduces pulmonary or breathing complications. Medical Analyst Aff., ¶¶ 46, 50 & n.12, 51-52.

176. A pressure injury can progress through four stages of development, with severity increasing through each stage from 1 to 4, based on the depth of soft tissue damage, and stage 4 being the most severe. Some pressure injuries are unstageable, meaning the extent of the injury cannot be determined. Other wounds include deep tissue injuries ("DTIs"), which involve a localized area of intact skin with unknown damage to the underlying soft tissue. Both unstageable pressure injuries and DTIs are very severe. Medical Analyst Aff., ¶¶ 48-49.

177. **"They tried to kill me at Cold Spring Hills . . .":** T.S. was admitted to Cold Spring Hills in April 2021 needing physical therapy to regain mobility after a car accident. T.S. was in his early 70's and was able to speak, although he had a tracheostomy.[27] His diagnoses included acute renal disease and sepsis.[28] T.S. also came to Cold Spring Hills with pressure injuries, deep tissue injuries to both heels, and edema to his scrotum.[29] W.S. visited her husband every weekday evening and on the weekends. She recounted, "he always looked like no one had taken care of him." Affidavit of Wendy Shapiro ("W.S. Aff."), ¶¶ 3-4, 6-7, 10-11.

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[27] A tracheostomy is a surgical incision performed in the front of the neck area so that a tube can be inserted into the windpipe (trachea) allowing for a direct airway to deliver oxygen to help an individual breathe. Medical Analyst Aff., ¶ 86.

[28] Medical Analyst Aff., ¶ 121. Sepsis is a systemic inflammatory response to infection in which there is fever, increased heart rate, decreased blood pressure, increased respiration and inadequate blood flow to internal organs. Complications of sepsis may include shock, multiple organ system failure and death. *Id.* at ¶ 84.

[29] Medical Analyst Aff., ¶ 121.

178. Although T.S. was admitted to Cold Spring Hills for rehabilitation, Cold Spring Hills provided such little adequate care that he lost significant weight, was dehydrated, and his sacral pressure injury worsened. Poor nutrition or hydration impedes the body's ability to heal. Medical Analyst Aff., ¶¶ 122-124, 126-127, 52; *see also id.* at ¶¶ 54-55 (impact of malnutrition and dehydration on nursing home residents; importance of sufficient staffing to ensure residents' nutritional and hydration needs are met).

179. Cold Spring Hills records reflect that its wound doctor determined that T.S.' existing sacral pressure injury increased in size and worsened from a stage 3 to the most severe stage 4 while T.S. was under the care of Cold Spring Hills. Medical Analyst Aff., ¶ 122.

180. Despite his need for nourishment and hydration to heal, T.S. lost at least 30 pounds in under four months while living at Cold Spring Hills. Medical Analyst Aff., ¶ 123; W.S. Aff., ¶ 7; *see also* Medical Analyst Aff., ¶¶ 124, 126-127. Cold Spring Hills records further document that, as per nursing staff, T.S. was observed disconnecting his feeding tube[30] and sucking and swallowing the formula from it. Another Cold Spring Hill record indicates that during a nurse's visit, T.S. gestured that he wanted a drink of water. Medical Analyst Aff., ¶ 124.

181. And, despite his serious pressure injuries, deep tissue injuries to his heels, and other conditions, W.S. observed that when she visited her husband, "he was always lying on his back in his bed and his call bell was always on the floor, where he could not reach or use it." W.S. Aff., ¶ 9. Lacking an accessible call bell, it is not surprising that staff found him on the floor of his room after he fell from his bed on two occasions. Medical Analyst Aff., ¶ 125.

[30] A feeding tube is a tube that is inserted through the stomach wall that provides nutrition directly to the stomach. Medical Analyst Aff., ¶ 81.

182. W.S. further observed that he always looked dirty, was never clean shaven, and his fingernails and toenails were always long—again, despite the importance of cleanliness to wound healing. W.S. Aff., ¶ 7; *see* Medical Analyst Aff., ¶ 53.

183. W.S. reported that, in August 2021, T.S. was taken to Plainview Hospital with the expectation of having his dialysis port and trach tube removed, but a nurse at the hospital told her that T.S. was dehydrated, and a dietitian "said that there was no way Cold Spring Hills was feeding him four to six times a day." W.S. Aff., ¶ 10. Indeed, T.S. was admitted to the hospital with diagnoses including dehydration, severe protein malnutrition, a stage 4 sacral pressure injury, and right foot osteomyelitis (infection in his bone). After being in the hospital for a short time, however, T.S. regained weight. Medical Analyst Aff., ¶¶ 126-127.

184. At the hospital, W.S.'s husband said to her: "[t]hey tried to kill me at Cold Spring Hills." She told the hospital staff "over my dead body" would she send her husband back to Cold Spring Hills. In September 2021, he was discharged from the hospital to another facility, where his wife reported he finally received the care he was supposed to receive at Cold Spring Hills. W.S. Aff., ¶¶ 10-12.

185. **Neglect of Pressure Injury and Activities of Daily Living:** C.A. was a resident of Cold Spring Hills from December 2020 through November 2021. Medical Analyst Aff. ¶ 103.

186. C.A. had a sacral pressure injury when he was admitted to Cold Spring Hills, which Cold Spring Hills' wound doctor classified as stage 3 near the time of his admission. According to the wound doctor, the pressure injury worsened to a stage 4 and required debridement of dead tissue during C.A.'s residency at Cold Spring Hills of nearly a year. Medical Analyst Aff., ¶ 104.

187. It is not surprising that C.A.'s pressure injury worsened. He was on a feeding tube and, according to his daughter, "could not do anything for himself, he was bedridden." His pressure

injury became darker while at Cold Spring Hills and his daughter noted staff almost never got C.A. out of bed—during her weekly visits over nearly a year, she only saw him sitting in a chair five or six times. Detective Aff., ¶¶ 43, 45-46, 54, 56, 59.

188. C.A. also lost over 20 pounds while he lived at Cold Spring Hills and depended on the facility to maintain his feeding tube. Medical Analyst Aff., ¶ 105. Based upon Cold Spring Hills records, despite C.A.'s serious weight loss within mere weeks, staff neither re-weighed him to verify the loss, which would have been standard practice, nor did they address the loss until a week later. *Id.* C.A.'s daughter observed his weight loss, and she and her siblings found his gown wet with food from his feeding tube when they visited. Detective Aff., ¶¶ 54-56.

189. Despite the importance of keeping C.A. clean and dry to promote the healing of his pressure injury and prevent it from developing an infection, at least twice a week, his daughters found his bed soaked with urine and the room smelling of it. When one of his daughters questioned staff about this, they blamed C.A., claiming they had recently changed him (a ridiculous proposition that assumes bedridden patients would not have episodes of incontinence). Although the staff told C.A.'s daughter they would change him again, they took so long that she had to change her father's adult diaper herself. Detective Aff., ¶ 68.

190. C.A.'s daughter added that for several months, staff also failed to bathe him regularly, and they failed to shave him or cut his nails, and the skin around his face was "flakey." Detective Aff., ¶ 59.

191. C.A.'s family transferred him to a different facility due to the "bad care" provided by Cold Spring Hills. Detective Aff., ¶ 99.

192. **Resident Father, Dependent on Cold Spring Hills Staff for All of His Needs, Felt He Was "Left There to Die":** G.S. was in his early 60s when he was admitted to Cold Spring

Hills after a hospital stay in June 2020. Before he was ill, he worked as an auto collision mechanic and was so kind-hearted he would feed stray cats. He had a diagnosis of West Nile virus, which weakened his muscles from the neck down in all of his limbs, causing impaired mobility.[31] This left him dependent on Cold Spring Hills staff for all of his needs.[32] He was on a ventilator, and he had a tracheostomy tube, or "trach",[33] and a urinary catheter.[34] He was also dependent on a feeding tube inserted in his stomach for nourishment.[35] Affidavit of S.D.S. ("S.D.S. Aff."), ¶¶ 3, 5-8, 12, 15, 26.

193. His daughter, a Licensed Practical Nurse ("LPN"), asked Cold Spring Hills several times to change the formula they had been feeding G.S. to a higher calorie formula because she observed G.S. looked emaciated. She said the DON told her that it was unnecessary, however, because her father had gained weight since he was admitted. But G.S. lost weight during his stay at the nursing home, and he informed his daughter that Cold Spring Hills was not weighing him. S.D.S. Aff., ¶¶ 2, 26-27; *see also* Medical Analyst Aff., ¶ 117. Significantly, however, weight monitoring and nutritional intake were required as part of G.S.'s nutritional care plan and they were also part of his treatment and plan of care for wound healing. Medical Analyst Aff., ¶ 117.

194. According to his daughter, staff also failed to suction[36] G.S. frequently enough and they did not even recognize when he needed to be suctioned, which resulted in a call to emergency services to provide assistance at Cold Spring Hills in July 2020. S.D.S. Aff., ¶¶ 18-19.

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[31] *See* Medical Analyst Aff., ¶ 115.

[32] *Id.*

[33] *See id.*, ¶ 86, for an explanation of tracheostomy.

[34] *See also id.*, ¶ 116. A urinary catheter is a tube that is inserted and forwarded into the bladder and attached to a collection bag to collect urine. *Id.* at ¶ 87.

[35] *See also id.* at 117.

[36] Suctioning is a method of removing mucous or congestion from the lungs to help keep the airway

195. Additionally, the sacral pressure injury that G.S. had when he was admitted to Cold Spring Hills grew larger while he was under Cold Spring Hills' care. S.D.S. Aff., ¶ 14.[37] G.S. was not bathed or provided regular hygienic care at Cold Spring Hills. His hands and toes were "filthy," his nails were long and "crusted," and he did not receive regular oral care. G.S. indicated to his daughter that he was not showered while at Cold Spring Hills. S.D.S. Aff., ¶ 30.

196. Cold Spring Hills records reflect that in late July 2020, Cold Spring Hills' nursing staff inserted a urinary catheter into G.S. Then, in late October 2020, nursing staff made two attempts on the same day to change his catheter, which resulted in G.S. being sent to a hospital. Their first insertion of a new urinary catheter returned blood, not urine, and nursing staff removed it. Their second insertion returned urine with blood. Later that day, G.S. was taken from Cold Spring Hills to a hospital, where he was admitted. Medical Analyst Aff., ¶ 119. A urologist at the hospital informed G.S.'s daughter that his urinary catheter was incorrectly placed into his prostate (rather than the catheter having been advanced from his urethra to his bladder[38]). S.D.S. Aff., ¶ 34. S*ee also* S.D.S Aff., at ¶15 (resident's daughter also said Cold Spring Hills did not provide proper catheter care for G.S.). Hospital records confirm that his catheter had been placed in his prostate instead of his bladder. The records also reflect that G.S.'s diagnoses included septic shock. Medical Analyst Aff., ¶ 119. He remained at the hospital for several weeks for treatment and until he could be transferred to a different skilled nursing facility, instead of returning to Cold Spring Hills. S.D.S. Aff., ¶ 34.

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clear. Suctioning is performed with a catheter and can be done nasally, orally or via tracheostomy. Medical Analyst Aff., ¶ 85.

[37] *See also* Medical Analyst Aff. ¶¶ 118, 120.

[38] Medical Analyst Aff., ¶ 119.

197. A hospital record dated the day of G.S.'s admission in October 2020 states his sacral pressure injury had exposed bone—soon confirmed to be a stage 4 with possible osteomyelitis (infected bone). The hospital also documented that G.S. had a pressure injury to his left leg upon admission. Medical Analyst Aff., ¶ 120.

198. G.S. refused to return to Cold Spring Hills after his hospital stay—he was "traumatized" by the way he was treated at Cold Spring Hills and "felt he was left there to die." Several of G.S.'s conditions improved after he was treated at a different facility. S.D.S. Aff., ¶¶ 34, 36.

199. In 2020, as G.S. lay on his exposed bone, with a catheter in his prostate and choking on his mucus, the Bent Philipson took close to $4 million out of Cold Spring Hills for themselves.

200. **Pressure Injury Neglected; Lack of Care:** From June 2020 to August 2020, resident L.G. suffered neglect and harm at Cold Spring Hills. According to M.G., L.G.'s daughter and decision-maker,[39] when L.G. was admitted to Cold Spring Hills, he was on a ventilator but "looked good," was sitting upright, and talking with his hands. That changed within weeks. Affidavit of M.G. ("M.G. Aff."), ¶¶ 3-5, 9-10, 12.

201. L.G. had pressure injury(s) to his right buttock / sacrum when he arrived at Cold Spring Hills.[40,41] M.G. would call Cold Spring Hills to check on it, and during a call on July 17, 2020, a nurse practitioner told her that her father was complaining that his "ass" was hurting him, but that his pressure injury was "fine." The nurse claimed that they were turning her father often.

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[39] Cold Spring Hills records show that it knew that M.G. was the decision-maker regarding her father's care at Cold Spring Hills. Medical Analyst Aff., ¶ 111.

[40] *See also* Medical Analyst Aff., ¶ 112 (hospital record prior to L.G.'s admission to Cold Spring Hills).

[41] *See also infra* ¶ 202.

(Turning is required to heal the wound and prevent new ones.) L.G. told his daughter, however, that Cold Spring Hills staff never turned him; indeed, M.G. always observed L.G. on his back when he was at Cold Spring Hills. M.G. Aff., ¶¶ 11, 13, 21-25.

202. Cold Spring Hills' records reflect that about a week after L.G. was admitted, a Cold Spring Hills wound care doctor noted that L.G. had a stage 3 sacral pressure injury and an unstageable pressure injury to his right buttock. Records dated nearly a month later, in mid-July 2020, indicate that the two pressure injuries merged into a single pressure injury. On July 15, 2020, the Cold Spring Hills wound doctor described the sacral pressure injury as stage 4, the most severe stage. Medical Analyst Aff., ¶ 112.

203. L.G. was hospitalized in early August 2020, due to a high white blood cell count and possible pneumonia. L.G.'s daughter said she learned from a treating hospital doctor that the pressure injury had advanced to stage 4—indeed, L.G.'s pressure injury was so big, the doctor at the hospital said he could fit his entire hand inside it. M.G. Aff., ¶¶ 25, 34-36, 38, 40. *See also* Medical Analyst Aff., ¶ 112 (hospital records confirmed stage 4 pressure injury).

204. The hospital treated L.G. for severe sepsis, ventilator-associated pneumonia, and an infection at the site of his feeding tube that he developed while at Cold Spring Hills. Medical Analyst Aff., ¶¶ 113-114. M.G. said that hospital nurses said her father was severely lethargic and dehydrated and "they were disgusted" by his condition and they had not previously seen such neglect from a nursing home. M.G. Aff., ¶¶ 39, 41.

205. As noted in many family stories, L.G.'s fingernails and toenails grew very long and he had to tell his daughter that he wanted them cut. L.G. appeared dirty, he was unshaven during one of M.G.'s visits, and he was always in a gown and not dressed, contrary to his therapy. M.G. Aff., ¶¶ 14, 20, 32, 39. Indeed, simply getting dressed is important to a resident's psychosocial

welfare and cleanliness and can also play an important role in occupational therapy. *See* Medical Analyst Aff., ¶ 75 (dressing); *see also id.*, ¶¶ 68-69 (requirements regarding residents' ADLs, including dressing); *id.*, ¶ 75 (bathing and grooming).

206. L.G. complained that Cold Spring Hills was disgusting and filthy, there was not much staff, no one would talk to him, and "the nurses were not nice to him." M.G. Aff., ¶ 27. Of course, L.G. and his fellow residents did not know that Respondents were siphoning "up-front profit" instead of providing sufficient staff.

207. **Neglect of Multiple Wounds; Mother's Stage 2 Pressure Injury Worsens to Gaping Stage 4 Pressure Injury in Three Months:** L.K. was in her late 70s and lived at Cold Spring Hills for several months starting in the summer of 2020 to receive wound care for her leg and rehabilitation following surgeries. Cold Spring Hills, however, did not properly treat her. While at Cold Spring Hills, L.K. had weekly appointments with an outside surgeon who was treating her leg. The surgeon informed L.K.'s daughter that on several occasions when L.K. arrived from Cold Spring Hills, the wound vac[42] placed on L.K.'s leg wound to promote healing was not operating. Cold Spring Hills staff did not know for how long it was not working, nor had they documented it or alerted the surgeon. Cold Spring Hills also failed to change the wound dressing on L.K.'s leg when required. Detective Aff., ¶¶ 47-48.

208. When L.K. was re-hospitalized, hospital staff noted a small pressure injury, distinct from her existing leg wound. After L.K. returned to Cold Spring Hills, a Cold Spring Hills nurse

[42] A wound vacuum, or "wound vac," is a device that promotes healing of a wound by applying continuous negative pressure. The device attaches to a wound by tubing and a vacuum seal. The pumping action of the wound vac helps to pull fluids out from a wound, remove bacteria, stimulates the growth of new tissue and helps to pull the wound edges closer together. Medical Analyst Aff., ¶ 89.

practitioner told her daughter that L.K. had a stage 2 pressure injury.[43] The Cold Spring Hills wound doctor documented the pressure injury as being to L.K.'s coccyx into her right buttock, although Cold Spring Hills' records also reflect other locations for the injury. L.K.'s pressure injury then worsened. Cold Spring Hills staff later told her daughter that L.K.'s pressure injury became unstageable.[44] Then, shortly before L.K. left Cold Spring Hills for home at the end of September 2020, a wound nurse told her daughter that L.K.'s pressure injury was a stage 4 and taught her daughter how to change the dressing on it. Yet, before this, Cold Spring Hills never informed L.K.'s daughter that the pressure injury had worsened to stage 4. Detective Aff., ¶¶ 49-50.

209. Stage 4 is the most severe pressure injury and involves full thickness tissue loss, where the lost tissue includes all layers of skin, and exposed bone, tendon or muscle that can be seen. Medical Analyst Aff., ¶ 48.

210. L.K.'s daughter related that when she saw L.K.'s pressure injury at home, it was "the most horrific thing I [have] ever seen in my life" —so large that someone's fist could fit inside of it. A homecare nurse was also shocked when she saw it. Detective Aff., ¶ 50.

211. L.K. is now at a different facility, where the doctors have advised that her pressure wound might get smaller but will never go away. Detective Aff., ¶ 51.

212. Her daughter photographed the massive pressure injury two days after L.K. left Cold Spring Hills, a redacted copy of which is attached as Exhibit 1 to the Detective Affidavit and shown below.

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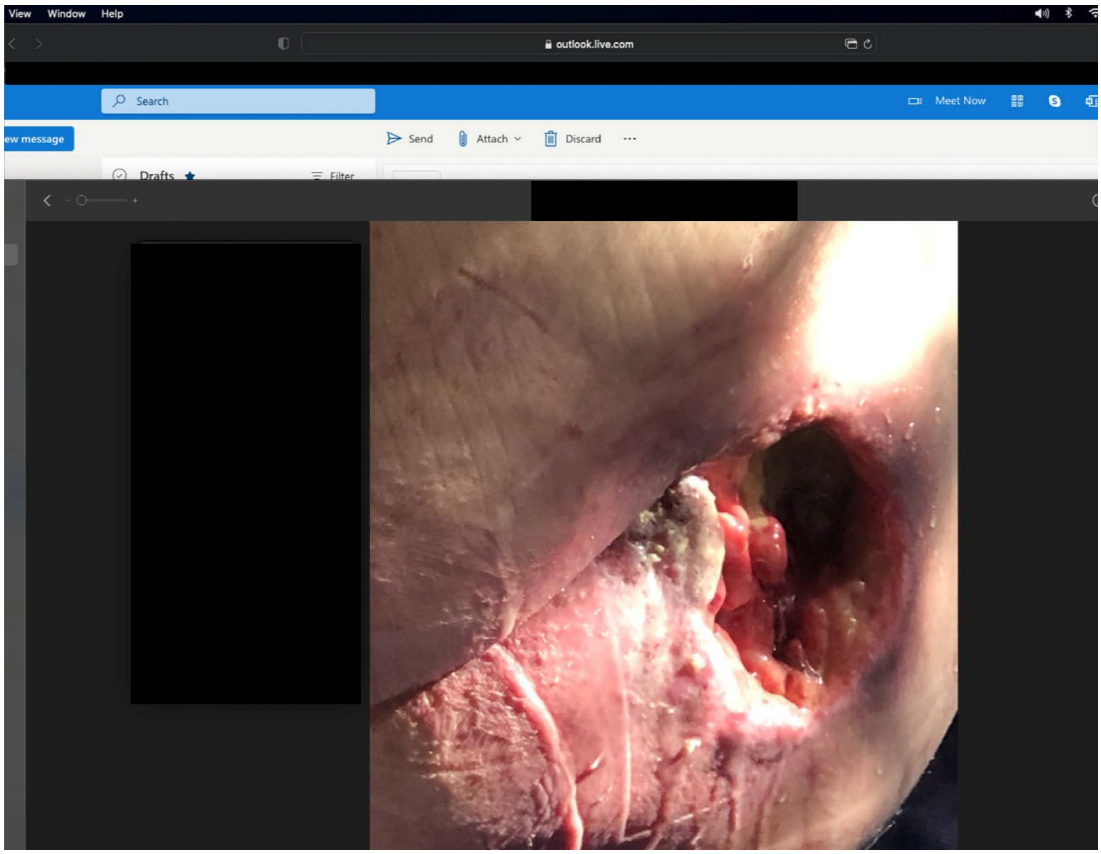
[43] A stage 2 pressure injury involves partial thickness loss of the inner layer of the two main layers of skin. It presents as a shallow open ulcer with a red or pink wound bed, without slough. (Slough is the dropping off of dead skin tissue from living tissue, after tissue has died.) Medical Analyst Aff., ¶ 48.

[44] Unstageable pressure injuries are very serious conditions. Medical Analyst Aff., ¶ 49.



213. Compounding L.K.'s lack of care, and despite the importance of hygiene in preventing new pressure injuries and facilitating the healing of those that develop, including preventing infection, Cold Spring Hills did not provide L.K. with 13 showers called for by her care plan from July through September 2020. Medical Analyst Aff., ¶¶ 132, 53.

214. **Neglect of Grandfather's Pressure Injury:** Resident M.W. entered Cold Spring Hills with a sacral pressure injury in late July 2020 and his nursing admission assessment noted a small opening on his sacral area. However, based upon Cold Spring Hills records, staff did not provide treatment to M.W.'s pressure injury at that time. The records at that time additionally lack a measurement of the pressure injury taken by Cold Spring Hills. Moreover, M.W.'s care plan, created by Cold Spring Hills, indicated that he was at risk for impaired skin integrity and required that wound rounds be performed weekly, turning and positioning be performed frequently, and treatments applied as ordered. However, M.W.'s pressure injury was not looked at by a wound

doctor until ten days after his admission to Cold Spring Hills; the doctor then documented measurements for the first time and recommended the course of treatment. By that time, the doctor assessed the pressure injury as "unstageable," which is very serious. Medical Analyst Aff., ¶ 106.

215. Although M.W. was admitted to Cold Spring Hills for rehabilitation and his care plan required frequent turning and positioning, his granddaughter said that Cold Spring Hills did not provide him that critical care. She said that Cold Spring Hills staff did not get M.W. out of bed and they failed to turn and position him as they should have. In addition to his pressure injury, she noted he was susceptible to pneumonia. Detective Aff. ¶¶ 40, 41; Medical Analyst Aff., ¶ 106; *see also* Medical Analyst Aff., ¶ 50 & n.12 (explaining turning and positioning and noting its importance to residents with limited mobility who are susceptible to pneumonia).

216. The staff at Cold Spring Hills was so pressed for time that once M.W.'s granddaughter observed with concern while a member of Cold Spring Hills staff roughly fed her vulnerable grandfather while he was on a FaceTime call with her—despite his difficulty swallowing and susceptibility to pneumonia. Detective Aff., ¶ 86.

217. Without sufficient supervision to ensure that staff render care safely and appropriately to residents, with sufficient time to do so safely, nursing home residents are at increased risk of serious harm from choking and aspiration. *See* Medical Analyst Aff., ¶¶ 55, 73.

218. M.W. told his granddaughter that he had not been bathed regularly at Cold Spring Hills. Detective Aff., ¶ 60. Cold Spring Hills records show that staff never showered M.W. during the two weeks he was a resident—yet his care plan specified that he was to receive a shower twice per week and also when necessary. Medical Analyst Aff., ¶ 107.

219. Then, in August 2020, after only 17 days at Cold Spring Hills, M.W. was re-hospitalized and admitted with diagnoses including sepsis and pneumonia. Hospital records reflect

that his sacral pressure injury had worsened in size and severity, and that he also had deep tissue injuries to both heels when he was admitted. Within days of his admission, the hospital assessed his sacral pressure injury as stage 4 with exposed muscle and bone. Medical Analyst Aff., ¶¶ 107-108.

220. Soon after he was admitted to the hospital, M.W. was placed on palliative care and in patient hospice. Medical Analyst Aff., ¶ 110. He died about a week after that, in late August 2020. Detective Aff., ¶ 42. Sepsis was a cause of his death. Medical Analyst Aff., ¶ 110.

