SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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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. _____/23

VERIFIED PETITION

- against -

ABRAHAM OPERATIONS ASSOCIATES
LLC d/b/a BETH ABRAHAM CENTER
FOR REHABILITATION AND NURSING,
DELAWARE OPERATIONS ASSOCIATES LLC
d/b/a BUFFALO CENTER FOR REHABILITATION
AND NURSING, HOLLIS OPERATING CO., LLC
d/b/a HOLLISWOOD CENTER FOR REHABILITATION
AND HEALTHCARE, SCHNUR OPERATIONS
ASSOCIATES LLC d/b/a MARTINE
CENTER FOR REHABILITATION AND NURSING,
LIGHT PROPERTY HOLDINGS ASSOCIATES LLC,
DELAWARE REAL PROPERTY ASSOCIATES LLC,
HOLLIS REAL ESTATE CO., LLC,
LIGHT OPERATIONAL HOLDINGS ASSOCIATES LLC,
LIGHT PROPERTY HOLDINGS II ASSOCIATES LLC,
CENTERS FOR CARE LLC d/b/a CENTERS HEALTH CARE,
CFSC DOWNSTATE, LLC, BIS FUNDING CAPITAL LLC,
SKILLED STAFFING, LLC, KENNETH ROZENBERG,
DARYL HAGLER, BETH ROZENBERG, JEFFREY SICKLICK,
LEO LERNER, REUVEN KAUFMAN, AMIR ABRAMCHIK,
DAVID GREENBERG, ELLIOT KAHAN, SOL BLUMENFELD,
ARON GITTLESON, AHARON LANTZITSKY,
JONATHAN HAGLER, and MORDECHAI “MOTI” HELLMAN,

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 allege upon information and belief:

PRELIMINARY STATEMENT

1. This special proceeding under Executive Law § 63(12) seeks injunctive relief to stop the repeated and persistent fraud and illegality of the persons and entities who have operated, owned and controlled, among others, the four nursing homes named herein, for the purpose of exploiting government funding of skilled nursing care through the Medicaid and Medicare programs. The facilities at issue in this Petition are: Beth Abraham Center for Rehabilitation and Nursing, a 448-bed facility in the Bronx ("Beth Abraham" or "Beth Abraham Center"), Buffalo Center for Rehabilitation and Nursing, a 200-bed facility in Buffalo ("Buffalo" or Buffalo Center"), Holliswood Center for Rehabilitation and Healthcare, a 314-bed facility in Queens ("Holliswood" or "Holliswood Center"), and Martine Center for Rehabilitation and Nursing, a 200-bed facility in White Plains ("Martine" or "Martine Center") (collectively, the "Nursing Homes"). As detailed throughout this petition, the Nursing Homes are largely controlled by Centers for Care LLC ("Centers"), a company owned by Respondents Kenneth Rozenberg and Daryl Hagler. This control is exercised by way of Consulting Services Agreements, pursuant to which the Nursing Homes pay Centers millions of dollars per year. Through this control, Centers caused the Nursing Homes to operate in a manner that resulted in neglect of, and harm to, residents but yielded great financial benefit for Rozenberg and Hagler.

2. All of the residents of the Nursing Homes are vulnerable, frail, elderly, or disabled individuals, and primarily Medicaid and Medicare beneficiaries, whose care is funded by New York taxpayers. New York law imposes on nursing home operators a "special obligation" to care for their residents and to ensure that they are provided with the "necessary care and services,"

including clinical care, treatment, diet, and health services, 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); 415.3(f); 415.12; 415.13; 42 CFR § 483.25; *see also* 42 § CFR 483.35; 483.10(d)(2). Respondents, including Rozenberg and other Nursing Homes' Operators and Nursing Homes' Owners (defined below), repeatedly and persistently violated these and other regulations and statutes that were designed to protect vulnerable nursing home residents.

3. Respondents also repeatedly and persistently committed and tolerated numerous acts of neglect against residents of the Nursing Homes, 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 defined by 10 NYCRR § 81.1(c).

4. As detailed in the accompanying affidavits, Respondents violated the above duties by engaging in repeated and persistent fraud and illegality, beginning as early as 2013 and continuing today, in their operation and control of the Nursing Homes. From at least 2018 through at least April 2023, Respondents' misconduct has included: (1) repeated and persistent neglect and inhumane treatment of residents who suffered and died under their care, due to Respondents' repeated disregard for, and violation of applicable laws, including those obligating Respondents to provide required resident care and sufficient staffing to deliver it, and to limit admissions to residents for whom the Nursing Homes were able to provide required care; and (2) a long history of insufficient staffing and resulting poor quality of care that began well before the COVID-19 pandemic, in violation of numerous New York State and federal statutes and regulations, so that the Respondents, including the Nursing Homes' Owners, could covertly transfer millions of dollars

in "up-front profit"[1] to themselves from the Nursing Homes. The preventable harm and humiliation suffered by the Nursing Homes' residents resulted from a complex web of corporate entities and fraudulent transactions implemented by Respondents Rozenberg, Hagler, and Centers. This web intentionally turned the Nursing Homes into money-making machines for those who controlled them. Indeed, as set forth in greater detail herein, Respondents covertly extracted exorbitant amounts of money from the Nursing Homes through their collusive relationship, in which Rozenberg is the majority owner of the Nursing Homes, Hagler is the majority owner of the real estate upon which the Nursing Homes sit, and both individuals own Centers, which they used to exercise control. While the COVID-19 pandemic shone a spotlight on the Respondents' malfeasance, the repeated illegal and fraudulent conduct proven herein persisted from well before the COVID-19 pandemic and continues through to the present.

Witnesses and Images

5. This Petition's findings include repeated and persistent preventable neglect, suffering, and humiliation of residents of the Nursing Homes, from well before the pandemic hit New York through and including April 2023. The sworn statements of residents, their family members, and employees of the Nursing Homes, the analysis of medical records of residents, and evidence in the accompanying Affidavits all support the Attorney General's findings. Those findings establish that Respondents repeatedly and illegally disregarded and violated state and federal laws so that they could hide from regulators and the public how many millions of dollars

[1] "Up-front profit taking" refers to Respondents' practice of making self-negotiated and/or collusive payments from the Nursing Homes to themselves, companies they control, or their Favored Persons disguised as legitimate "expenses" and other transfers of funds, as a priority over, and without regard to, ensuring that the Nursing Homes have used the public funds they received to meet their duty to provide required care, with sufficient staffing to render such care to its residents."

they were extracting from the Nursing Homes, while ignoring and violating the legal duties of the Nursing Homes and their owners to provide required resident care and sufficient staffing to deliver that care, and to limit admissions to residents to whom the Nursing Homes could provide required care. Respondents' callous disregard and repeated illegal conduct caused avoidable devastating physical and emotional harm to vulnerable residents, stripping them of their dignity, enabling Respondents to increase their personal profit through collusive, fraudulent transactions with the Nursing Homes.

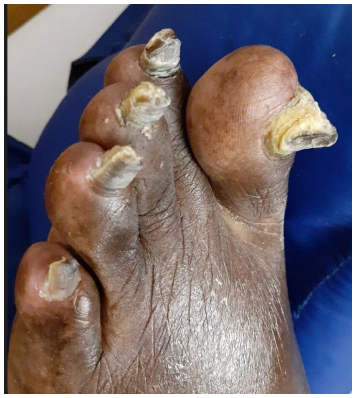
6. These accounts are difficult to read, and the photographs included in this Petition and in the accompanying affidavits are painful to see. Included below are a few of the many examples of Respondents' repeated and persistent illegality, and disregard for the Nursing Homes' duties to provide required care, resulting in neglect, suffering, and humiliation of the Nursing Homes' residents before the pandemic, during its height, and recently.

- **Failure to Timely Change Soiled Diapers, Sheets, and Bandage, and to Assist Resident Who Lacks Use of Arms to Eat/Drink, Leading to Loss of 20 Pounds in 3 Weeks.** A.P. was a resident at Buffalo Center from December 29, 2022, through January 14, 2023, after having his toe amputated due to diabetes. A.P. had previously had his right arm amputated and his left arm is paralyzed, due to a stroke. During the first four days A.P. was living at Buffalo Center, A.P. was given the wrong diet—in fact, he was given the diet for the resident who had formerly occupied his bed at the nursing home. A.P. also was not given his medications during that time. After three days at Buffalo Center, A.P.'s sister noticed that A.P.'s toe bandage still had not been changed; it bore the initials of the doctor at the hospital and had the date and time when it had been placed at hospital. A.P.'s sister asked staff why it had not been changed and they claimed not to know that it needed to be changed. After an hour, they brought a new bandage and she changed it herself. Once, as A.P.'s sister was leaving Buffalo Center, A.P. called and said that he had had a bowel movement and needed his diaper changed. She told the staff at the nurse's station that he needed to be changed. Seven hours later, A.P. called his sister again and said his diaper had not yet been changed. A.P.'s sister called Buffalo Center six times before someone finally answered, and she was told they were "shorthanded but would get to it." Because A.P. could not use his arms, he needed assistance eating and drinking. Yet, when A.P.'s sister visited him, she found food trays and drinks in his room that had not been touched; staff would deliver the trays and drinks, but nobody would assist him with eating or drinking. She asked why nobody helped him with eating and a staff member informed her

that the staff had "no idea he could not feed himself." During three weeks at Buffalo Center, A.P. lost 20 pounds. A.P.'s sister also noticed that his bed at Buffalo Center had the same dirty, stained, and ripped sheets on during most of his stay. A.P. has since left Buffalo Center and now lives with his sister, who cares for him (Affidavit of Marilyn Burke, attached hereto).

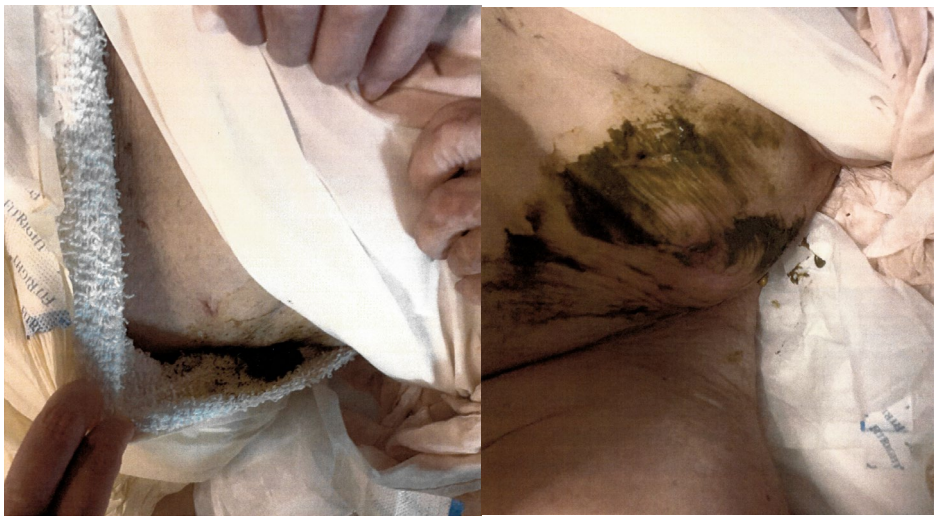
- **Resident Sits in Feces and Urine While Deep, Gaping Pressure Injuries Spread to the Bone from "Terrible Care."** Resident P.M. received "terrible care" at Martine Center, including delays in receiving prescribed medication, not receiving required care to clean his feeding tube, breathing treatments, wound care, or podiatry care, and being left in diapers soiled with urine and feces. In December 2021, P.M.'s family notified a nurse that he was in pain and needed his pain medication. The nurse answered that he was too busy and would administer the pain medication later. Despite waiting for two hours, P.M. never received the pain medication. At around 5:00 p.m., staff transferred P.M. to bed. His soiled diaper was saturated with urine, but the aides told P.M.'s family they were too busy to change it. The family cleaned and changed his diaper and found a Stage IV pressure ulcer on P.M.'s sacrum area (the area between the base of the spine and the tailbone). The pressure ulcer was bloody, with puss drainage, and had a foul odor. P.M.'s family visited again five days later and, upon arrival, found P.M. again wearing a diaper saturated with urine. They waited two and a half hours before Martine Center's staff cleaned him and put him in a clean diaper. In January 2022, P.M.'s family again found him lying in a diaper soiled with urine and feces and waited an hour for staff to clean P.M. and change his diaper. Approximately two months later, P.M. developed a fever and was hospitalized after the pressure ulcer on his sacrum worsened and spread internally to his bone. After P.M.'s hospital stay, his family moved him to another nursing home, because of the terrible care he received at Martine (*see* Affidavits of Rose Smith and Kaiona Murray Evans, attached hereto). The following photographs depict the condition of P.M.'s foot in December 2021 and pressure ulcer in March 2022 (*see* Smith Aff.):





- **Martine Staff Fails to Attach Resident's Colostomy Bag Causing Resident to Sit in Feces**. Resident B.M. received "appalling care" during her six-month stay at Martine Center. On an evening in July 2022, B.M.'s daughter visited her mother, who needed a

colostomy bag[2], and found her mother in pain and discomfort. B.M.'s daughter pulled her mother's hand from under the blanket to find that it was covered in feces. When B.M.'s daughter looked under the blanket, she found that no colostomy bag was attached and instead B.M. was wrapped in a towel filled with feces. As B.M.'s daughter unwrapped the towel, she saw exposed intestines with the surrounding area covered in feces. B.M. notified staff who indicated that the day shift never mentioned any issues, which left B.M.'s daughter to assume that her mother was left without a colostomy bag the entire day. While staff attempted to clean the area, B.M. complained that the area was burning, and even after the area was cleaned, B.M.'s daughter could still see feces smeared on and around B.M.'s open intestinal wound. In October 2022, during a visit, B.M.'s daughter found her mother's intestinal wound dressing around the colostomy bag soaked in feces. In December 2022, B.M.'s daughter again found her mother wrapped in a towel without her colostomy bag attached. However, this time the window in the room was open because B.M's roommate was covered in feces and the room smelled. The room had flies everywhere and B.M. was freezing (*see* Affidavit of Omayra Benitez, attached hereto). The pictures below depict B.M.'s condition in July 2022:



- **After Staff Ignores Call Bell, Resident Gets Up Alone, Falls, Breaks Femur, Lies on Floor for an Hour Waiting for Help.** In January 2020, Buffalo Center Resident L.S., who needed assistance walking, attempted to get to the bathroom by himself when no staff member responded to the call bell he activated in order to seek help. He fell and broke his

[2] A colostomy bag is a collection bag for feces that fits over a stoma, which is an opening creating by a colostomy. A colostomy is a surgical procedure that involves bringing the colon through an opening of the abdominal wall, turning it under like a cuff, and stitching it, to allow fecal matter to be eliminated from the body. *See* Affidavit of Medical Analyst Stephanie Keyser, hereinafter "Keyser Aff." at ¶ 38.

femur, laying on the floor for almost an hour before a staff member finally responded to his roommate's call bell. Later the same month, on January 30, 2020, L.S. died at Buffalo Center (*see* Affidavit of Larry J. Scinta, attached hereto).

- **Due to Lack of Staff, Martine Resident Waited Five Hours for Soiled Diaper to be Changed.** C.V. is a former resident at Martine Center, where she resided for about six weeks between October and November 2022. At Martine Center, C.V. heard call bells sounding day and night. Due to the lack of staff, C.V. often had to wait long periods of time (on average 45 minutes) for her soiled diaper to be changed. Once, she sat in a soiled diaper for approximately five hours, despite ringing her call bell for help multiple times. On another occasion, C.V. sat in a soiled diaper for so long that her buttocks began to hurt. When an aide finally came to change her, the aide was rough and C.V. cried out in pain. The aide then put the wipes down, told C.V. to do it herself, and left. The aide eventually returned and finished changing C.V. In two other instances, C.V. was left so long in diapers soiled with diarrhea that the diapers leaked all over her bed. Sitting in soiled diapers "disgusted" C.V. and made her "think nobody cared." During C.V.'s six-week stay at Martine, she only received one shower (Affidavit of Catherine Vanacore, attached hereto).

- **Humiliated Resident Sits in Soiled Diapers, Waiting 30 to 45 Minutes for Staff to Change Diaper**. Both before the pandemic and through present, Holliswood Resident HC16[3] has regularly been forced to wait long periods of time before staff assisted her to the bathroom or changed her diaper. Once, HC16's granddaughter heard her scream for staff to change HC16's diaper for duration of the granddaughter's visit at the nursing home. On another occasion, the granddaughter visited her grandmother for 30 to 45 minutes during which time staff failed to respond to her call bell. In another instance, HC16's granddaughter visited at 1 p.m. and learned from her grandmother that staff had failed to change the soiled diaper she was wearing since she woke up that morning (Bates Aff.).

- **Severely Dehydrated Resident Wandered Unnoticed by Staff onto City Street, So Neglected that He Was Unrecognizable to Son, and Hospitalized**. James Quinn's father, J.Q., was a resident in Buffalo Center's dementia[4] unit for three weeks in May 2021. While driving to visit J.Q. at the facility, Mr. Quinn noticed a man on the street whom he believed to be homeless. The man was unshaven, his hair was long, and his skin color was "bad." Mr. Quinn described this man as looking "like a zombie or a ghost." After Mr. Quinn arrived at the facility, there was a delay in staff bringing Mr. Quinn's father, J.Q., out to see him. Eventually, when staff brought J.Q. to Mr. Quinn, he was shocked to realize

[3] Within Det. Bates's Affidavit, Holliswood residents and employees are anonymized and referred to with the prefix "HC" and a number designation.

[4] 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. The most common type of dementia seen in elderly patients is Alzheimer's Disease, which is a terminal disease that cannot be reversed or cured. Other types of dementia include Vascular, Lewy Body, and Frontotemporal dementias. *See* Keyser Aff. ¶ 19.

that the man from the street had been his father, who had wandered off from the nursing home earlier that day, unnoticed by staff for some time. J.Q. was sent to the hospital later that day and diagnosed as severely dehydrated.[5] Once he had been given fluids at the hospital, J.Q. father's color came back, and he had a complete turnaround in physical appearance. Mr. Quinn was appalled at Buffalo Center's neglect of J.Q., stating, "I'm a garbage man, I get paid to pick up trash and clean up the streets. They pay these people [Buffalo Center] to take care of old people, and it shouldn't be a headache. Come on, do your job." After J.Q. was released from the hospital, Mr. Quinn arranged for J.Q. to be transferred to a different nursing home (*see* Affidavit of James E. Quinn Jr., attached hereto).

- **Resident Neglected During One Month Stay in 2019, Eye Wound Not Cleaned and Resident "Filthy."** Holliswood Resident B.H. was always "filthy" when his daughter visited because staff did not wash his hair or shave him often. He wore dirty clothes. Staff failed to clean an eye wound he had, causing pus to accumulate. In only a month of living at Holliswood, B.H.'s daughter noticed a significant difference in his appearance (*see* Holguin Aff. and Exhs. A, J). Photographs of B.H are below:

November 27, 2019

December 24, 2019

[5] 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 compromised state. Severe dehydration can lead to a condition called delirium which is a serious medical condition often triggered by infection; it is a sudden onset of change in cognition that resembles dementia. A resident can exhibit combative behaviors, refusal of care and be unaware of their surroundings and familiar family members and caregivers. As the cause of delirium is treated, the delirium can resolve. Keyser Aff. ¶ 26.

- **Resident's Fall Not Reported to Family nor Timely Treated, Delaying Brain Bleeding Diagnosis, Brain Surgery, and Resulting in Speech Defects**. On January 12, 2021, former Holliswood Resident M.W. fell from her bed. Without providing medical treatment or notifying her family, Holliswood staff wrapped M.W.'s head and put her back into bed. When M.W.'s daughter could not reach her by phone, she rushed to Holliswood Center the next day, but was turned away by staff. The daughter called the police and shortly thereafter, saw EMS rolling her mother out of Holliswood Center, unconscious and non-responsive, with no explanation from Holliswood's nursing supervisors as to the circumstances surrounding her mother's condition. At the hospital, a CT scan revealed that M.W. had a brain bleed, requiring emergency surgical opening of her skull. There was "evidence of contusion . . . likely caused by the traumatic impact the patient sustained." M.W. had been experiencing symptoms at approximately 2:30 P.M. but was not brought to the hospital until around 9 P.M. (Affidavit of Principal Auditor-Investigator Christine Rhody, hereinafter "Rhody Aff." at ¶ 66). Since then, M.W. has suffered speech defects and emotional extremes, and no longer resides at Holliswood, having left in early 2021 (Wong Aff.).

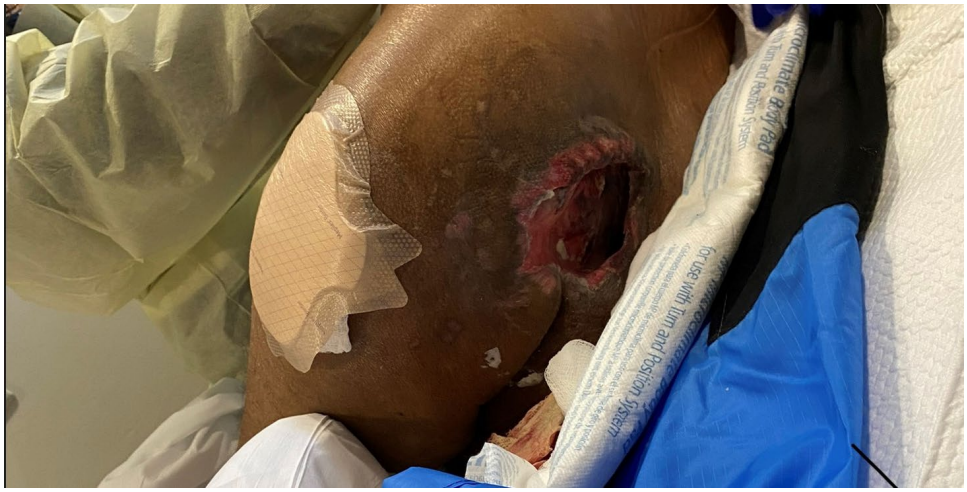
- **Neglected Resident Abandoned on Toilet for Hours; Attempts to Get Up and Falls, Smashing Face on Wall.** Even after the height of the pandemic, Buffalo Center had "virtually no staff" during weekends. When Resident D.E. requested assistance by pressing her call bell, staff rarely responded, and if they did, it was not for an hour or two. When she was helped to get to the toilet, it took staff up to an hour to return to assist her from the toilet to her bed or chair. One morning, D.E. had to go to the bathroom but was told that no staff was available to assist her. D.E. attempted to go without assistance and fell while on the toilet, smashing her face on a wall in the bathroom. D.E. suffered a bloody nose and was diagnosed with a concussion at the hospital. Ultimately, on June 10, 2021, D.E. became frustrated with the lack of care at Buffalo Center and checked herself out against medical advice (*see* Affidavit of D.E., attached hereto).

- **Staff Fail to Turn and Position Resident, Who Sits in Own Feces for Hours Because Staff and Facility Schedule Diaper Changes for Staff Convenience Rather Than on Residents' Needs.** Beginning during the height of the pandemic on April 28, 2020, and continuing through September 14, 2020, on at least 33 shifts, Holliswood's staff failed to record whether they "turned and positioned" former Resident L.S. Such care was necessary to avoid the development of pressure wounds due to his inability to move on his own. Holliswood's staff thereby failed to provide required care under L.S.'s care plan. When L.S. complained to staff about sitting in his own urine and feces in a soiled diaper for hours, staff refused to change him, explaining that it was not time for his "scheduled" change. However, Holliswood scheduled L.S.'s diaper changes only three times a day: 7 a.m., 12:30 p.m. and 8 p.m., which is unsurprising given the insufficient staffing at the facility. In between the "scheduled" changes, L.S. laid in a diaper soiled with his own feces. L.S. now

resides at another nursing home (Salvio Aff.; Rhody Aff. ¶¶ 60, 61; Budimir Aff. ¶¶ 56-57).