221. Hospital staff told his granddaughter that his condition was the worst case of neglect they had seen. M.W.'s granddaughter added that a hospital nurse called Cold Spring Hills to discuss her grandfather's condition, but the person at Cold Spring Hills hung up on the nurse. Detective Aff., ¶ 42.

222. While M.W. was being "force fed" and suffering a worsening pressure injury, sepsis, and pneumonia, Bent Philipson transferred federal healthcare stimulus payments from Cold Spring Hills to Philipson Family, an LLC controlled by Bent Philipson. See ¶¶ 405-6.

223. **Lack of Adequate Nutrition:** M.W was not alone in being at risk during meals. Unlike healthy and active adults who may have options as to their preferred weight, most nursing home residents need to maintain muscle mass, increase their nutrition and maintain their weight—certainly any medical need to lose weight would be part of their care plan and closely monitored. Residents may suffer from numerous obstacles to healthy eating—physical and emotional—but that does not relieve the nursing home of its duty to fulfill those needs. *See* Medical Analyst Aff., ¶¶ 9, 54-55, 73, 68-69; *see also id.* at ¶26-27. Family members of numerous residents described how Cold Spring Hills failed to provide their loved ones with the proper food, necessary nutrition or feeding assistance. For example, resident P.S.'s daughter said P.S. did not eat well at Cold

Spring Hills. He frequently did not receive the food he requested, he was also served food he could not chew, and, moreover, the food was "terrible" and served cold. His daughter often brought food for P.S. so that he would eat. C.B. Aff., ¶ 24; *see also* Detective Aff., ¶ 104 & Ex. 6 (Caring.com review stated the food at Cold Spring Hills "is unpalatable and looks like dog food").

224. Resident S.H. lost approximately 60 pounds within five months at Cold Spring Hills. Medical Analyst Aff., ¶ 91. During one visit, S.H.'s daughter saw her tray of food sitting in front of her uneaten—S.H. was unable to feed herself and staff had not helped her, physically or emotionally. Her daughter noted staff were never there to feed her. M.H. Aff., ¶ 15. M.H. took a photograph of the uneaten tray of food, a copy of which is attached as Exhibit 2 to the M.H. Aff.

225. Likewise, the daughter of Resident 47 described how her parent, a resident of Cold Spring Hills from late 2020 into 2022, did not eat well alone in the resident's room. Resident 47 needed assistance to eat, but staff failed to provide assistance, due to the lack of staff. Detective Aff., ¶¶ 52, 57.

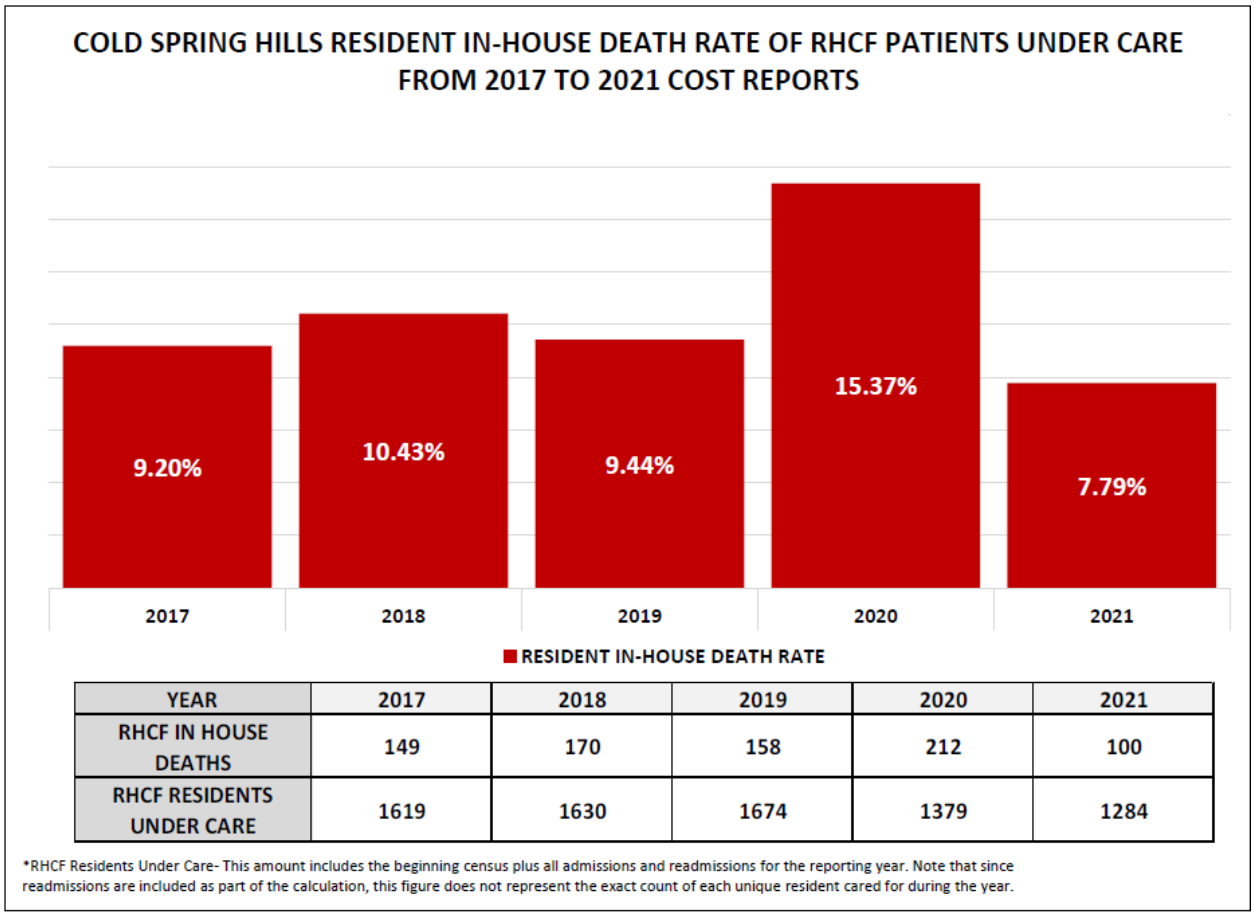
226. Records indicate that residents T.S. and G.S., dependent for nourishment through a feeding tube, lost dangerous amounts of weight—at least 30 pounds and nearly ten pounds, respectively—even though Cold Spring Hills' duty was to maintain their health. Medical Analyst Aff., ¶¶ 123-124, 127, 117; *see also* W.S. Aff., ¶ 7; S.D.S. Aff., ¶¶ 26-27. Records show that C.A., also dependent on a feeding tube for nutrition, had serious weight loss of over 20 pounds. Medical Analyst Aff., ¶ 105; *see also* Detective Aff., ¶ 54. In addition, at least one resident, T.S., was dehydrated when admitted to the hospital from Cold Spring Hills, although he was dependent on Cold Spring Hills to provide hydration. *See* Medical Analyst Aff., ¶ 126; W.S. Aff., ¶ 10.

227. Sufficient nursing home staffing plays a pivotal role in ensuring that a resident's proper nutritional needs are met. Many residents require physical assistance and/or supervision

while eating. Without adequate staffing at nursing homes to meet the needs and acuity of the residents, overburdened and/or under-supervised direct caregivers do not have sufficient time to properly assist and/or are rushed when assisting all of the nursing home's residents with dining, including, *e.g.*, providing assistance with lifting utensils or cutting food to an appropriate size so that the resident can chew and swallow it, safely feeding certain residents, preventing and monitoring for choking or aspiration, and encouraging other residents to consume sufficient nourishment. A nursing home that operates with insufficient staffing (whether by number of direct care staff, insufficient supervisory staff, and/or staff that is incompetent or ineffectively trained) creates a risk that its residents will not be fed or provided hydration timely or at all, thereby resulting in malnutrition, dehydration, and weight loss that can, in turn, cause additional physical ailments, overall decline in health, and hinder a resident's ability to heal from injury. Medical Analyst Aff., ¶¶ 54-55, 73; *see also id.*, ¶¶ 26-27, 68-69.

Cold Spring Hills' In-House Death Rate Rose Under Respondents' Control

228. In addition to the disturbing neglect described above, residents at Cold Spring Hills were at a higher risk of death under Respondents' ownership and control. The chart below reflects the rise of Cold Spring Hills' in-house death rate in 2018 and 2019 when compared to its 2017 level. (The chart below omits resident deaths after transfer to hospitals or similar facilities.) Auditor Aff., ¶ 254.



YEAR	2017	2018	2019	2020	2021
RHCF IN HOUSE DEATHS	149	170	158	212	100
RHCF RESIDENTS UNDER CARE	1619	1630	1674	1379	1284

*RHCF Residents Under Care- This amount includes the beginning census plus all admissions and readmissions for the reporting year. Note that since readmissions are included as part of the calculation, this figure does not represent the exact count of each unique resident cared for during the year.

229. Residents of Cold Spring Hills were also at greater risk of contracting COVID-19 due to multiple infection control failures at the onset of and during the pandemic. *See infra* ¶¶ 230-267.

Respondents' Failure to Ensure Proper Infection Control Procedures Endangered Cold Spring Hills' Residents and Staff.

230. Cold Spring Hills repeatedly failed to follow multiple infection control measures, endangering its residents and staff, including by (1) failing to have a dedicated infection preventionist ("IP") on staff; (2) failing to properly cohort residents; (3) failing to properly track COVID-19 infections; (4) floating staff to care for both COVID-19 positive and COVID-19 negative residents; (5) failing to communicate infection levels; and (6) failing to train staff. *See* Auditor Aff., ¶¶ 202-38.

231. These failures very likely contributed to 98 COVID-19 deaths in the facility during the first three months of the pandemic, March 1, 2020 through June 4, 2020. Auditor Aff., ¶ 239.

Cold Spring Hills Failed to Have a Dedicated, Specially Trained IP

232. As required by 42 CFR § 483.80(b)(4), Respondents failed to employ a dedicated IP for Cold Spring Hills. An IP has specialized training and is responsible for a facility's infection prevention and control program that prevents, identifies, reports, investigates, and controls infections and communicable diseases for all residents. *Id; see also* Medical Analyst Aff, ¶ 41.

233. During the height of the COVID-19 pandemic, Cold Spring Hills operated without a designated IP with specialized training. Instead, Cold Spring Hills' DON Denise Cagno ("DON Cagno") assumed the role of IP despite not having the required specialized infection prevention training, and in addition to her regular duties and responsibilities as the DON of a 588-bed facility—which already included an increased workload after Respondents Bent Philipson, Ventura, and Avi Philipson cut staffing. Auditor Aff. ¶ 209.

234. DON Cagno testified pursuant to an Executive Law § 63(12) subpoena that she did not relinquish any of her DON duties and responsibilities and maintained both positions until the beginning of July of 2020. DON Cagno acknowledged she knew that the IP position required specialized training that she did not have but nevertheless "was very confident in the fact that [she] knew how to initiate infection control protocol." SAAG Aff., Ex. 11 (November 24, 2020, pgs. 59, 78-79, 59).

235. However, Deborah Flack, who held various positions throughout her career, such as interim Administrator of Cold Spring Hills, DON, and the Vice President of Clinical Services at Ventura, conceded that it would be difficult for the same individual to work simultaneously as the DON and IP at a facility as large as Cold Spring Hills. SAAG Aff., Ex. 12 (pgs. 114-15). This

is especially true where working conditions are so poor due to insufficient staffing, including insufficient RN staffing.

236. When asked if she was qualified to work simultaneously as a DON and IP of a 588-bed facility such as Cold Spring Hills, DON Cagno demurred and instead testified that she was "very on top of things." SAAG Aff., Ex.11 (November 24, 2020, pgs. 86-87).

237. In any event, DON Cagno's self-serving claim that she was "on top of things" is belied by the facts. Cold Spring Hills violated multiple basic infection control protocols, in addition to cited by DOH. *See infra* ¶¶ 239-267, 371-378. These violations undoubtedly contributed to the death of 166 Cold Spring Hills residents in just three months, from March 1, 2020 through June 4, 2020, including 98 COVID-19 deaths and 68 non-COVID deaths. *See* ¶¶ 231, 285.

238. When asked under oath about Cold Spring Hills' assignment to DON Cagno of the responsibilities of an IP while also working as the DON, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

Cold Spring Hills Failed to Cohort Residents and Staff, Closing an Entire Building Merely to Save Utility and Staffing Costs, Using it for Storage Instead

239. Cold Spring Hills designated the Norwich Building for COVID-positive and presumed positive residents. But Cold Spring Hills failed to transfer to Norwich certain residents who developed symptoms consistent with COVID-19.[45] Instead, Cold Spring Hills allowed them to remain in their rooms in the other four buildings. Auditor Aff., ¶¶ 219-20.

[45] On April 2, 2020, CMS issued guidance which states, in pertinent part, that "long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status." Auditor Aff., Ex. 42. Subsequently, on April 29, 2020, in a letter to nursing home administrators, DOH mandated that nursing homes have protocols to separate residents into cohorts of positive, negative, and unknown status. Auditor Aff., Ex. 43.

240. DON Cagno admitted that "specialty patient[s]," meaning those residents who were on dialysis, on a ventilator, or had dementia, "stayed in their rooms and everything was done contained, within their rooms." SAAG Aff., Ex. 11 (November 24, 2020 at pgs. 235, 240).

241. Despite the evidence of the infection spreading throughout the facility, DON Cagno testified during this investigation that the same nursing staff could be assigned to care for both COVID-19 positive residents and non-COVID-19 residents during the same shift and on the same unit. SAAG Aff., Ex. 11 (November 24, 2020 at pg. 242).

242. DON Cagno also admitted that Cold Spring Hills did not even cohort within respective units, i.e., Cold Spring Hills did not create separate areas within a unit to cohort confirmed or suspected COVID-19-positive residents who were unable to be transferred to the Norwich Building. SAAG Aff., Ex.11 (November 24, 2020 at pages 249-53).

243. DON Cagno's complete disregard of DOH's directive further underscores that she was wholly unqualified to serve as an IP.

244. Specifically, in the Sagamore Building Cold Spring Hills repeatedly violated infection control protocols by consistently assigning its staff members to care for both symptomatic and non-symptomatic residents during the same shift, unnecessarily increasing risk to residents. Cold Spring Hills' daily nursing assignment sheets reflect that it consistently assigned its staff members to care for both symptomatic and non-symptomatic residents during the same shift. For example, daily nursing assignment sheets reflect that over the course of eight days in April and May 2020, during the day shift on unit three of the Sagamore Building, two CNAs were assigned to care for Resident 25, a COVID-19 positive resident, and Resident 25's roommate, Resident 19, in addition to other residents who were not symptomatic. Auditor Aff., Ex. 41.

245. Resident 19 tested positive for COVID-19 three days after Resident 25 died. Auditor Aff., ¶ 217.

246. To make matters worse, during the height of New York's COVID-19 infection rates downstate in 2020, Respondents continued to cause Cold Spring Hills to pay its related party "rent" and closed its Sagamore Building to avoid having to pay as much in utility and staffing expenses, disregarding the need to safely cohort residents consistent with basic infection control protocols. Auditor Aff., ¶¶ 91, 231.[46]

247. Daniel Schaffer, Executive Vice President of Ventura, admitted that the Sagamore Building was closed to cut staffing, electric, and water expenses. SAAG Aff., Ex. 7 (February 11, 2021 at pgs. 91-92). During the first wave of the pandemic, instead of utilizing Sagamore to properly cohort COVID-19 positive residents or those exhibiting symptoms consistent with COVID-19, Respondents closed Sagamore and consolidated residents in Cold Spring Hills' other buildings to serve the financial interests of its owners and its related parties, disregarding infection control guidance and resident health.

248. Respondents, however, did use the Sagamore Building for something else: storing the wheelchairs of deceased Cold Spring Hills residents. Detective Aff., ¶ 38. The photograph below was taken in May 2020 and provided to MFCU by an employee of Cold Spring Hills, showing a dayroom in the Sagamore Building filled with unused wheelchairs of deceased former residents.

[46] Cold Spring Hills' daily census records show that Cold Spring Hills began transferring residents from its Sagamore Building to other buildings in late April 2020. Auditor Aff., ¶ 229. DON Cagno testified that Cold Spring Hills shut down the Sagamore Building around June of 2020. SAAG Aff., Ex. 11 (December 1, 2020 at page 117).

249. When asked under oath about the closure of the Sagamore Building, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6 (pg. 102). As the wheelchairs were being parked in the Sagamore dayroom, Bent Philipson took nearly $4 million out of Cold Spring Hills as part of the fraudulent rent scheme. *See* ¶ 404.

Cold Spring Hills Failed to Properly Track the Progression of COVID-19 Throughout the Facility

250. Cold Spring Hills also used inadequate infection control tracking tools that failed to note resident outcome, making it impossible to properly track COVID-19 infections. A proper infection prevention and control program requires identifying resident infections and tracking and documenting infection outbreaks to combat a communicable disease like COVID-19 in a medical

facility.[47] A mechanism used for tracking residents with infectious conditions is a tracking document, such as a line listing form, the purpose of which is to record all necessary information in a single document—thus obviating the need for staff to review numerous, individual residents' medical records to track infections. Such a form tracks residents with potentially infectious conditions by noting a resident's name, onset and duration of symptoms, testing, treatment, and outcome.[48] Medical Analyst Aff., ¶ 44; *see also* 10 NYCRR § 415.19.

251. Cold Spring Hills' utilized precaution tracking forms that only noted whether a resident had symptoms consistent with COVID-19, and whether contact/droplet precautions were being implemented. Its precaution tracking forms failed to identify patient outcome, such as whether the resident left the facility, recovered, or died, the type of treatment received, and the date of onset of symptoms. Auditor Aff., ¶ 236.

252. Moreover, instead of noting a resident's medical outcome, Cold Spring Hills simply removed resident names from the precaution tracking forms with no explanation. For example, on a day in April 2020, Resident 27 appeared on Cold Spring Hills' precaution tracking form because s/he was on contact and droplet precautions due to having a fever and being in respiratory distress. Resident 27 died that same day and was simply removed from the line listing form. Auditor Aff., ¶ 237, Ex. 44. Cold Spring Hills staff reviewing this precaution tracking form would therefore have no idea how to track infections and treat residents, as the ultimate outcome was not recorded. Staff were also unable to see the patterns and trends of infection, and identify clusters of infection

[47] 42 CFR 483.80(a)(1) states that a facility "must establish an infection prevention and control program that must include, at a minimum, . . . [a] system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors . . . following accepted national standards.").

[48] The CDC provides guidance for a proper line list. *See* https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf.

throughout the facility, which is crucial for keeping residents and staff safe. *See* Medical Analyst Aff., ¶ 44.

253. DON Cagno conceded that Cold Spring Hills' precaution tracking form did not include the outcome of a resident's infection, and she asserted that she and other staff instead relied on the residents' medical records. SAAG Aff., Ex. 11 (November 24, 2020 at pgs. 120-21). But this utterly defeats the purpose of a line listing that contains all necessary information in one document, thus obviating the time-consuming need for staff to review numerous, individual resident medical records. Medical Analyst Aff., ¶ 44. Cold Spring Hills' failure to include resident outcomes on the precaution tracking form thwarted staff's ability to control the spread of COVID-19 throughout the facility, increasing the risk to all residents and staff. This is certain because many individual resident's charts reflect COVID-19 notations. Indeed, a Nurse Practitioner made the grim notation in several resident charts that "given the prevalence of COVID-19 in the building [Cold Spring Hills] would presume the presence of [ ] symptoms is due to COVID-19." Auditor Aff., ¶ 204.

254. Cold Spring Hills' precaution tracking form was created by DON Cagno and approved by Deborah Flack, the Vice President of Clinical Services at Ventura. SAAG Aff., Ex. 12 (pgs. 215-16). Notwithstanding the scores of COVID-19-related deaths at Cold Spring Hills in the spring of 2020, Deborah Flack claimed under oath when she testified pursuant to an Executive Law § 63(12) subpoena that the system "worked" and that she did not see any flaws or breakdowns in Cold Spring Hills' process of tracking COVID-19 infections. *Id.* at 241. Indeed, the inability to properly track COVID-19 infections throughout the facility put unnecessary stress on staff members during the early days of the pandemic, as explored more fully below.

Cold Spring Hills' Staff Suffered Extreme Grief and Stress During the Peak of the Pandemic that Was Exacerbated by Lack of PPE and Training, and Violations of Infection Control Protocols.

255. Employees of Cold Spring Hills described traumatic accounts of grief and stress during the peak of the COVID-19 pandemic.

256. For example, Cold Spring Hills Employee 5 ("Employee 5")[49] would be so overcome with stress that they would sit in the car and cry for thirty minutes before driving home from Cold Spring Hills. Likewise, Cold Spring Hills Employee 4 ("Employee 4"), who has worked at Cold Spring Hills for over ten years, has a vivid memory of a resident calling out: "Don't leave me, I can't breathe," and Employee 4 lived in fear they would contract COVID-19 and put their family at risk. Detective Aff., ¶¶ 24- 26.

257. Moreover, Employee 5 said that when they were notified during their shift that they tested positive for COVID-19, the DON made them stay to finish their shift, telling them: "You're asymptomatic, keep quiet, you're going to stay, and don't tell anyone." Detective Aff., ¶ 27.

258. When staff were sick and tried to stay home, management at Cold Spring Hills threatened them with lost pay or termination. Staff were also mandated to work double shifts and were threatened with termination if they did not comply. Administrator of Cold Spring Hills, Yossi Emanuel, condoned these threats. Detective Aff., ¶ 28.

259. For example, Cold Spring Hills Employee 7 ("Employee 7") cared for two residents who were ill with COVID-19 symptoms. Unsurprisingly, as Cold Spring Hills had limited PPE, Employee 7 tested positive for COVID-19. But Cold Spring Hills refused to pay Employee 7 when they were out sick with COVID-19. Detective Aff., ¶ 31.

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[49] Because these witnesses fear retaliation from Cold Spring Hills, MFCU is protecting the identities of these witnesses from disclosure until an appropriate protective order is in place in this matter. *See* Detective Aff., ¶¶ 8-9.

260. When Cold Spring Hills did provide PPE for employees, it was limited and meant to last the employees indefinitely. *See* Detective Aff., ¶ 32. After Employee 7 recovered from COVID-19 and returned to work, Cold Spring Hills provided them only one N-95 mask, a gown and a face shield, which were meant to last awhile. Employee 7 recalled nursing staff wearing plastic bags when they were short of gowns. *See* Detective Aff., ¶¶ 31-32.

261. Employee 4 also said that PPE had been difficult to get at Cold Spring Hills at least early in the COVID-19 pandemic, so staff purchased it for themselves online; when staff could only find garbage bags to wear, they were disciplined. Detective Aff., ¶ 34.

262. The availability of PPE remained problematic after the first wave of the pandemic. Cold Spring Hills Employee 2 ("Employee 2") explained that in November 2020, PPE again became hard to acquire and Cold Spring Hills employees continued to get COVID-19. Even by December 2021, Cold Spring Hills was not reliably providing PPE to staff. Detective Aff., ¶ 35.

263. Cold Spring Hills' staff received inadequate training regarding donning and doffing and proper handwashing. *See* 10 NYCRR § 415.19. A CNA reported the in-service training that Cold Spring Hills provided to her on these topics was only about ten minutes in length. Auditor Aff., ¶ 233.[50]

264. One family member observed during the summer of 2020 that masks were not worn by their loved one when he was around nursing staff, who were wearing masks. M.G. Aff., ¶ 30. Another family member was informed by their loved one that nursing staff entered his room without proper masks, gloves and gowns, and some staff wore street clothes. C.B. Aff., ¶ 27.

[50] In November 2020, Cold Spring Hills was fined $25,000 by OSHA for COVID-related workforce violations. Auditor Aff., ¶ 159.

Cold Spring Hills Failed to Communicate COVID-19 Exposure and Infections to Staff, Residents, and Family Members

265. Family members have complained that Cold Spring Hills staff failed to inform them, timely or at all, of the prevalence of COVID-19 at the facility and residents' exposure to it. *See* A.P. Aff., ¶¶ 9-10; M.G. Aff., ¶ 17; S.D.S. Aff., ¶ 29; Detective Aff., ¶¶ 90-95.

266. One family member was notified in April 2021 by her father, a resident, of COVID-19 deaths in his unit—not by Cold Spring Hills. C.B. Aff., ¶ 26.

267. Staff members at Cold Spring Hills complained about the lack of signage necessary to inform staff of residents suspected of having COVID-19. Employee 2 described how, in late May 2020, Cold Spring Hills stopped posting notices outside the doors of residents who were presumed COVID-19 positive; after this, many staff members became ill with COVID-19—further reducing staff. Cold Spring Hills Employee 6 also described the lack of PPE and signage, early in the pandemic, necessary to inform staff of those residents suspected of having COVID-19 who came from the hospital and were placed on contact precautions. Detective Aff., ¶¶ 35-36.