- **Unexplained Injuries from Unreported Falls; Diaper Rash on Vaginal area, Lower Back, and Buttocks from Neglect**. Staff at Beth Abraham did not attend to Resident A.C.'s needs, especially those regarding toileting, and she experienced multiple falls at the facility. On October 6, 2020, A.C. fell, but Beth Abraham staff informed her daughter that she was uninjured. On October 9, 2020, three days later, A.C. experienced pain and was sent to the hospital, where she was diagnosed with a dislocated hip that required an emergency hip replacement. The emergency room doctor who treated A.C. stated that her hip injury was likely due to a very recent fall (not one that occurred three days earlier), but Beth Abraham denied that A.C. had fallen that day. At the time she was sent to the hospital, A.C. had a diaper rash on her lower back, buttocks, and vaginal area, stemming from the lack of care she received from Beth Abraham staff during the time she lived at that facility. A.C. has since left Beth Abraham (*see* Rosa Aff.).

- **Cavernous Pressure Sores Resulting in Sepsis. Increased Risk of Death; Followed by Death.** Resident S.B. was not properly cared for at Martine. In particular, Martine failed to adequately address his pressure sores. During a visit in early October 2021, S.B.'s wife was shocked to find that his pressure ulcers had progressed to stage three and stage four ulcers. One of the ulcers was eating away most of his buttocks. After seeing her husband's terrible condition, S.B.'s wife began the process of having S.B. removed from Martine to be cared for at home. However, S.B.'s wife never got the chance to bring S.B. home, as he developed sepsis and was transferred to the hospital and died seven days later (*see* Affidavit of Jerinae Basden, attached hereto). The following picture depicts the condition of the ulcer on S.B.'s buttocks in October 2021:



7. Further instances of neglect, inhumane treatment, suffering and humiliation of the Nursing Homes' residents are detailed in the witness affidavits accompanying this Petition, which

include current or former residents at the Nursing Homes and/or their family members, Auditor-Investigators, Detectives, Medical Analyst Stephanie Keyser, RN, a Geriatric Care Manager, Laura Clutz, hired by the family of a Holliswood resident, and Buffalo-area Emergency Medical Technician/Paramedic Todd Swartz; the testimony attached hereto; and the other documents attached to the Affirmation of Special Assistant Attorney General Todd Pettigrew ("Pettigrew Aff."). The current and former residents and their family members are: Remy Allen, Alice Barner, Jerinae Basden, Joy Battison, Omayra Benitez, Aniwang Berrie, Elan Bonnema, Marilyn Burke, Louis Clark, Carrie Craft, Patricia Dragovic, Marie Dunn, Danielle Erick, Carla Forgione, Jill Franklin, Bianca Gutzmore, Susy Holguin, Antonietta Johnson, Sheryl Johnson, Kevin Jones, Carol Ann Lasalle, Yvonne Latty, Angela Lawrence, Kaiona Murray Evans, Anna Maria Naimoli, Noemi Oppenheimer, Thomas Passaro, Jr., Dorothy Pietraszewski, Mary Pinks, Nicholas Powers, James E. Quinn, Jr., Lisa Revell, Marlene Rodriquez, Aurea Rosa, Tyrone Salazar, Louis Salvio, Lauren Schneider, Larry J. Scinta, Jr., Jocelyn Smith, Rose Smith, Diane Snyder, Floyd David Snyder, Jr., Awilda Solas-Santiago, Cherell Toe, Catherine Vanacore, Cynthia Vega, Evelynn White, Jennie White, and Talia Wong. The Auditor-Investigator affiants are: Regional Chief Auditor-Investigator Dejan Budimir, Principal Supervising Auditor-Investigator Ann Winslow, Principal Auditor-Investigators Kizzy-Ann Waldropt and Christine Rhody, and Senior Auditor-Investigators Siobhan O'Leary and Christopher Giacoia. The Detective affiants are: Timothy Bates, Peter Olsen, Katie O'Neill, Scott Petucci, and David Ras. In addition, residents, family members, and staff expressed fear of retaliation by the Nursing Homes for telling the truth about their experiences in the Nursing Homes (*see*, *e.g.*, Affidavit of Detective Olsen, attached hereto at ¶ 8, Affidavit of Detective Bates, attached hereto at ¶ 8).

8. The tragic situation endured by the Nursing Homes' residents, as exemplified above, was preventable and flowed directly from Respondents' unconscionable repeated and persistent operation of the Nursing Homes with insufficient staff to provide required care. Respondents operated the Nursing Homes in this manner to reduce expenses, yet they required the Nursing Homes to continue admissions, despite the lack of staff, to increase revenue, while ignoring the many legal duties that this conduct violated. Through this conduct and fraudulent, collusive transactions, Respondents covertly converted over $83 million – including Medicaid and Medicare funds meant for resident care – from the Nursing Homes to Kenneth Rozenberg (the Nursing Homes' majority owner) and Daryl Hagler (the majority owner of the Nursing Homes' real property), and their family members, businesses, and other Favored Persons.[6]

Respondents Operated the Nursing Homes with Chronic Insufficient Staffing But Continued Resident Admissions, to Maximize Their Fraudulent Up-Front Profit Taking

9. When a nursing home is run properly, the largest expense it typically incurs is the cost of staffing. Thus, decreasing staffing levels and failing to pay staff sufficient compensation to enable the nursing home to hire and retain sufficient staffing are the quickest ways for for-profit nursing home owners to extract more funds for themselves: they cut staffing that the nursing homes need to provide required care; continue to accept resident admissions even when staffing is too low to provide required care to existing residents; and assign the remaining staff too many duties than they can perform in a given shift, requiring them to work harder, in worsening conditions, without sufficient Registered Nurse ("RN") supervision and training, while the residents wait

[6] "Favored Persons" refers to those who acted as strawmen managing members or nominal owners of the Nursing Homes, those who controlled their operations, and/or those to whom Rozenberg or Hagler directed money 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 (defined below) by these persons from the Nursing Homes.

longer for care, fail to receive required care, and, too often, predictably, get sicker and suffer avoidable pain and humiliation. This pattern reflects nursing home owners' disregard of many legal duties, and the prioritization of their personal financial gains above those legal duties, leading them to neglect residents' needs.

10. For instance, during the height of the pandemic, even when staff at Martine Center informed Centers that staffing was dire and thus, Martine Center should halt accepting admissions, Centers refused to do so. This is unsurprising because continuing to admit residents maximized revenue for the Nursing Homes. Centers's prioritization of revenue over resident care is evidenced by the following exchanges between desperate Martine staff members and Centers:

- On April 8, 2020, the Martine Center Director of Nursing requested, "please cancel admissions today. We have no nurses on 2 units on day shift. Martine is extremely short with nurses. CNAs are also very short on the units." The Martine Assistant Director of Nursing responded: "At this point! We need a diversion, we have no one to care for these residents. This is horrible." A Centers Admission Specialist rebuffed these requests, reminding them that only Centers higher-level staff could agree to call off new admissions" (see Pettigrew Aff. ¶ 51, Exh. 45 at 91-92).

- On April 13, 2020, the Director of Nursing indicated she asked to "suspend admissions coz I see that they are sending 2 today. This building is falling apart." The Martine Assistant Director of Nursing responded, "I can't believe they are still trying to send admissions when everyone is dieing (sic)" (Pettigrew Aff. ¶ 24, Exh. 18; ¶ 48, Exh. 42).

- On April 14, 2020, the Director of Nursing complained that she had no Registered Nurses and had four floors without nurses. Despite having advised Centers that Martine Center had no nurses and that Martine "can't handle additional loads right now," Centers nonetheless responded that it had already set up four admissions for that day (*see* Pettigrew Aff. ¶ 51, Exh. 45 at 98-99).

11. As set forth herein, from at least 2013 through at least April 2022, Respondents transferred tens of millions of dollars to themselves, their family members, and Favored Persons under this model by extracting up-front profit from the Nursing Homes under their ownership and/or control. They accomplished this through multiple means, including: cutting staffing

expenses; paying wages too low to maintain sufficient staff; relying heavily on agency staff members, who are often less familiar with the residents and their care needs; operating the Nursing Homes with chronically insufficient staffing levels—including RN staffing—to provide required care to the residents while requiring the Nursing Homes to continue resident admissions; entering into repeated fraudulent and illegal collusive transactions with the Nursing Homes to extract millions of dollars in up-front profit for themselves; and filing false documents with DOH to hide the amounts they were transferring to themselves from the Nursing Homes. In so doing, Respondents repeatedly prioritized their personal enrichment by minimizing staffing expenses while maximizing revenue from admissions and ignoring and violating many state and federal laws designed to protect nursing home residents.

12. These decisions violated multiple laws, including state and federal statutes and regulations promulgated to ensure quality care and resident safety and well-being.

13. The COVID-19 pandemic exposed and exacerbated the poor working conditions and deficient resident care created by the callous staffing decisions described above. When COVID-19 hit New York, Respondents' exploitative business model simply snapped under the poor working conditions they had created. Injunctive relief is required to halt these callous business practices.

Respondents Engaged in Repeated and Persistent Fraud and Illegality in Operating the Nursing Homes, Including Converting Over $83 Million in Government Funds and Hiding Their Profiteering Through the Use of Related-Party Companies

14. In addition to the injunctive relief referred to above, this special proceeding also seeks from Respondents restitution and disgorgement of over $83 million in converted government funds. While the Nursing Homes' Owners and the Nursing Homes' Operators (as defined in ¶¶ 69-70, below, and collectively, "the Nursing Homes' Owners and Operators") neglected their

residents by failing to provide required care, they simultaneously engaged in repeated and persistent fraudulent and illegal practices, starting in at least 2013, which covertly diverted funds from the Nursing Homes that should have been used for resident care. Indeed, Respondents repeatedly caused the Nursing Homes to enter into collusive transactions involving entities they and their family members own, all at the expense of the Nursing Homes' residents' health and dignity.

15. While Respondents repeatedly ignored and violated state and federal laws designed to protect the Nursing Homes' residents, Respondents' illegally converted many millions of Medicaid and Medicare funds through multiple fraudulent schemes that include, but are not limited to, repeatedly and persistently:

- Causing the Nursing Homes to enter into collusive real estate arrangements that saddled the homes with excessive debts and forced them to pay falsely inflated rents to real estate companies owned by Hagler;
- Extracting millions of dollars from the Nursing Homes through collusive related party transactions, including the payment of "fees" to sham vendors owned in whole or part by Rozenberg, Hagler, and/or their family members;
- Causing the Nursing Homes to make interest-free loans to other nursing homes owned and operated by Rozenberg for no discernable business purpose, which deprived the Nursing Homes of funds to spend on staffing; these loans were rarely repaid in full, if at all; and
- Causing the Nursing Homes to pay purported "salaries" to their owners – salaries that were frequently unreported, inflated, and in some instances, indicative of no-

show jobs, in that the purported "salaries" bore no relationship to any work supposedly performed.

Respondents Concealed Their Self-Dealing By Submitting False Documents and Certifications to the New York State Department of Health

16. The Nursing Homes' Operators and the Nursing Homes' Owners engaged in conduct designed to conceal the extent of their wrongful conversion of nursing home funds, thereby repeatedly and persistently committing additional fraud and illegalities. They did so by causing the Nursing Homes to file documents with the New York State Department of Health ("DOH") that contain false and fraudulent statements and/or misleading omissions. As set forth in greater detail below, the Nursing Homes' Owners and Operators, including Rozenberg, routinely flouted DOH rules, by repeatedly and persistently failing to disclose related party transactions on the Nursing Homes' cost reports. The Nursing Homes' owners and operators similarly ignored—thereby violated—the rules and regulations that prohibit transfers of funds from nursing homes without DOH approval and limit the amount of funds owners can withdraw from nursing facilities by failing to disclose transactions between the Nursing Homes and entities that are under common ownership and/or control.

17. Respondents engaged in the above-described repeated and persistent fraudulent conduct for self-serving purposes, including to: (1) hide the exorbitant amounts of Medicaid and Medicare reimbursement money that Respondents took as "up-front profit" from the Nursing Homes for their personal gain while repeatedly and persistently violating their duty to provide required care and staffing for their residents; and (2) falsely portray to regulators and the public that the Nursing Homes—which received hundreds of millions of Medicaid and Medicare dollars for resident care—were unprofitable or only minimally profitable investments for the owners. This conduct enabled Respondents and their industry lobbyists to: (1) support industry requests for

Medicaid rate increases based on the claim that the rates were "too low"; (2) continue to try to justify the owners' refusals to increase staff compensation to levels that would enable the Nursing Homes to hire and retain sufficient staffing; and (3) when confronted by evidence of their operation of nursing homes with insufficient staffing, to deflect and claim "staffing shortages"[7] were to blame, rather than their own conduct in ignoring the laws, operating the homes with insufficient staffing, creating poor working conditions as they continue resident admissions, assign staff more work than they can complete in a given shift, and refuse to increase staffing pay and levels—even as the owners extract millions of dollars from the homes covertly for themselves for their own profit.

Respondents Violated the Law and Must Be Held Accountable

18. Respondents' fraudulent and illegal conduct is detailed throughout this Petition and the accompanying Affidavits. The Nursing Homes' residents were put at risk for, and suffered, neglect and harm, due to Respondents' repeated decisions to funnel many millions of dollars as up-front profit out of the four facilities, rather than adequately fund resident care. Controlling persons of nursing homes, such as Rozenberg and other Nursing Homes' Owners and Operators, are directly liable under the PHL.[8]

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[7] For example, on July 24, 2021, when the Buffalo Times reported DOH's citation of Buffalo Center for Immediate Jeopardy to the health and safety of its residents based on a finding of "widespread" insufficient staffing, the president of NYS Health Facilities Association and NYS Center for Assisted Living declined to comment on the situation at Buffalo Center yet cited "inadequate funding from the state's low Medicaid reimbursements" and said "there are not enough people who want to work at nursing homes." *Understaffing Still Cited at Nursing Homes as State Gears up for New Staffing Standards*, The Buffalo News, 7/24/21.

[8] 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 a "controlling person" of a residential health care facility shall be deemed to mean any person who by reason of a direct

19. Instances of harm and neglect include failures to: (1) meet basic care needs; (2) provide proper wound care; (3) provide proper feeding; (4) provide care required under resident care plans; and (5) communicate vital health information. These failures occurred as a result of Respondents' operation of the Nursing Homes with insufficient staffing to care for their existing residents' needs while continuing to admit new residents into the facilities to increase revenue, so Respondents could covertly extract millions for themselves in up-front profit.

20. In addition to the risks attendant to Respondents' chronic understaffing of the Nursing Homes, the residents were further endangered by the Respondents' failures during the pandemic to ensure proper infection control, including failures to: cohort residents and staff, provide adequate health screening, and provide sufficient protective gear; and decisions to use laboratories owned by Rozenberg, even when their performance was poor and their delays in reporting test results increased risks to residents (*see* Sect. VII below). DOH survey citations and other data underscored the insufficient staffing and the Nursing Homes' infection control violations, putting Respondents on notice of regulatory violations and resident endangerment[9] (*see* Sect. IX below).

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or 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."

[9] The Attorney General anticipates that the Respondents will 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 its 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, because, among other reasons, 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

21. Moreover, Respondents controlled the Nursing Homes and maintained chronically inadequate staffing levels and continued resident admissions to increase their owners' up-front profit taking, 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; (3) regularly prioritize nursing home cost savings over the residents' human dignity; (4) work without sufficient training and supervision, predictably resulting in neglect of residents; and (5) work under very poor conditions with pay too low to enable the nursing homes to hire and retain sufficient staffing, including RN staffing, to provide required care.

Resident Neglect, Suffering, and Humiliation Could Have Been Prevented If Respondents Had Devoted Medicaid and Medicare Funds Towards Resident Care Instead of Themselves

22. Petitioner brings this special proceeding to bring transparency to the illegal and harmful manner in which Respondents have operated the Nursing Homes and to protect current and future Nursing Home residents from pain, neglect, suffering and humiliation. Petitioner asks this Court to enjoin Respondents from converting substantial amounts of Medicaid and Medicare funds from the Nursing Homes, and to mandate that the Nursing Homes spend those funds on direct care staffing (*i.e.*, nurses and aides), which will ultimately improve care to current and future residents. If, instead of prioritizing their concealed conversion of over $83 million in up-front profit through their repeated and persistent fraudulent and illegal schemes, Respondents had complied with the laws requiring the Nursing Homes to provide sufficient care and staffing, much of the neglect, pain, and suffering that residents experienced could have been prevented.

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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 the Nursing Homes 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 predate the COVID-19 pandemic, and Respondents' looting continued after the expiration of the declaration of emergency.

23. To illustrate, if Respondents had spent the $11.09 million they converted from Beth Abraham between 2019 and 2021 on direct care staffing, Beth Abraham could have provided between 75,000 and 77,000 additional hours of direct care to its residents each year (*see* Waldropt Aff. ¶¶ 82-83). At Holliswood, if Respondents took merely $4.8 million less in up-front profit over three years from 2019 through 2021 and instead spent that money on direct care staffing, Respondents could have provided between 32,500 and 34,800 additional hours of direct care to Holliswood's residents each year (*see* Budimir Aff. ¶ 142). If Respondents had permitted Buffalo Center to spend an additional $3 million on its staffing from 2019 through 2021, Buffalo Center could have provided between 34,000 and 46,900 additional hours of direct care to Buffalo Center's residents each year (*see* O'Leary Aff. ¶ 97). Had Respondents enabled Martine Center to spend an additional $1.2 million on staffing each year from 2019 through 2021, Martine could have provided between 30,248 and 33,598 additional hours of direct care to Martine's residents per year (*see* Winslow Aff. ¶¶ 157-60).

As Residents Suffered, Rozenberg Bought an Airline and Hagler Bought Over $130 Million Worth of Real Estate

24. If one had hoped that the deaths of over 400 Nursing Home residents during 2020 (due to COVID-19 and other causes), the first year of the pandemic, would have been a wake-up call for Respondents to change their exploitative practices and comply with the law, that hope was in vain. During the pandemic, as Centers denied the Nursing Homes' administrators' requests for more staffing and salary increases for low paid, overburdened direct care staff, many residents died, suffered, and were harmed and humiliated from lack of required care,. *See*, *e.g.*, §§ VI(D)-(E) below. Meanwhile, as discussed in greater length herein, Centers, Rozenberg, Hagler, their family members, and other Respondents siphoned millions of dollars in up-front profit from the Nursing Homes via inflated rents, inflated related-party loans, their ownership of companies that

did business with the Nursing Homes, and salaries for no-show jobs. In fact, during this same period of resident suffering, as a result of Respondents' disregard of the Nursing Homes' legal duties, Rozenberg bought the controlling interest in El Al Airlines in 2020, and according to a news article featured on Centers's own website, he increased his ownership stake in early 2023.[10]

25. After years of profiteering covertly from the Nursing Homes that Rozenberg owned and Centers controlled, Hagler used a bank account that received, among other sums, profits obtained fraudulently and illegally from the Nursing Homes to loan Rozenberg $103 million—at no interest and with no repayment terms or loan documentation—to facilitate Rozenberg's purchase of the Israeli national airline, El Al (Hagler Tr. at 171-73). In the fall of 2020, Rozenberg lent $109 million to a company controlled by his son to purchase a controlling stake in the airline for a total of $107 million (*see* Pettigrew Aff. ¶¶ 194-195, Exhs. 187-188). On May 19, 2021, Kenneth Rozenberg took control of El Al and was named to El Al's Board of Directors; six days later, Hagler joined Rozenberg as a director of El Al (*see* Pettigrew Aff. ¶¶ 196-97, Exhs. 189-90). These purchases occurred while Rozenberg and the Nursing Homes he owned and controlled ignored and violated their duties to provide required care and operate with sufficient staffing to deliver it.

26. Enriched with ample funds covertly and collusively converted from the Nursing Homes, Hagler has also been busy expanding his business empire recently. From May 2022 to November 2022, Hagler spent $132.4 million to purchase three properties in Brooklyn and Queens.[11]

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[10] https://centershealthcare.com/media/kenny-rozenberg-increases-el-al-stake/ (last accessed 6/27/23).

[11] https://therealdeal.com/2022/05/26/astoria-cigar-factory-converted-to-offices-highlighted-nyc-i-sales-last-week/ (last accessed 6/23/23); https://therealdeal.com/2022/07/11/daryl-hagler-

Respondents Are Solely Accountable for Creating Poor Working Conditions and Resulting Resident Neglect and Suffering

27. To the extent that Respondents respond to this Petition by attempting to place blame on the individual employees identified in incidents or otherwise shift liability to the staff of the Nursing Homes, this Court should not afford weight to any such arguments.

28. Indeed, this Court should not be deceived by any attempt to deflect the effect of Respondents' mismanagement and fraud onto the very individuals to whom Respondents were responsible for properly paying, supervising, training, and providing with the necessary resources to enable them to perform their duties. Respondents alone are responsible for their illegal and fraudulent conduct, and the resulting resident neglect, set forth in this Petition. The Petition should be read as pointing the finger at Respondents rather than the underpaid Nursing Home staff or employees whom they set up to fail, while Respondents siphoned $83 million for their other business ventures and personal profit.

Respondents Must be Enjoined From Their Illegal and Fraudulent Conduct to Protect Residents, and Must be Ordered to Implement Reforms and Disgorge Their Ill-Gotten Gains

29. To protect the vulnerable residents of the Nursing Homes, judicial intervention is required to enjoin Respondents' repeated and persistent fraudulent and illegal conduct. Petitioner also seeks restitution and disgorgement of the government healthcare funds that Respondents fraudulently transferred to themselves, and retained, converted, or disposed of without right in violation of Executive Law § 63-c.

30. Accordingly, for the reasons stated herein, the Attorney General respectfully asks the Court to promptly issue an order awarding Petitioner the relief it seeks to bring an end to

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books-63m-long-island-city-hotel-sale/ (last accessed 6/23/23); https://patch.com/new-york/prospectheights/crown-heights-shadow-towers-site-bought-buy-developers-report (last accessed 6/23//23).

Respondents' repeated and persistent fraudulent and illegal conduct that exploits vulnerable residents at the Nursing Homes, the Medicaid program, and the healthcare workers who are working in substandard conditions at the Nursing Homes, which was created by Respondents' conduct, including their violation of many laws designed to protect nursing home residents.

31. The Petition requests relief from the Court to end Respondents repeated and persistent illegal and fraudulent conduct and require them to implement measures to improve conditions at the Nursing Homes. Accordingly, Petitioner seeks an Order:

a. Declaring that:

   i. Respondents have engaged in repeated and persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12);

   ii. Respondents have repeatedly and persistently engaged in illegal acts in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12), by engaging in the financial fraud alleged herein, and in the operation of the Nursing Homes by illegally failing to deliver required care; and

   iii. Respondents have obtained, received, converted, and/or disposed of Government Healthcare funds, directly or indirectly, to which they were not entitled;

b. Permanently enjoining Respondents from:

   i. Further violating healthcare regulations relating to nursing home services in New York State;

ii. Further engaging in the illegal and fraudulent practices alleged herein;

iii. Engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program and federal Medicare Program;

iv. Admitting or allowing to be admitted to the Nursing Homes new residents until the Nursing Homes' Operators provide signed certifications to the Attorney General certifying that that an identified clinician has determined that the Operators have met their obligations to ensure: sufficient care and staffing for all existing residents and for any new residents, and that each Nursing Home's staffing level meets, at a minimum, 4.1 HPRD[12], and a minimum of 0.75 HPRD from RN staff for long-term stay residents; and that the Nursing Homes are otherwise fully complying with all New York State laws regarding minimum staffing levels and spending on direct care staff.

c. Directing Respondents to correct the Nursing Homes' false and misleading cost reports for 2018, 2019, 2020, and 2021 by October 25, 2023, and to submit to MFCU such revisions;

d. Appointing an independent financial monitor to oversee the Nursing Homes' financial operations, prevent the Nursing Homes from making

[12] Staffing levels at nursing homes are often measured using an "hours per resident per day" ("HPRD") metric.

collusive and self-dealing payments to Respondents, and cause the Nursing Homes to terminate loans with Related Parties; and granting the financial monitor specific authority to withhold any payments to any Respondent and any other Related Parties;

e. Appointing an independent healthcare monitor with the specific authority to visit and inspect the Nursing Homes at any time, to review all documents maintained by Respondents regarding the Nursing Homes, to oversee healthcare operations at the Nursing Homes, to make recommendations to improve the Nursing Homes compliance with their legal duties under state and federal law, and to enable the Nursing Homes to provide required care to all residents, and to ensure that the Nursing Homes take all necessary steps to avoid preventable neglect and improve healthcare outcomes for their residents;

f. Directing all Respondents except the Nursing Homes to pay for the expenses of the monitors appointed hereunder, and to pay for the Nursing Homes' implementation of the monitors' recommendations;

g. Directing Respondents to provide to MFCU a complete accounting of all monies wrongfully received and/or disbursed;

h. Directing that each Respondent disgorge to MFCU, for return to the government, all monies wrongfully received, as a result of Respondents' conversion of Government Healthcare funds and/or unjust enrichment, within 30 days;

i. Directing all Respondents, except the Nursing Homes, to pay restitution and/or damages to New York State;

j. Directing all Respondents, except the Nursing Homes, to reimburse the State for the costs of this investigation;

k. Directing each Respondent, except the Nursing Homes, to pay statutory costs in the amount of $2,000 pursuant to CPLR § 8303(a)(6);

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

m. During the pendency of this proceeding, preliminarily enjoining Respondents from:

i. Granting a preliminary injunction pursuant to Executive Law § 63(12), (i) enjoining all Respondents from engaging in any fraudulent, deceptive, or illegal acts in violation of Executive Law § 63(12), including but not limited to violations of the Public Health Law and those regulations promulgated to promote and ensure the wellbeing of nursing home residents; (ii) enjoining all Respondents from obtaining, receiving, converting, and/or disposing of Medicaid funds, directly or indirectly, to which they are not entitled; (iii) enjoining Respondents Kenneth Rozenberg, Daryl Hagler, Centers for Care LLC d/b/a Centers Health Care, Abraham Operations Associates LLC d/b/a Beth Abraham Center For Rehabilitation And Nursing ("Beth Abraham"), Delaware Operations Associates LLC d/b/a Buffalo Center For Rehabilitation And Nursing ("Buffalo

Center"), Hollis Operating Co., LLC d/b/a Holliswood Center For Rehabilitation And Healthcare ("Holliswood"), Schnur Operations Associates LLC d/b/a Martine Center For Rehabilitation And Nursing ("Martine Center"), Jeffrey Sicklick, Amir Abramchik, and Aron Gittleson from filing false and/or misleading Cost Reports; and (iv) enjoining Respondents Kenneth Rozenberg, Daryl Hagler, Centers for Care LLC d/b/a Centers Health Care, Abraham Operations Associates LLC d/b/a Beth Abraham Center For Rehabilitation And Nursing ("Beth Abraham"), Delaware Operations Associates LLC d/b/a Buffalo Center For Rehabilitation And Nursing ("Buffalo Center"), Hollis Operating Co., LLC d/b/a Holliswood Center For Rehabilitation And Healthcare ("Holliswood"), Schnur Operations Associates LLC d/b/a Martine Center For Rehabilitation And Nursing ("Martine Center"), Jeffrey Sicklick, Amir Abramchik, and Aron Gittleson from transferring any assets to the following entities: BIS Funding LLC, Skilled Staffing LLC, and CFSC Downstate, LLC;

ii. Appointing an independent healthcare monitor for the pendency of this action to oversee compliance with the preliminary injunction, including oversight of the healthcare functions at the Nursing Homes;

iii. Appointing an independent financial monitor for the pendency of this action to ensure compliance with this injunction, including

review of the financial condition of the Nursing Homes, and BIS Funding LLC, Skilled Staffing LLC, and CFSC Downstate LLC ("Related Party Vendors"), to ensure that the Nursing Homes maintain sufficient funds to: a) fund the operations of the Nursing Homes, in accordance with all applicable laws, rules, and regulations, b) implement the recommendations of the independent healthcare monitor and c) ensure compliance with this Order, including but not limited to, the prohibitions against the Nursing Homes transferring assets, directly or indirectly, to the Related Party Vendors; and

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

I. JURISDICTION AND VENUE

32. The Medicaid Fraud Control Unit ("MFCU") in the Office of the Attorney General of the State of New York ("OAG") is responsible for investigating and prosecuting, through criminal and civil proceedings, healthcare providers and persons who assist and facilitate providers' fraudulent schemes and illegal billing of the Medicaid and Medicare programs, and for protecting the State's vulnerable nursing home residents from abuse, neglect, and mistreatment. Based upon MFCU's investigation of Respondents' conduct, Petitioner has filed this special proceeding pursuant to the well-established authority vested in OAG by the Executive Law, Medicaid rules and regulations, and that vested in MFCU by its 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].

33. 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 "as 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); *see* Memo of Law, pp. 14-15.

34. 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).

35. Further, the Attorney General is empowered under the Tweed Law to investigate the misappropriation and misuse of any government funds, including Medicaid 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).

36. Moreover, 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. *See* Affirmation of Special Assistant Attorney General Todd Pettigrew ¶ 6, Exh. 192.

37. Similarly, the United States Department of Health and Human Services ("HHS") has specifically authorized the Attorney General, through MFCU, to recover Medicare damages in this action. *See* Affirmation of Special Assistant Attorney General Todd Pettigrew ¶ 5.

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

II. PARTIES

A. Petitioner

39. Letitia James is the Attorney General of the State of New York, and as such, Petitioner 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

40. Abraham Operations Associates LLC ("Abraham Operations"), d/b/a Beth Abraham Center for Rehabilitation and Nursing, is a New York limited liability company. Beth Abraham is a for-profit 448-bed nursing home located at 612 Allerton Avenue, Bronx, New York.

41. Light Operational Holdings Associates LLC ("Light Operational Holdings") is a New York limited liability company. Light Operational Holdings is the 98% owner of Beth Abraham.[13] Kenneth Rozenberg ("Rozenberg") is the 95% owner of Light Operational Holdings and for Beth Abraham Center, Rozenberg's adult daughter, Rivka Rozenberg, is Light Operational

[13] Initially, Respondent Jeffrey Sicklick was a 2% owner of Beth Abraham, but he transferred his interests to Kenneth Rozenberg's wife, Beth Rozenberg in 2018. Thereafter, in or about April 2023, the 2% ownership interest was transferred to Rivka Rozenberg.

Holding's 5% owner.[14] Together, Light Operational Holdings, Rivka Rozenberg, and Abraham Operations are referred to herein as "Beth Abraham Center's Owners and Operator."

42. Light Property Holdings Associates LLC ("Light Property") is a New York limited liability company. Light Property is the 100% owner of the real property located at 612 Allerton Avenue, Bronx, New York, and is the landlord of Beth Abraham. Daryl Hagler ("Hagler") is the 99% owner of Light Property and Jonathan Hagler, his son, is the 1% owner of Light Property.

43. Delaware Operations Associates LLC ("Delaware Operations"), d/b/a Buffalo Center for Rehabilitation and Nursing, is a New York limited liability company. Buffalo Center is a 200-bed for-profit nursing home located at 1014 Delaware Avenue, in Buffalo, New York. Rozenberg is the 90% owner of Buffalo Center and Jeffrey Sicklick is its 10% owner. Together, Rozenberg, Sicklick, and Delaware Operations are referred to herein as "Buffalo Center's Owners and Operator."

44. Delaware Real Property Associates LLC ("Delaware Real Property") is a New York limited liability company. Delaware Real Property is the 100% owner of the real property located at 1014 Delaware Avenue, in Buffalo, New York. Delaware Real Property is the landlord of Buffalo Center. Hagler is the 99% owner of Delaware Real Property and Jonathan Hagler is the 1% owner of Delaware Real Property.

45. Hollis Operating Co., LLC ("Hollis Operating Co.") d/b/a Holliswood Center for Rehabilitation and Healthcare, is a New York limited liability company. Holliswood is a 314-bed for-profit nursing home located at 195-44 Woodhull Avenue, Hollis, New York.

[14] Initially, Beth Rozenberg was the 5% owner of Light Operational Holdings. However, in or about April 2023, her 5% ownership interest was transferred to Rivka Rozenberg (for Beth Abraham only; however, with regard to Martine Center, as of the date of this pleading, approval of this transfer is still pending with DOH).

46. Rozenberg is the 95.5% owner of Holliswood. Jeffrey Sicklick is Holliswood's 2.5% owner and Leo Lerner is its 2% owner. Until September 30, 2021, Reuven Kaufman was a 10% owner of Holliswood. Together, Sicklick and Lerner and Hollis Operating Co. are referred to as "Holliswood's Owners and Operators."

47. Hollis Real Estate Co., LLC ("Hollis Real Estate Co.") is a New York limited liability company. Hollis Real Estate Co. is the 100% owner of the real property located at 195-44 Woodhull Avenue, Hollis, New York. Hagler is the majority (90%) owner of Hollis Real Estate Co. Mordechai "Moti" Hellman is its 10% owner.

48. Schnur Operations Associates LLC ("Schnur Associates"), d/b/a Martine Center for Rehabilitation and Nursing, is a New York limited liability company. Martine Center is a 200-bed for-profit nursing home located at 12 Tibbits Avenue, White Plains, New York.

49. Light Operational Holdings is the 65% owner of Martine Center. The remaining interest in Martine Center is held by Amir Abramchik (10%), David Greenberg (10%), Elliot Kahan (10%), Rozenberg (4%), and Sol Blumenfeld (1%). Rozenberg is the 95% owner of Light Operational Holdings, and as of the date of this filing, Beth Rozenberg is its 5% owner. Together, Light Operational Holdings, Abramchik, Greenberg, Kahan, Rozenberg, Blumenfeld and Schnur Associates are referred to herein as "Martine Center's Owners and Operator."

50. Light Property Holdings II Associates LLC ("Light Property II") is a New York limited liability company. Light Property II is the 100% owner of the property located at 12 Tibbits Avenue, White Plains, New York. Hagler is the 99% owner of Light Property II and Jonathan Hagler is its 1% owner.

51. BIS Funding Capital LLC ("BIS") is a New York limited liability company located in Rockland, New York. Hagler is the 99% owner of BIS and Jonathan Hagler is its 1% owner.

BIS received funds from several of the Nursing Homes, purportedly in exchange for software and major movable equipment and other goods and services.

52. CFSC Downstate, LLC ("CFSC Downstate") is a New York limited liability company. CFSC Downstate is owned by Rozenberg (1%), Rozenberg's adult daughter, Shoshana Areman (42%), Hagler (33%), Jonathan Hagler (10%), Amir Abramchik (13%), and his wife Deborah Abramchik (1%).

53. Skilled Staffing, LLC ("Skilled Staffing") is a New York limited liability company. Skilled Staffing is a staffing agency, majority owned by Shoshana Areman and minority owned by Elisabeth Farkas, Rozenberg's daughter-in-law, that charged and received transfers of money the Nursing Homes for "management" and "consulting" services.

Centers: The Controlling Entity

54. Centers for Care LLC d/b/a Centers Health Care, Centers for Specialty Care, and Centers Business Office[15] is a New York limited liability company located at 4770 White Plains Road, Bronx, New York. Centers controls and manages the Nursing Homes under the guise of providing management consulting services. Rozenberg and Hagler each have a 50% ownership interest in Centers.

C. Individual Respondents

55. Respondent Kenneth Rozenberg resides in Rockland County, NY and was at all relevant times: (1) an operator of the Nursing Homes pursuant to 10 NYCRR § 600.9; (2) the majority-interest owner of the Nursing Homes; and (3) the CEO and 50% owner of Centers. Rozenberg had knowledge of and participated in the illegal and fraudulent practices alleged herein. With his ownership interest in the Nursing Homes and his ownership and control of Centers,

[15] As noted earlier, Centers for Care LLC will be referred to as "Centers" throughout this Petition.

Rozenberg was a controlling person with the ability to direct the management and policies of those entities.

56. Respondent Beth Rozenberg resides in Rockland County, New York, with her husband, Kenneth Rozenberg, and until recently, was an owner of Beth Abraham. Between 2017 and April 2023, Beth Rozenberg has held a 5% interest in Light Operational Holdings, which, in turn, holds a 98% interest in Beth Abraham. This 5% interest in Light Operational Holdings equates to a 4.9% interest in Beth Abraham. In 2018, Beth Rozenberg acquired a direct 2% interest in Beth Abraham, but transferred that interest to Rivka Rozenberg in or about April 2023. Thus, from 2018 to April 2023, Beth Rozenberg held a 6.9% interest in Beth Abraham, comprised of the above-described 4.9% indirect interest and the additional 2% direct interest in Beth Abraham that she acquired in 2018. Until approximately April 2023, Beth Rozenberg was also a minority owner of Martine Center because Light Operational Holdings owns a 65% interest in Martine Center. She is a former 50% shareholder of Centers.

57. Respondent Jeffrey Sicklick lives in Rockland County, New York. He is a minority owner of Buffalo Center (10%) and Holliswood (2.5%), and from 2017 through 2018, he was a minority owner of Beth Abraham (2%) and Martine Center (2%). He is the Director of Operations at Centers and owns a minority interest in approximately a dozen Centers-affiliated nursing homes. According to the Centers website, he serves as "the supervisor of all facility administrators in the Centers family."[16]

58. Respondent Amir Abramchik lives in Queens County, New York. He has a 10% ownership interest in Martine Center, and a minority share in approximately a dozen other Centers-

[16] Centers Health Care, Our Leadership, https://centershealthcare.com/leadership/jeffrey-sicklick (last visited June 23, 2023).

affiliated nursing homes. He and his wife are the owners of Ontario Center, another Centers-affiliated nursing home. He further serves as Centers's Chief Operating Officer. He owns 13%, and his wife 1%, of CFSC Downstate.

59. Respondent Elliot Kahan lives in Rockland County, New York and is a 10% owner of Martine Center. He is Centers's Chief Marketing Officer.

60. Respondent David Greenberg, a resident of New Jersey, is a 10% owner of Martine Center. He also serves as the Administrator of Boro Park Center, a Centers-affiliated nursing home.

61. Respondent Sol Blumenfeld, a resident of New Jersey, is a 1% owner of Martine Center. He has previously served as the administrator in other Centers-affiliated nursing homes.

62. Respondent Aron Gittleson lives in Rockland County, New York. He was, from January 2019 until July 2022, a 2% owner of Respondent Martine Center. He also serves as a Finance Director for Centers.

63. Respondent Aharon Lantzitsky resides in Rockland County, New York and was, from January 2019 until July 2022, a 2% owner of Respondent Martine Center. He also serves as a Division President of Centers and was previously a Regional Administrator of Centers.

64. Respondent Leo Lerner resides in Kings County, New York and is a 2% owner of Holliswood.

65. Respondent Reuven Kaufman resides in Ocean County, New Jersey, and until September 30, 2021, was a 10% owner of Holliswood.

66. Respondent Daryl Hagler resides in Rockland County, New York and, at all times relevant hereto, has been the majority owner of the real estate companies that own the properties leased by all of the Centers-affiliated nursing homes, including Beth Abraham Center, Buffalo

Center, Holliswood Center, and Martine Center. He is the CFO of Centers and owns 50% of Centers. He is also the 99% owner of BIS and 33% owner of CFSC Downstate.

67. Jonathan Hagler is Daryl Hagler's adult son, and a 1% owner of Delaware Real Property, Light Property II, and Light Property—the landlords for Buffalo Center, Martine Center, and Beth Abraham Center, respectively. He resides in Rockland County. He is also a 1% owner of BIS and a 10% owner of CFSC Downstate.

68. Mordechai "Moti" Hellman, a resident of New Jersey, is a 10% owner of Hollis Real Estate Co., Holliswood's landlord.

69. Abraham Operations Associates LLC, d/b/a Beth Abraham Center for Rehabilitation and Nursing; Delaware Operations Associates LLC, d/b/a Buffalo Center for Rehabilitation and Nursing; Hollis Operating Co., LLC d/b/a Holliswood Center for Rehabilitation and Healthcare; and Schnur Operations Associates LLC, d/b/a Martine Center for Rehabilitation and Nursing, shall at times hereinafter be collectively referred to as the "Nursing Homes' Operators."

70. Kenneth Rozenberg, Beth Rozenberg, Jeffrey Sicklick, Amir Abramchik, Elliot Kahan, David Greenberg, Sol Blumenfeld, Aron Gittleson, Aharon Lantzitsky, Reuven Kaufman and Leo Lerner shall at times hereinafter be collectively referred to as the "Nursing Homes' Owners."

71. Light Property, Delaware Real Property Associates LLC, Hollis Real Estate Co., and Light Property II shall at times hereinafter be collectively referred to as the "Landlords."

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

72. Petitioner brings this proceeding pursuant to Executive Law § 63(12), which authorizes the Attorney General to seek injunctive relief, restitution, disgorgement, and costs

against any person who has engaged in or otherwise demonstrates repeated illegal and/or fraudulent acts in the carrying on, conducting, or transaction 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." MFCU investigates and brings proceedings to address and remedy abuse and neglect of nursing home residents and Medicaid provider fraud, and, when authorized, to recover Medicare funds diverted in connection with schemes to defraud the New York State Medicaid program. As noted above, MFCU has received authorization to recover Medicare funds in this proceeding from the United States Department of Health and Human Services ("HHS"), Office of the Inspector General, pursuant to 42 USC § 1396b(q)(3). When assessing liability under the "illegality" prong of Executive Law § 63(12), courts have repeatedly found that a violation of state, federal, or local law constitutes illegality within the meaning of Executive Law § 63(12). *See State v. Princess Prestige*, 42 N.Y.2d 104, 107 (1977).

73. 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 Memorandum of Law ("Memo of Law") accompanying this Petition. Certain of these statutes and regulations are set forth as follows:

74. 18 NYCRR § 504.6(d) requires 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.

75. State and federal law impose many obligations on nursing home operators to ensure nursing homes provide required care and maintain staffing sufficient to provide such care to their

residents, and to ensure they are treated with dignity. *See, e.g.*, 10 NYCRR §§ 415.1(a), 415.3, 415.11(c), 415.12, 415.13, 415.22, 415.26; 42 CFR §§ 483.10, 483.25, 483.35.

76. Operators of nursing homes are also responsible for ensuring that nursing homes comply with their duties to file accurate cost reports and with State laws that limit equity withdrawals from nursing homes by owners and otherwise require notice to, and approval from, DOH before making such withdrawals. *See* PHL § 2808(5)(c); 10 NYCRR § 400.19; *Brightonian Nursing Home v. Daines*, 21 N.Y.3d 570 (2013). Nursing home operators are also responsible for ensuring that nursing homes comply with DOH's disclosure requirements, including, but not limited to, disclosure of related parties and related party transactions. *See* 10 NYCRR § 86-2.2

77. Respondents also repeatedly ignored and violated certain sections of the PHL, as follows:

> **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 § 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."

78. Regulations of DOH adopted under the foregoing statutes, and repeatedly and persistently ignored and 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 the resident's care plan.[17]

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 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 ensuring 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 adequate supervision to residents to prevent accidents.

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.

[17] A care plan is a document that nursing homes must prepare for each resident and that must "include[] measurable objectives and timetables to meet each resident's medical, nursing and mental and psychosocial needs." 10 NYCRR § 415.11(c). The care plan establishes the personal and health care services needed, frequency of the services, diet, and other necessary concerns regarding the resident. Nursing homes must update care plans at least every three months or more frequently as required. *See* 10 NYCRR § 415.11; 42 CFR § 483.21; *see also* Keyser Aff. ¶ 4.

10 NYCRR § 415.12(j): requiring facility to ensure that a resident is offered sufficient fluid intake to maintain proper hydration and health.

10 NYCRR § 415.13 – requiring the provision of nursing services, also reflected in federal law at 42 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.

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 § 415.17 – 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 42 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(i)(1)(ii) – requiring facility to accept and retain only those nursing home residents for whom it can provide adequate care.

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

10 NYCRR § 86-2.2 – requiring facility to file complete and accurate annual financial and statistical reports (Medicaid Cost Reports) to DOH.

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

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

(1) – False claims
(4) – Conversion
(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.

80. Respondents repeatedly 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 § 483.21 – 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 competencies and skills sets to assure resident safety.

42 CFR § 483.50 – requiring that nursing homes must provide 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 its 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, communicable diseases, and controlling infection.

81. In addition, at all relevant times, New York law imposed on nursing homes a "special obligation" to care for their residents, including by ensuring that they provide each resident with the care, treatment, diet, and health services that they need to attain their "highest practicable quality of life" under 10 NYCRR § 415.1(a). Respondents repeatedly and persistently violated the above regulations before, during, and after the pandemic.

THE ATTORNEY GENERAL'S FINDINGS OF FACT

82. 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, and the resulting preventable neglect and harm of residents of the Nursing Homes and Respondents' wrongful, concealed conversion of over $83 million in Medicaid and Medicare and other healthcare payments. The Attorney General finds that Respondents have violated New York State and Federal law as follows:

83. As demonstrated in the accompanying witness affidavits, transcripts of testimony, and other evidence submitted contemporaneously herewith, Respondents repeatedly and persistently ignored and violated the law and prioritized up-front profit-taking by the owners of the Nursing Homes and their related parties, resulting in tragic human consequences, including the neglect and mistreatment of residents who suffered death, injury, infection, pain, humiliation, and loss of dignity.

84. While the Attorney General has adduced significant evidence of Respondents' wrongdoing, this Office has not taken the testimony of Respondent Kenneth Rozenberg, who unjustifiably refused to appear for his examination under oath despite having been subpoenaed pursuant to Executive Law § 63(12) and failed to move to quash same. Rozenberg's counsel attempted to excuse his refusal to appear and testify under oath by claiming that he could not do so without knowing whether the instant matter had been referred for criminal investigation and whether there was a parallel federal investigation (*see* Pettigrew Aff. ¶¶ 149-55, Exhs. 142-48). Rozenberg's fears of possible criminal prosecution are indeed telling, yet do not provide a valid basis for refusing to comply with a duly issued investigatory subpoena, because he, like any witness, has a right to exercise his Fifth Amendment privilege against self-incrimination in

response to questions. His conduct in refusing to comply with the subpoena reflects his attempt to thwart and impede the Attorney General's investigation.

85. The same can be said of Respondent Hagler. Hagler initially testified for a partial day of examination under oath pursuant to Executive Law § 63(12) on June 23, 2022.[18] During his testimony, Hagler presented as intentionally evasive, and incredibly, claimed that he did not remember the answers to many questions put to him, including how many hours he worked as Centers Chief Financial Officer the *preceding week* (Hagler Tr. at 258-260). Before the day's testimony was finished, Hagler asked for the courtesy of ending his examination early and agreed to resume testimony on another day, ultimately agreeing to appear on August 11, 2022. However, he, like Rozenberg, refused to appear for the second day of testimony, to which he had previously agreed, citing the same specious justification – namely, that he would not appear without being advised as to whether the matter had been referred for criminal investigation and whether there was a pending parallel federal investigation (*see* Pettigrew Aff. ¶¶ 149-155, Exhs. 142-148). Again, this is not a valid basis for refusing to testify pursuant to an investigatory subpoena. As such, when Hagler refused to appear on August 11, to which he had previously agreed, the Attorney General noted his non-appearance on the record, and closed the remainder of the examination.[19] The Attorney General reserves the right to seek any and all inferences and remedies stemming from Rozenberg and Hagler's unjustified refusals to appear.