Cold Spring Hills' Multiple Infection Control Violations Contributed to at Least 98 Resident COVID-19 Deaths in Three Months

268. Cold Spring Hills' myriad of infection control violations coupled with insufficient staffing, including RN supervision staffing, contributed to 98 COVID-19 deaths at the facility throughout each of its five buildings between March 2020 and June 2020. Auditor Aff., ¶ 239.

269. Despite designating two units in the Norwich Building for residents experiencing COVID-19 symptoms, over 75% of the residents who died from COVID-19 at the facility from March 2020 through June 4, 2020 resided in other units. Auditor Aff., ¶ 240. The below table illustrates where the COVID-19 deaths occurred during this period:

Cold Spring Hills Resident COVID-19 Deaths by Building from March to June 4, 2020

Building Name	March 2020 COVID Deaths	April 2020 COVID Deaths	May 2020 COVID Deaths	June 2020 COVID Deaths	Total COVID Deaths	Percentage of Death
Brookville	2	13	0	0	15	15.31%
Norwich (COVID-19 building)	2	15	7	2	26	26.53%
Sagamore	2	8	2	0	12	12.24%
Seacliff	2	14	5	0	21	21.43%
Woodcrest	2	12	10	0	24	24.49%
Total	10	62	24	2	98	100%

270. Cold Spring Hills' multiple infection control failures were clear violations of the laws and regulations governing nursing homes in New York and put countless residents at risk of harm and death.

271. When asked under oath about infection control protocols at Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

Respondents Failed to Provide Cold Spring Hills with Sufficient and Properly Trained Staff, Resulting in Unconscionable Resident Neglect

272. Chronically insufficient staffing at Cold Spring Hills, including staffing cuts in the months leading up to the pandemic, endangered its residents. Indeed, Cold Spring Hills' CMS RN Staffing Rating dropped almost immediately after Respondents took control, and evidence produced by Respondents shows Bent Philipson actively engaged in further cuts in nursing staff and staffing expenses after he assumed sole control of its operations in 2019. Auditor Aff. ¶¶ 153, 196-97.

273. Insufficient RN staffing results in overall lack of supervision and training of nursing staff and is one of the most significant factors leading to resident neglect and abuse. Medical Analyst Aff., ¶ 26.

274. Interviews with staff and family members confirm the terrible impact on the residents of Bent Philipson's decisions to cut staffing expenses at Cold Spring Hills. *See, e.g.,* ¶¶ 121-227, 287-96, 299-344.

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.

276. Bent Philipson took complete control of Cold Spring Hills in May 2019. In the third quarter of 2019, Cold Spring Hills had a "two star" or "BELOW AVERAGE" RN Staffing rating,[52] yet Bent Philipson sought to further cut nursing staff at Cold Spring Hills several times. Auditor Aff., ¶ 166. On September 23, 2019, in response to receiving the Cold Spring Hills Weekly Report from the payroll vendor via email, Bent Philipson wrote, "Please look into professional

[51] The CMS Staffing Rating specifically reflects the number of staffing hours in the nursing department of a nursing home relative to the number of its residents. This ratio is expressed as a star rating, with the lowest rating of "one star" signifying the lowest number of staff per resident, and the highest rating of five-star signifying the highest number of staff per resident. The CMS Staffing Rating is one of three components that make up the Overall Rating of a facility. Auditor Aff., ¶ 164, Ex.1 (p. 19).

[52] Starting in the second quarter of 2018, CMS began utilizing Payroll-Based Journal ("PBJ") data as the basis for Overall and RN Staffing ratings. These ratings are based on PBJ data that was submitted two quarters prior to publication. Auditor Aff., ¶ 166, n.22.

nursing, it's gone up, and I think there is room to go way down." Auditor Aff., Ex. 32. When asked under oath about this email directive to "look into professional nursing" while Cold Spring Hills had a below average RN staffing rating, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6 (pgs. 83-85).

277. In the second and fourth quarters of 2019, the CMS Overall Staffing Rating and RN Staffing ratings each dropped to "one star" ("MUCH BELOW AVERAGE"), likely due to non-submission of PBJ data. Auditor Aff., ¶ 166.

278. In the first quarter of 2020, going into the COVID-19 pandemic, the CMS Overall Staffing Rating and RN Staffing Rating were each "two stars" ("BELOW AVERAGE"), where they remained, until the second quarter of 2022.[53] Auditor Aff., ¶ 167.

279. The table below reflects Cold Spring Hills' Overall and RN Staffing Ratings from the first quarter of 2019 through the second quarter of 2022. Auditor Aff., ¶¶ 166-67.

Year	Overall Staffing	RN Staffing
Q1 2019	3 Stars	3 Stars
Q2 2019	1 Star	1 Star
Q3 2019	2 Stars	2 Stars
Q4 2019	1 Star	1 Star
Q1 2020	2 Stars	2 Stars
Q2 2020	2 Stars	2 Stars
Q3 2020	2 Stars	2 Stars
Q4 2020	2 Stars	2 Stars
Q1 2021	2 Stars	2 Stars
Q2 2021	2 Stars	2 Stars
Q3 2021	2 Stars	2 Stars
Q4 2021	2 Stars	2 Stars
Q1 2022	2 Stars	2 Stars
Q2 2022	2 Stars	2 Stars

[53] When asked under oath about Cold Spring Hills CMS Star Ratings, Bent Philipson asserted his privilege against self-incrimination approximately 41 times. SAAG Aff., Ex. 6.

280. Yet notwithstanding these low ratings, in early February 2020, just before COVID-19 hit downstate New York in March 2020, Bent Philipson orchestrated a plan to cut $1.6 million in expenses by eliminating staff at Cold Spring Hills, and asked Yossi Emanuel, the Administrator at Cold Spring Hills, to carry out his plan to reduce payroll costs. Auditor Aff., ¶ 196, Ex. 30.

281. On February 7, 2020, Yossi Emanuel complied, and emailed Bent Philipson and Daniel Schaffer a budget cut chart that outlined Bent Philipson's request for $1.6 million in savings. The budget cut plan targeted direct care positions including a wound care nurse[54] and resulted in the termination of a DON[55] and other Minimum Data Set RNs. Auditor Aff., ¶ 197, Ex. 27. Bent Philipson made these budget cuts despite Cold Spring Hills having received official notice from DOH on February 6, 2020, that all nursing homes must prepare for the coming pandemic. Auditor Aff., ¶ 200, Ex. 40.

282. Sufficient RN staffing is critical to prevent nursing home neglect. Medical Analyst Aff., ¶ 26. RNs supervise LPNs and CNAs, and ensure they are providing adequate care and treatment free from neglect and abuse. Moreover, RNs ensure that LPNs and CNAs are effectively trained initially and as needed in their work. RNs are also responsible for treating acute care needs, performing complex health assessments, administering complex treatments, complying with medical orders, and communicating with physicians and specialists. RNs perform assessments of residents' needs and create individualized care plans when residents are admitted to the facility and periodically throughout their time in the nursing home. Since LPNs cannot perform assessments of residents' needs, RN supervision is essential on all units on all shifts. When nursing

[54] Wound care RNs are critical in the treatment of residents suffering from pressure injuries, or wounds. The duties and responsibilities of a wound care nurse include assisting in assessing and treating wounds. Medical Analyst Aff., ¶ 53. As such, the termination of a wound care nurse negatively impacts the care and treatment of those residents suffering from pressure injuries.

[55] This refers to a DON other than DON Cagno referenced above.

homes operate with insufficient LPN staffing, they also assign RNs to perform "med pass"—to administer medications to residents on a given Unit, which leaves such RNs less time to perform the important duties only RNs can do. Medical Analyst Aff., ¶¶ 20 & n.4, 28.

283. Respondents' decision to cut RN staffing at Cold Spring Hills appreciably increased the risk of resident neglect and abuse. *See* Medical Analyst Aff., ¶ 26.

284. Internal nursing assignment sheets from Cold Spring Hills during this period reflect the significant impact of these financial cuts: April 2020, "2 nurses *unsafe staffing" on Seacliff 1, the ventilator unit; and May 2020, "2 nurses—unsafe staffing for vent unit!!" Auditor Aff., Ex. 36.

285. Unsurprisingly, Respondents' failure to provide sufficient staffing led to increased deaths: in the three-month period from March 1, 2020 through June 4, 2020, a total of 166 Cold Spring Hills' residents died, including 98 COVID-19 deaths and 68 non-COVID-19 deaths. Auditor Aff., ¶ 242.

286. When asked questions under oath about cutting staffing and expenses at Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination approximately 62 times. SAAG Aff., Ex. 6. During the height of COVID-19 pandemic, Bent Philipson took out $3,975,000 from Cold Spring Hills. *See* ¶ 404.

Staff at Cold Spring Hills Corroborate Insufficient Staffing and Resulting Neglect

287. Cold Spring Hills' staff confirmed that insufficient staffing was a problem at the facility starting before the pandemic, and that it continued into 2022.

288. Cold Spring Hills Employee 1 has worked at Cold Spring Hills for more than eight years and stated that Cold Spring Hills operated without enough staff to care for the needs of its residents and to cover all of the shifts. Detective Aff., ¶ 10. Due to insufficient staffing at Cold Spring Hills, residents fall more frequently, wait longer to receive their medication, wait longer

for assistance to go to the bathroom and sit in feces waiting to be changed, they do not receive proper hydration or their showers or meals on time—and when they do receive their food, they are rushed to eat quickly. *Id.* at ¶ 12.

289. Employee 2, who has worked at Cold Springs Hills for over eight years, stated as recently as May 2022 that staffing has been low and staff feel rushed to finish with one resident and move on to the next resident. Employee 2 described how some staff are "double diapering" the residents to save time. The practice of "double diapering" means that staff dresses a resident in two diapers, so that when a resident soils the first diaper and needs to be changed, staff take off the dirty diaper and then pull the clean one back up. Detective Aff., ¶¶ 13, 15.

290. Employee 2 further stated that staffing levels per unit should have included an RN, one to two LPNs, and five CNAs, but during the peak of the pandemic, there was typically an RN covering three units, and each unit had only one LPN (or sometimes none) and only two CNAs. Despite these staffing issues, Cold Spring Hills laid off approximately 24 members of staff between September and November 2020, according to Employee 2. Detective Aff., ¶¶ 17, 29.

291. Cold Spring Hills Employee 3 ("Employee 3") has worked at Cold Spring Hills for over six years. Employee 3 stated that staffing has always been an issue at Cold Spring Hills—before, during and after the peak of the COVID-19 pandemic. Employee 3 stated that, as of November 2021, it was common for Cold Spring Hills to assign the employee to care for eleven residents, rather than the eight residents Employee 3 should have been assigned. Employee 3 added they have additional residents to care for because there are usually not enough CNAs assigned to the unit during shifts. Detective Aff., ¶ 18.

292. Employee 3 also said that Cold Spring Hills was using a lot of staff who are employed by a staffing agency. Detective Aff., ¶ 19. Nursing home reliance on agency staff creates

inconsistencies in staffing that can adversely impact the continuity of care of the residents and result in reduced staff accountability. *See* Medical Analyst Aff., ¶ 66.

293. Employee 4 stated that low staffing had been a major issue at Cold Spring Hills since before the COVID-19 pandemic, and it had been getting worse since at least 2017. Due to the insufficient staffing, Employee 4 has to take time away from nursing duties to perform CNA duties. Detective Aff., ¶ 20.

294. Due to insufficient staffing to cover all shifts, Cold Spring Hills "mandates" staff to stay after their shift ends to work additional hours. Working the longer hours adds stress to staff's lives, and the insufficient staffing has caused more "callouts," meaning staff are not coming to work, increasing the burden on staff who do report to work. Detective Aff., ¶¶ 10, 14, 28. Employee 2 confirmed that Cold Spring Hills administration mandates staff to stay and work additional hours and threatens to write staff up or terminate them if they try to refuse. *Id.* at ¶ 14. The low staffing levels require staff to work longer hours and carry heavier workloads. Heavier workloads cause friction amongst the staff and creates stress on the units. *Id.* at ¶¶ 13, 15.

295. Insufficient staffing has also caused more staff to be "floated" off their regular unit to work their shift on a different unit. Detective Aff., ¶¶ 11, 21.

296. Floating of staff to different units adversely impacts both the residents and the staff because the staff who are assigned to work on units other than their regular assignment lack the same opportunity to establish familiarity and form relationships with residents, which is important for resident comfort, security, and continuity of care. *See* Medical Analyst Aff., ¶ 66. CSH Employee 2 confirmed that low staffing prevents staff from developing relationships with the residents. Detective Aff., ¶ 16.

Cold Spring Hills Nurses Notify Their Union of Unsafe Staffing Levels

297. Staff at Cold Spring Hills were so concerned about unsafe staffing levels at the facility that they notified their union. In July 2022, Cold Spring Hills' union, 1199 SEIU, received nine notices regarding unsafe staffing, some of which were on forms entitled "Notice of Unsafe Staffing Situation" from nursing staff members regarding seven of the fifteen units at Cold Spring Hills, mostly during the day shift. Notably, three of these notices were dated on consecutive dates regarding the ventilator unit at Cold Spring Hills. The notices identified specific factors that compromised the delivery of quality resident care or posed potential or actual harm to the residents, including (1) insufficient number of RNs (sometimes no RNs); (2) inability to delegate, perform, or safely supervise; and (3) the delay or omission of medication and/or treatment. These notices also contained attached handwritten notes indicating that the specified units were short staffed and/or had "unsafe" staffing conditions. Auditor Aff., ¶ 191, Ex. 38.

New York State Ombudsman Program Corroborates Insufficient Staffing Levels

298. In December 2021, members of the New York State Office for the Aging Ombudsman Program ("Ombudsmen"), advocates for nursing home residents, also advised of staffing issues at Cold Spring Hills. During a Resident Council meeting in late 2021, the President of Nursing at Cold Spring Hills admitted there was a staffing shortage at Cold Spring Hills. Detective Aff., ¶¶ 22-23.

Families Corroborate Insufficient and Inattentive Staff and Adverse Effects on Residents

299. Not surprisingly, family members also reported low and inattentive staffing, and its negative effects on the quality of care provided to residents at Cold Spring Hills. As noted, family members have complained that Cold Spring Hills staff were not responsive to the residents, and several said that Cold Spring Hills staff did not regularly come to their loved ones' rooms or answer

their call bells. *See* M.H. Aff., ¶ 17 (family member observed physical therapist in resident mother's room viewing social media on his device, instead of providing treatment to resident, while resident was in the room with him); M.G. Aff., ¶ 29 (family member had to tell staff to provide resident father with a call bell, after observing he did not have one); C.H. Aff., ¶¶ 9, 12, 14, 17-18 (staff "consistently took too long" to answer resident's call bell and did not check on him regularly); C.B. Aff., ¶¶ 21-22, 34, 36 (staff not responsive to resident's call bell for bathroom use; Administrator walked out of meeting with family; Cold Spring Hills did not arrange for appropriate type of transportation to transfer resident to hospice facility, given resident's fragile condition, thus delaying his transfer by a day); Detective Aff., ¶ 108 & Ex. 10 (Yelp review stated resident mother with tracheostomy had to suction herself because staff was too busy; resident also developed deep vein thrombosis from sitting in chair for ten hours a day); *id.* at ¶ 111 & Ex. 13 (Yelp review stated that author observed staff let resident lie on floor bleeding for five minutes before helping her after she fell from wheelchair); *id.* at ¶ 102 & Ex. 4 (Google review stated staff forgot to plug oxygen machine in, leaving resident mother buzzing repeatedly for the nurse, unable to breathe; staff also "forgot" to feed her and didn't answer author's calls; staff also left mother wet with urine for four hours); *id.* at ¶ 110 & Ex. 12 (author of Yelp review stated their own time at Cold Spring Hills were the worst months of their life; facility was "terribly understaffed and you could press a call button and wait for hours until someone showed up to help"; "nights and weekends were nightmares"); *id.* at ¶ 105 & Ex. 7 (Caring.com review stated that, one night, there were no staff on the floor and the author of the review had to call 911 to obtain care for resident brother; after emergency services personnel walked the floor looking for a staff member, they told the author, "'[T]his is crazy! You better get your brother out of here'"); *id.* at ¶ 106 & Ex. 8 (Caring.com review stated staff didn't respond when resident husband became very ill—they were

too busy; resident went into septic shock with a high fever; author "would not put an animal" there); *id.* at ¶ 104 & Ex. 6 (Caring.com review stated that staff leaves residents in wheelchairs in the courtyard and they do not return); *id.* at ¶ 109 & Ex. 11 (Yelp review stated staff "never answer the phone and [i]f they do they're unprofessional" and "dad died in this horrible place because he was ignored").

300. As another example, one family member reported, "On many occasions throughout his stay at Cold Spring Hills, my father had to transfer himself from his chair to his wheelchair and from his wheelchair to his chair because no one responded to his call bells, and no one was around to help him." C.B. Aff., ¶ 19.

301. The same family member, C.B., stated her father, resident P.S. "hated nights because no one was around to help him if he needed something, anything." She described high nursing staff turnover. She said that when she visited her father during the day shift, there were two nurses and three aides; during the evening shift, she saw only one nurse and two aides, and during the overnight shift, she saw only one nurse and one aide—and the one aide was always sleeping. C.B. added that the nursing staff on her father's unit often complained to her that they were short staffed and short of supplies. They also told her there were days when there were no aides on duty and only one LPN to care for the residents on her father's floor. Instead of addressing the shortages, the nursing supervisors and administrators accused the nursing staff of lying. C.B. said the floor on which her father resided was a "ghost town" during the overnight shift. During her night visits, she often observed lights continuing to flash at the nurses' station, "but no one was around to answer them, so they just kept flashing." C.B. Aff., ¶¶ 8-11.

302. Likewise, A.P. stated when she visited her mother in mid-December 2021, her mother's unit was a "ghost town," with no staff around. A.P. Aff., ¶ 28.

303. W.S. also observed that the residential floor on which her husband, T.S., lived was "always a ghost town and it was hard to find a staff member to talk to." W.S. Aff., ¶ 9.

304. A social worker informed M.G. that during the summer of 2020, there were only about three to four staff members to care for 40 residents. M.G. Aff., ¶ 13.

305. **Resident Falls:** One of the serious consequences of inadequate staff and staff inattention is that residents are more likely to fall. *See* Medical Analyst Aff., ¶¶ 26, 33, 36-37; *see also id.* at ¶¶ 71, 75 (staff's failure to assist timely or at all with toileting and dressing can lead to residents falling); Detective Aff., ¶ 12 (employee stated insufficient staffing has resulted in residents falling more frequently).

306. Resident P.S. fell twice, once in August 2020 and again in June 2021. After the August 2020 fall, a Cold Spring Hills housekeeper, not a nurse or aide, found him on the floor. He suffered a skin tear to his arm from both falls. Medical Analyst Aff., ¶ 129.

307. Resident T.S. also fell twice in 2021 and was found on the floor of his room both times. Medical Analyst Aff., ¶ 125.

308. And, as noted, Resident C.P. experienced an "unwitnessed" fall, knocking the dental bridge from her mouth. A.P. Aff. ¶¶ 17-21; Medical Analyst Aff., ¶¶ 96-97.

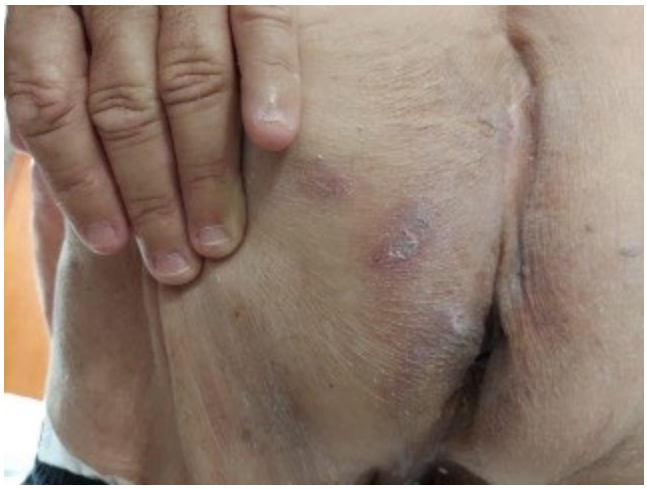
309. Resident 47 fell from a wheelchair numerous times while living at Cold Spring Hills from late 2020 to 2022. Cold Spring Hills records state Resident 47 had dementia, wandered into other residents' rooms, and spent a considerable amount of time in the dining room. *See* Medical Analyst Aff., ¶¶ 99-101; Detective Aff., ¶¶ 52, 74. A record dated October 2021 reflects that staff brought Resident 47 in a wheelchair to the dining room "for safety." Medical Analyst Aff., ¶ 100.

310. Resident 47's family member said that on at least one occasion, she observed Resident 47 in the resident's wheelchair, pushed up against a table in the dining room with the wheels locked and the resident's body pinned to the table to prevent movement. Although a Cold Springs Hill supervisor told the family member it was done for safety reasons, the family member considered this to be a restraint. Detective Aff., ¶ 74.

311. Pinning a resident in a locked wheelchair against a barrier that is in front of him or her is not an acceptable method of monitoring a resident or preventing falls and it constitutes mistreatment. *See* Medical Analyst Aff., ¶ 102.

312. **Medication Delay and Error:** In addition, family members have said that staff failed to timely or properly administer medication to residents. *See* M.H. Aff. ¶ 16; C.H. Aff., ¶ 9; C.B. Aff., ¶¶ 12-13; Detective Aff., ¶ 66. *See also supra* ¶ 297, addressing Cold Spring Hills staff's notices to 1199 SEIU regarding unsafe staffing levels and identifying factors that compromised delivery of quality resident care or posed potential or actual harm to the residents, including the delay or omission of medication and/or treatment.

313. For example, resident P.S. lived at Cold Spring Hills from April 2020 to August 2021. P.S.'s daughter, C.B., reported that staff applied medication to P.S.' buttocks that he was allergic to, and it caused him pain and bleeding. He had difficulty sitting. C.S. said P.S. complained to a nurse, but the nurse did not report the issue to the treating physician at Cold Spring Hills. C.B. Aff., ¶ 17. C.B. took a photograph of the affected area on her father, a copy of which is attached as Exhibit 2 to the C.B. Aff. and shown below.



314. Social media accounts also reported medication errors. *See* Detective Aff., ¶ 103 & Ex. 5 (Google review stated resident "husband's health and mental status declined enormously in less than 72 hours of being there;" Cold Spring Hills administered medication resident had never taken before, advising family he needed it to settle down; resident was in hospital intensive care unit at time of 2021 review); *id.* at ¶ 107 & Ex. 9 (Caring.com review stated Cold Spring Hills administered Haldol to resident father despite heart condition and resident was incoherent and unable to open eyes, as a result; facility has "inadequate staff who . . . are not concerned with the health of your loved ones;" "they have no interest in care and will drug your loved ones as they see fit to not have to be bothered with them").

315. A Cold Spring Hills employee has confirmed that insufficient staffing at Cold Spring Hills has resulted in residents waiting longer to receive their medication. *See* Detective Aff., ¶ 12.

316. **Residents Made to Wear Diapers and Suffer Health Risks, Discomfort and Degradation Without Timely Toileting Assistance:** Due to lack of sufficient staff to provide basic care, such as proper and timely assistance with toileting, at least some residents who were continent were made to wear diapers. As one example, resident P.S. lived at Cold Spring Hills

from April 2020 to August 2021. His daughter, C.B., said that staff regularly dressed P.S. in adult diapers rather than underwear, even though he was continent, because, staff told her, this practice was "easier for him and for them." C.B. Aff., ¶ 23; *see also* C.H. Aff., ¶¶ 12-14, 17 (family member said staff put continent father in diapers "because they consistently took too long to answer his call bell"); Detective Aff., ¶ 104 & Ex. 6 (Caring.com review stated staff put residents in diapers instead of bringing them to the toilet.).

317. Cold Spring Hills staff put another resident with dementia in adult diapers in 2021 during the same time that the resident's bathroom door was broken and the resident was left to defecate and urinate on the floor of the resident's room. Cold Spring Hills did not repair the broken door for several months. *See* Detective Aff., ¶¶ 64, 79.

318. Putting residents in adult diapers takes less time than helping residents to the toilet. In other words, staff would disregard residents' requests for help to be transferred to the toilet such that residents soiled their diapers, and staff also failed to check and change residents in a timely manner, leaving them to sit in soiled diapers. This practice humiliates residents and can cause a decline in health and well-being. *See* C.H. Aff., ¶¶ 12-14; C.B. Aff., ¶ 23; A.P. Aff., ¶¶ 26, 36-38; M.H. Aff., ¶ 14; M.A.G. Aff., ¶¶ 11-12; Detective Aff., ¶ 68; Medical Analyst Aff., ¶¶ 71-72, 68-69; *see also* Detective Aff., ¶¶ 12, 70, 15 (insufficient staffing has caused residents to wait longer for assistance to go to the bathroom and to sit in feces waiting to be changed; planned discontinuance of bed pads as a way to hold nursing staff accountable for providing timely toileting assistance; staff feel rushed with residents and some double diaper residents to save time). *See generally* Medical Analyst Aff., ¶¶ 72, 27 n.6 (insufficient nursing home staffing to provide required care based on residents' needs and acuity leads to residents suffering excessive delays in receiving toileting assistance and staff's failures to timely change residents' diapers).

319. P.S.'s daughter said that when staff eventually brought P.S. to the toilet, they often left him there. She said that throughout her father's stay at Cold Spring Hills, he had to wait for over one hour for nursing staff to respond to his call bell when he needed to go to the bathroom. When the staff did move him to the bathroom, they consistently left him there alone. When the nursing staff did not respond to her father's call bell, her father phoned her and she, in turn, would have to call the nurses' station for help on his behalf. C.B. Aff., ¶ 21; *see also* Detective Aff., ¶ 106 & Ex. 8 (Caring.com review stated staff never provided resident husband with assistance while he was on the toilet; instead, 80-year-old wife had to clean resident.)

320. In 2019 and 2020, a family member of another Cold Spring Hills resident repeatedly complained in emails to the Cold Spring Hills Administrator about insufficient CNA staffing that resulted in their loved one not being taken out of bed and toileted on time. In March 2019, the family member confirmed with a Cold Spring Hills staff member that there was an "elective reduction in staffing of nurses [sic] aides in the Woodcrest building" on the day shift from five to four CNAs. Almost a year later, in April 2020, the resident's floor had "zero CNAs for the evening shift, until one brave soul from the morning shift volunteered to stay over." In June 2020, the resident waited an hour for assistance with going to the bathroom and was left on the toilet for forty minutes before staff provided the resident the assistance needed to get off of the toilet. Further, in 2020, staff did not get the resident out of bed at least one day every weekend for about four months because there were only three CNAs on the day shift. Auditor Aff., ¶ 139, Ex. 39.

321. Another issue with putting residents in adult diapers for staff convenience is that Cold Spring Hills has not had enough diapers to supply to them, further subjecting the residents to

indignities and endangering their health. *See* M.A.G. Aff., ¶¶ 6, 11-13, 18; Medical Analyst Aff., ¶ 72.

322. Resident P.S.'s daughter said that not only did staff make her father wear diapers when he did not want to, but when he started wearing them, "he had to beg for [diapers], and he was allotted only five per day because they didn't have enough of them"—thus further degrading him. A head nurse advised they should buy their own supply if P.S. needed more. Furthermore, the diapers they gave P.S. were too large and leaked all over. Because Cold Spring Hills was also short of bed pads (which absorb bodily fluids), everything on his bed got wet. C.B. Aff., ¶ 23.

323. A Cold Spring Hills employee confirmed there was a shortage of diapers, towels, bedsheets, and bed pads for the residents even as recently as late 2021. Detective Aff., ¶¶ 81-82.

324. The Ombudsmen said the same: there was a chronic shortage of supplies at Cold Spring Hills since before the peak of the COVID-19 pandemic, including diapers. Detective Aff., ¶ 84.

325. A resident of the Woodcrest building cited a lack of draw sheets, green pads, diapers, towels, and gowns, resulting in a delay of care. Two days after being informed of a supply shortage, Cold Spring Hills was notified that it was "way over" on its order of double extra-large diapers. Despite having a diaper shortage, Cold Spring Hills decided to scale down the order to save about $200. Auditor Aff., ¶ 195, Exs. 39, 39a.

326. Bent Philipson, when asked under oath whether a resident sitting in a soiled diaper for more than an hour due to the unavailability of staff was quality care, asserted his privilege against self-incrimination. SAAG Aff., Ex. 6 (pg. 113).

327. **Hygiene Failures:** Another consequence of inadequate staffing and inattentive staff suffered by the residents is that Cold Spring Hills failed to provide basic hygienic care to its

residents, such as bathing, oral care, and nail care. These failures very likely contributed to harm suffered by the residents, including loss of dignity, abrasions, infection, and worsened injuries. *See* A.P. Aff., ¶¶ 7-8, 12, 14-20, 24-26, 28, 34-38; W.S. Aff., ¶ 7; M.H. Aff., ¶¶ 9-13; S.D.S. Aff., ¶ 30, 14, 34; M.G. Aff., ¶¶ 8, 11, 12, 20, 25, 32, 39, 40, 41; E.L. Aff., ¶ 16, 10, 12; C.H. Aff., ¶¶ 11, 20, 23, 25, 28; M.A.G. Aff., ¶ 19; Detective Aff., ¶¶ 60, 42, 45-46, 59, 68, 49-51; Medical Analyst Aff., ¶¶ 53, 68-69, 75 & n.18, 98, 122, 126, 118, 120, 112-113, 128, 106-108, 104, 132. Some residents who were deprived of showers were also deprived of prompt toileting assistance, thus compounding their health risks, discomfort, and humiliation. *See* A.P. Aff., ¶¶ 7-8, 12, 26, 34, 36-38; M.H. Aff., ¶¶ 9-12, 14; C.H. Aff., ¶¶ 11-14, 17, 20, 23, 28; Medical Analyst Aff., ¶ 128 Detective Aff., ¶¶ 59, 68.

328. The Ombudsmen also received complaints from family members that Cold Spring Hills failed to provide regular showers to the residents. Detective Aff., ¶ 61.

329. **Filthy Conditions:** Family members, residents and employees complained that the rooms at Cold Spring Hills were filthy. MFCU heard reports of feces on walls and bedsheets, dirty floors and bathrooms, mold, holes in bedding, water leaks, no running water, that there was trash, food, and other items left on the floor or under residents' beds, and the dishes were not washed with soap. *See* E.L. Aff., ¶¶ 15, 17; W.S. Aff., ¶ 8; A.P. Aff., ¶ 13; C.B. Aff., ¶¶ 23, 31; M.G. Aff., ¶ 27; Detective Aff., ¶¶ 75-76, 78-80.

330. For example, the following photographs show the poor condition of resident C.P.'s room in June 2021, during her daughter's first visit since the start of the pandemic:

Dirty sink and no hot water handle

Feces on toilet seat and urine in toilet

Garbage and debris under bed

331. When asked under oath about the photograph directly above depicting garbage and debris under a resident's bed, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6 (pg. 115).

332. Employee 2 provided to MFCU the below photograph, taken at Cold Spring Hills in August 2020, which shows the poor condition of a resident bed, illustrative of a resident care problem caused by supply shortages and understaffing. Detective Aff., ¶ 69.

Torn, cracked, and filthy mattress at Cold Spring Hills

333. Compounding this, the lack of PPE prevented housekeeping staff from entering residents' rooms during the height of the COVID-19 pandemic. Employee 4 recalled that there was no housekeeping in residents' rooms because Cold Spring Hills did not provide housekeeping staff with PPE. Detective Aff., ¶ 37.

334. Family member C.B. additionally reported that in 2021, one of her relatives observed someone clean her father's toilet bowl, sink and the floor with the same brush and then enter the rooms of other residents with the same brush, increasing the chances of bacterial cross-contamination between rooms. C.B. Aff., ¶ 32.

335. Insufficient staffing can lead to a lack of appropriate cleaning of high touch surfaces and resident rooms and common rooms. Failures to properly clean rooms and surfaces increase the risk of infection transmission among residents and staff. *See* Medical Analyst Aff., ¶ 45; *see*

also id. at ¶ 40 & n.11 (citing 10 NYCRR §§ 415.19(c), 42 CFR § 483.80(e)) (proper handling of linens is a part of basic infection control practices); *id.* at ¶ 8 & n.1 (citing 10 NYCRR § 415.1(a), 10 NYCRR § 415.5(h)) (a nursing home is a resident's home, and the facility is to provide a safe, clean, comfortable, and homelike environment, housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior, and clean bed and bath linens in good condition).

336. **Failures in Communicating with Families:** Due to limited staff, Cold Spring Hills failed to timely and accurately communicate with residents' family members about the residents. Many family members reported that their calls to Cold Spring Hills and requests to speak or meet with Cold Spring Hills nurses, doctors, management, or other staff required repeated attempts or went unanswered entirely.

a. For example, in December 2021, Cold Spring Hills informed A.P. that her resident mother was diagnosed with COVID-19, but A.P. was unable to find out whether her mother was quarantined because it was so difficult to obtain information from Cold Spring Hills. A.P. Aff., ¶ 29; *see also id.*, ¶¶ 15-16, 23, 38.

b. Likewise, M.G. described how her calls to Cold Spring Hills about her father generally went unanswered; when staff did answer her calls, they deflected her questions about her father's care. She described how staff were not prepared to answer her questions during the care plan meeting, and the administrator did not answer her calls. M.G. Aff., ¶¶ 15, 18, 21.

See also, e.g., S.D.S. Aff., ¶ 28 (communication with Cold Spring Hills was "terrible;" calls to Cold Spring Hills repeatedly went unanswered; DON accused family member of lying when she said DON's voicemail box was full); M.H. Aff., ¶ 19 (Cold Spring Hills ignored family member's

complaints about "bad treatment" of resident mother); Detective Aff., ¶ 59, 87, 88, 89 (despite requests for updates on resident's severe pressure injury, family received very few calls from wound nurse over the course of a year; even after family member notified Cold Spring Hills that resident father was not receiving basic care, Cold Spring Hills did not provide care; calls to Cold Spring Hills went unanswered and required multiple attempts to reach someone; family member said Cold Spring Hills' upper management is absent and her messages went unanswered).

337. When staff members have responded to family members, they have indicated they do not have time to discuss a resident's care or condition, they have provided inaccurate or unclear information, and/or or they were callous. *See* M.H. Aff., ¶¶ 9-12 (nursing staff told family member that staff were showering resident mother regularly and documenting it, but staff member previously told family member they were not showering mother due to broken equipment); M.G. Aff., ¶¶ 19, 20, 21, 26 (staff member who answered family member's call about resident father's pressure injury laughed and hung up on her; staff could not provide family member with resident father's physical therapy schedule; staff could not advise when podiatrist would visit Cold Spring Hills so that resident could finally have toenails cut; Cold Spring Hills provided family member with conflicting information on scheduling FaceTime calls with resident father during the summer of 2020); S.D.S. Aff., ¶¶ 18-20, 24, 28, 22-23, 35 (DON provided family member with incorrect diagnosis for resident father; CNA told family member she had no time to talk to her; physical therapist and social worker provided different reasons for termination of resident's physical therapy, one relating to insurance coverage; when family member complained about how Director of Physical Therapy was handling resident father, he told family member she could take her father elsewhere; staff could not inform resident's family what was wrong with resident who was having difficulty breathing while on ventilator; staff could not inform family member of Cold Spring

Hills' policy on suctioning residents on ventilators, when resident father was on ventilator and required suctioning; staff told family member it was not Cold Spring Hills' policy to use pulse oximeters on residents on ventilators, but after family member questioned policy as to resident's care and well-being, they gave resident pulse oximeter; family member had to "fight to get [] father out of Cold Spring Hills" and to a different facility because Cold Spring Hills didn't properly action the paperwork); C.B. Aff. ¶ 15 (when family member raised to nursing staff that resident father's wet bandages needed to be changed more frequently, they told her they did not have time).

338. Sometimes when family members tried to call Cold Spring Hills for check-ins about their loved ones, staff told them that all was "fine," only to find out later that the resident was suffering from some serious injury or a health issue. *See, e.g.*, M.G. Aff., ¶¶ 16, 21-25, 35, 40; Medical Analyst Aff. ¶¶ 112-114 (social worker consistently said resident father was "fine" and "he is in great hands," but resident was sent from Cold Spring Hills to hospital with an infection at his feeding tube site, a stage 4 pressure injury and was also treated for severe sepsis and ventilator-associated pneumonia; nursing staff said resident's pressure injury was "fine" and improving, but family member later learned at hospital it was a severe stage 4 so large that a hand could fit inside it); A.P. Aff., ¶¶ 30-37 (nurse assured family member that resident mother who had fainted and was found unresponsive was "fine," but the next day, family member observed mother was again unresponsive and she was informed that mother was lethargic and had a kidney blockage that required a catheter, and she had a urinary tract infection for which she spent a week in the hospital); *see also* Detective Aff., ¶¶ 87, 42, Medical Analyst Aff., ¶¶ 106-108, 110 (social worker always "painted a picture of sunshine and rainbows" about resident grandfather who, within mere weeks, was hospitalized and died); S.D.S. Aff., ¶ 18 (nurse told family member

resident was okay when other nursing staff said he was unresponsive and having difficulty breathing while on a ventilator).

339. The Ombudsmen also received complaints from families about Cold Spring Hills communication failures. Detective Aff., ¶ 97.

340. **Social Isolation:** Cold Spring Hills staff limited or controlled residents' communication with their family members. M.G. said that Cold Spring Hills staff restricted when she and her resident father could speak via FaceTime during the summer of 2020. Moreover, her father told her that staff never left him alone when he spoke with her via FaceTime, so he could not speak freely about how bad it was there. M.G. Aff., ¶¶ 26-28. Another family member, C.B., said that her many calls to Cold Spring Hills to schedule visits with her resident father in at least the spring of 2020 weren't answered or returned, thus inhibiting her father's visits with his family. She said that later, another family member's calls to schedule visits weren't returned. C.B. Aff., ¶¶ 28, 30. As noted, when resident P.L.'s cousin and co-guardian called Cold Spring Hills repeatedly in the spring of 2020 to speak with him, staff denied her requests. Instead, they told his cousin that he was asleep and could not talk. He died soon thereafter. E.L. Aff., ¶¶ 13-14.

341. Family members additionally reported that there appeared to be no recreation or organized activities for the residents at Cold Spring Hills. *See* E.L. Aff., ¶ 19; C.B. Aff., ¶ 7. One resident's family reported that he slept all day while there. C.B. Aff., ¶ 24.

342. The Ombudsmen said that they had received complaints about a lack of socialization and activities for Cold Spring Hills residents during the COVID-19 pandemic. Residents were socially isolated and had to remain in their rooms with a lack of activities provided. The Ombudsmen also said the residents suffered from depression. The Ombudsmen further

advised that Cold Spring Hills does not emphasize resident mental health and there is no one interacting with residents. Detective Aff., ¶¶ 71-72.

343. Recreation therapy and activities are important to residents' overall physical health, cognition and emotional well-being. They help to mitigate the risks of isolation and depression. Loneliness and social isolation negatively impact physical and mental health and contribute to a higher mortality rate in older adults. When there is insufficient staffing, overworked staff are required to focus on residents' physical needs, without the opportunity to spend time with each resident, much less provide recreational therapy to a resident. Medical Analyst Aff., ¶¶ 64-65, 67.

344. When asked questions under oath about the quality of resident care at Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination approximately 44 times. SAAG Aff., Ex. 6.

"Let's keep everyone in over the weekend": Disregarding Cold Spring Hills' Inability to Care for Its Residents, Bent Philipson Prioritized His Revenue Stream and Respondents' Up-Front Profit-Taking

345. Despite Cold Spring Hills' inability to care for its residents, Bent Philipson pushed the facility to keep resident admission numbers up; he consistently reviewed daily census information, and pressured staff when he thought census numbers were dropping, because census drives revenue, and he was taking the revenue for himself rather than providing care.

346. For instance, on October 21, 2019, in response to receiving the Cold Spring Hills morning census report, which contained admission, discharge, and daily census information, Bent Philipson replied: "How did they lose 8 pts [patients] in a weekend." Auditor Aff., ¶ 157, Ex. 33. Even though this report noted that three residents were discharged, three residents went to the hospital, and two residents died, Bent Philipson expressed no concern about the welfare of the residents.

347. Indeed, Bent Philipson, a person with no medical qualification whatsoever, directed retention of residents simply to generate revenue, substituting his instruction for the actual care needs of residents. For example, on November 1, 2019, Bent Philipson, in response to receiving the Cold Spring Hills' "End of Day Report" that indicated no drop in census, wrote: "Nice. Let's keep everyone in over the weekend." Auditor Aff., ¶ 157, Ex. 33.

348. When asked under oath if he was involved in the operation and management of Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6. Yet, in the years about which he refused to speak, Bent Philipson took over $9.5 million from Cold Spring Hills for himself.

349. **Even during periods of unsafe staffing levels, Cold Spring Hills continued to admit new residents:** Despite not being able to adequately care for its current residents due to lack of staff, a review of Cold Spring Hills' admission records shows that Cold Spring Hills continued to admit new residents. In its 2021 Cost Report alone, Cold Spring Hills reported that it admitted 582 new residents in 2021. Auditor Aff., ¶ 192.

350. When asked under oath about Cold Spring Hills' census, Bent Philipson asserted his privilege against self-incrimination approximately 25 times. SAAG Aff., Ex. 6.

Staffing Cuts Were a Point of Pride for Respondents in their Mortgage Refinancing

351. Respondents used staffing cuts not only to facilitate their up-front profit-taking from Cold Spring Hills without regard to care, but also to facilitate yet another scheme enabling Respondents to extract funds. In 2018, Respondents sought refinancing of the mortgage Cold Spring Hills was paying, for their own benefit. At the time the mortgage was refinanced, in assessing the likelihood of repayment on the mortgage, Greystone Funding Corporation ("Greystone") addressed the quality of care provided at Cold Spring Hills. Greystone asserted that

following the purchase of Cold Spring Hills in 2016, new ownership instituted "numerous changes aimed at cutting expenses while delivering a higher, more reliable quality of care." Specifically, this assessment noted that new ownership "decreased payroll expenses by $4.5 million, reduced bad debt by over $700K, reduced food costs by $400K, and reduced pharmacy and nursing supplies by nearly $3 million." Auditor Aff., ¶ 82, Ex. 18. Lender Greystone, which has no business interest in quality of care, certainly described the massive cuts in patient-focused care, but its conclusion was based on information from Respondents and completely contrary to CMS' assessment. In the years following new ownership's decision to significantly cut costs, including staffing, Respondents caused Cold Spring Hills' Overall Ratings to drop from "three stars" ("AVERAGE") to "two stars" ("BELOW AVERAGE") in the third quarter of 2016, where those ratings remained through the third quarter of 2022. *See* ¶ 120.

Cold Spring Hills Submitted False Data to CMS, Inflating Direct Care Staff Numbers

352. Cold Spring Hills submitted false RN staffing data to CMS.

353. Cold Spring Hills is required to report PBJ staffing data to CMS. A nursing home must disclose overall staffing numbers, as well as staffing "detail," or supporting calculations. An analysis published by the Long-Term Care Community Coalition compiles PBJ data reported to CMS and summarizes it at the state, regional, and national levels and publishes this data online for public use. The data provides ratios of nursing hours per resident for each day ("HPRD") with respect to RNs, LPNs, and CNAs. Auditor Aff., ¶ 176.

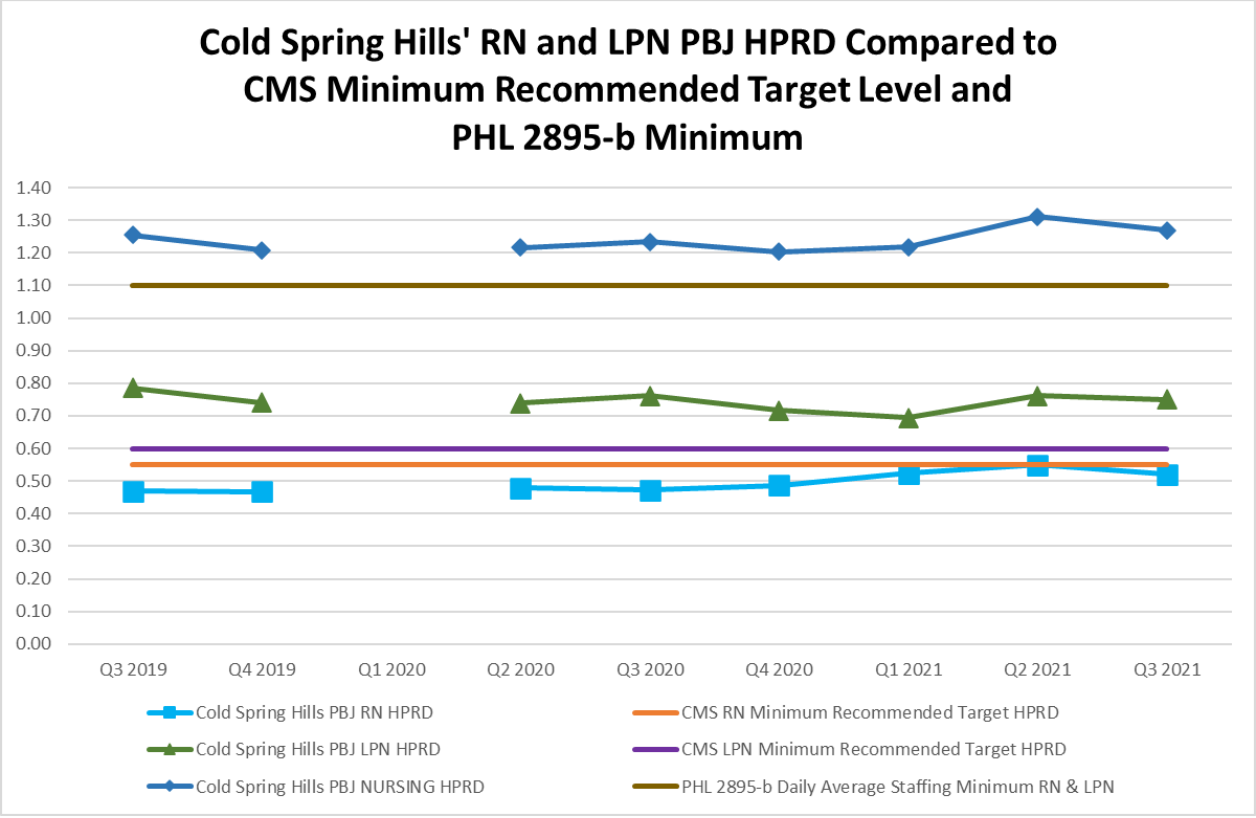
354. CMS recommends a range between 0.55 HPRD and 0.75 HPRD for RNs to maximize resident care.[56] This range depends on whether the residents require short or long-term care. Specifically, 0.55 HPRD is recommended for short-term care residents and 0.75 HPRD is

[56] The total nursing HPRD range to maximize resident care is between 3.55 and 4.1.

recommended for long-term care residents. The PHL § 2895-b (effective 2022) requires a daily minimum staffing level of 1.1 HPRD for combined RNs and LPNs. Auditor Aff., ¶¶ 177-78.

355. These minimum quantitative staffing levels, however, do not relieve a facility from its obligation under New York law to employ sufficient staff to meet the qualitative minimum staffing level to properly care for its residents as prescribed in other federal and state regulations.

356. Conservatively, MFCU conducted an analysis comparing Cold Spring Hills' RN PBJ HPRD to CMS' lowest recommended level of 0.55 HPRD for RNs. Even with this benefit, the graph below shows how the lack of sufficient RN staffing levels at Cold Spring Hills placed it consistently below the lowest CMS-recommended ratio of 0.55 HPRD. Auditor Aff., ¶ 179.



357. In addition to operating Cold Spring Hills with insufficient staffing levels, the owners and operators of Cold Spring Hills falsely represented higher numbers of RN staff to the government.

358. As show in the chart below, an analysis of Cold Spring Hills' reported staffing data compared with the supporting detail reports Cold Spring Hills submitted to CMS revealed that Cold Spring Hills inaccurately reported its hours of Unit RN direct care nursing to CMS by over 11,000 hours—or nearly 6.5%—from the third quarter of 2019[57] to the third quarter of 2021.[58] Auditor Aff., ¶¶ 180-81.

Q3 2019 - Q3 2021	RNs
Publicly Reported PBJ Hours	171,993.35
Cold Spring Hills Internal PBJ Detail Hours	160,907.85
Variance	11,085.50
% Difference	-6.45%

359. Cold Spring Hills provided false unit RN data in part by reporting other staff positions improperly, such as administrative RNs, and non-RNs, including clerical staff. The number of unit RNs counted by Cold Spring Hills in its PBJ detail reports were significantly inflated as compared to actual supporting timecard and payroll records. Specifically, Cold Spring Hills frequently and incorrectly counted as Unit RNs (direct care RNs) in its PBJ detail reports individuals whom Cold Spring Hills had categorized in its timecards as administrative RNs and non-RNs, including clerical staff.[59] Unit RNs are responsible for providing direct care to residents,

[57] This coincides with the period that Bent Philipson assumed sole control of Cold Spring Hills.

[58] Cold Spring Hills did not report its staffing data to CMS for the first quarter of 2020. As such, data for the first quarter of 2020 is not included in the graphs addressing staffing levels. Auditor Aff., ¶ 178, n.24.