IV. BACKGROUND

86. Medicaid is a joint state and federal program designed to provide access to medical care by providing medical benefits to those who would not otherwise be able to afford it. It is

[18] The transcript of Hagler's June 23, 2022 testimony is hereto annexed. All transcripts are annexed hereto, organized by witness name in alphabetical order.
[19] The transcript of the August 11, 2022 non-appearance is hereto annexed.

funded by New York State and Federal funds. The Medicaid Program provides reimbursement to medical providers for medical services and goods to eligible needy persons. Medicaid beneficiaries must meet defined income thresholds to be eligible for Medicaid.

87. The residents of the Nursing Homes are vulnerable, elderly and/or disabled individuals. The majority of these residents are Medicaid recipients, and the full cost of their care is covered by the Medicaid program. Additionally, a portion of their residents are Medicare beneficiaries, and the cost of their care is covered by Medicare, a health care program primarily for elderly individuals that is funded by the federal government.

88. By enrolling as a Medicaid provider, a healthcare provider must agree to abide by all rules and regulations of the Medicaid Program pursuant to Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State, Section 504.3. *See* 18 NYCRR § 504.3[i]; *see also* 18 NYCRR § 515.2(a)(1). Further, 18 NYCRR § 504.6(d) requires that a provider can submit Medicaid claims only for services provided in compliance with Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State.

89. Medicaid providers are required to sign annual Medicaid Electronic Certification forms, attesting that they will follow the rules and regulations of the Medicaid program. The Certification reads:

> 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 and the Office of the Medicaid Inspector General 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 eMedNY Provider Manuals and other official bulletins of the Department.

(Emphasis added). As discussed below in § XI, Rozenberg and Centers's Controller signed such certifications on behalf of the Nursing Homes (*see* Pettigrew Aff. ¶¶ 156-91, Exhs. 149-84).

A. Rozenberg and Hagler Control the Centers Network of Companies, the Nursing Homes, and Many of Their Related Parties

90. Centers holds itself out on its website as "the largest and most complete post-acute health care continuum in New York."[20] Centers is an umbrella organization that manages nursing homes, adult day care facilities, diagnostic laboratories, home health care and managed care services, health education, and urgent care services.[21] Centers is owned by Rozenberg and Hagler (Hagler Tr. at 14-15). Rozenberg is Centers's Chief Executive Officer[22] and Hagler is its Chief Financial Officer (Hagler Tr. at 13-14; *see also* Budimir Aff. ¶ 20).

91. Rozenberg and Hagler are longstanding business partners and next-door neighbors who socialize together. They have known each other for over 25 years and started doing business together over 20 years ago (Hagler Tr. at 15:10-23).

92. In total, the Centers website lists 38 nursing home facilities in New York State that it operates, controls, and/or manages. Centers also provides purported administrative and business support to nursing homes in New Jersey, Rhode Island, and Kansas (Budimir Aff. ¶ 21).

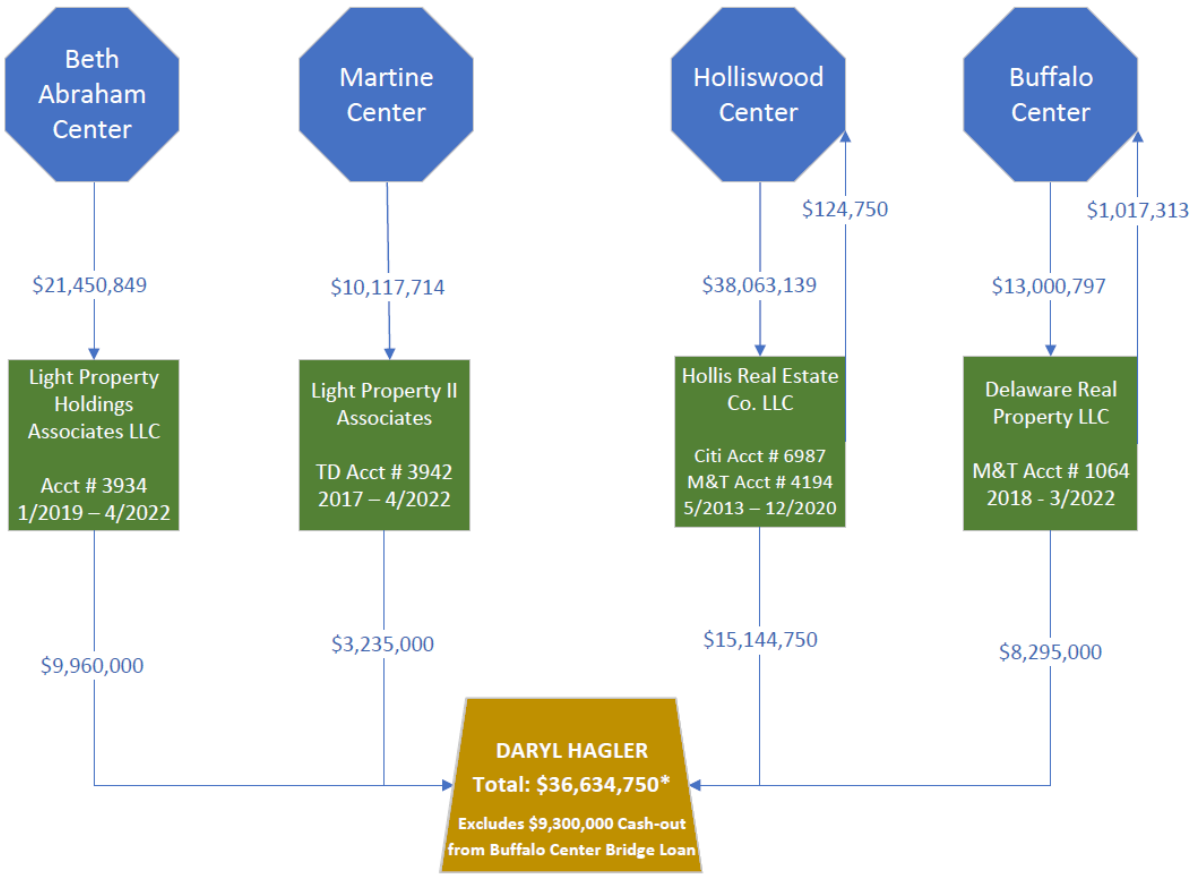
93. Rozenberg is the majority owner of 32 limited liability companies that operate Centers-affiliated nursing homes in New York State (Budimir Aff. ¶ 22, Exh. 21, 31a, 31b, and

[20] Centers Health Care, Centers Health Care Gives Back to Seven Selected Organizations With a $2500 Grant Within Each of Centers' Regions (Feb. 9, 2022), https://centershealthcare.com/media/centers-health-care-gives-back-to-seven-selected-organizations-with-a-2500-grant-within-each-of-centers-regions (last visited June 23, 2023); *see also* Centers Health Care, https://centershealthcare.com (last visitedJune 23, 2023).
[21] *See* Centers Health Care, https://www.centershealthcare.com (last visitedJune 23, 2023).
[22] *See* Centers Health Care, Our Leadership, https://centershealthcare.com/leadership (last visited Nov. 17, 2022).

34). In addition to being the majority owner of Centers-affiliated nursing homes in New York State, Rozenberg is also an operator of each facility (*id.*).

94. Hagler owns most of the companies that own the real estate where the Centers-affiliated nursing homes are located (Hagler Tr. at 18; Budimir Aff. ¶ 26, Exh. 33). As such, Hagler is effectively the related party landlord for the majority of Centers-affiliated nursing homes in New York State, including the Nursing Homes at issue herein. Together, Rozenberg and Hagler entered into several related party loans through their respective operations and real estate entities. As set forth in greater detail below, Hagler and Rozenberg profited handsomely from these arrangements—draining the Nursing Homes of over $70 million—all while Respondents operated the Nursing Homes in disregard and violation of the many State and federal laws requiring them to provide required.

95. As one example reflected in the chart below, from the fraudulent real estate schemes alone, Respondents transferred over $27 million to Hagler from the Nursing Homes from [insert dates] – again, while Rozenberg, Centers, Hagler and other Respondents ignored and violated state and federal laws designed to protect nursing home residents. Notably, from March 2019 through March 2021, Hagler transferred over $103 million from his personal account at Popular Bank to Rozenberg's personal account at Popular Bank (*see* Waldropt Aff. ¶ 91). 27,



96. Both together and individually, Rozenberg and Hagler, along with their family members, own many of the companies to which the Nursing Homes transfer significant funds to pay for various purported services and goods (*see, e.g.,* Budimir Aff. ¶¶ 26, 29, Exh. 49a-49y, Petition Exh. 28; Hagler Tr. at 14-15; 17; 30-35; 37-42; 44-48; 48-50; 55; 61-66). Respondents direct the Nursing Homes to make payments to these related party vendors, while disregarding the Nursing Homes legal duties under state and federal law. From December 2018 through April 2022, through these related party arrangements and transactions, Rozenberg and Hagler, and their family members, extracted nearly $7 million from the Nursing Homes (*see* § VIII[B][2] below).

97. On its website, Centers disclaims ownership of the nursing homes with which it is affiliated and purports to provide merely "administrative and business support" to those facilities:

> Centers Health Care affiliated facilities and companies are independently owned and operated. Centers Health Care provides administrative and business support to its affiliated health care providers. Centers Health Care is neither the owner nor operator of any health care provider or managed care plan.[23]

98. In reality, however, Centers acts as a *de facto* operator, exerting significant control over, and making all major decisions for, Centers-affiliated nursing homes, including the Nursing Homes. Centers exercises this control through the "Consulting Services Agreements" that Centers enters with each Centers-affiliated nursing home. As discussed herein, Centers controls decisions including setting budgets, determining staffing levels, promulgating infection control policies, and accepting resident admissions. Indeed, per the "Consulting Services Agreement," Centers provides most of the services required to operate a nursing home, including operational consulting, accounts receivable, billing, accounts payable, payroll, reports, bookkeeping, pharmacy assistance, human resources, purchasing, clinical consulting services, policy and procedures, training, performance improvement, survey and inspection corrections, electronic medical records, marketing, temporary staffing, and information technology (*see* Consulting Services Agreements annexed to Budimir Aff. f.n. 5, Exh. 1a-1d). In short, the Nursing Homes are controlled by Centers, and Centers is, in turn, controlled by Rozenberg and Hagler. The Consulting Services Agreements between Centers and the Nursing Homes are counter-signed by Rozenberg on behalf of both the Nursing Homes and Centers (*id.*).

99. Under the Nursing Home Operators' control and operation, in tandem with Centers's management and control, the Nursing Homes failed to provide sufficient care, as required by regulation, subjecting many residents to humiliation, and loss of dignity. Family members observed many such incidents, devastated by witnessing the brutal effects of

[23] *See* Centers Health Care, https://centershealthcare.com (last visited June 23, 2023).

Respondents' prioritization of their financial interests over the well-being and safety of the Nursing Homes' residents and their legal duties to provide required care to their residents.

B. Rozenberg and Centers Chronically Understaffed the Nursing Homes

100. As set forth herein, much of the neglect suffered by the Nursing Homes' residents could have been avoided had Respondents permitted the Nursing Homes to retain and spend sufficient funds to appropriately staff the Nursing Homes.

101. CMS publishes Nursing Home ratings publicly via the "Care Compare" website, including ratings for Staffing. The CMS Staffing rating is a separately published rating for each facility. It, along with two other ratings, is also a component of the rating published as the Overall rating of a facility. The Staffing rating is based on CMS's expectation of the number of staffing hours that the nursing department of a facility needs, relative to the number of residents, adjusted by the acuity (or medical complexity) of the residents' medical needs. *See* Budimir Aff. ¶ 66-69. This ratio is expressed as a star rating and indicates how poorly (1 Star, "much below average") or well (up to 5 Stars, "much above average") a facility has done meeting CMS's expected staff levels.

102. As further explained below, at ¶¶ 113-16, 206-11, 224-47, the poor staffing conditions at the Nursing Homes were obvious to Respondents, who were familiar with the facilities' publicly published CMS-star ratings, and who created the poor conditions by exercising control to cut and limit staffing expenses and continue accepting resident admissions. For much of the past few years, CMS rated the Nursing Homes with the lowest possible one- or two-star ratings in staffing. Since April of 2018, Holliswood has had a one-star staffing rating, which is "much below average" (Budimir Aff. ¶ 70). In fact, Holliswood entered the COVID-19 pandemic with a one-star staffing rating—with disastrous consequences (*see* § V[B][2][ii]). Beginning in April 2018, Beth Abraham had a two-star staffing rating. This low staffing rating existed

immediately prior to the pandemic and dropped to a one-star in January 2021 continuing through April 2022 (Waldropt Aff. ¶ 50). In fact, by April 2022, conditions at Buffalo Center were so poor that it was not even rated on the star rating system and was denominated a Special Focus Facility.[24]

103. Despite notice of the publicly available low CMS staffing ratings, Respondents continued to: ignore and violate laws designed to protect residents; operate the Nursing Homes with chronic insufficient staffing; cause the Nursing Homes to accept admissions despite insufficient staffing to provide required care to existing residents to increase revenue; and fail to increase staffing levels. As a result, residents suffered neglect and mistreatment before and throughout the pandemic.

104. As the financial analysis in § VIII below reflects, Respondents could have prevented much of this neglect and suffering, had they not siphoned over $83 million in Medicaid funding from the Nursing Homes.

V. RESPONDENTS ROZENBERG, CENTERS, THE NURSING HOMES' OPERATORS, AND THE NURSING HOMES' OWNERS REPEATEDLY AND PERSISTENTLY VIOLATED NURSING HOME REGULATIONS, RESULTING IN RESIDENT NEGLECT.

A. Respondents' Business Model Maximizes Profits at the Expense of Resident Care, in Violation of the Laws Designed to Protect Residents

105. Respondents repeatedly and persistently neglected many of the Nursing Homes' residents starting at least as early as January 2019, in violation of various state and federal nursing home statutes and regulations Respondents neglected the Nursing Homes' residents by failing to provide "timely, consistent, safe, adequate and appropriate services, treatment, and/or care . . .

[24] Special Focus Facilities are nursing homes that have: (1) more problems than other nursing homes (about twice the average number of deficiencies); (2) more serious problems than most other nursing homes (including harm or injury experienced by residents); and (3) a pattern of serious problems that has persisted over a long period of time (*see* CMS, Special Focus Facility Program, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification /CertificationandComplianc/Downloads/SFFList.pdf (last visited Nov. 17, 2022)).

including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living." 10 NYCRR § 81.1(c); *see also* 10 NYCRR § 415.4(b).

106. This neglect flows predictably from the "insufficient staffing and continued admissions" business model that Centers imposed on the Nursing Homes. From the time they purchased the Nursing Homes through to the present, Respondents Rozenberg and Hagler, Centers, and the Nursing Homes' Owners and Nursing Homes' Operators implemented policies that maximized up-front profit-taking that benefitted the owners, their family members and Favored Persons, with the primary goal of increasing facility revenue, decreasing expenses, with conscious disregard for the impact on the residents and the laws protecting them. As discussed in detail throughout this Petition, these policies include, but are not limited to: cutting staff and staffing expenses to maximize the Nursing Homes Owners' concealed up-front profit-taking, resulting in too few direct care staff to provide required care; continuously admitting residents to increase revenue, in spite of direly inadequate staffing levels; and underfunding infection control programs to cut costs, thereby increasing residents' risk of exposure to COVID-19 and other infections.

107. As noted above, one of the most lucrative ways for nursing home owners to increase their taking of up-front profits is to reduce staff while maintaining or increasing the number of residents. But, as the evidence herein demonstrates, cutting staff—especially while continuing to admit residents to the facility—increases the incidence of preventable resident neglect.

108. Despite the obvious risk of increased resident neglect and legal violations, Respondents' operation of the Nursing Homes with minimal staffing was at the forefront of Respondents' business plans for each of the Nursing Homes, and their operation in this model persisted despite its adverse effects on residents.

Respondents Filed Certificate of Need Applications for the Nursing Homes

109. When a prospective buyer proposes the purchase of a nursing home in New York State, the individuals or entities applying to become the operator must be approved by the New York State Public Health and Health Planning Council ("PHHPC"). DOH administers this process, which requires applicants to submit a Certificate of Need ("CON") application to DOH that sets forth, among other things, the proposed ownership and finances of the facility (O'Leary Aff. ¶ 19).

110. The CON applications for Martine Center, Buffalo Center, and Beth Abraham Center detailed a plan whereby the Nursing Home Operators would increase capital while simultaneously reducing the operating expenses for the facilities, primarily through cuts to direct care staff at the facilities (Winslow Aff. ¶¶ 68; O'Leary Aff. ¶ 28; Waldropt Aff. ¶ 51).

111. The CON application submitted in connection with the purchase of Buffalo Center is illustrative. Correspondence submitted as part of the Buffalo Center CON application confirms that Respondents planned to reduce the number of Certified Nurse Aide ("CNA") and Licensed Practical Nurse ("LPN") positions, along with orderlies, attendants, technicians, and specialists, through a 23% reduction in full-time employees, measured through full-time equivalent ("FTE") hours (*see* O'Leary Aff. ¶ 28, Exh. 50).

112. Once their CON applications were approved, Respondents acquired the Nursing Homes and cut direct care staff, leaving the Nursing Homes inadequately staffed even before the COVID-19 pandemic. They also reduced salaries, leaving the Nursing Homes poorly positioned to recruit and retain staff given the low wages. Unsurprisingly, under Respondents' ownership, operation, and management of the Nursing Homes, residents care suffered.

Overall and Staffing Star Ratings for the Nursing Homes Dropped Under Respondents' Control

113. The decline in care at the Nursing Homes is reflected by the decline in the Nursing Homes' star ratings, as discussed in ¶ 102 above. From the time the Nursing Homes' Owners purchased the Nursing Homes and Centers began controlling them, through the present, CMS Star ratings for both Overall and Staffing have dropped dramatically or failed to improve. The chart below, based on the Star Ratings from January of the year specified, demonstrates this decline[25]:

Year	Month Published	Overall	Staffing	Overall	Staffing	Overall	Staffing	Overall	Staffing
2015	January	3	1	4	4	5	4	4	1
2016	January	4	1	2	2	4	2	3	1
2017	January	4	1	2	3	3	2	4	1
2018	January	4	3	2	3	4	2	5	1
2019	January	3	2	2	2	3	1	5	3
2020	January	2	1	1	2	1	1	4	2
2021	January	2	1	1	2	2	1	4	2
2022	January	2	1	1	1	2	1	2	1

(Budimir Aff. ¶ 73).

114. The above chart demonstrates that by January 2022, none of the Nursing Homes merited above 2 stars ("below average") in their Overall rating and one star ("much below average") in their Staffing rating.

115. The inadequate staffing evidenced by the above CMS Star ratings led to neglect, poor treatment and poor resident outcomes.

[25] The yellow shaded boxes of the chart correspond to the time periods during which Respondents owned the Nursing Homes.

116. Moreover, by April 2022, conditions at Buffalo Center were so poor it had been added to the Special Focus Facility list, where it remained until March 2023. Indeed, Buffalo Center had been under scrutiny by CMS for the 14 months that preceded its designation as a Special Focus Facility (*see* Pettigrew Aff. ¶ 90, Exh. 84). Of the over 15,000 nursing homes in the country, only 87 are on this list of the most egregious offenders (*see* CMS, Special Focus Facility Program). During the time Buffalo Center was on the Special Focus Facility List, it was no longer rated on CMS's star system due to that designation. At the time, the CMS website stated that Buffalo Center was "not rated due to a history of serious quality issues."[26]

B. <u>Before, During, and After the Peak of the COVID-19 Pandemic, Respondents Repeatedly and Persistently Violated Numerous Legal Duties to Residents by Neglecting and Mistreating Them</u>

117. While the Nursing Homes violated their duties of care to their residents, Respondents' callous disregard for and looting of the Nursing Homes caused neglect and harm. Below are some of the heart-wrenching illustrations of the Nursing Homes' neglect of their residents, which Respondents failed to prevent or stop.

118. Several of the witnesses in the Attorney General's investigation expressed strong fear of retaliation from the Nursing Homes for cooperating in this investigation, including a fear that the care provided to their loved one would further decline in retaliation if they cooperated with this investigation (*see*, *e.g.*, Det. Olsen Aff. ¶ 8, Det. Bates Aff. ¶ 8).

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[26] Buffalo Center was recently removed from the Special Focus Facility list. This is of no import. To the extent that Respondents may have remedied the conditions that led to Buffalo Center having been designated a Special Focus Facility, this merely underscores that Respondents could have better staffed and operated the facility all along but chose not to do so. It is also an example of "yo-yo compliance," in which a facility temporarily improves its performance when under state or federal scrutiny, but subsequently returns to its substandard performance due to its own disregard of laws designed to protect residents. This is often a pattern in poor performing nursing homes. Moreover, Buffalo Center currently has a CMS rating of one star overall and one star for staffing, indicating that it has barely improved, despite having been removed from the Special Focus Facility list.

1. Respondents Neglected and Mistreated Residents Before the COVID-19 Pandemic, in Violation of Their Duties to Provide Required Care

119. Prior to the pandemic,[27] Respondents Rozenberg, Centers, the Nursing Home Operators, and the Nursing Homes' Owners neglected and denied necessary care to residents at the Nursing Homes, including assistance with toileting and incontinence, assistance getting in and out of bed, and assistance showering. These failings were due, in large part, to Respondents' operation of the Nursing Homes with insufficient staffing to provide required care. *See generally* Sect. VI.

120. The Nursing Homes' employees routinely ignored and/or were too short-staffed to respond to call bells (*see, e.g.*, Affidavits of B.J., Casey, Anna Maria Naimoli, Antonietta Johnson, Marie Dunn, M.P., Solas-Santiago), which are devices located bedside that have buttons that residents can press to request and signal their need for help from staff while lying or sitting in bed. The purpose of a call bell is for the resident to signal to staff a need for care (*e.g.*, for help: getting pain medication, moving, eating, drinking, using the toilet, changing a soiled diaper, and/or with personal hygiene or grooming). Ignoring a call bell is tantamount to refusing to meet the resident's needs (*see* Keyser Aff. ¶ 16).

121. Residents who were unable to get to the bathroom and use the toilet independently were forced to sit in their own feces and urine (*see*, *e.g.*, B.J. and Dunn Affs.; *see* Pettigrew Aff. ¶ 7-9, Exh. 1-3; Det. Bates Aff. ¶ 199), for hours at a time (*see* L.S. Aff.). At times, this led to urinary tract infections, skin rashes, suffering and loss of dignity (*see* R.D. Aff., Affidavit of Dorothy Pietraszewski, attached hereto, Naimoli Aff., and Johnson Aff.).

[27] The time before the COVID-19 pandemic, defined as any time prior to March 1, 2020, will hereinafter be called the "Pre-Pandemic Period."