[59] CMS PBJ Policy Manual dated June 2022 describes the services of RNs with Administrative Duties as:

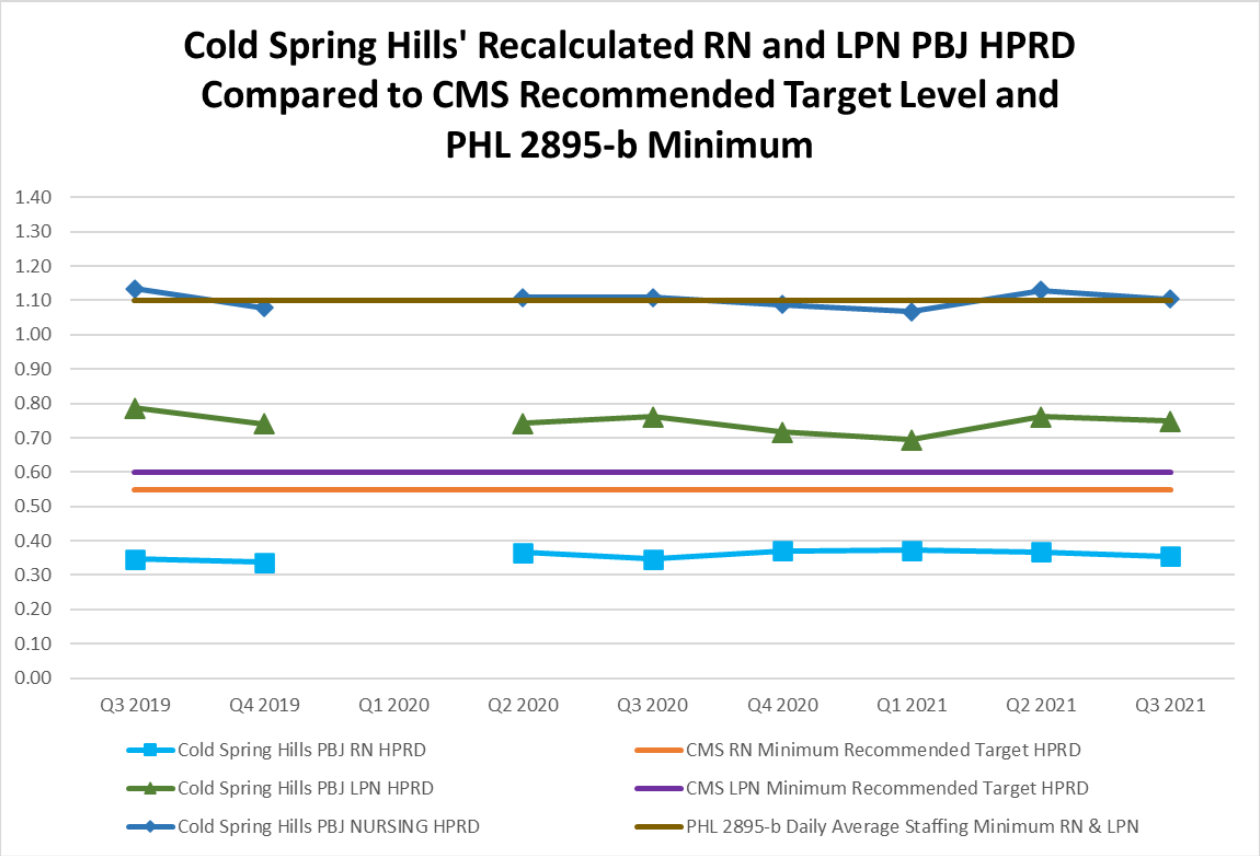
> Nurses (RN) who, as either a facility employee or contractor, perform the Residential Assessment Instrument Function in the facility and do not perform direct care functions. Also include other RNs whose principal duties are spent conducting administrative functions.

whereas direct care is not the principal responsibility of administrative RNs. And, non-RNs, including clerical staff, are not RNs. Classifying unit RNs in this way in the PBJ detail reports creates the false appearance that Cold Spring Hills had more RNs providing direct care to residents than it did. Auditor Aff., ¶¶ 182-84.

360. **The Records go Missing:** Cold Spring Hills' PBJ detail could not be verified because in response to subpoenas issued by the Attorney General, Cold Spring Hills failed to produce reliable staffing data, such as complete electronic timecard data, and daily nursing assignment sheets from 2019 through 2021. Concerningly, Cold Spring Hills represented that it could not even locate a vast number of its daily nursing assignment sheets. Cold Spring Hills' failure to maintain and produce these records prevented a detailed analysis of its daily timecards and nursing shifts. Auditor Aff., ¶ 172.

361. However, it was possible to recalculate the direct care RN hours that Cold Spring Hills reported in its PBJ detail report for the third quarter of 2019 through the third quarter of 2021, specifically by removing the hours that Cold Spring Hills deceptively reported for administrative RNs and non-RNs in violation of CMS reporting rules. The chart below accurately reflects direct care RN hours based on the PBJ detail reports from the third quarter of 2019 through the third quarter of 2021. The light blue line with intermittent squares at the bottom of the chart reflects that Cold Spring Hills number of direct care RN hours for that period consistently fell below the 0.55 CMS recommended RN staffing level. Auditor Aff., ¶ 185-86.

The Manual describes the services of RNs as "those persons licensed to practice as RNs in the State where the facility is located" and states to include geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. The Manual also states not to include RN hours that are already reported elsewhere. Aud. Aff., ¶ 183, Ex. 35.



Cold Spring Hills Under-Reported Its COVID-19 Resident Deaths to DOH by 52% and Had 166 Deaths from March 1, 2020 to June 4, 2020, Including 14 More Non-Covid-19 Deaths than the Same Three Months in 2019

362. Cold Spring Hills underreported its early COVID-19 deaths to DOH by 52%, failing to report 51 resident COVID-19 deaths from March 1, 2020 to June 4, 2020. Auditor Aff., ¶ 241.

363. MFCU reviewed data that was published by DOH from March 1, 2020 through June 4, 2020 that showed the number of deaths reported by Cold Spring Hills as COVID-19 deaths, including presumed or confirmed as COVID-19, and occurring either at the facility or the hospital. MFCU also reviewed the medical records of Cold Spring Hills' residents who died but were not reported by Cold Spring Hills as COVID-19 fatalities. Auditor Aff., ¶ 243.

364. Using Cold Spring Hills' own Policy and Procedure entitled "COVID-19 Surveillance and Tracking," dated March 13, 2020 and revised April 30, 2020, which defines a suspected case of COVID-19 as "a resident who displays a fever of 100 or above and acute respiratory illness where testing was not performed," MFCU identified an additional 51 COVID-19 deaths from March 1, 2020 through June 4, 2020 that Cold Spring Hills failed to report to HERDS as suspected or confirmed COVID-19 deaths.[60] Auditor Aff., ¶¶ 244, 246.

365. Thus, Cold Spring Hills should have reported 98 COVID-19 deaths to DOH through HERDS for this period.[61] Auditor Aff., ¶ 247.

366. Cold Spring Hills, however, only reported 47 COVID-19 deaths to DOH through HERDS for this period.[62] Auditor Aff., ¶ 247.

367. During his testimony in this investigation pursuant to an Executive Law § 63(12) subpoena, Dr. Grigoriy Krichmar, the Medical Director at Cold Spring Hills, admitted that Cold

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[60] Using this definition of a suspected case of COVID-19, MFCU reviewed all resident medical records of those residents who exhibited these symptoms of COVID-19 on or before the date of their death. MFCU also reviewed Cold Spring Hills' internal expiration list, the COVID-19 roster, their precaution tracking forms, the New York State Death Registry, and death certificates. MFCU's analysis included every resident of Cold Spring Hills who fell within the definition of suspected COVID-19 contained within Cold Spring Hills' COVID-19 Surveillance and Tracking policy and procedure. Auditor Aff., ¶ 245.

[61] In May of 2020, DOH conducted a limited review of resident deaths at Cold Spring Hills, and isolated 25 deaths for further review under their methodology at the time. DOH then consulted with Cold Spring Hills Medical Director, Dr. Krichmar, and through this process, they agreed that 11 additional resident deaths should have been reported as COVID-19 deaths to HERDS. During this longer-term investigation, MFCU reviewed resident deaths at Cold Spring Hills that occurred from March 2020 through June 4, 2020 using Cold Spring Hills' resident records and its own written criteria for identifying COVID-19 deaths. DOH only reviewed resident deaths at Cold Spring Hills up until May 2020. Moreover, during this review, DOH noted that several residents it reviewed did not exhibit symptoms consistent with COVID-19. However, MFCU has discovered that several of these same residents did in fact have symptoms consistent with COVID-19. Auditor Aff., ¶ 247, n.27.

[62] Though Cold Spring Hills reported 48 deaths to DOH initially, one of those residents was not dead, and so that resident is not included in this total. Auditor Aff., ¶ 242, n.26.

Spring Hills failed to report COVID-19 deaths to HERDS. Dr. Krichmar testified that seven residents had COVID-19 listed on their death certificate but were not reported to HERDS. SAAG Aff., Ex. 13 (pgs. 337-39). For example, resident M.G.2.'s death certificate indicates she died from "respiratory distress, COVID-19" on April 10, 2020. Resident 9's death certificate indicates they died from "respiratory distress, pneumonia COVID-19" in April 2020. And Resident 29's death certificate indicates they died from possible COVID-19 in April 2020. However, these resident deaths were not reported to DOH as due to COVID-19. Auditor Aff., ¶¶ 248-49, Ex. 46.

368. Dr. Theodore Allen, a doctor at Cold Spring Hills, testified in his examination, pursuant to an Executive Law § 63(12) subpoena, that without a positive COVID-19 test, he could not record COVID-19 as the cause of death on a resident's death certificate. SAAG Aff., Ex. 14 (pgs. 138-140). But the guidance from the National Vital Statistics System from April 2020, which is consistent with Cold Spring Hills' own policy, provides: "In cases where a definite diagnosis of COVID–19 cannot be made, but it is suspected or likely (e.g., the circumstances are compelling within a reasonable degree of certainty), it is acceptable to report COVID–19 on a death certificate as 'probable' or 'presumed.'" Auditor Aff., ¶ 251, Ex. 47. Dr. Allen testified that he considered this guidance optional, choosing instead to conceal the true number of residents who died from COVID-19 at Cold Spring Hills. SAAG Aff., Ex. 14 (pgs. 139-140). But Dr. Krichmar, the Medical Director at Cold Spring Hills, disagreed, testifying that Dr. Allen should have indicated COVID-19 on more death certificates. SAAG Aff., Ex. 13 (pg. 284).

369. When asked under oath about COVID-19 deaths at Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination approximately 12 times. SAAG Aff., Ex. 6.

370. Deaths at Cold Spring Hills did not increase solely due to COVID-19. Further analysis shows that during the three-month period from March 1, 2020 to June 4, 2020, a total of 166 Cold Spring Hills residents died—98 from COVID-19, or presumed COVID-19, and 68 from other causes. Auditor Aff., ¶ 242. However, comparing the same period in 2019 and excluding the 98 COVID-19 deaths from 2020, the Cold Spring Hills discharge logs and the New York State Death Registry show that the number of non-COVID-19 resident deaths at Cold Spring Hills increased significantly between 2019 and 2020 for this three-month period. Specifically, between March 1, 2019 and June 4, 2019, 54 residents died at Cold Spring Hills, compared to 68 residents during the same period in 2020. Auditor Aff., ¶ 253. These 14 additional resident deaths are unexplained and suggest that Cold Spring Hills' quality of care and operational deficiencies, including insufficient staffing, led to increased non-COVID-19 mortality during the period, when Respondents' already deficient staffing model snapped.

DOH Inspections Dating Back to August 2018 Show Respondents' Disregard for Resident Welfare – Multiple Citations Including a Finding of "Immediate Jeopardy"

371. From August 2018 to July 31, 2022, DOH issued 59 citations to Cold Spring Hills for violations of New York nursing home laws, rules and regulations, or violation of Executive Orders.[63] Specifically, Cold Spring Hills received two citations for violating residents' right to freedom from abuse, neglect, and exploitation; three citations in quality of care; one citation in physical environment; two citations in other services; and two citations in administration for a total of ten complaint-related citations. Auditor Aff., ¶ 158. Thus, since at least that time, Respondents

[63] Although DOH annual recertification surveys of nursing homes are supposed to be unannounced, too often nursing homes surmise or learn the dates of planned onsite surveys and temporarily change their operations to make it appear to the DOH survey team as if the nursing homes operate in greater compliance with regulatory requirements than they do on a regular basis. Auditor Aff., ¶ 33.

were on notice of negative findings issued by DOH from surveys and inspections related in part to resident care.

372. Despite being on notice of these deficiencies, Respondents disregarded the care and well-being of Cold Spring Hills' residents and cut staffing to inadequate levels.

373. The COVID-19 pandemic was not an inflection point for Respondents' management and ownership of Cold Spring Hills: it was the point of total failure resulting from Respondents' up-front-profit model.

374. Cold Spring Hills received five citations as a result of the facility's three focused Infection Control Surveys conducted between May 6, 2020, and December 22, 2021. These citations included: (1) failure to follow infection control guidelines while handling soiled resident clothing to prevent the spread of infection; (2) failure to close the door of a COVID-19 positive resident; (3) failure to notify a family member of a positive COVID-19 infection or death; (4) failure to ensure a housekeeping employee wore the appropriate PPE; and (5) failure to make certain an individual present at the facility was tested for COVID-19. Auditor Aff., ¶ 160.

375. When asked under oath about Cold Spring Hills the five citations for infection control deficiencies, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

376. **2022 "Immediate Jeopardy:"** On May 9, 2022, DOH conducted an on-site survey and held Cold Spring Hills in "Immediate Jeopardy." Auditor Aff., ¶ 161. Immediate Jeopardy means "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 USC § 488.301.

377. In that inspection, DOH cited Cold Spring Hills for not performing cardiopulmonary resuscitation ("CPR") on a resident of Cold Spring Hills because the resident

was wearing a facility-provided DNR (do not resuscitate) bracelet, but the resident's chart did not support the DNR designation, and CPR should have been performed on the resident. DOH fined Cold Spring Hills $10,000 for this deficiency. Auditor Aff., ¶ 161. A copy of the Statement of Deficiencies MFCU received from DOH is attached as Exhibit 20 to the SAAG Aff.

378. When asked questions under oath about DOH's finding of "Immediate Jeopardy," Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6 (pgs. 174-76).

V. RESPONDENTS BENT PHILIPSON, BENJAMIN LANDA, AND THEIR AGENTS CREATED SCHEMES TO TRANSFER MILLIONS TO THEMSELVES AND FAVORED PERSONS THROUGH SELF-DEALING AND COLLUSIVE TRANSACTIONS IN ORDER TO CONCEAL THEIR UP-FRONT PROFIT-TAKING.

379. Around 2016, Respondents Bent Philipson and Benjamin Landa and their agents created and used a complex web of related party companies in order to control Cold Spring Hills' operations and real estate. Respondents split ownership of the nursing home's operations from the real estate upon which it was located and increased the nursing home's purported "rent" and "management" expenses through self-dealing related party transactions. From 2016 to 2021, Respondents Bent Philipson, Benjamin Landa, David Zahler, Avi Philipson, and Joel Leifer used their many related party LLCs to obscure the magnitude of the fraudulent up-front profit-taking they directed to themselves, their family members, and other Favored Persons, under the guise of purported legitimate business transactions.

380. Through the three fraudulent schemes discussed below, and through additional persistent illegality through those schemes and other deceptive acts, Respondents exercised control over Cold Spring Hills and converted over $22.6 million in government funds. Auditor Aff., ¶ 70. These asset transfers were funded in part by Respondents' cuts to staffing costs and were made at the expense of Cold Spring Hills' residents who did not receive the services for which the Medicaid and Medicare programs paid Cold Spring Hills.

381. From 2016 through 2021, Respondents converted $22,626,853.86 from Cold Spring Hills through collusive related party transactions, in order to extract up-front profit. The amount includes: (i) Cold Spring Hills' "cash flow rental payments" to its related party landlord, Cold Spring Realty, from 2016 to 2020; (ii) over $2 million in interest on the fraudulent promissory note that Bent Philipson required be paid in 2018; and (iii) the transfer of funds from Cold Spring Hills to related parties—Ventura, Highview, and Rosewell. Auditor Aff., ¶ 70.

The Fraudulent Promissory Note Scheme: Respondents Required Cold Spring Hills to Pay a $16 Million Promissory Note with 13% Interest

382. Once in concealed control of Cold Spring Hills operations and real estate to force Cold Spring Hills to pay a $16 million promissory note with 13% interest, in violation of a DOH directive prohibiting interest obligations, for the purpose of siphoning millions of dollars to related party Cold Spring Realty.

383. During the review process for the Respondents' purchase of Cold Spring Hills, DOH requested affidavits from any proposed member of the operating entity or real property entity as to their willingness to contribute resources disproportionate to their membership interest. DOH specifically directed that any equity contributed should be provided without interest. Auditor Aff., ¶ 71.

384. In response, Bent Philipson guaranteed, in a signed letter that he provided to DOH, the payment of any cash contributions or other capital obligations on behalf of his son, Avi Philipson, for the purchase of the operations of Cold Spring Hills. In addition, Bent Philipson and Benjamin Landa provided DOH with signed affidavits stating that they would "provide the needed equity" to purchase Cold Spring Hills and the real property on which it is located. Auditor Aff., ¶¶ 72-73.

385. The owners of Cold Spring Realty took out a mortgage, or a collection of loans, to purchase the property where Cold Spring Hills is located. However, the purchase price exceeded the total from the loans. Rather than provide equity, to cover the gap between the purchase price and the loans, the owners of Cold Spring Realty entered into a high interest rate transaction with themselves. Specifically, the owners of Cold Spring Realty created a corporate alter ego, Lending Partners, and executed a promissory note in which Lending Partners loaned Cold Spring Realty owners $16 million at 13% interest. Auditor Aff., ¶ 74, Ex. 14.

386. In so doing, Benjamin Landa and Bent Philipson fraudulently violated their representations to DOH that they would "provide the needed equity," and that they would not extend a loan with exorbitant interest. The 13% interest for the Lending Partners loan was almost four times the prime interest rate of 3.5% in 2016. Auditor Aff., ¶ 74. Moreover, there was essentially little, if any, risk that the purported "loan" plus high interest would not be repaid because Respondents Bent Philipson and Benjamin Landa also controlled Cold Spring Hills and all of its related party LLCs. *Id.*

387. The 13% interest promissory note operated as a concealed vehicle through which Respondents Bent Philipson and Benjamin Landa funneled $5.6 million in interest payments to Cold Spring Realty, which was owned by Philipson Family, LLC, Benjamin Landa, Lifestar, and Cheskel Berkowitz, who had his payments sent to Ross CSH Holdings and ZBL Management. Auditor Aff., ¶ 75.

388. Ultimately, Bent Philipson and the other owners of Cold Spring Realty caused Cold Spring Hills to pay this fraudulent promissory note plus $5.6 million interest to themselves to increase their personal profit while depleting the amount of working capital it had to pay for staffing and care. *See* Auditor Aff., ¶ 75.

389. When asked questions under oath about the $16 million promissory note and the 13% interest rate therein, as well as representations made to DOH regarding the purchase of Cold Spring Hills, Bent Philipson asserted his privilege against self-incrimination over 30 times. SAAG Aff., Ex. 6.

Include "Accrued Interest:" Bent Philipson Directed Conversion of $2 Million at the 2018 Refinancing

390. In November 2018, Cold Spring Realty refinanced the mortgage through Greystone, a Department of Housing and Urban Development lender. The new mortgage included the original loans and the entire $16 million promissory note, plus unpaid interest of more than $2 million. Auditor Aff., 77. In an email to Greystone dated November 2, 2018, Bent Philipson directed that the payoff amount include the remaining $2 million in interest on the promissory note. Auditor Aff., Ex. 16. In another email exchange prior to the closing, on November 9, 2018, Bent Philipson stated, "No delays. We must close." Auditor Aff., Ex. 17. This further highlights his treatment of Cold Spring Hills as his personal source of cash.

391. In addition, upon the closing of the refinancing loan, each owner of Cold Spring Realty received payment of more than $500,000 interest on the promissory note, in further disregard of DOH's directive that any capital contribution be made interest free. Cheskel Berkowitz' portion of the interest payment from the refinanced mortgage was made to ZBL Management, a company owned by Joel Zupnick and Cheskel Berkowitz. Auditor Aff., ¶¶ 79-80.

392. And under the new mortgage, Cold Spring Hills was obligated, and did in fact, pay Cold Spring Realty's mortgage, which was now significantly increased by $23,216,685.95, in accordance with the predatory "lease." Auditor Aff., ¶ 81.

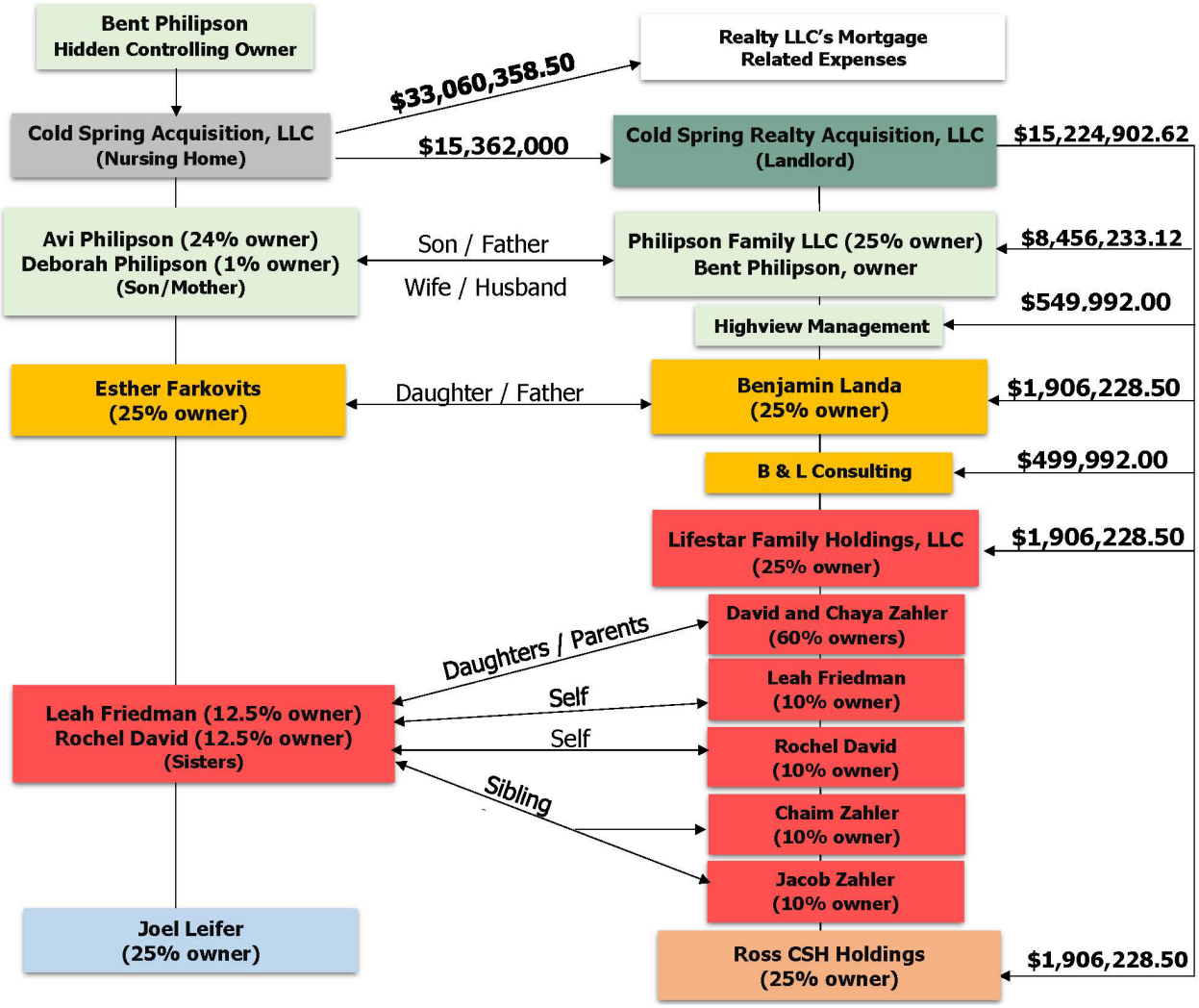
393. Cold Spring Realty refinanced the mortgage a second time in March of 2020. However, Cold Spring Realty was issued a prepayment penalty of $7,699,334.06. When combined

with the legal fees, this increased the principal of the mortgage to $85,185,784.16. Auditor Aff., ¶ 84.

The "Cash Flow Rental" Rent Payment Scheme: Respondents Converted Over $15.3 Million from Cold Spring Hills Through "Cash Flow Rental" Payments that Flowed Through a Collusive Lease with Cold Spring Realty

394. Members of three families—Benjamin Landa's family, Bent Philipson's family and David Zahler's family—were represented on both sides of the collusive lease agreement between Cold Spring Hills and its related party landlord Cold Spring Realty. Through a fraudulent rent payment schedule, Respondents converted over $15.3 million from 2016 through 2021. The below chart illustrates these collusive relationships and conversion of funds. Auditor Aff., ¶ 91.

Bent Philipson, Benjamin Landa and David Zahler Were on Both Sides of the Self-Dealing "Lease" Between Cold Spring Hills and Cold Spring Realty, with Relationships and Cash Flow in 2016 through 2021



395. Under the terms of the lease, Respondents Bent Philipson and Cold Spring Realty required Cold Spring Hills to make purported "rent" payments of "debt service" and taxes to both Cold Spring Realty and/or to its mortgagor directly, which it did. These payments from Cold Spring Hills covered the entire cost of Cold Spring Realty's mortgage payment, insurance, and real estate taxes on the real property on which Cold Spring Hills sat. Beginning in June of 2019, Cold Spring Hills began paying the debt service portion of its mortgage, in its entirety, to Greystone directly, thus obviating the need for Cold Spring Realty's existence, which was a sham

to conceal the further distributions. In this way, through the lease, Respondents forced Cold Spring Hills to transfer $33,060,358.50 for "debt service" from 2016 through 2021, including $18,644,093.74 directly to Greystone and $2,985,274.16 indirectly through Cold Spring Realty.[64] Auditor Aff., ¶¶ 85-86, Ex. 19.

396. The predatory related party "lease" also requires Cold Spring Hills to pay Cold Spring Realty an additional $4 million annually as "cash flow rental." Auditor Aff., ¶ 87. These additional "cash flow rental" payments siphoned millions of dollars annually from Cold Spring Hills operations funds instead of being spent on care and staffing for residents. Respondents Bent Philipson and Benjamin Landa directed these funds to Cold Spring Realty, as up-front profit for its owners: Benjamin Landa, the Philipson Family LLC, Lifestar, and Cheskel Berkowitz.

397. The "debt service" payments and "cash flow rental" payments saddled Cold Spring Hills with obligations to its related party landlord that far exceeded any reasonable rent. And Petitioner found nothing showing that Bent Philipson and Cold Spring Realty invested any of these payments or any mortgage proceeds back into its operations or fiscal plant. Auditor Aff., ¶ 87.

398. It is also noteworthy that Cold Spring Realty and its owners benefited not only from Cold Spring Hills' payments of the mortgage and taxes, and its exorbitant "cash flow rental" transfers, but also from reaping the tax benefit of any depreciation of the buildings, any appreciation in the value of the real property upon which the nursing home is located and paid for, as well as any additional tax benefits. *See* Auditor Aff. ¶ 88.

[64] Although Petitioner is entitled to recover the amounts of "debt service" payments Cold Spring Realty extracted from the nursing home, Petitioner is not seeking disgorgement of those amounts at this time, despite indications of inflation of valuation of the real property to funnel additional funds to Respondents.

399. The exploitative nature of the Cold Spring Hills lease with Cold Spring Realty is not surprising given that Cold Spring Hills did not negotiate any of its terms. Rather Joel Leifer, a nominal owner and managing member of Cold Spring Hills at the time the lease was signed, testified during his examination under Executive Law § 63(12) that Bent Philipson and Benjamin Landa, owners of Cold Spring Realty, unilaterally decided the terms of the purported lease, including, critically, the amount Cold Spring Hills would be obligated to pay Cold Spring Realty, including $4 million annually over the debt service. *See* SAAG Aff., ¶ 5 (pg. 102).

400. The inflated rent caused Cold Spring Hills to pay 10.41%, 8.86%, and 13.20% of its total operating revenue towards its rent expense in 2018, 2019, and 2020, respectively, as reported on the Cost Report for those years. Auditor Aff., ¶ 92, Exs. 20 a-c. In 2020, this ratio placed Cold Spring Hills as the seventh highest rent to revenue ratio in Nassau County (out of 31 homes) and the ninety-first highest rent to revenue ratio in New York (out of 379 homes), putting Cold Spring Hills in the highest 25% in the state and above the New York average rent-revenue ratio of 10.62%, entirely as a result of Respondent's self-dealing. Similarly, in 2018 Cold Spring Hills' rent-to-revenue ratio also exceeded the 2018 New York average of 8.65%.[65] Auditor Aff., ¶ 92.

401. This means Respondents Bent Philipson and Ben Landa intentionally caused Cold Spring Hills to pay exorbitantly high rent rather than paying staff. Yet, even these state averages are inflated, as they include in the average the "rent" ratios that Cold Spring Hills and many other for-profit nursing homes paid to their related party landlords, including other facilities owned by

[65] Notably, state-wide average was not available for 2019 because DOH did not have the Cost Report data available for 2019.

some of the Respondents, for the financial benefit of their owners. Thus, the inflated self-dealing "rent" schemes, industry-wide, distorts the actual cost of operating such facilities.

402. During the period 2016 through October 2020,[66] Cold Spring Hills paid Cold Spring Realty a total of $15,362,000 in "cash flow rental" payments pursuant to the "lease" agreement. Auditor Aff., ¶ 93. The chart below depicts the amount of "cash flow rental payments" and debt service payments by year.

From 2016 through 2020 Respondents Transferred Over $15.3 Million from Cold Spring Hills to Cold Spring Realty as "Cash Flow Rental"

	2016	2017	2018	2019	2020	Total
Debt Service[67]	$0.00	$0.00	$597,054.58	$2,388,219.58	$0.00	$2,985,274.16
"Cash flow rental"	$750,000.00	$3,000,000.00	$4,875,000.00	$2,626,000.00	$4,111,000.00	$15,362,000.00
Total	**$750,000.00**	**$3,000,000.00**	**$5,472,054.58**	**$5,014,219.58**	**$4,111,000.00**	**$18,347,274.16**

403. When asked questions under oath about the "lease," Bent Philipson asserted his privilege against self-incrimination approximately 20 times. SAAG Aff., Ex. 6.

404. Bank records for Cold Spring Realty show that the $15,362,000 of "cash flow rental" payments it received from Cold Spring Hills was further converted through $15,224,902.62 in disbursements to Cold Spring Realty's owners: Benjamin Landa, Philipson Family, LLC, Cheskel Berkowitz,[68] and Lifestar. The total amounts of Cold Spring Hills' funds converted by the

[66] In October 2020, Cold Spring Hills ceased making "cash flow rental" payments to Cold Spring Realty. Auditor Aff., ¶ 91.

[67] Cold Spring Hills rarely utilized Cold Spring Realty to pay for the debt service costs. Prior to refinancing, Cold Spring Hills would deposit funds into two sinking funds held in Cold Spring Realty accounts. After refinancing, Cold Spring Hills would typically pay Greystone directly. Auditor Aff., ¶ 86.

[68] Cheskel Berkowitz received converted funds directly from Cold Spring Realty until approximately June 2017, at which time his payments were made through Ross CSH Holdings LLC, his pass-through company. Auditor Aff., ¶ 76.

owners of Cold Spring Realty or entities they control from 2016 through 2020 are summarized in the table below.[69] Included within the amounts are the payments of $549,992.00 and $499,992.00 made by Cold Spring Realty to Highview and B&L Consulting, respectively, purported management and consulting companies owned by Bent Philipson and Benjamin Landa. Auditor Aff., ¶ 94.

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 it to facilitate the conversion of $2,937,499.50, or 78.33% of the total "cash flow rental" payments, for his benefit through the pass-through, Cold Spring Realty, which he also controlled. In 2020, during the height of the pandemic, Bent Philipson controlled Cold Spring Hills and Cold Spring Realty and caused the conversion of $3,975,000 of Cold Spring Hills' funds, through its payments to Cold Spring Realty, by the Philipson Family, LLC—all while Cold Spring Hills operated with insufficient staff to provide the care required under its residents' Care Plans, cut its staffing

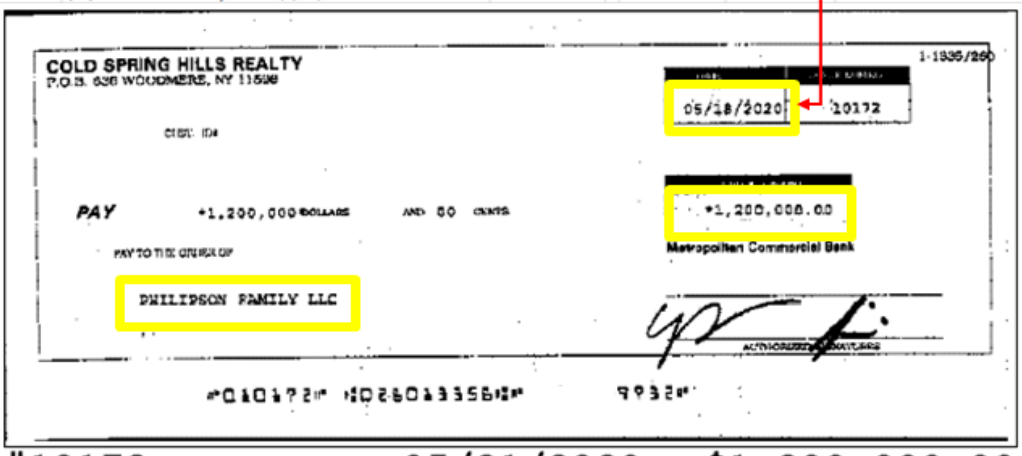
[69] Each sum of money received by the individual owners of Cold Spring Realty included a portion of the interest on the fraudulent promissory note discussed above. Auditor Aff., ¶ 94.

expenses and levels, and closed its Sagamore building to reduce utility expenses, all at risk to its residents. Auditor Aff. ¶ 95.

406. **Stimulus Funds go Straight to Respondents:** Cold Spring Hills continued to make these "cash flow rental" payments to Cold Spring Realty during the height of the COVID-19 pandemic—including after it had received government stimulus funds. Thus, the illegal conversion of $15,224,902.62 from Cold Spring Hills through Cold Spring Realty included a portion of those COVID-19 stimulus funds. On April 17, 2020, $1.7 million from the HHS stimulus program was deposited into Cold Spring Hills' operating account and on April 24, 2020, an additional $139,000 in stimulus funds was deposited. On May 18, 2020, a $1.2 million wire transfer was made to Cold Spring Realty from Cold Spring Hills' operating account.[70] That same day, Bent Philipson and Avi Philipson sent a check for the exact same amount from Cold Spring Realty to Philipson Family, an LLC controlled by Bent Philipson. The matching timing, and amount of these transactions supports the finding that Bent Philipson, through the Philipson Family, LLC, converted $1.2 million in stimulus funds from Cold Spring Hills. Bent Philipson's illegal conversion of these stimulus funds paid to Cold Spring Hills rendered these funds unavailable to Cold Spring Hills to hire sufficient staff, to ensure adequate RN supervision, and provide required care to residents during the height of the pandemic, and thereafter. Auditor Aff., ¶¶ 96-97. The below images detail these transfers:

[70] This $1.2 million payment was a part of the $3,975,000.00 that Philipson Family received in 2020 for "cash flow rental."

Cold Spring Acquistion LLC Citibank Account *2653			Cold Spring Realty Acquisition LLC Metropolitan Commercial Bank *9732			
Transaction Date	Transaction Description	Amount	Check Date	Transaction Date	Transaction Description	Amount
4/17/2020	Electronic Credit: US HHS Stimulus HHS Payment * CARES ACT Relief	$ 1,706,723.72				
4/24/2020	Electronic Credit: US HHS Stimulus HHS Payment * CARES ACT Relief	$ 139,896.65				
5/18/2020	CBUSOL Transfer Debit: Wire to Cold Spring Realty LLC	$ (1,200,000.00)		5/18/2020	Wire from Cold Spring Acquisition	$ 1,200,000.00
			5/18/2020	5/21/2020	Check Number: 10172	$ (1,200,000.00)
5/22/2020	Electronic Credit: US HHS Stimulus HHS Payment * CARES ACT SNF Pmt	$ 1,565,000.00				
8/27/2020	Electronic Credit: US HHS Stimulus HHS Payment * CARES ACT NH Pmt	$ 888,700.00				
11/2/2020	Electronic Credit: US HHS Stimulus HHS Payment * CARES ACT NH Pmt	$ 69,618.79				
11/30/2020	Electronic Credit: US HHS Stimulus HHS Payment * CARES ACT NH Pmt	$ 13,478.33				
	Note: The above highlights a few of the many debit and credit transactions in this account. The remaining account balance after 5/18/2020 wire to CS Realty LLC was $1,582,495.15.					



407. When asked under oath about these stimulus funds and the $1.2 million May 18, 2020 transfer to Cold Spring Realty, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

Respondents' Transfer of Over $3 Million of the Converted $11 Million Between 2018 and 2020 in "Cash Flow Rental Payments" from Cold Spring Hills to Cold Spring Realty Also Violated the Equity Withdrawal Transfer Limit

408. PHL § 2808(5)(c) requires nursing home owners to obtain written permission from DOH prior to withdrawing equity or transferring assets in excess of 3% percent of a nursing home's total revenue for the prior year, precisely because, as the Court of Appeals has noted, such withdrawals "may impair facility operations and thus occasion detriment to the welfare of an utterly reliant resident population." *Brightonian Nursing Home* v. *Daines*, 21 N.Y.3d 570, 574 (2013). As the chart below depicts, in addition to constituting an illegal conversion for personal profit, the withdrawal of more than $3,930,389.18 of the $11 million converted in so-called "cash

flow rental" transfers from Cold Spring Hills to Cold Spring Realty, between 2018 and 2020, violated PHL § 2808(5)(c) because Respondents neither applied for nor received approval by DOH. Auditor Aff., ¶¶ 114-16.

$3.9 Million Transferred from Cold Spring Hills to Related Parties From 2018 Through 2020 in Violation of Equity Withdrawal Limit

	2018	2019	2020	Total
Prior Year's Total Revenue[1]	$85,728,855.00	$92,288,900.00	$100,917,291.00	$278,935,046.00
3% Calculated Limit	**2,571,865.65**	**2,768,667.00**	**3,027,518.73**	**8,368,051.38**
Transfers to Cold Spring Realty Owners	3,750,002.31	3,750,000.00	3,975,000.00	11,475,002.31
Transfers to Highview	-	563,438.23	-	563,438.23
Transfers to Rosewell	135,000.02	125,000.00	-	260,000.02
Total Equity Withdrawals/Transfers	**$3,885,002.33**	**$4,438,438.23**	**$3,975,000.00**	**$12,298,440.56**
Total Equity Withdrawals/Transfers above 3% limit	**$1,313,136.68**	**$1,669,771.23**	**$947,481.27**	**$3,930,389.18**

409. Prior to this, and as shown above, Respondents also transferred over $823,000 between 2018 and 2019 from Cold Spring Hills to a corporation owned by Bent Philipson (Highview) and an LLC owned by Joel Leifer (Rosewell); these transfers violated the equity withdrawal rule under 10 NYCRR 400.19(3)(i), as these amounts combined with other equity withdrawals exceed three percent of Cold Spring Hills' assets for which Respondents failed to obtain DOH approval. Auditor Aff., ¶ 116.

[1] The review of the 3% equity withdrawal violations was limited to the years 2018 through 2020 because the analysis requires reviewing the prior year's Cost Report; Cold Spring Hills did not file a full-year Cost Report in 2016.

410. When asked under oath about equity withdrawals in violation of state statutes and regulations, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6 (pgs. 122-24).

The Fraudulent Management/Consulting Fee Scheme: Respondents' Conversion of $5,249,298.30 in Purported Consulting and Management Fees Through Ventura, Highview, and Rosewell from 2016 through 2021

411. Respondents Bent Philipson, Highview Management, Ventura, Avi Philipson, Joel Leifer, and Rosewell, converted a total of $5,249,298.30 in purported "consulting" or "management" fees from Cold Spring Hills. From 2016 through 2021, Cold Spring Hills, under the control of Bent Philipson and Benjamin Landa, transferred its funds for purported management or consulting services directly and indirectly to three related parties—Ventura, Highview, and Rosewell—that were owned by individuals who also had ownership interests in the nursing home or its related party landlord Cold Spring Realty. Two of these LLCs were owned by Bent Philipson and one by Joel Leifer. *See supra* ¶¶ 46-7, 55. While Cold Spring Hills ostensibly paid these entities for services, its staffing levels and CMS Staffing Ratings and Overall Ratings decreased and its rent expenses increased. *See supra* ¶¶ 120, 275-78. Thus, these "consultants" were paid for increasing their own profiteering to the detriment of the residents of Cold Spring Hills.

Ventura

412. Respondents Bent Philipson, Ventura and Avi Philipson used Ventura to form a collusive related party arrangement between Ventura and Cold Spring Hills to conceal Bent Philipson's conversion through Ventura of $4,260,860.05 in assets from Cold Spring Hills from 2019 through 2021. Auditor Aff., ¶ 101.

413. As described above, Bent Philipson and Benjamin Landa planned the acquisition of Cold Spring Hills' operations and real property. They placed their adult children as straw owners of Cold Spring Hills, formed Cold Spring Realty to buy the real estate on which Cold Spring Hills

was located, and agreed to pay their LLC Sentosa for purported consulting services. *See supra* ¶ 45, 56-61 & n.9, 73, 90-110.

414. As described above, until 2019, Bent Philipson and Benjamin Landa, as *de facto* owners of Cold Spring Hills, directly and/or through their company Sentosa, exercised control over Cold Spring Hills' finances. *See supra* ¶ 60 & n.9, 108-11, 73, 92, 97, 57, 379.

415. When asked under oath about Sentosa, Bent Philipson asserted his privilege against self-incrimination approximately 8 times. SAAG Aff., Ex. 6 (pgs. 26-27, 53).

416. When, in the spring of 2019, Benjamin Landa and Sentosa reportedly ceased involvement in the operations of Cold Spring Hills and Bent Philipson formed Ventura as his new vehicle for controlling Cold Spring Hills' finances. *See* Auditor Aff., ¶ 59. He accomplished this by installing his son and nominal managing member, Avi Philipson, and Cold Spring Hills Administrator, Yossi Emanuel, who at the time were both in their 20s. *See id.*, ¶¶ 43, 197 & Ex. 6; SAAG Aff., Ex. 15 (October 29, 2020 at pg. 30).

417. Yossi Emanuel, as Administrator of Cold Spring Hills, and Bent Philipson, as President & CEO of Ventura, executed a contract for Ventura's provision of "consulting and advisory services" to Cold Spring Hills, effective as of May 1, 2019 (the "Ventura contract"). Auditor Aff., Ex. 9.

418. During his § 63(12) examination, Avi Philipson testified that, in his capacity as managing member, he "allowed [the contract with Ventura] to happen." SAAG Aff., Ex. 8 (pg. 172). He testified that his role as managing member of Cold Spring Hills was to "put the correct people in place" to run the facility properly. *Id.* at 85. And, when asked about Cold Spring Hills' need for the services Ventura would provide, Avi Philipson conceded that Cold Spring Hills already had an Administrator and qualified managers and clinicians on staff. *See id.* at 158-59.

And moreover, despite being the owner of Axis Health, a company that provides consulting services to other facilities, Avi Philipson testified that he still chose Ventura, his father Bent Philipson's company, to provide consulting services to his own nursing facility, Cold Spring Hills. *Id.* at 179-184.

419. When asked under oath if Avi Philipson had any input regarding the amount of money Cold Spring Hills pays Ventura, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6 (pg. 57).

420. The Ventura contract with Cold Spring Hills is a contract between Ventura and each of six New York skilled nursing facilities ("SNFs") owned by Bent Philipson.[71] Yossi Emanuel signed the Ventura contract for Cold Spring Hills. *See* Auditor Aff., Ex. 9.

421. On its face, the Ventura contract provides in Section 3.2(i) that each of the facilities including Cold Spring Hills will pay Ventura "Costs" as follows:

> Each Facility that utilizes the services of Ventura staff for its back office operations ("BOO") shall reimburse Ventura for salaries and benefits ("Costs") of its staff utilized for that Facility's BOO. The BOO to be provided by Ventura shall include, but not be limited to, compliance, labor/union negotiations and contracting, admission coordination/marketing, accounts payable, payroll, fiscal consulting, therapy consulting, administration, purchasing and admissions software. The Costs will be allocated to, and shared by each Facility utilizing the services of Ventura staff according to each Facility's bed capacity. For illustrations purposes, Facility A which [h]as 100 beds and Facility B which has 200 beds utilizes Ventura for BOO the Costs of which are $50,000.00. The $50,000.00 will be allocated between Facility A and Facility B as follows: Facility A will pay to Ventura 1/3 of $50,000.00 or a fee of $16,666.00 and Facility B will pay to Ventura 2/3 of $50,000.00 or a fee of $33,334.00.
>
> Auditor Aff., Ex. 9.[72]

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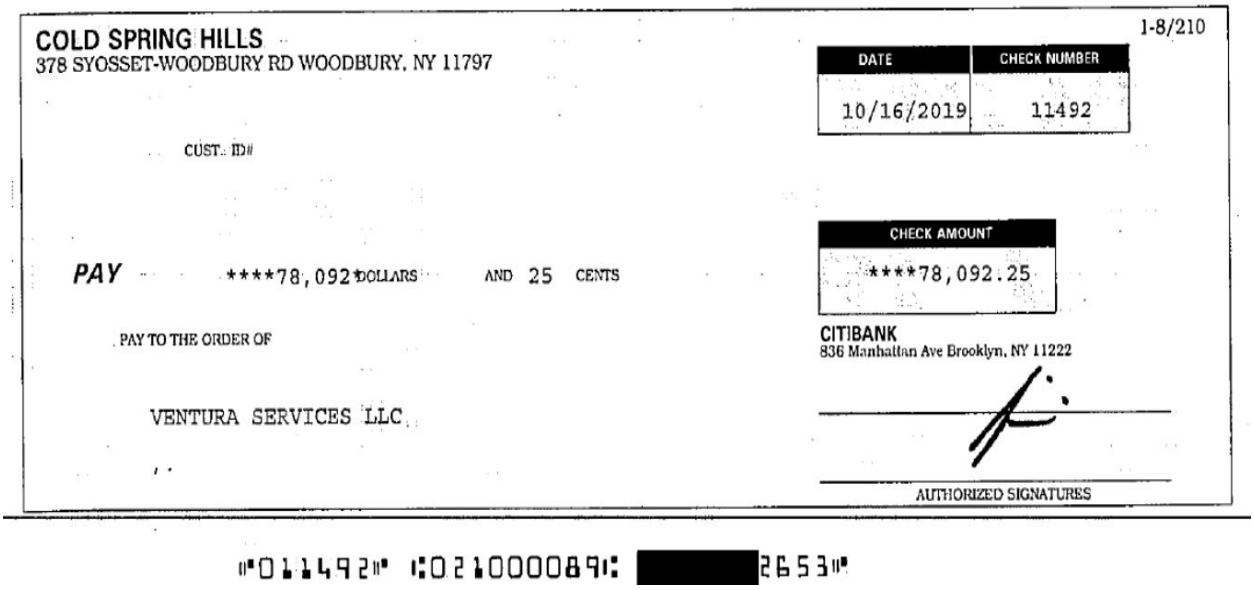
[71] Ventura's bank statements also reveal that from May 2019 through 2021, Ventura received $9,885,195.61 from other sources, including at least 17 other nursing homes, at least 6 of which are located in New York. Auditor Aff. ¶ 59.

[72] This fee to be paid by each facility including Cold Spring Hills is subject to certain further adjustments, including a 5% surcharge. Auditor Aff., Ex. 9 (Section 3.2 (iv).

422. Ventura is simply Bent Philipson's mechanism for running Cold Spring Hills in a way that enables him to siphon millions of dollars from the facility for his own benefit and the benefit of the other owners, their related parties and other Favored Persons through his fraudulent salary and fringe benefit scheme. Respondent Bent Philipson's exercise of control over Cold Spring Hills' included control over its operating account. Shortly after contracting with Ventura in May of 2019, Bent Philipson signed checks on behalf of Cold Spring Hills issued to various vendors—despite not being listed as a signatory on the Citibank account records. The check image below is an example of a check signed by Bent Philipson and issued to his own company, Ventura. Auditor Aff., ¶ 151.


COLD SPRING HILLS
378 SYOSSET-WOODBURY RD WOODBURY, NY 11797

1-8/210

DATE	CHECK NUMBER
10/16/2019	11492

CUST. ID#

PAY ****78,092 DOLLARS AND 25 CENTS

CHECK AMOUNT
****78,092.25

PAY TO THE ORDER OF

VENTURA SERVICES LLC

CITIBANK
836 Manhattan Ave Brooklyn, NY 11222

AUTHORIZED SIGNATURES

⑈011492⑈ ⑆021000089⑆ [redacted]2653⑈

423. Ventura is not an independent third party. Ventura is a related party owned by Bent Philipson through which he exercises control of its operations, including its related party transactions. As discussed above, in the months leading up to the COVID-19 pandemic, Bent Philipson orchestrated a staffing plan to cut $1.6 million in expenses by eliminating staff at Cold Spring Hills. *See supra* ¶¶ 112, 280-81. Moreover, Bent Philipson was involved in the decision to replace Yossi Emanuel as the Administrator of Cold Spring Hills with Deborah Flack, the Senior

Vice President of Clinical Services at Ventura, as the new Administrator of Cold Spring Hills. SAAG Aff., Ex. 7 (February 10, 2021 pg. 216).