122. When residents inevitably soiled themselves after staff failed to timely respond to call bells or otherwise provide assistance with using the toilet, staff frequently neglected to clean residents, and failed to change their clothing. Examples of Respondents' many failures to adequately provide residents with required care and assistance with their toileting and related care needs during the Pre-Pandemic Period include:

i. The son of Buffalo Center Resident L.S.—a former police officer—frequently had to clean him and change his clothes because it was not done by staff. This caused L.S. to cry and apologize to his son. His son noticed that sheets that were stained with urine one day were still on the bed when he returned the following day (*see* Scinta Aff).

ii. Buffalo Center Resident BC3[28] was unable to toilet herself without assistance. Her brother often found her in bed, sitting in a diaper filled with feces, on sheets that were soiled with urine and feces. In 2018, she developed a urinary tract infection and C. difficile and was later hospitalized and died from complications from these infections (*see* Affidavit of Det. Petucci Aff. attached hereto at ¶ 88-92).

iii. The girlfriend of Buffalo Center Resident G.S. visited him daily and had to change his diaper several times when staff did not do so in a timely manner. He never seemed properly groomed; she had to shave him and wash and comb his hair. She also gave him sponge baths because he never looked clean (s*ee* Pietraszewski Aff.).

iv. The husband of a Buffalo Center resident described an incident in which his wife needed to go to the bathroom; after waiting two hours for assistance, he finally took her himself. In another instance, she had soiled herself and when the husband rolled her over in her bed to assist, she had food underneath her, which "disgusted" him (*see* Pettigrew Aff. ¶ 7, Exh. 1).

i. Holliswood Center Resident HC5's daughter visited her mother often and sometimes saw that her mother had not been changed and had feces and urine all over her bed and dirty diapers on the floor of the shared bathroom (*see* Det. Bates Aff. ¶¶ 113-15).

ii. Holliswood Center Resident HC16's granddaughter heard her grandmother screaming for a diaper change after sitting in soiled diapers for hours. On one occasion, HC16's granddaughter visited at 1 P.M. and learned from her

[28] Within Det. Petucci's Affidavit, Buffalo Center residents are anonymized and referred to with the prefix "BC" and a number designation.

grandmother that she hadn't been changed since she woke up that morning (*see* Det. Bates Aff. ¶¶ 209-10).

iii. Beth Abraham Resident M.P. noticed staff ignoring her roommate's call bell when the roommate's diaper was soiled, but since M.P. was "younger and more outspoken," she got more attention and would ring her own call bell to get staff's attention and direct them to change her roommate's diaper (*see* M.P. Aff.).

iv. On multiple occasions, urine soaked through Beth Abraham Resident M.R.'s diaper and seeped onto her clothes (*see* Craft Aff.).

123. Residents who lacked the physical strength and ability to get in and out of bed independently, or to otherwise reposition themselves, were left to languish in bed for hours, as there were no staff members available to assist them. Residents who lack the physical strength and ability to move their bodies independently (*i.e.*, from side to side or front to back) typically have individualized care plans that require staff to turn and position their bodies at specified intervals of time, to prevent pressure on areas of skin for prolonged periods of time, which can cause pressure ulcers (Keyser Aff. ¶ 24). The lack of turning and positioning, and toileting/incontinence care placed residents in grave danger of developing pressure ulcers[29] or blood clots (Keyser Aff. ¶ 32, 51). Examples of medical harm to residents due to inadequate toileting during the Pre-Pandemic Period include:

i. As a result of lack of incontinence care (described above), Buffalo Center Resident G.S. developed pressure ulcers that the facility failed to properly treat, as well as a urinary tract infection and C. Difficile (*see* Pietraszewski Aff.).

[29] Pressure ulcers are types of wounds that develop on the skin. The skin is the largest organ in the body and it requires an adequate supply of blood to provide oxygen and nutrients to maintain skin health and integrity. Prolonged pressure on the skin, primarily in areas where bones are near the skin's surface (*i.e.*, on a person's hips, spine, heels, feet, and/or head), prevents adequate blood supply to the area, which increases the risk of pressure ulcer development. Pressure ulcers can develop quickly, in as little as two hours, if pressure is not relieved by use of pressure relieving devices and changing the position of the body. *See* Keyser Aff. ¶ 20.

ii. Beth Abraham Resident A.L. was left for hours in a dirty diaper, and once, when she asked to use the bathroom, was told to toilet in her diaper instead. She developed a pressure ulcer and a urinary tract infection (*see* Lawrence Aff.).

124. Often the residents who were not receiving regular toileting and/or incontinence care attempted to toilet themselves, resulting in falls that caused significant injuries. Examples of falls due to lack of toileting assistance during the Pre-Pandemic Period include:

i. In March 2019, Buffalo Center staff failed to respond to Resident B.J.'s call bell, leading her to attempt to toilet herself. While she attempted to toilet herself, she fell in the bathroom, breaking her leg, and hitting her face on the wall (s*ee* Affidavit of Louis Clark, attached hereto).

ii. In January 2020, a Buffalo Center resident attempted to get to the bathroom by himself when no staff member answered his call bell. He fell and broke his femur, laying on the floor for almost an hour before a staff member finally responded to his roommate's call bell (*see* Scinta Aff.).

iii. Holliswood Center Resident HC16 fell at least five times trying to reach the bathroom by herself after staff ignored her call bells (*see* Bates Aff. ¶¶ 213-14; *see also* Rhody Aff. ¶ 77) (noting medical records chronicling over nine falls in 2020 alone).

iv. While attempting to toilet herself when staff was unresponsive to her call bell, Martine Center Resident A.C. fell at least twice, and one of the falls resulted in an injury requiring stitches (*see* Naimoli and A. Johnson Affs.).

125. Residents were not showered or bathed regularly, receiving only an occasional sponge bath. Residents who did not receive regular showers or baths during the Pre-Pandemic Period include:

i. Beth Abraham Resident M.P. stayed at facility for three months and never received a single shower (*see* M.P. Aff.).

ii. Buffalo Center Resident D.E. never received a shower or had her hair washed in nearly three weeks at the facility (*see* D.E. Aff.).

iii. Martine Center Resident C.R. appeared to not have showered for one month and developed a rash due to lack of hygiene (*see* Affidavit of Carla Forgione, attached hereto).

126. Respondents failed to groom residents and to perform oral, nail, and skin care and properly dress wounds. Residents who did not receive adequate grooming and/or wound care from the Nursing Homes during the Pre-Pandemic Period include:

i. At Buffalo Center, diabetic Resident M.D.'s skin was "caked up like paste on the bottom of her feet." Her skin would stick to her socks when they were pulled off (*see* Affidavit of Cherell Toe, attached hereto).

ii. A Beth Abraham resident developed gangrene on her foot, which staff had covered with a sock, and her family and friends only discovered the condition when they noticed an unpleasant smell emanating from her foot (*see* Craft. Aff.).

iii. Beth Abraham Resident M.R. often appeared dirty; her hair was not combed or cleaned, and her clothes were often soiled (*see* Craft Aff.).

iv. Martine Center Resident E.B. often appeared unkempt; staff told her daughter that she refused to shower but E.B. lacked the mental capacity for such a refusal. (*see* Affidavit of Sheryl Johnson, attached hereto).

Holliswood Resident B.H. was always "filthy" when his daughter visited because staff did not wash his hair or shave him often. He wore dirty clothes. Staff failed to clean an eye wound he had, causing pus to accumulate. In only a month of living at Holliswood, B.H.'s daughter noticed a significant difference in his appearance (*see* Holguin Aff. and Exhs. A, J). *See* Photographs of B.H, ¶ 6 above.

127. Residents were not given access to timely meals and/or assistance with feeding, where needed. Residents who were not adequately given food during the Pre-Pandemic Period include:

i. Holliswood Resident HC16 became "emaciated" and staff told HC16's granddaughter that they could not help HC16 eat or accept food deliveries that her family orders for her because of shift changes (*see* Bates Aff. ¶ 225, 227).

ii. Holliswood Resident P.D.R. complained to his son that the food was undercooked and cold; P.D.R. lost approximately 50 pounds in under two

years and now looks like "skin and bones," "like a shell of himself" (*see* Driver Aff.).

iii. Holliswood Resident B.H. experienced a 7% drop in body weight in approximately one month (*see* Rhody Aff. ¶ 64; *see also* Holguin Aff.).

128. Respondents failed to maintain a sanitary environment in the Nursing Homes prior to the pandemic, which frequently smelled of urine and/or feces and was dirty (*see*, *e.g.*, Holguin Aff.; M.P. Aff.; Craft; Det. Bates Aff. ¶¶ 127, 201, 247). At Beth Abraham, staff neglected to clean up food trays in a timely manner (J. White Aff.). At Martine, a resident and her daughter found a dead mouse in the resident's closet (*see* S. Johnson Aff.).

129. Respondents also failed to safeguard the Nursing Home residents' clothing and belongings causing the residents further indignity. Residents whose belongings were not safeguarded by the Nursing Home prior to the pandemic include:

i. Holliswood Resident HC7's daughter bought him an electronic keyboard to play, as he used to play piano in church. When he was transferred to a different floor, the keyboard went missing, as did some of his clothing, and staff claimed they couldn't find the items (Det. Bates Aff. ¶ 128; *see* also Holguin Aff. [referring to B.H.'s clothes, sneakers, reading glasses, and dentures]).

ii. Beth Abraham frequently lost or damaged Resident F.E.'s property, including his hearing aids; F.E.'s dentures also broke while he resided at Beth Abraham and the facility did not replace them or the hearing aids for months (Det. Ras Aff. ¶¶ 62, 66-67).

2. Respondents' Neglect and Mistreatment of the Nursing Homes' Residents Intensified During the COVID-19 Pandemic, in Violation of Their Duties to Provide Required Care

130. On March 5, 2020, Holliswood residents began to show symptoms of COVID-19 (Rhody Aff. ¶ 34). In the weeks that followed,[30] more and more residents developed COVID-19 infections, at Holliswood, and then at Beth Abraham and Martine Center. By early April 2020, all

[30] The period from March 1, 2020 through June 30, 2020 will be hereinafter called the "Peak-Pandemic Period."

four of the Nursing Homes, including Buffalo Center, had identified residents and staff displaying COVID-19 symptoms (*see* Rhody Aff. ¶ 35, Exh. 2; Pettigrew Aff. ¶ 10-11, Exh 4-5; Eusebio[31] [5/20/21] Tr. at 213; Eusebio [6/24/21] Tr. at 67; Serebrowski[32] Tr. at 28).

131. With the rapid spread of COVID-19 across the Nursing Homes and New York State, many employees of the Nursing Homes became unavailable to work (whether sick, quarantined, or sidelined due to lack of childcare and school closures), further diminishing the low staffing levels at the Nursing Homes. As a result of the skeletal staffing, the already neglected residents were further ignored and subjected to increased instances of neglect and mistreatment, as well as the heightened threat of illness and death.

i. Neglect and Mistreatment at Holliswood Center During the Peak-Pandemic Period

132. With the spread of COVID-19 throughout Holliswood during the Peak-Pandemic Period, facility staffing levels dwindled and resident care suffered. CNAs struggled to help with basic Activities of Daily Living ("ADLs") such as bathing, toileting, washing, cleaning, transferring, and bed mobility (*see* Det. Bates Aff. ¶¶ 15, 16, 62-66, 90). Residents who required assistance from more than one staff member often had to wait long periods to receive care until additional staff members could be located (*id.*). In other instances, individual staff members tried to provide care without the necessary second person, which resulted in several resident falls during Hoyer lift[33] transfers (*see* Det. Bates Aff. ¶¶ 16, 63, 90). Indeed, Holliswood residents suffered

[31] On May 20, 2021 and June 24, 2021, Martine Center Director of Nursing Nora Eusebio testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcripts of such testimony are hereto annexed.
[32] On November 17, 2020, Buffalo Center's Administrator Yechezkel "Zeke" Serebrowski testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of such testimony is hereto annexed.
[33] A Hoyer lift is a mechanical lifting device that is used in nursing homes to move residents who are unable to bear weight on their legs or are unable to participate in the transfer process, and who

falls at increased rates during the Peak-Pandemic Period (Rhody Aff. ¶ 52), including multiple unattended falls, some of which resulted in serious head or neck injuries (*see, e.g.*, Vega Aff.; Revell Aff.).

133. Resident J.V. suffered multiple falls during February to April 2020—including one that caused a brain hemorrhage for which he was hospitalized (Vega Aff.; Rhody Aff. ¶ 84). Resident D.J. fell during physical therapy on February 27, 2020, when no one was there to catch him, and fractured his proximal humeral neck (bone in shoulder) (Rhody Aff. ¶ 58; Revell Aff.).

134. During the Peak-Pandemic Period, Holliswood's staff continued to neglect residents' toileting and incontinence needs (*see* Rhody Aff. ¶¶ 59, 67, 74, 79; Det. Bates Aff. ¶¶ 182, 199, 209, 210, 211).

135. Holliswood Center's staff repeatedly failed to timely turn and position[34] residents who lacked the physical strength and ability to move their bodies independently, during the Peak-Pandemic Period, and some residents developed painful pressure ulcers that grew in size as a result. Examples of Holliswood residents who were neglected in this way include:

a. Resident HC17 was admitted to Holliswood in 2020 with pressure ulcers on his sacrum and right and left heels. After his admission, all three ulcers worsened, and another ulcer developed on his right ankle (Rhody Aff. ¶ 63). Resident HC17 complained to his daughter that the staff had left him in bed

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are totally dependent on staff members to transfer them from one surface to another. They are operated by manual hydraulic lift, battery, or electric powered. The transfer of a patient by means of a Hoyer lift requires two nursing home staff members for a number of reasons, including that: it is necessary to have one person to operate the lift and the other, to maintain their hands on the resident and guide the resident to his/her destination; two individuals should ensure proper attachment of the sling to the lift; and to provide reassurance to the resident during the procedure (*see* Keyser Aff. ¶ 33-34).

[34] "Turning and positioning" is the process of changing a nursing home resident's position, such as by rolling them from one side to the other, or from one side to their back. Nursing homes are required to turn and position residents who are unable to ambulate or reposition themselves. Turning and positioning is necessary to enhance blood flow and prevent pressure injuries. The most common cause of pressure injuries in nursing home residents is the nursing home's failure to turn and position residents (*see* Keyser Aff. ¶ 20-24).

all day (Det. Bates Aff. ¶ 243). In addition, HC17 developed sepsis caused by a urinary tract infection and was transferred to the hospital (Rhody Aff. ¶ 63).

b. During at least 33 shifts in a four-and-a-half month period, Holliswood staff failed to record having turned and positioned Resident L.S. (Rhody Aff. ¶ 61). When L.S. complained to staff about sitting in a soiled diaper for hours, staff refused to change him, explaining that it was not time for his scheduled change. However, L.S.'s diaper changes were scheduled merely three times a day: 7 A.M., 12:30 P.M. and 8 P.M. In between these times, he laid in his own feces (Salvio Aff.).

c. *See also* Det. Bates Aff. ¶¶ 63, 172, 203, 254.

136. As they had before the COVID-19 pandemic, staff at Holliswood continued to fail to timely answer resident call bells, making residents wait for hours at a time before responding (*see, e.g.*, Salvio Aff.).

137. Residents at Holliswood also reported that they did not receive their medication on a timely basis during the Peak-Pandemic Period (*see* Salvio Aff.; Det. Bates Aff. ¶¶ 151, 180). These residents' experiences are consistent with a disturbing trend of missed medication administration and/or failure to document medication administration at Holliswood during the Peak-Pandemic Period, as discussed in § V(H) below.

138. Holliswood residents also suffered dehydration during the Peak-Pandemic Period, including the following two residents:

a. Prior to the pandemic, Resident HC17 would beg his daughter for water when she visited. During the pandemic, when they spoke by video, HC17 could barely open his mouth because it was so dry (Det. Bates Aff. ¶ 246).

b. Another resident, D.J., had been hospitalized in February 2020, during the Pre-Pandemic period, and was found to be severely dehydrated (Rhody Aff. ¶ 58). Just months later, on April 20, 2020, D.J. was again hospitalized and diagnosed with severe dehydration, septic shock, a urinary tract infection, renal failure, and COVID-19. He died two days later of septic shock and cardiac arrest (*see* Revell Aff.; s*ee also* Rhody Aff. ¶ 57).

139. During the Peak-Pandemic Period, communication between Holliswood staff and residents' family members was sparse. In at least one case, a family member learned that her relative was sick, and called and emailed repeatedly for updates but no one at Holliswood provided one. Holliswood did not contact her about her relative's condition until after her relative had died (*see* Vega Aff.). The elder advocate that she hired to represent her relative's interests similarly tried repeatedly to reach Holliswood and felt frustrated by the lack of updates on her client's declining condition (*see* Clutz Aff.).

140. Holliswood failed to take appropriate steps in seeking supplemental medical care for the residents during the Peak-Pandemic Period, at times delaying the transfer of residents to the hospital until they became severely ill. When D.J.'s sister learned from Holliswood that her brother was feeling sick and not eating during the week of April 13, she insisted that Holliswood send him to the hospital (Revell Aff.). However, Holliswood refused, even though staff was well aware of D.J.'s worsening condition as he began to show signs of a fever on April 2, 2020: notes in D.J.'s medical chart throughout April indicate that he was feverish, lethargic, had a poor appetite, and refused to eat (Rhody Aff. ¶ 57). By the time Holliswood transferred D.J. to the hospital on April 20, 2020, he had septic shock, a urinary tract infection, acute renal failure, COVID-19, and severe dehydration (Rhody Aff. ¶ 57). He died two days later of septic shock and cardiac arrest (Revell Aff., Rhody Aff. ¶ 57).

ii. Holliswood Residents Suffered and Died during the Peak-Pandemic Period

141. Not only were Holliswood's residents neglected, but during the Pandemic, in 2020, the percentage of Holliswood's population who died was higher than it had been in every year dating back at least to 2015.

142. As set forth below, as COVID-19 spread throughout the facility, historically insufficient staffing levels left Holliswood unprepared to adequately treat its residents. Residents

suffered immensely as many fell ill from COVID-19 and did not receive required care for their needs. Some lost significant amounts of weight and looked like "skeletons," had difficulty breathing, felt pain in their chests, spiked high fevers, and died (*see, e.g.,* Det. Bates Aff. ¶ 153). Indeed, between March 18, 2020 and May 14, 2020, 70 of Holliswood's residents died from COVID-19—more than 22% of the resident population (Budimir Aff. ¶ 48, Exh. 11).

143. Had Centers and Rozenberg permitted Holliswood to retain and spend more of its Medicaid and Medicare funds to operate with sufficient staffing, or to halt admissions in the face of insufficient staffing, instead of continuing to operate with these practices while the owners covertly extracted millions of dollars in up-front profit for themselves and Favored Persons, Holliswood would have been better prepared to address the situation during the pandemic of staff being sick or quarantined and could have prevented many tragic outcomes. Indeed, as set forth in § VI(E)(2), below, Holliswood's staffing during the Peak-Pandemic Period reached crisis levels.

iii. Neglect and Mistreatment at Beth Abraham Center During the Peak-Pandemic Period

144. Like Holliswood, Beth Abraham continued to provide substandard care during the Peak-Pandemic Period, resulting in the neglect, suffering, mistreatment, and humiliation of numerous Beth Abraham residents. Family members described their relatives as looking visibly neglected: appearing dirty with unkempt hair and nails (*see*, *e.g.*, Det. Ras Aff. 32). One resident only received a single shower from February to April 2020 (White. Aff.). Family members also described seeing Beth Abraham staff without masks or other personal protective equipment ("PPE") during video calls with their relatives (Latty Aff.). Staff at Beth Abraham failed to turn and position at least one resident during this time (White Aff.).

iv. Neglect and Mistreatment at Buffalo Center During the Peak-Pandemic Period

145. The first wave of COVID-19 hit Buffalo Center slightly later than the other facilities—late March to early April of 2020 (O'Leary Aff. ¶ 43). The first diagnosis of COVID-19 at the facility was on or about March 30, 2020.[35] By then, Buffalo Center had been on notice from DOH for several months that the outbreak was pervasive, and cases of infection were likely to develop at the facility (Serebrowski Tr. at 70). In addition, starting March 10, 2020, Centers had been in communication with all Centers-affiliated nursing homes, including Buffalo Center, instructing them to prepare for the spread of COVID-19 (*id.* at 66). Nevertheless, Respondent Buffalo Center's Operator ran the facility with chronic insufficient staffing, causing it to enter the pandemic already understaffed (*see* § VI[E][1] below).

146. In April 2020, the number of COVID-19 cases rose in both the resident and staff populations. By April 30, approximately 24% of the resident population at Buffalo Center had been infected with COVID-19, and 16 staff members had either been confirmed or were suspected of having COVID-19 (O'Leary Aff. ¶ 43). By the fall of 2020, over 100 residents and a dozen staff members had contracted COVID-19 and there had been at least 15 resident deaths at the facility due to the infection (*id.* ¶ 44). Unsurprisingly, as the virus spread among residents and staff, Buffalo Center's self-made staffing crisis intensified and its resident care suffered.

147. With staffing levels low and COVID-19 levels high, resident neglect escalated at Buffalo Center during the Peak-Pandemic Period. Respondent Buffalo Center's Operator failed to ensure that residents' soiled diapers were changed, that residents were turned and positioned, and that residents' call bells were answered (*see* Det. Petucci Aff. ¶¶ 26-27, 37, 83-84; Affidavit of Patricia Dragovic, attached hereto).

[35] This first diagnosis was through a new resident admission (Serebrowski Tr. at 30).

148. Not only did staff members at Buffalo Center ignore call bells during the Peak-Pandemic Period, they went so far as to discourage residents from using them in the first place (*see* Det. Petucci Aff. at ¶¶ 83-84; Dragovic Aff.).

v. Neglect and Mistreatment at Martine Center During the Peak-Pandemic Period

149. Symptoms of COVID-19 were first discovered in a Martine Center resident early in the pandemic, on or around March 19, 2020 (Eusebio [6/24/21] Tr. at 67). In the weeks that followed, COVID-19 quickly spread throughout the facility and large numbers of Martine Center employees stopped showing up for work out of fear, or because they became sick, further shrinking the customary skeleton-crew staffing levels at Martine Center. As a result, the already-neglected Martine Center residents were further ignored and subjected to increased risk of illness and death.

150. Martine residents who were neglected during the Peak-Pandemic Period include the following:

a. When Resident P.B.F. was hospitalized following a brief stay at Martine Center, she was dehydrated, malnourished, had blood clots in her legs, was unable to move and had lost 20% of her weight during the two weeks she was at Martine Center (*see* Affidavit of Kevin Jones, attached hereto).

b. When Martine Center confined its residents to their rooms to limit the spread of COVID-19, Resident C.R. found it difficult to get assistance with tasks she did herself when she could move about freely, such as replacing oxygen tanks and getting water and pull-up diapers. C.R. resorted to wringing out her soiled pull-ups and reusing them. C.R.'s daughter noticed during Facetime calls that her mother was wearing the same clothes each day and her health appeared to be declining. On April 18, 2020, the facility doctor and C.R.'s daughter discussed putting C.R. on the COVID-19 drug protocol. C.R. died on April 19, 2020, after displaying a 103-degree fever (*see* Forgione Aff.).

151. In fact, one Martine resident, whose family members could no longer visit her due to COVID-19 restrictions, resorted to giving Martine staff members what she described to her daughter as "tips" so that they would do their jobs and pay attention to her:

a. During the pandemic, upon Resident A.C.'s request, her adult children would drop off cash (typically $100 bills) at the Martine Center security desk, which she used to "tip" or pay staff members. When A.C. gave "tips" or "paid the aides," she got better care, such as a shower twice a week and timely assistance getting dressed. In total, between the Spring of 2020 and Fall of 2021, these "tips" could have amounted to around $10,000 (see A. Johnson and Naimoli Affs.).

152. Martine Center staff echoed the residents' and family members' accounts of the horrific care and substandard staffing levels at the facility during the Peak-Pandemic Period, including the following instances:

a. Working at Martine Center during the height of COVID-19 was exhausting for CNA MCE1[36]—one of the worst periods of [her] life." There were days when CNA MCE1 was the only CNA assigned to the unit's[37] 3-11 p.m. shift. When this happened, MCE1 prioritized feeding the residents and changed as many diapers as she could; she rarely was able to provide necessary treatments, such as turning and positioning to prevent skin ulcers, range of motion exercises, showers, and baths. Residents who needed to be transferred out of bed using a Hoyer Lift were often left in bed all day (*see* Olsen Aff. ¶ 14).

b. Residents were not turned and positioned or taken out of bed each day, and showers and baths were cut back. More than once, a RN asked a CNA to complete wound care on a resident – a procedure that was outside the scope of the CNA's certification and therefore impermissible for the CNA to perform – because the facility had insufficient RNs to provide the required care (*see* Det. Olsen Aff. ¶ 30-31).

c. Residents were not bathed or groomed regularly, and dementia residents wandered throughout the facility unsupervised. A CNA who had been assigned 14 residents who were totally dependent upon her to feed them was only able to feed 8 to 11 of them; the remaining residents went without a meal unless a nurse fed them – which was not guaranteed as the nurses were also too busy (*see* Det. Olsen Aff. ¶ 58).

d. During this period, Martine Center even failed to keep residents hydrated. The Assistant Director of Nursing ("Martine ADON") observed, "these

[36] Within Det. Olsen's Affidavit, Martine Center employees are anonymized and referred to with the prefix "MCE" and a number designation.
[37] Based upon Martine Center census in April 2020 each unit averaged approximately 35 residents (*see* Winslow Aff. ¶ 46).

> residents are so thirsty, [the] rec[reation staff] needs to go around with a hydration cart tomorrow, this is so sad" (Pettigrew Aff. ¶ 12, Exh. 6).

153. Notably, the Martine Center Medical Director, who also served as an attending physician at Martine and who was at Martine full time during the Peak-Pandemic Period, described this period as a "traumatic time" because of the "death, pain, [and] suffering" at Martine Center. Martine Center staff focused on providing care to the residents who were sick, and consequently COVID-19 negative residents "couldn't get regular care because of COVID related" cases (Buddhavarapu Tr. at 231-32).

3. Respondents' Neglect and Mistreatment of Residents Continued After the Peak-Pandemic Period, in Violation of Their Duties to Provide Required Care

154. The Peak-Pandemic Period was not the wake-up call it should have been for Respondents and even as the pressures of the Peak-Pandemic Period subsided, they made no effort to stop operating the Nursing Homes with staffing insufficient to care for the residents' needs, thereby minimizing staffing expenses. Similarly, Respondents continued to prioritize up-front profit taking through collusive related party transactions that benefitted Rozenberg, Hagler, their families, and other Favored Persons, while Respondents violated their legal duties to provide required care to their residents, and staffing to provide it.

155. After the first wave of the pandemic subsided in the Summer of 2020[38], the Nursing Homes continued to operate with too few employees to provide required care to the residents; in some instances, under the control of Centers, and Rozenberg, the Nursing Homes even enacted new budgetary and staffing cuts (see § VI[E][4], below). As a result, the Nursing Homes continued to neglect and mistreat their residents. Residents' families, who were barred from the Nursing Homes well past the Peak-Pandemic Period, had to watch their loved ones deteriorate from afar.

[38] July 1, 2020 through the present is hereinafter called "Post-Peak Period."

Like the Pre-Pandemic and Peak-Pandemic Periods, in the Post-Peak Period that followed, low staffing levels resulted in the Nursing Homes failing to provide required care, such as turning and positioning, changing soiled diapers, assisting residents to get in and out of bed and move around the facility, toileting, and bathing, all in violation of New York State law and regulations. Respondents' failures oftentimes resulted in residents sustaining physical injuries and illnesses, and, at times, resulted in resident deaths.

i. Neglect and Mistreatment at Martine Center During the Post-Peak Period

156. During the Post-Peak Period, Martine Center's Operator failed to ensure that residents received the care to which they were entitled and, as a consequence, residents suffered. Examples of Martine residents receiving inadequate care include the following:

a. Resident P.M. received "terrible care" at Martine Center, including untimely administration of medication, being left in wet and soiled diapers, and not receiving feeding tube care, breathing treatments, wound care, or podiatry care. In December 2021, P.M.'s family notified a nurse that he was in pain and needed his pain medication. The nurse answered that he was too busy and would do it later. Despite waiting for two hours, P.M. never received the medication. At around 5:00 p.m., staff transferred P.M. to bed. His diaper was saturated with urine, but the aides told P.M.'s family they were too busy to change him. The family cleaned and changed his diaper and found a Stage IV pressure ulcer on P.M.'s sacrum area. The pressure ulcer was bloody, with puss drainage, and had a foul odor. P.M.'s family visited again five days later and, upon arrival, found P.M. in a saturated diaper again. They waited two and a half hours before Martine Center staff changed him. In January 2022, P.M.'s family again found him in a diaper soiled with urine and feces and waited an hour for staff to clean and change him. Approximately two months later, P.M. developed a fever and was hospitalized after the sacral pressure ulcer spread to his bone. After P.M.'s hospital stay, his family moved him to another nursing home, because of the terrible care he received at Martine (*see* Smith and Murray Evans Affs.). *See* photographs depicting the condition of P.M.'s foot in December 2021 and pressure ulcer in March 2022 (*see* Smith Aff.), at ¶ 6_ above.

b. Resident S.B. was not properly cared for at Martine. In particular, Martine failed to adequately address his pressure sores. During a visit in early October 2021, S.B.'s wife was shocked to find that his pressure ulcers had progressed to stage three and stage four ulcers. One of the ulcers was eating

away most of his buttocks. After seeing her husband's terrible condition, S.B.'s wife began the process of having S.B. removed from Martine to be cared for at home. However, S.B.'s wife never got the chance to bring S.B. home, as he developed sepsis, was transferred to the hospital and died several days later (see Affidavit of Jerinae Basden, attached hereto). The picture on ¶ 6 above depicts the condition of the ulcer on S.B.'s buttocks in October 2021.

c. Resident J.F. was often left in her bed when she would have liked to have been moved because there was not enough staff to complete her two-person transfer. She was regularly left overnight in a soiled diaper because there were not enough aides on the floor to change her. In July 2022, Martine Center was short diapers in her size so she and other residents had to either not wear diapers or wear the wrong size. If residents chose not to wear a diaper, they could not get out of bed. In September 2022, there was an overnight shift during which she did not receive any care and had to sit in a soiled diaper for hours (*see* Affidavit of J.F., attached hereto).

d. Resident T.P.'s physical wellbeing declined quickly while at Martine, including the development of welts on his legs and the loss of weight. In September 2020, a Martine therapist told T.P.'s son that T.P. was weak and could not get out of bed. The therapist said that she told the facility doctor about T.P.'s condition and commented that, if T.P. were her father she would take him to the hospital. T.P.'s family had him transferred to the hospital where T.P. passed away on October 12, 2020 (*see* Affidavit of Thomas Passaro, Jr., attached hereto).

e. Resident T.K.L. would routinely wait hours for someone to change her soiled diaper. On multiple occasions, she asked her daughter to call Martine to get someone to assist her. After less than three months at Martine, T.K.L.'s daughter removed her mother from Martine and cared for her at home (*see* Affidavit of Carol Ann Lasalle, attached hereto).

f. Resident B.M. received "appalling care" during her six-month stay at Martine Center. On an evening in July 2022, B.M.'s daughter visited her mother, who needed a colostomy bag, to find that her mother was in pain and discomfort. B.M.'s daughter pulled her mother's hand from under the blanket to find that it was covered in feces. When B.M.'s daughter looked under the blanket she found that no colostomy bag was attached and instead B.M. was wrapped in a towel filled with feces. As B.M.'s daughter unwrapped the towel she saw exposed intestines with the surrounding area covered in feces. B.M. notified staff who indicated that the day shift never mentioned any issues, which left B.M.'s daughter to assume that her mother was left without a colostomy bag the entire day. While staff attempted to clean the area, B.M. complained that the area was burning, and even after

the area was cleaned, B.M.'s daughter could still see feces smeared on and around B.M.'s open intestinal wound. In October 2022, during a visit, B.M.'s daughter found her mother's intestinal wound dressing around the colostomy bag soaked in feces. In December 2022, B.M.'s daughter again found her mother wrapped in a towel without her colostomy bag attached. However, this time the window in the room was open because B.M.'s roommate was covered in feces and the room smelled. The room had flies everywhere and B.M. was freezing (*see* Benitez Aff.). The pictures on ¶ 6 above depict B.M.'s condition in July 2022.

g. Former Resident C.V. resided at Martine Center for about six weeks between October and November 2022. At Martine Center, C.V. heard call bells sounding day and night. Due to the lack of staff, C.V. often had to wait long periods of time (on average 45 minutes) for her soiled diaper to be changed. Once, she sat in a soiled diaper for approximately five hours, despite ringing her call bell for help multiple times. On another occasion, C.V. sat in a soiled diaper for so long that her buttocks began to hurt. When an aide finally came to change her, the aide was rough and C.V. cried out in pain. The aide then put the wipes down, told C.V. to do it herself, and left. The aide eventually returned and finished changing C.V. In two other instances, C.V. was left so long in diapers soiled with diarrhea that the diapers leaked all over her bed. Sitting in soiled diapers "disgusted" C.V. and made her "think nobody cared." During C.V.'s six-week stay at Martine, she only received one shower (Vanacore Aff.).

h. In December 2022 through January 2023, Resident C.O.'s daughter visited her at Martine Center. C.O.'s room and bathroom were filthy, with old razors and medication lying around. C.O.'s daughter once saw Martine Center staff attempting to place her mother on a toilet seat that had feces on it. While at Martine Center, C.O. looked dirty and unkempt. C.O.'s daughter also found it difficult to reach her mother, as there were no telephones in resident rooms and when she called the facility, she was placed on hold for long periods of time and/or hung up on by the facility (*see* Affidavit of Elan Bonnema, attached hereto).

i. One woman has visited her significant other at Martine Center weekly for the past ten months. Upon admission, her significant other's room was so dirty that she had to bring cleaning products herself to clean the walls, bed, and bathroom herself. She still routinely cleans his food tray, walls, and bathroom. Staff at Martine Center told her that his room had mice. She has had to call the nurse's station over ten times, including as recently as April 2023, to get a Martine staff member to change her significant other's diaper and attend to other needs. On about five occasions, she has seen staff use a Hoyer lift operated by one person [when two are required] to get her significant other out of bed (*see* Affidavit of Alice Barner, attached hereto).

157. Martine Center staff corroborated these accounts of poor staffing and deficient care at the facility during this Post-Peak Period. Further examples of neglect and deficient care include the following:

a. During this time, aides frequently changed residents' diapers only once per 8-hour shift, and they commonly placed two diapers on residents to limit overflow. When staffing was low, one CNA prioritized feeding residents, which could take 20 to 25 minutes per resident; this left her with limited time to complete other required treatments, which often were significantly delayed, or simply not done. Martine Center's low staffing was a self-perpetuating problem because newly hired employees quit when they saw how understaffed it was (*see* Det. Olsen Aff. ¶ 15).

b. CNAs were forced to triage care by prioritizing feeding and diaper changes and by delaying or often skipping other care, including range-of-motion assistance, turning and positioning, and resident hygiene. At least one CNA regularly transferred residents out of bed by herself, even when their care plans called for two staff members to be present, because there was no one else to help her. When that CNA was assigned to a shift with only one other aide, she was often unable to eat or take breaks. In fact, this CNA has had difficulty sleeping because she dwells on the care that she was unable to complete (*see* Det. Olsen Aff. ¶¶ 49-50).

c. The conditions at Martine were unclean. The smell of stale urine pervaded Martine Center such that one CNA was glad to have needed to wear a mask (*see* Det. Olsen Aff. ¶¶ 57-58).

d. Residents at Martine Center do not get turned and positioned, nor do they get their soiled diapers changed, until the morning shift arrives (*see* Det. Olsen Aff. ¶ 91).

ii. Neglect and Mistreatment at Holliswood During the Post-Peak Period

158. During this Post-Peak Period, Holliswood Center's Operator continued to neglect and mistreat its residents.

159. Holliswood also failed to report falls to family members and delayed time-sensitive transfers to the hospital, with tragic consequences. The following are examples of inadequate care during the Post-Peak Period:

a. On January 12, 2021, former Resident M.W. fell from her bed. Without notifying her family or providing medical treatment, staff wrapped M.W.'s

head and put her back into bed. M.W.'s daughter could not reach M.W. starting the evening of January 12; The next day, staff reported to M.W.'s family that M.W. was becoming increasingly lethargic and would not awaken. On that day, M.W.'s daughter went to Holliswood Center but staff attempted to turn her away. The daughter called the police and shortly thereafter, saw EMS rolling her mother out of Holliswood Center, unconscious and non-responsive, with no explanation from Holliswood's nursing supervisors as to how she became non-responsive or the circumstances of any injury. At the hospital, a CT scan revealed that M.W. had bleeding in her brain, requiring emergency surgery to open her skull. According to hospital records, there was "evidence of contusion onto the left frontal area, likely caused by the traumatic impact the patient sustained." M.W. had been experiencing symptoms at approximately 2:30 P.M. but was not brought to the hospital until around 9 P.M. According to her daughter, M.W. now suffers speech defects and emotional extremes (*see* Wong Aff.; Rhody Aff. ¶ 66).

b. Beginning May 12, 2021, C.C. was diagnosed with pneumonia at Holliswood Center. Her condition worsened over the next two weeks, as she had difficulty formulating words and breathing, was dizzy, and developed a fever. C.C.'s daughter reported that when she and C.C. alerted Holliswood that C.C. was not feeling well, staff did not address their concerns until Holliswood finally transferred C.C. to the hospital on May 23, 2021. By then, C.C. was in acute respiratory failure and had become septic. C.C. was intubated and admitted to the ICU. She remained at the hospital for approximately one month until June 22, 2021. She did not return to Holliswood (*see* Rhody Aff. ¶ 72; White Aff.).

160. Holliswood's Operator also failed to ensure that residents received their medication and treatments on time (*see* Rhody Aff. ¶¶ 71, 73; *see also* § VI(H) below).

161. Holliswood similarly failed to timely assist residents to the bathroom and residents continued to sit in urine and feces for extended periods of time, including in the following instances:

a. Current resident R.A.'s experience at Holliswood, "was bad when I got here but now it's worse." When R.A. first arrived, she was told to use her diaper two or three times before asking to be changed. Over the last year Holliswood staffing levels have gotten even worse. R.A. waits hours for aides to change her diaper and is told almost every other day by Holliswood staff that, "we're short today, so some things can't get done today." Due to the insufficient staffing, nine out of ten times, not everyone on R.A.'s floor gets changed (*see* Affidavit of Remy Allen, attached hereto).

b. Resident C.C. was forced to sit in a dirty diaper for hours at a time (White Aff.).

c. Resident HC12 feared that she would fall while getting out of bed to go to the bathroom but staff was non-responsive to call bell (Det. Bates Aff. ¶ 182).

d. Resident P.D.S. was left in soiled diapers for up to three days at a time and his mattress and pillow were often wet with urine from not being changed. When P.D.S.'s sister reported this to staff, they made excuses for why they could not help. P.D.S. later developed sepsis, necessitating his transfer to a hospital on February 2, 2021. According to medical records, when Resident P.D.S. was hospitalized, he was unresponsive, had respiratory distress, and was lethargic. The hospital diagnosed resident P.D.S. with not only sepsis, but also pneumonia and acute hypoxemic respiratory failure. Resident P.D.S. was subsequently admitted to the intensive care unit, received oxygen, was intubated, and was sedated to ease his distress (*see* Smith Aff.; Rhody Aff. ¶¶ 68, 69).

162. Holliswood's staff also continued to neglect residents' personal hygiene during this Post-Peak Period, including in the following instances:

a. Current resident R.A. has been told that aides are too short-staffed to shower her, which left her feeling undignified (*see* Allen Aff.)

b. Resident HC11 had inflamed gums and a thick layer of mucus lining his teeth. A staff member told HC11's son that she did not know whether anyone was brushing his teeth. HC11's hair also grew long and was greasy and appeared unwashed (Det. Bates Aff. ¶ 167-70). A photograph of HC11's neglected teeth is below:

c. Resident P.D.S. did not receive regular showers and baths at Holliswood and had overwhelming body odor (Smith Aff.).

d. In November and December 2021, Resident HC19 only had a total of four showers. At times, he went almost one week without even a bed bath. As of February 2022, Resident HC19 was unshaven, in need of a haircut, and appeared as if he had not received a shower or bath in some time based on his dandruff buildup (See Det. Bates Aff. ¶ 268; Rhody Aff. ¶ 82).

e. During several months of his stay, Resident HC9 received just a handful of washings, including showers, bed baths and sponge baths (Rhody Aff. ¶ 76; see also Det. Bates Aff. ¶ 142).

163. During this Post Peak period, Holliswood's Operator failed to maintain a sanitary environment at the facility, including by failing to maintain clean toilets and prevent rodent infestations. Indeed, one resident's toilet was clogged, unusable, and smelly (*see* Det. Bates Aff. ¶ 144) and another resident sees mice daily, but her complaints about it have been ignored (*see* Allen Aff.).

164. Holliswood also continued to lose track of residents' clothes and personal belongings, including those needed by the residents, such as two pairs of glasses, clothing and sneakers, and a cell phone (Det. Bates Aff. ¶¶ 119, 136, 175-76, 183, 194; Smith Aff.). This resulted in decreased quality of life and loss of dignity. In failing to safeguard residents' belongings, Holliswood's Operator violated residents' rights under 10 NYCRR § 415.3(g)(2).

165. Respondent Holliswood's Operator also failed to keep residents' families and friends informed about their loved ones' care, including in the following instances:

a. Resident C.C.'s daughter made numerous attempts to reach staff at Holliswood to discuss her mother's complaints that she was missing doses of medication but was unable to reach any staff members (White Aff.).

b. Resident HC9's wife frequently attempted to contact his social workers, who did not return her calls (Det. Bates Aff. ¶ 147).

c. Holliswood not only failed to inform Resident HC19's son when his father had been transferred to the hospital in January of 2022, but also misrepresented the father's condition days later (Det. Bates Aff. ¶ 267).

iii. Under Respondents' Control, Holliswood had a Staggering Increase in the Percentage of its Population that Died

166. In 2020, Holliswood experienced an increased number of deaths that was part of a disturbing trend that first manifested at least as early as 2016, after Respondents had been operating the facility for over one year (*see* Budimir Aff. ¶ 47). Under Respondents' watch, from 2015 through 2019, the percent of Holliswood's population who died increased over 7 percent and rose appreciably for 5 of 6 years between 2015 and 2020. Meanwhile, Respondents Rozenberg and Hagler, their family members and other Favored Persons extracted millions of dollars in up-front profit from the Nursing Home. The following table illustrates the rising percentage of Holliswood's population that died from 2015 to 2020:

From 2015 through 2020, the Percent of Holliswood's Population that Died Increased Over 12% Under Respondents' Control

Year	Death Count	Source	Total Patients Under Care	Percent who Died
2015	20	Death Certificates	829	2.41%
2016	25	Death Certificates	709	3.53%
2017	49	Death Certificates	736	6.66%
2018	64	Cost Report	666	9.61%
2019	63	Cost Report	667	9.45%
2020	110	Death Certificates	746	14.75%

See Budimir Aff. ¶ 47.

167. Sadly, as was the case during the Peak-Pandemic Period, not only did residents suffer neglect at Holliswood, but a higher percentage of its residents died than in the previous five

years. During 2020, 110 Holliswood residents died from various causes. This number represents a 75% increase in Holliswood's death count when compared to the preceding year and a staggering 149% increase in Holliswood's death count when compared against the annual average number of deaths at Holliswood for 2015-2019. *See* Budimir Aff. ¶¶ 50-1. This is unsurprising, given the inadequate staffing and neglect described herein.

iv. Neglect and Mistreatment at Beth Abraham During the Post-Peak Period

168. As was the case at Holliswood and Martine Center, Beth Abraham's Operator continued to ignore and violate state and federal laws and operated the facility with chronic insufficient staffing to provide required care for its residents, resulting in neglect, suffering, and humiliation of its residents during the Post-Peak Period—while its owners continued covertly to extract significant up-front profit for their own benefit.

169. After the peak of the pandemic, Beth Abraham continued to be dirty and smelly (Oppenheimer Aff.). At least one Beth Abraham resident developed pressure ulcers when staff failed to turn and position them regularly (Solas-Santiago Aff.). Residents wandered the halls unsupervised (Det. Ras Aff., ¶ 88, Latty Aff.); others were left in one place for hours at a time without supervision or stimulation (Oppenheimer Aff.).

170. Beth Abraham neglected residents in various other ways, too, during this period, including as follows:

a. In late 2020, Beth Abraham's staff pushed Resident A.R., who was wheelchair-bound, into an extremely hot shower that caused burns to his legs. Although A.R. told his family about the burns, Beth Abraham staff failed to inform them. When A.R. was subsequently hospitalized for pneumonia, his family learned for the first time that he had Stage II pressure ulcers from his stay at Beth Abraham (Solas-Santiago Aff.).

b. In April 2021, Beth Abraham's staff repeatedly made excuses to Resident A.L.R.'s mother about why A.L.R. was unavailable to Skype. A.L.R.'s mother went to Beth Abraham but could not enter, due to visitation having been suspended for COVID-19, and called 911 to check on her daughter.