424. Ventura made several Cold Spring Hills employees who were not responsible for the provision of direct care to residents into Ventura employees. For instance, Bibi Persaud, an Accounts Receivable Biller in the Finance Department and Linda Campbell, RN, Director of Minimum Data Set were moved to "corporate payroll" and became employees of Ventura. Auditor Aff., ¶ 146, Ex. 27.

425. Ventura also exercises control over Cold Spring Hills' finances. Ventura employee Moshe Krigsman testified during his § 63(12) examination that he is responsible for accounts receivables for five nursing homes, including Cold Spring Hills.[73] SAAG Aff., Ex. 10 (pgs. 34-35, 80). Likewise, Ventura employee Helena Bernstein testified during her § 63(12) examination that she is responsible for paying Cold Spring Hills' bills. SAAG Aff., Ex. 16 (pgs. 57-58).

426. Bent Philipson also caused Cold Spring Hills to pay for Ventura employees' exorbitant salaries and bonuses, luxury cars, spas, and fine dining, among other things. Auditor Aff., ¶ 103.

427. For example, in 2019 Daniel Schaffer, the Executive Vice President of Ventura, received a salary of $600,000 from Ventura. Auditor Aff, ¶ 106. However, also in 2019, the Cold Spring Hills Cost Report listed Daniel Schaffer as an Assistant Administrator of Cold Spring Hills with a salary of approximately $100,000, through when he testified pursuant to an Executive Law § 63(12) subpoena, his did not identify this role of an Assistant Administrator at Cold Spring Hills

[73] Despite working for multiple nursing homes, Ventura's books and records indicate that Cold Spring Hills paid for Moshe Krigsman's entire salary of $250,000 in 2020, as well as an additional $35,000 in compensation beginning in June of 2020, through Ventura. Prior to working at Ventura, Moshe Krigsman was Cold Spring Hills' "Director of Finance." Auditor Aff. ¶ 111.

as part of his employment history. Auditor Aff., Ex. 20b (pg. 59); s*ee also* SAAG Aff., Ex. 7. Then, in 2020, Bent Philipson increased Daniel Schaffer's salary at Ventura by $250,000 to $850,000 and, in 2021, he increased Schaffer's salary by another $150,000 to $1 million. Auditor Aff., ¶ 106.

428. **Bent Philipson's $250k/year (& perks) Admin Assistant:** In addition, during her § 63(12) examination, Stella Vilardi testified that she receives an annual salary of $250,000 plus bonuses. Ventura has also paid for Ms. Vilardi's luxury car, gas, tolls, and car insurance, even when used for personal business. SAAG Aff., Ex. 9 (pgs. 29-32, 57, 86-87, 192-193). Although the contract calls for Cold Spring Hills to share the fee on a per-bed ratio, Ms. Vilardi testified that she only spends one percent of her time working on matters involving Cold Spring Hills. *Id.* at 189. Despite Ms. Vilardi spending a mere fraction of her time on matters involving Cold Spring Hills, in 2020 and 2021 Cold Spring Hills paid $29,698.44 of Ms. Vilardi's salary for both years, in accordance with the Ventura contract. Auditor Aff., ¶ 109. Although Ms. Vilardi's title, Executive Director of Ventura, implies high status and skills, her testimony revealed that she is actually the administrative assistant to Bent Philipson. SAAG Aff., Ex. 9 (pgs. 189-90).

429. Helena Bernstein, Ventura's Chief Financial Officer, testified in her § 63(12) examination that she received a $150,000 salary increase from 2019 to 2020, bringing her 2020 salary from Ventura to $350,000. SAAG Aff., Ex. 16 (pgs. 59-60). She further testified that she additionally receives annual bonuses that are not contingent on a positive job performance evaluation but are decided solely at Bent Philipson's discretion. *Id.* at 59-60, 64. In 2021 Helena Bernstein was approved for a $150,000 bonus; by April of 2022, she had received approximately half of this. SAAG Aff., Ex. 17.

430. Bent Philipson has also received a salary and a luxury car lease through Ventura. Auditor Aff., ¶ 110.

431. The below chart shows the $596,598.15 that Bent Philipson extracted from Cold Spring Hills to pay to Ventura for compensation of three of his favored executives and himself, in 2020 and 2021 alone—while he was working to cut staff at Cold Spring Hills. This is merely a portion of what Cold Spring Hills has paid Ventura since 2019. *See* Auditor Aff., ¶ 110.

Cold Spring Hills 2020 and 2021 Payments to Ventura for Inflated Salaries and Other Fringe Benefits

Ventura Employee	Total Salary[74]	Cold Spring Hills' Portion of Salary	Cold Spring Hills' Portion of Bonus	Cold Spring Hills' Portion of Auto Expenses	Total Paid by Cold Spring Hills' 2020 and 2021
Bent Philipson	$100,000.00	$39,104.40	-	$19,970.83	$59,075.23
Daniel Schaffer	$1,850,000.00	$322,387.52	-	$3,942.85	$326,330.37
Helena Bernstein	$700,000.00	$91,243.68	$39,457.84	$5,993.28	$136,694.80
Stella Vilardi	$500,000.00	$59,396.88	$8,505.92	$6,594.95	$74,497.75
Total	**$3,150,000.00**	**$512,132.48**	**$47,963.76**	**$36,501.91**	**$596,598.15**

432. In sharp contrast to these enormous salaries and bonuses paid to Ventura employees, nursing staff and other critical care employees at Cold Spring Hills received measly bonuses in 2020 despite working on the front lines during the pandemic. Even then, each employee had to work a minimum of five shifts to even be considered for a nominal bonus CNAs could earn a bonus of $150, LPNs, and Respiratory Therapists could earn a bonus of $200, and RNs could earn a bonus of $250. Auditor Aff., ¶ 107.

433. Avi Philipson believed these meager bonuses to the front-line workers would ensure adequate staffing if there was a second wave of the pandemic in late 2020. In fact, when

[74] These salaries were calculated by using a 2021 Ventura supporting schedule, which shows salaries for those employees in 2020 and 2021 who received raises in 2021.

asked to explain what plans were in place to prepare for a potential second wave of the pandemic, Avi Philipson testified in an examination that he would implement the "same bonus structures." SAAG Aff., Ex. 7 (pgs. 228-29).

434. The chart below shows that from 2019 through 2021, Ventura billed Cold Spring Hills for various expenses, including salaries and bonuses, totaling $4,334,949.34.

May 2019 through 2021 Expenses Billed by Ventura to Cold Spring Hills

Category	2019	2020	2021	Total
American Express	$37,509.76	$150,741.70	$71,979.05	$260,230.51
Salaries	Unknown[75]	$909,404.31	$1,010,579.73	$1,919,984.04
Bonuses	$34,525.94	$16,761.85	$32,039.66	$83,327.45
401k Match[76]	Unknown	$4,711.01	$14,311.78	$19,022.79
All other Expenses	$766,541.69	$836,849.64	$448,993.22	$2,052,384.55
Total	**$838,577.39**	**$1,918,468.51**	**$1,577,903.44**	**$4,334,949.34**

435. The American Express expenses noted above include charges for spa gift certificates, travel expenses, lodging, and fine dining for Ventura employees. For example, on December 16, 2019, Daniel Schaffer charged $4,524.01 at Wall Street Grill in Brooklyn, New York, $1,708.49 of which was charged to Cold Spring Hills. Auditor Aff., ¶ 103.

436. Cold Spring Hills also paid $50,271.86 in 2020 for Ventura's corporate parties. Auditor Aff., ¶ 101.

437. Despite receiving payment, Ventura has provided little if any value to Cold Spring Hills or its residents. The consequences of this valueless contract have been: (i) the resident neglect described in this Petition; (ii) the conversion of funds, including Medicaid, Medicare, and COVID-

[75] The Ventura supporting documents did not separate the salaries from all other expenses in 2019. Auditor Aff., ¶ 102, n.15.

[76] The Ventura supporting documents did not separate the 401K match expenses from all other expenses in 2019, 2020 and for a few months in 2021. Auditor Aff., ¶ 102, n.16.

19 disaster relief funds, that should have been used for resident care and maintenance of the facility; and (iii) regulatory sanctions, including 59 citations by DOH and a $25,000 fine issued by OSHA for COVID-related workforce violations. *See supra* ¶ 371, ¶ 263 n.50. Another real and sad cost to the residents of Cold Spring Hills is the rise of Cold Spring Hills' in-house death rate in 2018 and 2019 when compared to its 2017 level. *See supra* ¶ 228.

438. When asked under oath if Cold Spring Hills pays for bonuses, cars, insurance, and extravagant parties for Ventura employees, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

439. The agreement between Ventura and Cold Spring Hills is an illegitimate scheme. First, Bent Philipson does not have approval from DOH to own or operate Cold Spring Hills, and his influence and control over the operation has been concealed from DOH. Thus, Bent Philipson was not authorized by DOH to exercise influence or control over the operations of Cold Spring Hills. Second, Bent Philipson has demonstrated that his involvement in Cold Spring Hills is predatory—namely, converting the facility's funds and funneling them to his other interests for his own benefit and the benefit of the other owners and Favored Persons. *See supra* ¶¶ 379-446. If Cold Spring Hills was under legitimate direct management as approved in the CON process, the facility would not have engaged Ventura at all, much less under the terms of the Ventura contract. Through Ventura, Bent Philipson has made Cold Spring Hills into his personal profit center and means to distribute its funds to those he favors, rather than a resident-focused nursing home that fulfills its legal duties to provide required care and staffing.

440. When asked questions under oath about Ventura, Bent Philipson asserted his privilege against self-incrimination approximately 96 times. SAAG Aff., Ex. 6.

Highview

441. Bent Philipson also converted Cold Spring Hills funds through another purported management/consulting related party, Highview, in furtherance of this persistent fraudulent scheme. After May of 2019, Bent Philipson, Avi Philipson and Ventura also caused Cold Spring Hills to pay Highview, owned by Bent Philipson, for duplicative, unnecessary, and sham management services. Auditor Aff., ¶¶ 99-100.

442. In email correspondence dated April 19, 2021, between counsel for Highview and the OAG, Highview's counsel confirmed that Highview is essentially a holding company that does not provide any management services to Cold Spring Hills. SAAG Aff. Ex. 18.

443. Rather, Highview is an alter ego of Bent Philipson, which he uses to increase his extraction of funds from Cold Spring Hills. Highview's receipt of $563,438 in funds transferred from Cold Spring Hills represents his hidden conversion of those funds, which were falsely characterized as legitimate management fees on the Cold Spring Hills Cost Report filed with DOH. Bank records analysis shows this payment was in fact for legal fees for a lawsuit completely unrelated to Cold Spring Hills; the lawsuit was related to workers' compensation insurance policies for other nursing homes. Auditor Aff., ¶¶ 99, 100

444. When asked under oath about Highview, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6

Rosewell

445. From 2016 through 2021, Rosewell, owned by Joel Leifer, the 25% nominal owner of Cold Spring Hills, converted $425,000.02 from Cold Spring Hills for sham management services. Cold Spring Hills received invoices from Rosewell for "professional services" with no further description or explanation—and paid them. Auditor Aff., ¶ 113, Ex. 23.

446. In a letter dated April 29, 2021, in response to an Executive Law § 63(12) subpoena for production of records, counsel for Rosewell informed the OAG, that Rosewell "is engaged in business that does not involve Cold Spring Hills." SAAG Aff., Ex. 19. Yet Rosewell produced two invoices to Cold Spring Hills for "Professional Services." Auditor Aff., Ex. 23.

447. Respondents' use of these purported management and consulting companies was part of their fraudulent scheme to extract up-front profit and funds from Cold Spring Hills.

448. This is further illustrated by the fact that Respondents attempted to use these sham companies to convince the nominal owners of Cold Spring Hills that the facility was being run and staffed appropriately even though it was not. During his testimony in an examination pursuant to Executive Law § 63(12), when nominal owner Avi Philipson was asked what services Cold Spring Hills' management companies provided to the facility; he admitted that the nursing home had existing employees who provided the same services as those purportedly provided by the management and consulting companies. Moreover, he testified he could not remember many specific conversations with the consultants of Cold Spring Hills. *See* SAAG Aff., Ex. 8 (pgs. 122-27, 158-59, 184). He did, however, have a remarkedly specific recollection of Cold Spring Hills' Administrator and consultants telling him that "the facility always has appropriate staffing for the residents that are there." *Id.* at 205. The fact that this response was one of the only substantive discussions he could allegedly recall further indicates that Respondents required Cold Spring Hills to pay bogus fees to their management LLCs that are either complete shams, or whose primary role was to cut the nursing home's staffing expenses to create up-front profit while disregarding Cold Spring Hills' duties to provide required care and staffing to its residents, while self-validating their decision to do so. In any event, Respondents' purported management and/or consulting

service providers all disregarded the state and federal laws imposing duties on Cold Spring Hills, making Respondents' hidden conversion of taxpayer funds through them all the more pernicious.

449. Other indicators of the lack of value of the purported consulting and management services are reflected by Cold Spring Hills' lower CMS Ratings, the increase of the in-house death rate from 2017 to 2018, the massive failure of care during the COVID-19 pandemic, and the documented neglect and chronic insufficient staffing set forth in detail throughout this Verified Petition. The Respondents' "consulting" and "management" services merely helped drive the facility into the ground.

Respondents Bent Philipson, Avi Philipson, and Cold Spring Hills Transferred Over $18 Million More of Nursing Home Funds to Related Parties Owned by Themselves and Cold Spring Realty

450. In addition to and separate from the $22.6 million that Respondents illegally converted from Cold Spring Hills as set forth above, between 2016 through 2021, Bent Philipson, Avi Philipson and Cold Spring Hills, through control of Cold Spring Hills's operations, caused it to transfer over $15 million more directly, and over $3.5 million more indirectly, of its assets to related party LLCs owned and controlled by Bent Philipson, Avi Philipson, and David Zahler. These related parties include the Graph Insurance LLCs, which purportedly provided insurance services, and Comprehensive, which purportedly provided food, laundry, and supplies services. Auditor Aff., ¶¶ 118, 121.

451. Using the Graph Insurance LLCs, Respondents Bent and Avi Philipson made Cold Spring Hills transfer over $10.6 million to the Graph Insurance LLCs, directly and indirectly, for purported general and personal liability insurance, as follows:

a. Cold Spring Hills paid $6,780,199.40 to Graph MGA, owned by Avi Philipson, and Graph MGA in turn transferred $97,861,849.21 to Standard and Preferred Insurance, a company owned by Bent Philipson;

b. Cold Spring Hills paid $175,213.08 to Graph Management, LLC, owned by Avi Philipson;

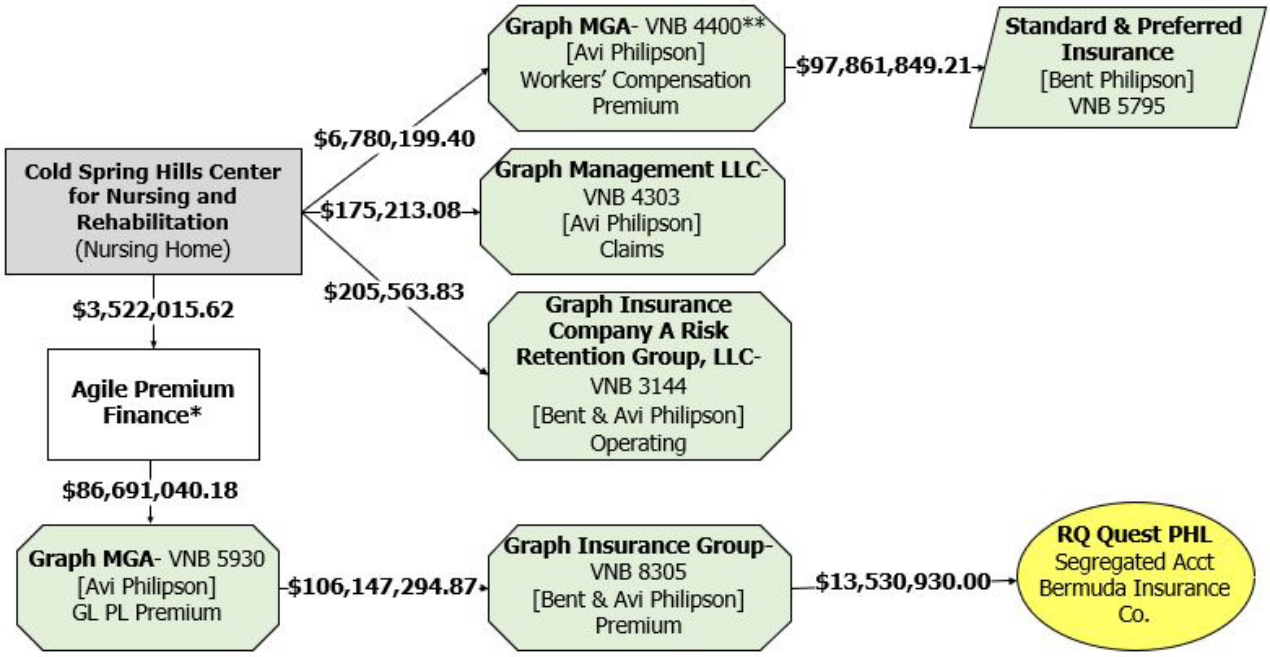
c. Cold Spring Hills paid $205,563.83 to Graph Insurance Company A Risk Retention Group, LLC, owned by Bent and Avi Philipson; and

d. Cold Spring Hills also paid over $3.5 million from 2019 through 2021 to Agile Premium Finance to advance its entire premium for a general liability policy to Graph MGA. Respondents Bent and Avi Philipson negotiated this transaction without Cold Spring Hills' involvement. Notably, a 2020 Commercial Insurance Premium Finance Agreement and Disclosure was signed by Bent Philipson as the "manager" of Cold Spring Hills. Because these policies were financed, Cold Spring Hills was obligated to pay the entire premium and interest to "Agile Premium Finance" monthly. These funds were commingled with other insurance premiums and then transferred to another Graph entity, which is jointly owned by Bent and Avi Philipson.

These asset transfers from Cold Spring Hills to the Graph Insurance LLCs are set forth in the chart below.[77] Auditor Aff., ¶¶ 118-19.

[77] This chart does not reflect every transaction that occurred in or between the bank accounts listed.

Cold Spring Hills Transferred over $10.6M from 2017-2021 to 5 Bank Accounts of 3 Related Party LLCs Owned by Avi Philipson, Its Nominal Managing Member, Straw Owner and the Son of Bent Philipson



Notes:
* Payments CSH made to a bank account held in the name of Agile Premium Finance were commingled with funds from other entities and then was transferred to a bank account held in the name of Graph MGA, which in turn commingled these funds with other nursing home entities and brokerage accounts to transfer to the Graph Insurance Group.
** Payments CSH made to Graph MGA (Flat Iron Agency) were commingled with other health care and insurance entities and subsequently sent to Standard and Preferred.

452. In March 2022, Avi Philipson suddenly transferred $2.7 million to Cold Spring Hills from Graph MGA after Cold Spring Hills encountered a sudden cash flow deficit due to the unexpected closing of its operating and payroll accounts, preventing Medicaid and Medicare payments from being deposited. Of the $2.7 million, $1.3 million was transferred to Cold Spring Hills on March 2, 2022, followed by another $1.4 million on March 16, 2022. Auditor Aff., ¶ 120. Ventura's Chief Financial Officer, Helena Bernstein, characterized this transfer as a "loan" from Graph MGA to Cold Spring Hills, although there are no supporting documents or other indicia of a loan. *See* SAAG Aff., Ex. 16 (pgs. 83-84).

453. By April 30, 2022, Cold Spring Hills had repaid Graph MGA for this "loan" in two payments, $700,000 and $2,000,000. The $2,000,000 repayment to Graph MGA occurred a day

after Cold Spring Hills received a wire of over $2 million from the Health Resources & Service Administration as part of the Provider Relief Fund, similar to when, in May 2020, Cold Spring Realty issued a check to the Philipson Family, LLC after it had received stimulus money.[78] Auditor Aff., ¶ 120; *see also supra* ¶ 405.

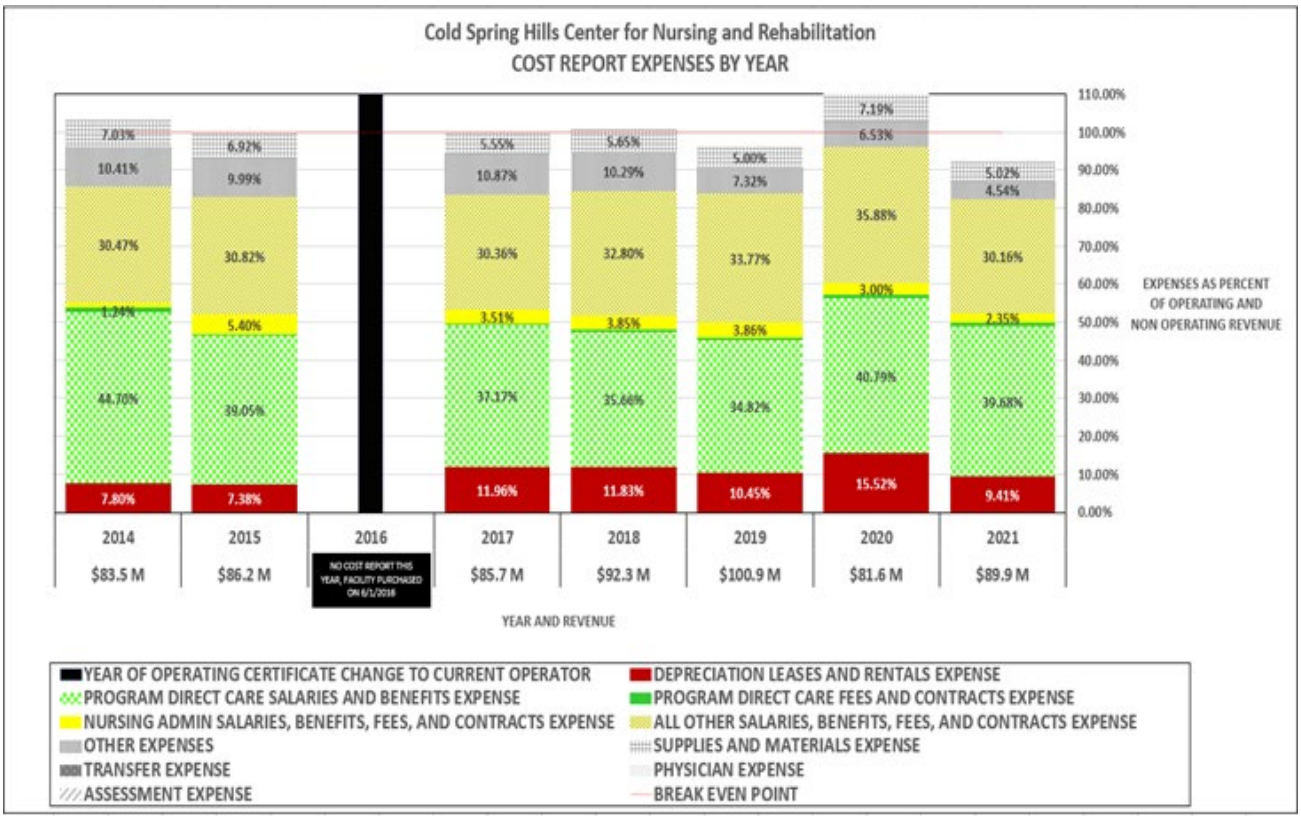
454. During an examination pursuant to Executive Law § 63(12), Bent Philipson invoked his privilege against self- incrimination when asked questions related to the Graph Insurance LLCs and Standard and Preferred. Specifically, Bent Philipson invoked his privilege against self-incrimination when asked if Cold Spring Hills pays monies received from the Medicaid Program to the Graph Insurance LLCs and Standard and Preferred. Bent Philipson also invoked his privilege when asked if monies were being funneled out of Cold Spring Hills to the Graph Insurance LLCs and why it was even necessary for the Graph Insurance LLCs to "broker" Standard and Preferred insurance on behalf of Cold Spring Hills. And, when asked if there was a written contract between the Graph Insurance LLCs and Standard and Preferred, Bent Philipson also invoked his privilege against self-incrimination. SAAG Aff., Ex. 6 (pgs. 91-92).

455. From 2016 through 2021, Respondents transferred over $8.1 million in Cold Spring Hills' funds to an LLC, "Comprehensive," affiliated with David Zahler for purported food, laundry, housekeeping, and supply services. David Zahler is an owner of Lifestar, as depicted in the chart above, which is an owner of Cold Spring Realty. Auditor Aff., ¶ 121.

[78] Provider relief fund payments are made to eligible providers who diagnose, test, or care for individuals with possible or actual cases of COVID-19 and have health care related expenses and lost revenues attributable to COVID-19. Providers can use the payments to continue supporting patient care and respond to workforce challenges through recruitment and retention efforts.

Respondents Cut the Nursing Home's Staffing Expense and Fraudulently Increased Its Related Party Expenses

456. Respondents' control of Cold Spring Hills' operations began in June 2016. The chart below of Cold Spring Hills' annual expenses based on its cost report data for the years 2014 through 2021 reflects that under Respondents' control, Cold Spring Hills increased its percentage of expenses on rent and management companies and decreased its percentage of expenses on direct care staffing. The chart reflects the increase in "depreciation and rentals" expense through the red sections at the bottom of the bars. Likewise, the chart reflects the increase in "all other salaries, benefits, fees, and contract expense" through the tan sections toward the top of bars. It also reflects the corresponding squeeze in the middle—a decreasing trend in direct care staffing spending through the light green sections of the bars, which represent "program direct care salaries and benefits expense." Auditor Aff., ¶¶ 170-71.



457. Also notably, the cost report expense chart above reflects how Respondents' manipulation of the nursing home's revenue relative to expenses, and reporting of that data on its cost reports, can create the false impressions that Medicaid rates are "too low" to enable quality of care, increased staffing levels, and/or to enable operators to be profitable. On the vertical axis, the *apparent* break-even point is at the 100% mark, where revenue and expenses are matched. The chart reflects that through their cost reports, Respondents controlled Cold Spring Hills' expenses, including through related party transactions, to ensure that its reported expenses and revenue netted out to appear to be almost even in 2017 and 2018, appeared to result in a loss in 2020, and resulted in an apparent small gain in 2021, quite close to the loss in 2020. While this careful orchestration can be used by some to claim that Cold Spring Hills is an *unprofitable* operation, the findings of this investigation reflect instead that those who have controlled Cold Spring Hills have extracted millions of dollars each year in "up front profit" through related party transactions disguised as expenses. That manipulation both disguised the looting, made the nursing home appear unprofitable, and, as shown in the next section, made the filings with DOH false.

Avi Philipson Repeatedly Certified False and Misleading Cost Reports to Conceal the Extraction of "Up-Front Profit" Through Highview, Graph Insurance LLCs, and Comprehensive.

458. Nursing homes are required to file annual "Cost Reports" to report income, expenses, assets, liabilities, and statistics to the DOH pursuant to 10 NYCRR § 86-2.2. DOH uses and relies upon the information disclosed on Cost Reports. Schedule 16 of the Cost Report and the instructions thereto require that every nursing home identify and list each company with which it has a "Non-Arm's Length Arrangement." Schedule 16 of the Cost Report defines a "Non-Arm's Length Arrangement" as:

> An arrangement between the operator of a facility and an organization related to operator by common ownership and or control for the furnishing of services, facilities, or supplies; An

> arrangement where there is a family relationship between the operator and the organization, and where services, facilities, or supplies are furnished and in instances where the operator and the organization are involved in any other business.

459. For each entity identified as a "Non-Arm's Length Arrangement," the facility must attach a Part III, which requires disclosure of financial information and an audited financial statement. *See* Auditor Aff., ¶¶ 18-19.

460. Avi Philipson, owner and operator of Cold Spring Hills, violated 10 NYCRR Part 86-2 when he submitted false annual Cost Reports from 2017 through 2021 by failing to disclose "related companies" or "Non-Arm's Length Arrangements," such as Highview, the Graph Insurance LLCs, Comprehensive, and Prudent Consulting. Auditor Aff., ¶ 122, Exs. 20 a-d.

461. Cold Spring Hills paid Highview payments totaling $563,438 in 2019 for purported management fees. However, Highview provided no legitimate service to Cold Spring Hills. *See supra* ¶¶ 441-43. Cold Spring Hills failed to identify Highview as a related party on the 2019 Cost Report, specifically on the Pre-fatory 5 Ownership Information- Related Companies schedules, in Schedule 16, and failed to file a Part III. Highview was identified as a related party only in the notes section of Cold Spring Hills' 2019 Cost Report. Auditor Aff., ¶ 127.

462. Cold Spring Hills failed to identify the Graph Insurance LLCs as a related parties on Cost Reports from 2017 through 2021, as it was required to do on the Pre-fatory 5 Ownership Information-Related Companies schedules, Schedule 16, and failed to file a Part III. This is despite the Graph Insurance LLCs being owned by Avi Philipson and/or Bent Philipson, with the Graph Insurance LLCs in turn transferring millions of dollars to another Bent Philipson company, Standard and Preferred. Like Highview, the Graph Insurance LLCs were inappropriately listed as related parties only in the notes section of the 2020 and 2021 Cost Reports. Auditor Aff., ¶ 128.

463. From 2016 through 2021, Cold Spring Hills paid Comprehensive, a company that purportedly provides food, laundry, housekeeping, and supply services to Cold Spring Hills, $8.1 million. Comprehensive is affiliated with David Zahler, an owner of Lifestar, which is an owner of Cold Spring Realty. Comprehensive is therefore a related party, yet from 2017 through 2021, Comprehensive was not disclosed on Cold Spring Hills' Cost Reports on the Pre-fatory 5 Ownership Information-Related Companies schedules, Schedule 16, nor was a Part III filed. Auditor Aff., ¶ 129.

464. From 2016 through 2021, Cold Spring Hills paid $640,679.00 to Prudent Consulting, a company that purportedly provided fiscal services to Cold Spring Hills. Prudent Consulting is owned by Joel Leifer and is therefore a related party. Cold Spring Hills failed to fully disclose Prudent Consulting on Cost Reports from 2017 through 2021, as it was required to do on the Pre-fatory 5 Ownership Information-Related Companies schedules, Schedule 16, and failed to file a Part III. Prudent Consulting was only listed as related to the facility operator in Part 4, Schedule 1, Schedule of Fees and Contracted Services of Cold Spring Hills' 2017 through 2019 Cost Reports, which means it was not fully disclosed to DOH. Auditor Aff., ¶ 130.

465. In addition to not properly disclosing Highview, the Graph Insurance LLCs, Comprehensive, and Prudent Consulting, Avi Philipson, the owner and operator of Cold Spring Hills, repeatedly and persistently violated disclosure requirements by failing to submit required audited financial statements by filing a Part III for each related party.

466. Moreover, Avi Philipson repeatedly falsely certified that the Cost Reports submitted to DOH from 2017 through 2021 were "true and complete," by submitting the following false certification as the operator of the facility. Auditor Aff., ¶ 126.

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and/or imprisonment under New York State Law and Federal Law.

Certification of Operator:

I also certify, the Part(s) III, if required to be filed as part of this report, was (were) completed in accordance with RHCFARM [Residential Health Care Facility Accounting and Reporting Manual] and the information called for in Part III has been reported for each lender or organization related to the provider as defined in Schedule 16 of Part II.

I also certify that all salary and non-salary expenses presented in the RHCF-4 [Cost Report] with the exception of those expenses attributable to Research, Physicians' Offices and other Rentals, Gift Shop, Public Restaurant, Fund Raising and Sold Services considering the adjustments contained in the Part II and the recoveries of expenses detailed in Exhibit I of the Part IV were incurred to provide patient care in the facility.

467. The false information and misleading omissions on these Cost Reports had the effect of concealing from readers of the Cost Reports, including DOH, the full extent of Cold Spring Hills' transactions with related parties, which Cold Spring Hills used to transfer millions to its owners and the owners of its related parties. Specifically, Respondents were able to conceal that they caused Cold Spring Hills to transfer over $45.5 million in its funds to its owners and the owners of its related parties from 2016 through 2021. Auditor Aff., ¶¶ 131-32.

468. Respondents must be stopped from continuing this pattern of repeated and persistent illegal conduct, violating financial disclosure laws that are intended to bring transparency to related party transactions and their looting of government reimbursement intended for care required to be provided to residents.

469. When asked under oath about Cold Spring Hills' Cost Reports, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

Cold Spring Hills Repeatedly and Persistently Violated Conditions of Participation in the Medicaid Program and Ventura and Others Filed False Medicaid Claims Certifications on its Behalf

470. Cold Spring Hills is a registered "Provider" with DOH, subject to program regulations and a Medicaid Provider Agreement that explicitly makes the New York State Medicaid Regulations the foundation of the relationship between the State and the provider. *See* Auditor Aff., ¶ 2.

471. By its conduct in the operation of Cold Spring Hills, its operator repeatedly and persistently violated Title 18 NYCRR § 515.2, which requires that a provider submit medical claims only for services provided in compliance with Title 18 of the Official Compilation of Codes, Rules, and Regulations of New York State. Moreover, pursuant to 18 NYCRR § 518.7(a), Medicaid payments may be withheld, "when [the department] has determined that a provider has abused the program or has committed an unacceptable practice."

472. By their conduct in the operation of Cold Spring Hills, its operator, owners, family members and Favored Persons repeatedly and persistently and fraudulently committed multiple violations of Title 18 NYCRR § 515.2(b), which prohibits as an "unacceptable practice" conduct which constitutes fraud and abuse, including the following:

> (1) False claims:
> (i) submitting, or causing to be submitted, a claim or claims for:
> (a) Unfurnished medical care, services or supplies.
> . . .
>
> (4) Conversion: Converting a medical assistance payment, or any part of such payment, to a use or benefit other than for the use intended by the medical assistance program
>
> (5) Bribes and Kickbacks: Unless the discount or reduction in price is disclosed to the client and the department and reflected in a claim, or a payment is made pursuant to a valid employer-employee relationship, the following activities are unacceptable practices:

(i) soliciting or receiving either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program;

(ii) soliciting or receiving either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program;

(iii) offering or paying either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program; or

(iv) offering or paying either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program.

. . .

(8) Receiving additional payments: Seeking or accepting any gift, money, donation or other consideration in addition to the amount paid or payable under the program for any medical care, services or supplies for which a claim is made.

. . .

(10) Conspiracy: Making any agreement, combination or conspiracy to defraud the program by obtaining, or aiding anyone to obtain, payment of any false, fictitious or fraudulent claim.

. . .

(12) Failure to meet recognized standards: Furnishing medical care, services or supplies that fail to meet professionally recognized standards for health care . . . .

473. In addition, by its conduct in the operation of Cold Spring Hills, its operator repeatedly and persistently violated regulatory requirements by deceptively submitting to DOH a

false Certification Statement for Provider Utilizing Electronic Billing (the "Medicaid Electronic Certification"), which falsely stated, in pertinent part:

> I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized *and done so in accordance with applicable federal and state laws and regulations.*
>
> * * *
>
> In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Medicaid Management Information Systems Provider Manuals and other official bulletins of the Department . . . .

Auditor Aff., ¶ 29 (Emphasis added).

474. These certifications were false because of Cold Spring Hills' repeated and persistent conduct of committing unacceptable practices under New York's regulations including: failing to provide required resident care free from neglect, operating the nursing home with insufficient staff, putting medical assistant payments to uses and benefits other than intended by the Medical Assistance Program, and submitting false claims and statements, including Cost Reports.

475. Moreover, in 2020 and 2021, while employed at Ventura, Moshe Krigsman fraudulently signed and submitted the annual Medicaid Electronic Certification on behalf of Cold Spring Hills. In 2019 Moshe Krigsman was employed at Cold Spring Hills as the Director of Finance. In January 2020, Moshe Krigsman was "moved to corporate," i.e., was placed on Ventura's payroll and was provided an email account of Ventura's d/b/a Philosophy Care Centers. SAAG Aff., Ex. 10 (pgs. 48, 71, 89). Thereafter, in February 2020, and again in 2021, Moshe Krigsman signed and submitted to DOH Cold Spring Hills' Medicaid Provider Billing Certifications. In the 2020 certification, Moshe Krigsman identified himself as the Chief Financial Officer of Cold Spring Hills, and in the 2021 certification identified himself as Senior Vice

President of Finance for Cold Spring Hills. When completing these certifications, he used his old Cold Spring Hills email address. Auditor Aff. ¶ 135, Ex. 24. This was done to deceive DOH into believing he worked for Cold Spring Hills, rather than the undisclosed management company, Ventura. It also underscores the lack of a distinction between Ventura and Cold Spring Hills in Bent Philipson's actions. And it shows Respondents Bent Philipson's, Avi Philipson's, and other individual Respondents' persistent and fraudulent pattern of conduct in using corporate entities as their alter egos, disregarding corporate forms, or using them to suit their own personal interests. Avi Philipson, the nominal owner and operator of Cold Spring Hills, or another authorized employee of Cold Spring Hills, was required to execute and submit these Certification Statements to DOH, but he did not. Auditor Aff. ¶ 136.

476 When asked under oath if Moshe Krigsman deceived DOH with respect to Cold Spring Hills' Medicaid Certifications, Bent Philipson asserted his privilege against self-incrimination. SAAG Aff., Ex. 6.

Injunctive Relief Will Ensure that Medicaid and Medicare Funds are Spent on Providing Direct Care to Residents.

477. This special proceeding seeks to bring transparency to the reality that much of the human pain and humiliation experienced by Cold Spring Hills' residents was avoidable and can be prevented in the future. It can be prevented only if Respondents stop—through compelled court action if necessary—transferring substantial amounts of Medicaid and Medicare funds from Cold Spring Hills to Cold Spring Hills' owners, their family members, and Favored Persons, and instead permit Cold Spring Hills to retain the Medicaid and Medicare funds it is paid and invest substantially more of that money in direct care staffing to provide required care to its residents.

478. Much of the neglect, the insufficient staffing levels, and the level of service are not an unavoidable result of the COVID-19 pandemic. The investigative findings herein reflect that

the harm was the foreseeable and unacceptable result of the Respondents' repeated deceptive practices, fraudulent violations, and disregard of many state and federal laws in the operation of Cold Spring Hills in the years prior to the pandemic. Callously, over the past two years of the ongoing pandemic, Respondents have continued to transfer significant amounts of nursing home funds to themselves and their Favored Persons through collusive and self-dealing related party transactions. At the same time, after cutting staffing, Respondents have refused to raise salaries and staffing levels of nurses and other staff to create the working conditions that would enable Cold Spring Hills to meet its obligations to provide required care and staffing to its residents. Despite the human suffering of the residents and staff that continues to result from Respondents' repeated transfer of funds out of the nursing home to themselves through related party transactions, Respondents' have continued their repeated violations of law, and their deceptive and fraudulent conduct in the operation of Cold Spring Hills.

479. Respondents prioritized the personal profit of Cold Spring Hills' owners, family members, related parties, and Favored Persons over the residents and the duty to provide required care and staffing for them under state and federal law. Respondents' conduct continues. It must stop.

AS AND FOR THE FIRST CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED AND PERSISTENT FRAUD

AS AGAINST RESPONDENTS 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, HIGHVIEW MANAGEMENT INC., 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

480. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

481. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent fraudulent conduct. Executive Law § 63(12) defines fraud and fraudulent conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions."

482. Respondents, through their agents and employees, repeatedly and persistently committed fraud by engaged in the above-described scheme to convert millions of dollars from Medicaid and Medicare funds that Cold Spring Hills received as reimbursement for services purportedly rendered by Cold Spring Hills that did not conform with applicable laws and regulations, including refraining from engaging in unacceptable practices in violation of 18 NYCRR § 515.2;

483. Respondents thereby engaged in repeated and persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE SECOND CAUSE OFACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED AND PERSISTENT FRAUD

AS AGAINST RESPONDENTS COLD SPRING HILLS ACQUISITION, LLC D/B/A COLD SPRING HILLS CENTER FOR NURSING & REHABILITATION, COLD SPRING HILLS REALTY ACQUISITION, LLC, PHILIPSON FAMILY, LLC, LIFESTAR FAMILY HOLDINGS, LLC, ROSS CSH HOLDINGS, 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

484. The State repeats and alleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

485. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent fraudulent conduct. Executive Law § 63(12) defines fraud and fraudulent conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions." Respondents, through their agents and employees, repeatedly and persistently committed fraud by:

a. Entering into complex real estate transactions, including but not limited to a collusive and/or self-dealing lease agreement obligating Cold Spring Hills to pay exorbitant rent in addition to mortgage expenses; and

b. Entering into a scheme that caused Cold Spring Hills to acquire a $16 million promissory note subject to 13% interest for the purpose of bolstering Respondents' personal up-front profit.

c. Engaging in unacceptable practices, in violation of 18 NYCRR § 515.2.

486. Respondents thereby engaged in repeated and persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE THIRD CAUSE OF ACTION PURSUANT TO EXECUTIVE LAW § 63(12): REPEATED AND PERSISTENT FRAUD

AS AGAINST RESPONDENTS COLD SPRING HILLS ACQUISITION, LLC D/B/A COLD SPRING HILLS CENTER FOR NURSING & REHABILITATION, COLD SPRING HILLS REALTY ACQUISITION, LLC, VENTURA SERVICES, LLC D/B/A PHILOSOPHY CARE CENTERS, HIGHVIEW MANAGEMENT, INC., 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

487. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

488. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent fraudulent conduct. Executive Law § 63(12) defines fraud and fraudulent conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions."

489. Respondents, through their agents and employees, repeatedly and persistently committed fraud by:

a. Failing to seek approval from DOH for withdrawals and transfers from Cold Spring Hills in excess of the disclosure thresholds as set forth in PHL § 2808(5)(c);

b. Preparing, filing, and/or causing to be filed with DOH false annual financial and statistical reports (Medicaid Cost Reports) that failed to properly disclose related parties and submit required financial statements, pursuant to 10 NYCRR § 86-2.2;

c. Preparing, filing, and/or causing to be filed with DOH false and/or misleading documents concerning an application for a CON, on behalf of Cold Spring Hills;

d. Preparing, filing, and/or causing to be filed with DOH false annual billing certifications;

e. Submitting false and misleading information to DOH to effect the purchase of Cold Spring Hills; and

f. Engaging in unacceptable practices, pursuant to 18 NYCRR § 515.2;

490. Respondents thereby engaged in repeated and persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE FOURTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED AND PERSISTENT ILLEGALITY

AS AGAINST RESPONDENTS COLD SPRING HILLS ACQUISITION, LLC D/B/A COLD SPRING HILLS CENTER FOR NURSING & REHABILITATION, VENTURA SERVICES, LLC D/B/A PHILOSOPHY CARE CENTERS, HIGHVIEW MANAGEMENT, INC., ROSEWELL ASSOCIATES, LLC, BENT PHILIPSON, AVI PHILIPSON, ESTATE OF DEBORAH PHILIPSON, JOEL LEIFER, LEAH FRIEDMAN, ROCHEL DAVID, and ESTHER FARKOVITS

491. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

492. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent illegal acts and/or illegality. A violation of any state, federal or local law constitutes "illegality" within the meaning of Executive Law § 63(12) and is actionable thereunder when persistent or repeated.

493. Respondents, through their agents and employees, repeatedly and persistently committed illegalities by failing to comply with their legal obligations to provide Cold Spring Hills' residents the care required under New York and federal regulations law by failing to:

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 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);

c. 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 §483.70(e);

d. 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;

e. 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);

f. 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);

g. 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);

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

i. 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 Cold Spring Hills is required to develop, as required by 10 NYCRR § 415.13(a);

j. 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;

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

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

m. 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);

n. 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);

o. 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);

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

q. 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);

r. 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);

s. 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);

t. 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;

u. 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;

v. 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.

494. Respondents also engaged in repeated or persistent illegality in the carrying on, conducting and transaction of business, in violation of Executive Law § 63(12), by engaging in unacceptable practices pursuant to 18 NYCRR § 515.2 .

AS AND FOR THE FIFTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED AND PERSISTENT ILLEGALITY

AS AGAINST RESPONDENTS COLD SPRING HILLS ACQUISITION, LLC D/B/A COLD SPRING HILLS CENTER FOR NURSING & REHABILITATION, VENTURA SERVICES, LLC D/B/A PHILOSOPHY CARE CENTERS, HIGHVIEW MANAGEMENT, INC., ROSEWELL ASSOCIATES, LLC, BENT PHILIPSON, AVI PHILIPSON, ESTATE OF DEBORAH PHILIPSON, JOEL LEIFER, LEAH FRIEDMAN, ROCHEL DAVID, and ESTHER FARKOVITS

495. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

496. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent illegal acts and/or illegality.

497. A violation of any state, federal or local law constitutes "illegality" within the meaning of Executive Law § 63(12) and is actionable thereunder when persistent or repeated. Respondents' repeated and persistent violations of the PHL and Social Services Law, and federal Social Security Act and Medicare counterparts, are all actionable under Executive Law § 63(12).

498. Respondents, directly and through their agents and their employees, repeatedly and persistently committed illegalities by failing to comply with their legal obligations to provide Cold Spring Hills' residents the care required under New York law by failing to:

a. Refrain from engaging in unacceptable practices, in violation of 18 NYCRR § 515.2;

b. Seek approval from DOH for withdrawals and transfers from Cold Spring Hills in excess of the disclosure thresholds, in violation of 10 NYCRR § 400.19(b)(1) and PHL § 2808(5)(c);

c. Provide adequate and appropriate medical care to each resident in violation of PHL § 2803-c(3)(e); and

d. Provide courteous, fair, and respectful care and treatment to each resident in violation of PHL § 2803-c(3)(g).

e. Refrain from submitting an incorrect or improper claim, or refrain from causing such claim to be submitted, or refrain from receiving payment for the incorrect or improper claim, in violation of NYCRR § 518.3(a);

499. Respondents are also liable for violation of federal Medicare payment statutes and regulations, including 42 U.S.C. 1320a-7k, which defines an overpayment as "any funds that a person receives or retains under title XVIII or XIX [of the Social Security Act]" to which the person, after applicable reconciliation, is not entitled" and requires that overpayments of Medicare funds be repaid within 60 days.

500. Respondents thereby engaged in repeated fraudulent acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE SIXTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63-c:
MISAPPROPRIATION OF PUBLIC FUNDS

AS AGAINST ALL RESPONDENTS

501. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

502. Respondents obtained, received, converted, or disposed of funds, either directly or indirectly, from the Medicaid and Medicare Programs to which they were not entitled, as alleged in the foregoing paragraphs of this Verified Petition.

503. The acts and practices of Respondents complained of herein constitute a misappropriation of public property, in violation of the Tweed Law, Executive Law § 63-c. By reason of the foregoing, the State is entitled to restitution from the Respondents in an amount not less than $22 million.

AS AND FOR THE SEVENTH CAUSE OF ACTION:
PURSUANT TO COMMON LAW UNJUST ENRICHMENT

AS AGAINST ALL RESPONDENTS

504. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

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

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.

507. Respondents are therefore liable to the State in an amount to be determined by the Court for funds unlawfully received from the Medicaid and Medicare Programs.

REQUEST FOR RELIEF

WHEREFORE, Petitioner respectfully requests that this Court grant relief pursuant to Executive Law § 63(12), Executive Law § 63-c, PHL § 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 the up-front conversion of Cold Spring Hills 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 a complex real estate transaction, including through a collusive and/or self-dealing lease agreement in violation of Executive Law § 63(12);

3. Respondents engaged in repeated and persistent fraud by causing Cold Spring Hills to pay a $16 million promissory note with exorbitant interest in violation of Executive Law § 63(12);

4. Respondents engaged in repeated and persistent fraud and illegality by failing to seek approval from DOH for withdrawals and transfers from Cold Spring Hills and making false statements and certifications to DOH regarding equity withdrawals and transfers, cost report information, CON applications, annual billing certifications, and to effectuate the purchase of Cold Spring Hills in violation of Executive Law § 63(12);

5. Respondents repeatedly and persistently engaged in illegality in the operation of Cold Spring Hills in its failure to deliver adequate care to

residents of Cold Spring Hills, contrary to the regulations set forth in paragraphs 493a-493v above, in violation of Executive Law § 63(12);

6. Respondents repeatedly and persistently engaged in illegality in the operation of Cold Spring Hills by failing to refrain from engaging in unacceptable practices and failing to adhere the laws and regulation set forth in paragraph 498a-498e, all in violation of Executive Law § 63(12);

7. 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 Executive Law § 63(c); and

8. 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 Cold Spring Hills, but which were not performed in conformance with applicable laws and regulations.

B. 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;

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.

Dated: New York, New York
December 15, 2022

LETITIA JAMES
Attorney General of the State of New York

By: Amy Held

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Counsel for New York

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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

Petitioner,

- 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.

Index No.: _____

VERIFICATION

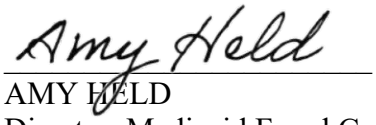
Amy Held, an attorney duly admitted to practice before the Courts of the State of New York, affirms the following under penalty of perjury:

I am Director of the New York State Attorney General's Medicaid Fraud Control Unit, of Counsel to Attorney General of the State of New York Letitia James, attorney for Petitioners in this action. I am acquainted with the facts set forth in the foregoing Petition, based on my review of the files of the Medicaid Fraud Control Unit and information provided by Special Assistant Attorneys General and auditors and investigators participating in the investigation of this matter, and said Petition is true to my knowledge, except as to matters which were therein stated to be

upon information and belief, as to those matters I believe them to be true. The reason I make this verification is that Petitioner State of New York is a body politic.

Dated: New York, New York
December 15, 2022

LETITIA JAMES
Attorney General of the State of New York



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