EMTs responded to Beth Abraham and found A.L.R. to have a 103-degree fever. A.L.R. was transferred to a hospital where she was diagnosed with a kidney infection, pneumonia, dehydration, a UTI, and constipation. A few days after A.L.R. returned to Beth Abraham, she was hospitalized again with a second UTI; she arrived at the hospital with a dirty diaper as Beth Abraham staff had neglected to change her before her transfer to the hospital (Rodriquez Aff.).

c. Staff did not meet Resident A.C.'s needs, especially regarding toileting, and she experienced multiple falls at the facility. Three days after one such fall, A.C. experienced pain and was sent to the hospital, where she was diagnosed with a dislocated hip that required an emergency hip replacement. The emergency room doctor who treated her stated that her injury was likely due to a fall that occurred even more recently than three days earlier but Beth Abraham denied to A.C.'s family that such a fall had occurred. At the time she was sent to the hospital, A.C. had a diaper rash on her lower back, buttocks, and vaginal area, stemming from her time at Beth Abraham (see Rosa Aff.).

d. Staff failed to change Resident E.O.'s diaper frequently enough—in one instance, he was left in a dirty diaper for over six hours—and he developed a UTI during his stay at Beth Abraham (Oppenheimer Aff.).

e. Resident T.S. observed Beth Abraham's staff leaving other residents to sit in their dirty diapers. Staff failed to timely respond to his call bell to assist him to the bathroom. T.S. had a urinary catheter, and Beth Abraham's staff did not clean it frequently enough, causing T.S. to develop a UTI. Beth Abraham was dirty and staff only changed bedsheets once per week – and the laundered sheets were often stained (T.S. Aff.).

v. Neglect and Mistreatment at Buffalo Center During the Post-Peak Period

171. Consistent with the experiences of residents at Martine Center, Holliswood, and Beth Abraham, Buffalo Center did not improve during the Post-Peak Period. Instead, the severity and frequency of resident neglect and mistreatment intensified during the Post-Peak Period. Staffing worsened and care and treatment continued to be deficient, risking residents' physical and emotional well-being. Due to short staffing, the neglect worsened. At times, staff failed to complete wound care, turn and position residents, and timely toilet resident residents (*see* O'Leary Aff. ¶ 56). Individual CNAs were often left to care for as many as 80 residents on their shift (Det. Petucci Aff. at ¶¶ 23, 27, 42, 74). Staff members could not complete their assigned tasks and

residents went without care. For instance, CNAs worked 16-hour shifts, and had to care for as many as 60 to 80 residents at a time (Det. Petucci Aff. at ¶¶ 10, 24, 26, 36, 60). As a result of this short staffing, residents were left in their beds for an entire day and CNAs were unable to provide showers to residents as scheduled in the residents' care plans (*see id.* ¶¶ 16, 27, 41-42, 66). Examples of low staffing and the resulting harm to residents include the following:

a. When Resident D.E., who is disabled, requested assistance through her call bell, 90% of the time, staff failed to respond, even when she heard them laughing and talking outside her room, and if they did, it was not for an hour or two. As a result, D.E. often felt she had "no choice" but to get herself to the bathroom, by sliding out of bed and shuffling to the bathroom while holding onto things in her room. When she was assisted to the toilet, it took staff up to an hour to return to her room to assist her off the toilet and back to bed. Buffalo Center had "virtually no staff" during weekends. One morning, D.E. attempted to go to the bathroom unassisted because her numerous prior attempts at getting assistance had gone unanswered. D.E. fell while on the toilet, smashing her face on the wall. D.E. began to bleed profusely from her nose. After lying on the bathroom floor for a time, D.E. wiggled her way to the call button. Several minutes later, staff members responded and gave her tissues to clean herself but no other treatment. Two hours later, she demanded to be sent to the hospital, where she was diagnosed with a concussion (*see* D.E. Aff.).

b. James Quinn's father J.Q. was a resident in Buffalo Center's dementia unit for three weeks in May 2021. While en route to visit J.Q. at the facility, Mr. Quinn passed a man on the street who looked like a zombie or a ghost. The man was unshaven, his hair was long, and his skin color was bad. Upon arriving at the facility, staff brought Mr. Quinn's father, J.Q., to him. Mr. Quinn was shocked when he realized that the man he had passed on the street had been his father, who had just eloped[39] from the facility. J.Q. was sent to the hospital later that day and found to be severely dehydrated. Once he had been given fluids at the hospital, his father's color came back, and he had a complete turnaround in physical appearance (*see* Quinn Aff.).

c. Resident L.H.'s room regularly smelled like urine and feces, and his daughter had to change his clothes and linens, which were soiled, during

[39] In the nursing home context, "elopement" occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so safely. *See* CMS, State Operations Manual Appendix PP, at 333, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf (last visited June 23, 2023).

her visits. L.H. was embarrassed by being left in soiled clothes and would throw the clothes in the garbage (*see* Affidavit of Bianca Gutzmore, attached hereto).

d. Resident Y.C. was routinely left lying in her dirty diaper and needing to be changed. She also developed pressure ulcers on her legs, which were not properly treated and for which bandages were not regularly changed, causing them to smell (*see* Affidavit of Aniwang Berrie, attached hereto).

e. Resident C.P., who only resided at Buffalo Center for one week in January of 2022, was found by her husband on the floor of her room with a twisted and swollen ankle. When C.P.'s husband was able to find staff to assist, the staff placed C.P. in her bed without providing any treatment to C.P.'s ankle. Buffalo Center never had enough staff to provide timely incontinence care, so C.P. was forced to sit in soiled diapers or her husband changed C.P.'s diaper (*see* Affidavit of Nicholas Powers, attached hereto).

f. A member of the Buffalo Center therapy staff described several residents who failed to receive required care, including, a resident who was not turned and positioned pursuant to the schedule meant to treat developing pressure sores, residents who needed daily changes of their bandages, and yet their wounds remained in the same bandages for days, and a resident who complained that her skin was burning after her colostomy bag had leaked, but staff did not clean or help her (*see* Pettigrew Aff. ¶ 192, Exh 185).

g. Resident A.P. resided at Buffalo Center from December 29, 2022, through January 14, 2023, after having his toe amputated due to diabetes. A.P. had previously had his right arm amputated and his left arm is paralyzed, due to a stroke. During the first four days A.P. was living at Buffalo Center, A.P. was given the wrong diet—in fact, he was given the diet for the resident who had formerly occupied his bed at the nursing home. A.P. also was not given his medications during that time. After three days at Buffalo Center, A.P.'s sister noticed that A.P.'s toe bandage still had not been changed; it bore the initials of the doctor at the hospital and had the date and time when it had been placed at hospital. A.P.'s sister asked staff why it had not been changed and they claimed not to know that it needed to be changed. After an hour, they brought a new bandage and she changed it herself. Once, as A.P.'s sister was leaving Buffalo Center, A.P. called and said that he had had a bowel movement and needed his diaper changed. She told the staff at the nurse's station that he needed to be changed. Seven hours later, A.P. called his sister again and said his diaper had not yet been changed. A.P.'s sister called Buffalo Center six times before someone finally answered, and she was told they were "shorthanded but would get to it." Because A.P. could not use his arms, he needed assistance eating and drinking. Yet, when A.P.'s sister visited him, she found food trays and drinks in his room that

had not been touched; staff would deliver the trays and drinks, but nobody would assist him with eating or drinking. She asked why nobody helped him with eating and a staff member informed her that the staff had "no idea he could not feed himself." During three weeks at Buffalo Center, A.P. lost 20 pounds. A.P.'s sister also noticed that his bed at Buffalo Center had the same dirty, stained, and ripped sheets on during most of his stay. A.P. has since left Buffalo Center and now lives with his sister, who cares for him (Burke Aff.)

h. In January 2023, Resident L.D.'s daughter found him lying in urine-soaked sheets at Buffalo Center. On another occasion, L.D. was given an enema to treat constipation, yet the staff at Buffalo Center did not clean or change him until the next morning. He had been lying in his own feces for approximately 12 hours. L.D.'s family eventually decided to have him discharged but, following a subsequent hospitalization, he needed nursing home care again. L.D.'s family placed him at a different nursing home, which his daughter noted was "so much better than Buffalo Center. It was like night and day" (*see* Affidavit of Joy Battison, attached hereto).

i. M.A.S. is a 77-year-old woman with schizophrenia who resided in Buffalo Center from January 2022 to January 29, 2023. During her time at Buffalo Center, her needs went unanswered. When she was first admitted to the facility, she did not have a call bell. Between April 2022 and January 2023, M.A.S.'s brother and his wife visited her daily and observed M.A.S.'s floor to be short-staffed, and saw a nurse manager "running ragged," performing many tasks that should have been done by others. M.A.S.'s sister-in-law, an RN, regularly changed her clothes and sheets and gave M.A.S. bed baths, because the facility did not. When M.A.S.'s brother observed that her schizophrenia was worsening, he asked to see her medical record. Three or four weeks later, when he was finally able to view his sister's chart, he discovered that she had not been given her schizophrenia medication for 31 days. M.A.S.'s brother asked a medication nurse why his sister had not been given medication as prescribed, and was told that it had never been ordered and the staff would have to "borrow" medication from another resident until M.A.S.'s medications could be ordered. On January 29, 2023, at 2:30 a.m., Buffalo Center personnel called M.A.S.'s brother and advised that she was being taken to the hospital as her oxygen levels had dropped. Starting at 6:00 a.m., M.A.S. and his wife made several calls to Buffalo Center to learn more about M.A.S.'s status. These calls went unanswered, and 2:00 p.m., M.A.S. and his wife called the hospital directly and learned that M.A.S. had been admitted to the ICU with dehydration and sepsis. Upon being discharged from the hospital, M.A.S., did not return to Buffalo Center, but instead moved to a different nursing home. When M.A.S.'s brother went to Buffalo Center to retrieve her items, two CNAs told him that on the day before her hospitalization, they complained "all day" to

> nurses about M.A.S.'s condition, but nothing was done to help her (*see* Affidavits of Floyd David Snyder, Jr. and Diane Snyder, attached hereto).

172. Inadequate staffing caused additional neglect and indignities. For example, staff failed to distribute snacks and many residents were forced to eat in isolation in their beds as there was not enough staff present to take residents to the dining room for meals.

173. From May 1 through May 3, 2021, DOH conducted an unannounced survey at Buffalo Center (*see* Pettigrew Aff. ⁋ 13, Exh. 7). DOH conducts on-site inspections at nursing homes, called surveys, to determine nursing homes' compliance with state and federal laws. During the surveys, DOH surveyors visit the facility, review records, observe resident care, and interview residents and staff. After DOH completes a survey, it sends a report to the facility, which DOH later posts on its website (Budimir Aff. ¶ 17-18).

174. As a result of the DOH survey, Buffalo Center was placed in Immediate Jeopardy ("IJ"),[40] primarily due to its "widespread" failure to provide sufficient staff to adequately care for its residents (*see* Pettigrew Aff. ⁋ 13, Exh. 7).

175. As detailed below, as part of its Plan of Correction following the IJ finding, Buffalo Center increased its staffing briefly, but the staff levels quickly dropped again after about two months (*see* Det. Petucci Aff. ¶ 38).

176. In the following months, Buffalo Center's Operator continued to violate the law, allowing resident mistreatment to continue, including the following instances:

[40] A nursing home is placed in "Immediate Jeopardy" where its noncompliance with legal requirements "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R.§ 488.301. States are required to "take immediate action to remove the jeopardy and correct the deficiencies" in nursing homes placed in Immediate Jeopardy or to terminate such nursing homes from Medicaid. *See* 42 U.S.C. § 1396r(h)(1)(A).

a. In February 2022, Resident L.S. laid in her own urine-soaked brief for almost 24 hours, from 8:30 a.m. until the morning of the following day (*see* L.S. Aff.).

b. Resident S.D. was left unchanged in his feces-filled diaper and in a bed also filled with feces (*see* Dragovic Aff.).

VI. RESPONDENTS REPEATEDLY AND PERSISTENTLY FAILED TO ADEQUATELY STAFF THE NURSING HOMES AS REQUIRED BY LAW, CAUSING NEGLECT AND SUFFERING FOR THE NURSING HOMES' RESIDENTS

177. The instances of neglect and mistreatment described above, could have been avoided had Respondents permitted the Nursing Homes to retain and spend sufficient funds to adequately staff the Nursing Homes to ensure that residents "attain or maintain the highest practicable physical, mental, and psychosocial well-being" and receive all care provided for in the residents' care plans, as required under 10 NYCRR § 415.13. However, as set forth below, Respondents consistently operated the Nursing Homes with insufficient staffing to provide required care, in violation of State and federal laws, and continued resident admissions to maximize their own profits, and while covertly extracting millions in up-front profit.

A. Staffing at the Nursing Homes Repeatedly and Persistently Failed to Meet Staffing Thresholds for Adequate Resident Care

178. In addition to the firsthand accounts of short-staffing and suffering set forth herein and in the accompanying affidavits, Respondents' poor staffing at the Nursing Homes is reflected in the data discussed below, including payroll data and comparisons to established staffing thresholds.

179. Minimum staffing thresholds in nursing homes are not a new concept. For over three decades, 10 NYCRR § 415.13 has required nursing homes 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, as determined by resident assessments and individual plans of care."

180. As noted earlier, nursing department staffing levels are often measured using an "hours per resident per day" ("HPRD") metric. HPRD is calculated by dividing the total hours staff worked in each day by the number of residents in the facility on that same day (*see* O'Leary Aff. ¶ 68).

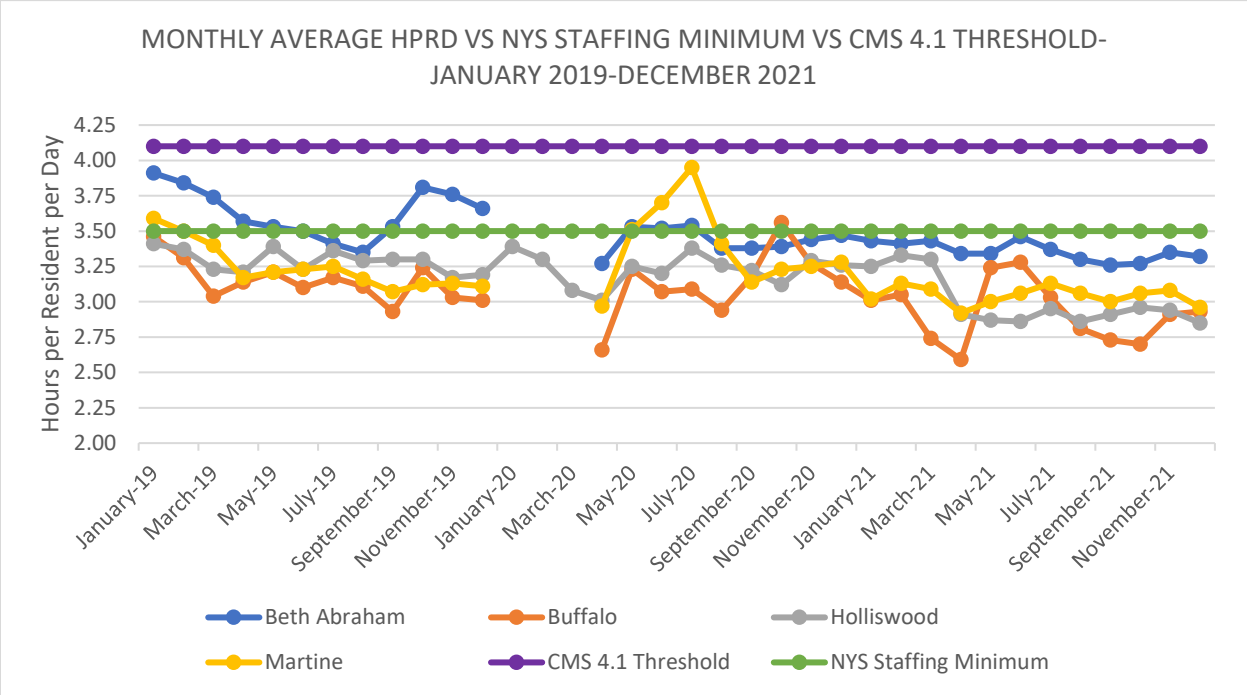
181. In 2001, CMS released a report, which was based on a Congressionally mandated study that was entitled "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." The study concluded that there was "strong evidence" that "supports the relationship between increases in nurse staffing ratios and avoidance of critical quality of care problems." Marvin Feuerberg, "Centers for Medicare & Medicaid Services (CMS) Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report" [Dec. 2001], Baltimore, MD: CMS; 2001 (the "2001 CMS Report"). The 2001 CMS Report identified 4.1 HPRD for long-term residents as the staffing threshold "below which quality of care was compromised." *Id*. CMS noted that the closer a nursing home gets to 4.1 HPRD (2.8 HPRD from CNAs and 1.3 HPRD for licensed nursing staff, specifically including .75 HPRD from RNs), the greater the improvements in quality care. *Id*.

182. In June 2021, recognizing the dire outcomes suffered by nursing home residents because of historically low staffing levels in for-profit nursing homes, New York State passed legislation that requires nursing homes to provide a minimum total of 3.5 HPRD. *See* Pub. Health Law § 2895-b (effective April 1, 2022). The legislation further requires that, of the 3.5 HPRD minimum, 2.2 hours must be provided by nursing aides (CNAs) and 1.1 hours must be provided by licensed staff (*i.e.*, RNs or LPNs).

183. 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 (*see*, *e.g.*, 10 NYCRR § 415.13; 42 CFR § 483.35). In other words, 3.5 HPRD is the floor, not the ceiling, for required staffing.

184. Although Public Health Law § 2895-b was enacted after much of the conduct complained of herein, it nonetheless provides a useful benchmark against which to assess the historical failure of the Nursing Homes to attain even minimal staffing levels. This Petition refers to the 3.5 HPRD Minimum Quantitative Staffing Level as the "NYS Staffing Minimum."

185. Indeed, whether measured against the CMS Threshold, or the NYS Staffing Minimum, the Nursing Homes' staffing has been woefully inadequate across all nursing disciplines, as shown in the following chart:



(*See* O'Leary Aff. ¶¶ 78-80).

186. As the above chart demonstrates, from January 1, 2019, through December 31, 2021, based on the Nursing Homes self-reported, payroll-based journal submissions to CMS, *none* of the Nursing Homes ever attained the 4.1 CMS Threshold HPRD. In fact, the Nursing Homes were significantly below that threshold. During this three-year period, including Pre-Pandemic, Peak-Pandemic, and Post-Peak Periods, Beth Abraham Center averaged 3.47 HPRD; Martine Center, 3.21 HPRD; Holliswood Center, 3.17 HPRD; and Buffalo Center, 3.10 HPRD (O'Leary Aff. ¶¶ 78-80).[41]

187. When measured against the NYS Staffing Minimum established by Public Health Law § 2895-b, the Nursing Homes fare no better. Since January 1, 2019, Beth Abraham Center met or exceeded this minimum quantitative standard in only thirteen months, and never since July 2020 (O'Leary Aff. ¶ 80). Martine Center met or exceeded this standard in only five months (O'Leary Aff. ¶ 80). Buffalo Center met or exceeded this statute's minimal requirements in just three months during this period (O'Leary Aff. ¶ 80), and Holliswood Center *never* met the statute's requirements (Budimir Aff. ¶ 56, 59). Over this period, Buffalo Center and Holliswood Center had ten months and nine months, respectively, when they provided less than 3 HPRD on average to their residents (O'Leary Aff. ¶¶ 78-80; Budimir Aff. ¶ 56).

[41] The data is based upon the Nursing Homes' Payroll-Based Journal ("PBJ") data. Nursing homes are required to submit PBJ data to CMS, which compiles the data on a quarterly basis. The data includes the hours staff are paid to work each day, for each facility, aggregated by staff reporting category. Examples of reporting categories include DON, Administrative Registered Nurses, Registered Nursing, Administrative Licensed Practical Nurses, Licensed Practical Nurses, Certified Nurse Aides, Certified Medication Aides, and Nurse Aides in Training (*see* Budimir Aff. ¶ 52). CMS waived the reporting requirement for PBJ data during peak COVID-19 and therefore this data is not available for Beth Abraham, Buffalo, and Martine from January through March 2020.

B. Respondents Repeatedly and Persistently Operated the Nursing Homes with Insufficient Supervisory Staff

188. In nursing homes, RNs assume the primary, daily medical responsibilities for the care of the residents. RN staff, including the Director of Nursing ("DON"), the Assistant Director of Nursing ("ADON"), Unit Managers and Supervising RNs, supervise and manage the resident units. They are involved in clinical aspects of the resident care, communicating with the medical providers, and ensuring that the needs of the residents are being met. They also oversee the units to ensure that they are running smoothly (*see* Keyser Aff. ¶¶ 5-8; *see also* Ramos Tr. At 27-28[42]).

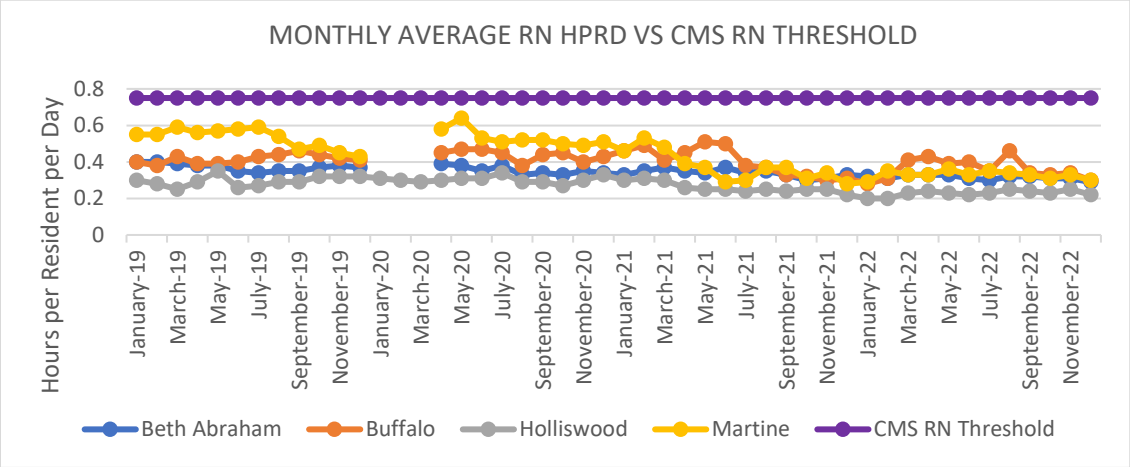
189. Only RNs are permitted assess residents and perform certain specialized procedures. For example, if a traumatic event occurs, such as a fall, only RNs are permitted to assess the resident's need for further treatment, and only RNs are permitted to insert intravenous lines. RNs are also responsible for the overall supervision of the nursing staff. These duties include ensuring that all residents receive required care. RNs also supervise, train, and hold accountable other direct care staff so that the resident units operate in an effective, competent, and efficient manner (Keyser Aff. ¶¶ 6-7, 11-13).

190. The lack of RNs places the residents of the facility at risk of harm. Without sufficient RN staffing, RNs may be forced to prioritize care among the residents, leaving one or more residents in potentially dangerous situations. Insufficient RN staffing carries the risk that there will be no one to assure that daily and necessary care is provided to the residents by other members of the nursing staff (Keyser Aff. ¶ 12).

[42] On December 22, 2020, Holliswood DON Annmarie Ramos testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of her testimony is hereto annexed.

191. The 2001 CMS Report noted that the closer a nursing home gets to 0.75 HPRD for RNs (as part of the overall 4.1 HPRD Threshold), the greater the improvements in quality care.[43]

192. In reaching this conclusion, the 2001 CMS Report examined RN staffing levels with data that excluded management nursing staff (which the 2001 CMS Report did not define). MFCU, however, analyzed the RN staffing levels at the Nursing Homes *with management nursing staff* (RN DON and RN Administrative positions) *included.* The following graph shows the average RN HPRD at the Nursing Homes from January 2019 through December 2021, including management nursing staff, compared to the 0.75 HPRD CMS RN Threshold:



(O'Leary Aff. ¶ 81).

193. As the above graph shows, between January 2019 and December 2022, even with management nursing staff included, none of the Nursing Homes met this 0.75 HPRD CMS RN Threshold.

194. In fact, the Nursing Homes were still frequently far below the CMS RN Threshold. For instance, Beth Abraham provided *less than half* of the CMS RN Threshold for all but two months out of this period for which data is available (*see* O'Leary Aff. ¶ 81).

[43] *See* 2001 CMS Report.

195. Holliswood also delivered far less RN care than other New York State nursing homes. The average RN HPRD for all nursing homes in New York State during this three-year period ranged from 35.4 to 43.1 minutes per resident per day. Out of the three-year period analyzed, Holliswood Center's RN HPRD exceeded half of the statewide average in only three months (*see* Budimir Aff. ¶ 60-61).

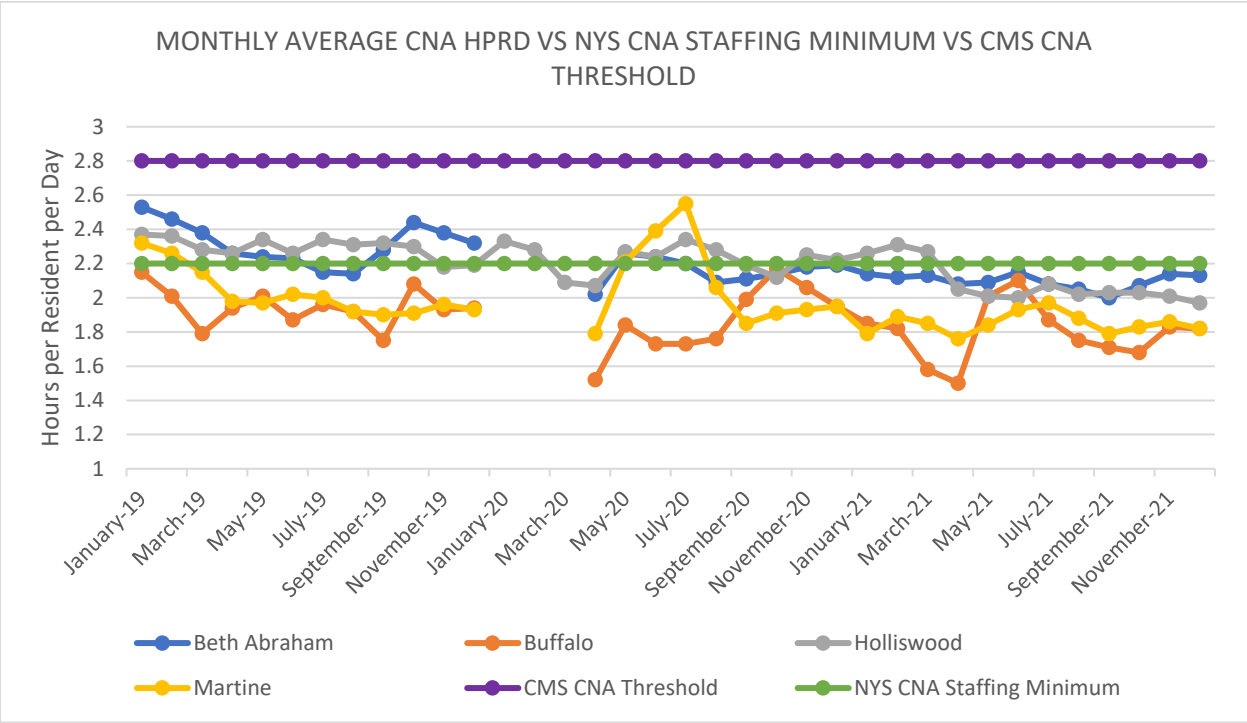
C. Respondents Repeatedly and Persistently Operated the Nursing Homes with Far Too Few Certified Nursing Assistants

196. CNAs are the backbone of daily resident care. Even though they are the lowest paid members of the nursing staff, CNAs are responsible for many of the most time-consuming services that are essential for compliance with each resident's care plan. Those services include assisting residents out of bed and turning and positioning residents in bed, so that pressure ulcers do not develop, helping residents use the bathroom and providing timely incontinence care for those who cannot toilet themselves, to prevent urinary tract or similar infections. These services afford residents a quality of life that they cannot achieve on their own. Without adequate CNA staffing, not only are residents more likely to suffer loss of dignity, but they are also put at risk of neglect with potentially serious, even life-threatening, consequences (Keyser Aff. ¶¶ 14-48).

197. In light of this, the 2001 CMS Report noted that CNA staffing of 2.8 HPRD is necessary to provide all care on a timely basis. This Petition refers to the 2.8 HPRD threshold as the "CMS CNA Threshold." The Report also noted that CNA staffing levels below the CMS CNA Threshold are likely to lead to missed or delayed care episodes. The Nursing Homes, however, largely failed to meet the CMS CNA Threshold.

198. Similarly, the NYS Staffing Minimum requires nursing homes to provide a minimum of 2.2 HPRD from CNAs (the "NYS CNA Staffing Minimum").

199. The following chart shows the monthly average CNA HPRD for each of the Nursing Homes, compared with the CMS CNA Threshold of 2.8 HPRD and the NYS CNA Staffing Minimum of 2.2 HPRD:



200. The above chart, which is based on the Nursing Homes' PBJ data, confirms that, between January 2019 and December 2021, the Nursing Homes *never* met the CMS CNA Threshold of 2.8. In fact, none of the facilities even reached 2.6 HPRD in any given month (*see* O'Leary Aff. ¶¶ 82-83).

201. In fact, the much lower NYS CNA Staffing Minimum was only met or exceeded by the Nursing Homes in 24 percent of the months between January 2019 and December 2022, the period for which data is available. Buffalo Center only met the NYS CNA Staffing Minimum three times during this period and Martine Center has not met the standard since July 2020 (*see* O'Leary Aff. ¶ 84). Beth Abraham has only met the minimum 15 times in four years (*id.*). Moreover, these minimum quantitative staffing levels 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.

202. Respondents' decision to operate the Nursing Homes with such chronically deficient staffing has serious consequences for residents: when there are not enough CNAs to provide turning and positioning, incontinence care, showers, and other basic care requirements, the residents' health is at risk (Keyser Aff. ¶¶ 14-48). The resulting neglect, as detailed above, was thus entirely foreseeable to Respondents, who repeatedly ignored and violated their legal duties to provide required care and sufficient staffing to deliver it, and to limit admissions.

203. Moreover, the staffing deficiencies described above are unsurprising given that the Centers business model is to maximize concealed extraction of up-front profits by operating the Nursing Homes with low staffing levels, while continuing to admit new residents, at the expense of resident care and while ignoring and violating state and federal laws designed to protect residents.

D. Centers Controls Staffing and Budgets at the Nursing Homes and Requires the Nursing Homes to Maintain Inadequate Staffing Levels

204. The historically low staffing levels at the Nursing Homes are not established by the Nursing Homes' personnel. Instead, Centers dictates staffing levels for the Nursing Homes.

205. Centers develops and establishes the staffing levels for each nursing discipline on each shift at the facilities through the implementation of a staffing budget (Weisz [3/31/22] Tr. at 47-50). Centers then closely monitors the staffing levels to ensure that the Nursing Homes stay within the budgets that Centers sets (*see* Pettigrew Aff. ¶ 14-18, Exh. 8-12; Winslow Aff., ¶¶ 32-35).

206. Centers controls staffing tightly because it is typically the highest cost for a nursing home (Budimir Aff. ¶ 62). Although staffing levels are purportedly calculated by assessing each

resident's specific acuity level and determining the total nursing staff for every resident in the entire facility (Eusebio [5/20/21] Tr. at 188), Centers sets the staffing budgets for the Nursing Homes, instead of allowing on-site clinicians or regional nurses or physicians to do so, even though those healthcare providers are better suited to assess the level of nursing care required for each facility's unique mix of residents (Flanagan Tr. at 300-01; Weisz [3/31/22] Tr. at 45-50, 137-39; Hendrix Tr. at 66, 74)[44]. Centers sets PAR Levels[45] based on a facility's census and a target ratio of residents to staff (Flanagan Tr. at 101; 171-72, 296-98, 300-01). This target ratio is based on an "industry standard," as opposed to a ratio tailored to the specific needs of residents at each facility (Flanagan Tr. at 172; 300-301). Centers thereafter regularly updates the budget based on the facility's census, or the number of residents in the nursing home each day (Flanagan Tr. at 296, *see also, e.g.*, Pettigrew Aff. ¶ 19, Exh. 13). Centers does this through a Workforce Management group that monitors staffing levels, including at the Nursing Homes (Liff Tr. at 35-36).[46]

207. Workforce Management employees regularly update Centers's leadership about staffing, including Centers COO Abramchik, and Director of Finance Jeff Gross, on precisely the amount by which a facility exceeds its staffing budget (*see, e.g.*, Pettigrew Aff. ¶ 20, Exh. 14 at 11

[44] On June 9, 2021, Centers Chief Nursing Officer Heidi Hendrix testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of her testimony is hereto annexed.
[45] PAR levels are the number of CNAs, LPNs, and RNs per unit per shift that Centers allocates in its budget for each of its facilities ("PAR Levels"). One of Holliswood's ADONs, Alesia Floyd, testified on April 14, 2021, that Centers sets PAR Levels as an effort to ensure that there is "enough staff to cover the patients . . . so that they could provide them with the adequate care" (Floyd Tr. at 100-01). Holliswood's staffing coordinator, Ruffa Arias, testified on January 26, 2021, that if there are not enough staff to meet PAR Levels, she cannot guarantee that all services will be provided (Arias Tr. at 41). PAR Levels are recorded as the number of "required" staff on each facility's staffing sheets (Rhody Aff. ¶ 13). The transcripts of the examinations cited in this footnote, which were each taken pursuant to Executive Law § 63(12) investigatory subpoenas, are hereto annexed.
[46] On February 24, 2021, Holliswood Center's Administrator Dovid Liff testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of his testimony is hereto annexed.

[a text message dated 9/11/2020 from J. Gross to D. Liff complaining that a Workforce Management supervisor "is still saying Holliswood is staffing above the agreed upon budget"]; *see also* Pettigrew Aff. ¶¶ 21-22, Exhs. 15-16. Workforce Management is also responsible for ensuring that the Nursing Homes reduce staffing in accordance with Centers's staffing budget limits (*see, e.g.*, Pettigrew Aff. ¶ 23, Exh. 17) ("Holliswood Center . . . is having difficulty adjusting to the new budgets. [Workforce Management] is working with the facility to assist compliance."); (Pettigrew Aff. ¶ 22, Exh. 16) (Holliswood was not within budget and "will be worked on"); (Pettigrew Aff. ¶ 25, Exh. 19). Accordingly, the Nursing Homes' insufficient nursing staffing levels did not occur by happenstance but were the product of Centers's significant efforts to track and enforce compliance with a budget it set that demanded inadequate staffing.

208. The extent to which Centers tracked its facilities' staffing via budget performance is exemplified by the "Score Card" Centers issued to Martine Center quarterly from the fourth quarter of 2019 through the third quarter of 2020. The Score Card compiled several different measures of Martine's performance, including its census, survey star rating, quality measure star rating, rehospitalization rate, Medicare length of stay, and Budget Hours. The Budget Hours metric on each Score Card showed the historical Budget Hours for the previous six quarters. For each quarter, Centers used the Budget Hours to track the number of hours that each staff position was over or under the staffing budget set by Centers (*see* Pettigrew Aff. ¶¶ 14-18, Exh. 8-12).

209. Despite Centers's efforts to enforce its budgeted hours on the Nursing Homes, Martine failed to even staff at the inadequate level that Centers had approved. For instance, during the fourth quarter of 2019, Martine Center was under-budget by almost seven full-time LPNs (*see* Winslow Aff. ¶ 34-35). That trend continued during the Peak-Pandemic Period in the second quarter of 2020, when Martine Center was under-budget by approximately 16 full-time CNAs and

15 full-time LPNs (*see* Winslow Aff. ¶ 34-35). Rozenberg and Centers could have increased compensation for CNAs and LPN positions to levels that would have enabled the Nursing Homes to hire and retain more staff, yet the owners kept covertly transferring up-front profits to themselves. And in the third quarter of 2020, Rozenberg bought an airline.

210. In December 2019, after Holliswood reached a relative peak in its staffing, as measured by HPRD (Budimir Aff. ¶ 56), a Workforce Management supervisor advised Holliswood's administrator that certain departments were overbudget and offered strategies for lowering hours in those categories (*see* Pettigrew Aff. ¶ 25, Exh. 19).

211. The next month, in January 2020, Abramchik and Jeff Gross approached multiple Centers Facilities, including Holliswood, about proposed budget cuts. Abramchik wanted to "meet individually with each administrator to fully 'reset' the budgets (*i.e.* look at the entire facility from scratch and build it out)" (*see* Pettigrew Aff. ¶ 26, Exh. 20, ¶ 128, Exh. 122). Holliswood's Administrator opposed the proposed cuts (*see* Pettigrew Aff. 27, Exh. 21), but in the months following Centers's proposed budget cuts, Holliswood's HPRD declined until April 2020 (*see* Budimir Aff. ¶ 56), setting the stage for a foreseeable and avoidable tragedy during the Peak-Pandemic Period, as set forth above.

E. Respondents Repeatedly and Persistently Failed to Ensure Sufficient Staffing at the Nursing Homes, During the Pre-Pandemic, Peak-Pandemic, and Post-Peak Periods

212. Given Respondents' transfer of millions of dollars in up-front profit to themselves, their family members, and Favored Persons while they ignored and violated their duties, and their failure to staff the Nursing Homes at even the most minimal levels, the woefully deficient staffing conditions at the Nursing Homes were inevitable, as was their residents' suffering. From January 1, 2019, through December 31, 2021, Respondents failed to address the residents' need for additional staffing, despite having notice of such shortcomings. And Respondents Rozenberg,

Centers, and the Nursing Homes' Operators repeatedly and persistently decreased staff, leading to poor care during the Pre-Pandemic, Peak Pandemic, and Post-Peak Periods.

1. Centers Operated the Nursing Homes with Insufficient Staffing to Provide Required Care During the Pre-Pandemic Period

213. Holliswood's CNAs reported that Pre-Pandemic staffing was "horrible" (Det. Bates Aff. ¶ 14). Staff members complained to Holliswood's staffing coordinator that, before she began her employment in July 2019, they were "always working short," meaning working while short-staffed (Arias[47]: 43-44). Pre-pandemic, CNAs and LPNs at Holliswood Center also complained weekly to their union contract administrator about low staffing and its impact on resident care, reporting that they were forced to work despite short staffing and that they did not take breaks to avoid being disciplined for not providing all the necessary care (Det. Bates Aff. ¶¶ 89-90). Staff members further reported that they could not get to certain tasks, such as showering residents and performing transfers into and out of bed (*id.*). LPNs complained that they were each required to care for 40 residents by themselves (*id.* ¶ 89), whereas the staffing ratio is typically 20 residents to 1 LPN for most nursing homes (*id.*).

214. The contract administrator for the union was concerned about these complaints and brought them to Holliswood's Administrator and DON. One representative admonished Holliswood's Administrator for these working conditions, explaining that "[union] member abuse is resident abuse" (Det. Bates Aff. ¶ 94).

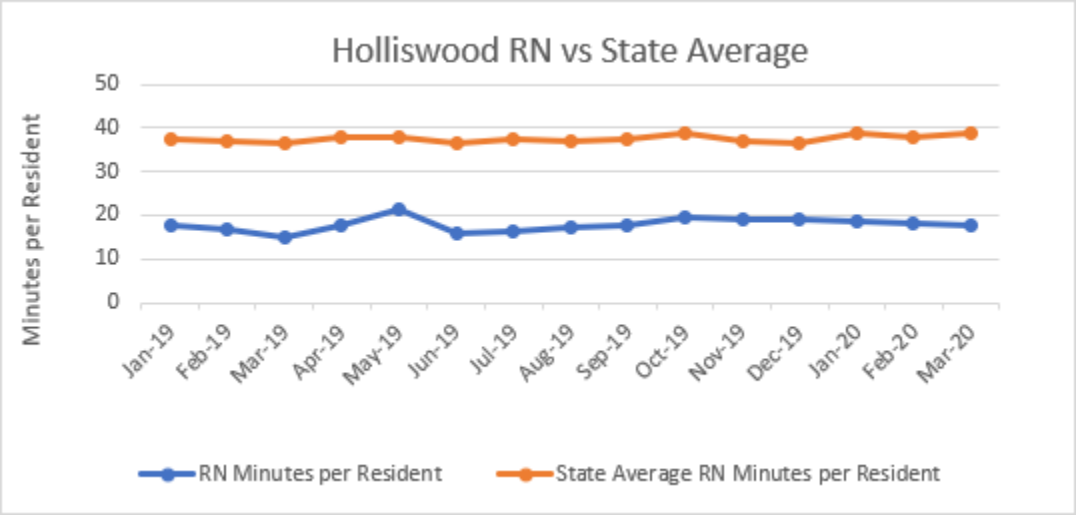
215. These staff complaints were borne out by the payroll data that Holliswood disclosed to CMS, which demonstrate deficient staffing during the Pre-Pandemic and Peak-Pandemic Periods.

[47] On January 26, 2021, Holliswood Center's Compliance Officer Ruffa Arias testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of such testimony is hereto annexed.

216. From January 1, 2019, through March 31, 2020, Holliswood's direct care staffing HPRD consistently fell below the monthly average HPRD for all facilities in the state, ranging from 5.34% to 12.25% below the state average (Budimir Aff. ¶ 58).

217. Holliswood's RN staffing was drastically lower than the state average, ranging from 43.73% to 59.41% below the state average, as shown below:

Holliswood's RN Staffing Was Drastically Lower Than the State Average

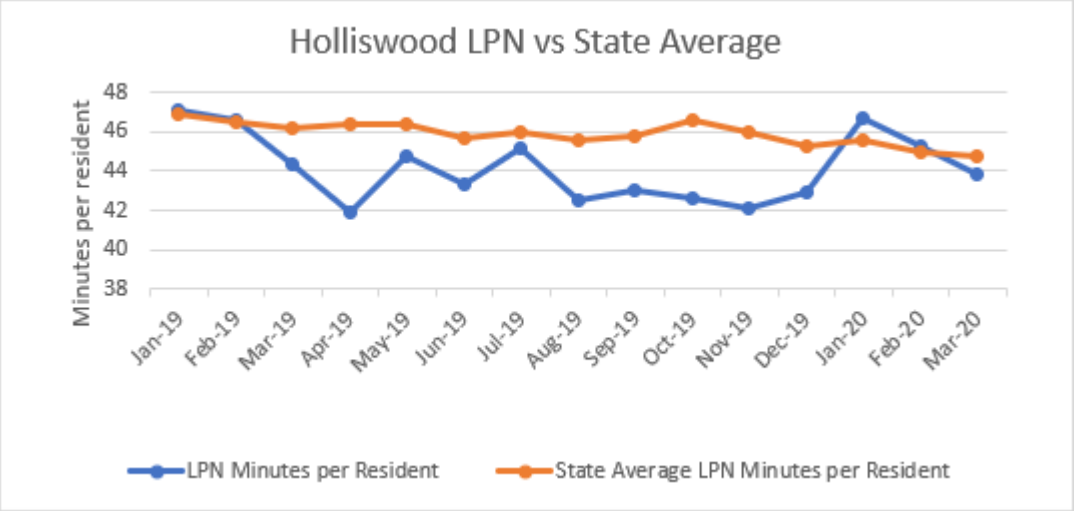


(*See* Budimir Aff. ¶ 58).

218. Thus, not only was Holliswood's RN staffing below the CMS Threshold, it was also significantly below the average for other facilities in New York during the same time period from January 2019 to March 2020.

219. Similarly, Holliswood's LPN staffing fell significantly below the state average during the same period. Holliswood's LPN minutes per resident per day were below the state average for 11 of 15 months during this Pre-Pandemic period, and ranged from 1.89% to 9.76% below average, as demonstrated below:

Holliswood's LPN Staffing Fell Significantly Below the State Average



(*See* Budimir Aff. ¶ 58). Thus, for a 15-month timeframe, Holliswood's LPN staffing level was below the average of other facilities in New York nearly 75% of the time. *See* Budimir Aff. ¶ 58. This correlates with instances of resident neglect, and the owners' continued concealed transfer to themselves of up-front profit through collusive, fraudulent related party transactions.

220. MFCU's analysis of Holliswood's payroll records corroborates the low levels of staffing that it reported to CMS in its payroll-based journal submissions. Based on Holliswood's payroll and timecard records for RNs, LPNs, and CNAs, Holliswood's average HPRD was 2.97 in January 2020, 2.95 in February 2020, and 2.78 in March 2020 (Rhody Aff. ¶ 9). Taken together, an analysis of both PBJ data and payroll data confirm that Respondents operated Holliswood with insufficient staffing and reflects that Holliswood's staffing levels fell well short of both the CMS Threshold and the NYS Staffing Minimum (*See* Rhody Aff. ¶ 9; Budimir Aff. ¶¶ 52-57).

221. The Pre-Pandemic staffing deficiencies were not unique to Holliswood.

222. Indeed, before the onset of the COVID-19 pandemic, Centers controlled Martine Center and caused it to operate with insufficient staffing levels to provide required care to residents. Martine failed to meet its PAR levels 14% of the days during the third and fourth

quarters of 2019 by an average of over 28 nursing hours per day (see Rhody Aff. ¶ 24). Martine employees and even certain Centers employees complained repeatedly about low staffing, but Respondents did nothing to improve it, even as they continued to extract up-front profit for themselves, as the following examples illustrate:

a. Leading up to March 2020, Martine Center constantly struggled with staffing shortages on the units occurring almost daily, and some shifts occasionally went unfilled (Oliver Tr. At 85-86)[48].

b. On February 27, 2020, less than one month before Martine Center had its first COVID-19 case, the Administrator pleaded with Centers management, explaining, "we really need assistance with LPNs. It's not looking good. Our acuities are a lot higher as we are suffering terribly with staffing shortages. We need to do something quick" (*see* Pettigrew Aff. ¶ 28, Exh. 22).

c. On March 11, 2020, right before the pandemic took hold, the DON made a similar plea to Centers for nurses, asking what could be done to boost staff morale (*see* Pettigrew Aff. ¶ 29, Exh. 23).

d. The Administrator and DON's concerns about staffing were echoed by numerous staff members, from CNAs to RNs (*see* Det. Olsen Aff. ¶¶ 69, 76).

e. The Staffing Coordinator/H.R. Director believed Martine was short-staffed and voiced her concerns on multiple occasions to the Administrator and DON, but the staffing shortages were never resolved (Oliver Tr. At 85-89).

223. Centers management knew about the insufficient staffing levels at Martine (Moore[49]: 181) but did not remedy the situation. Accordingly, the Martine DON took matters into her own hands, using the Clinical DON's name to arrange a job fair to recruit staff because when units were short-staffed, it impacted both the residents and staff (*see* Pettigrew Aff. ¶ 29, Exh. 23;

[48] On December 9, 2020, Martine's Director of Human Resources and Staffing, Yalanda Nicole Oliver-Hardwell ("Oliver") testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of that testimony is hereto annexed.
[49] On June 3, 2021 and July 21, 2021, Centers Regional Director of Clinical Services Gemma Moore testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of such testimony is hereto annexed.

Eusebio [6/24/21] Tr. at 199, 217, 225). The Martine DON did this because she had "insisted so many times" that Martine Center needed an answer "if DOH asked what are we doing as a facility to increase staffing" (*see* Pettigrew Aff. ¶ 29, Exh. 23).

224. Leading up to the pandemic, Centers also consistently operated Buffalo Center with inadequate staffing to provide required care. As noted above in ¶ 185, in 2019, nursing staff levels never approached the CMS threshold, and, in fact, only reached the lower NYS Staffing Minimum in one month during the year. Indeed, Buffalo Center failed to meet its own PAR Levels over 38% of the days during the third and fourth quarters of 2019 by an average of nearly 65 nursing hours per day (*see* Rhody Aff. ¶ 23). LPN staffing was particularly low prior to the pandemic, as Respondents operated Buffalo Center such that it failed to meet LPN PAR Levels over 68% of the days by an average of over 21 hours per day (*id.*).

225. The lack of nursing staff was keenly felt by the Buffalo Center staff:

a. CNAs BCE2[50], employed since March 2019, and BCE7, employed since November 2019, stated the staffing levels have always been low and described their inability to provide showers to residents and properly handle those residents who were two person assists (Det. Petucci Aff. ¶¶ 25, 27, 67).

b. A.F., a CNA at Buffalo Center since January 2018, also stated staffing levels have always been low and described resident care that had to be bypassed due to low staffing (Det. Petucci Aff. ¶¶ 11, 16).

c. Residents and their family members also noted the effects of low staffing. Following the change of ownership to Centers in 2015, families noted the drop in care level as staffing decreased (see Toe Aff). Family members also observed the obvious shortage of staff (Det. Petucci Aff. ¶¶ 74, 85).

[50] Within Det. Petucci's Affidavit, Buffalo Center employees are anonymized and referred to with the prefix "BCE" and a number designation.

226. Similarly, Centers operated Beth Abraham with inadequate staffing during the pre-Pandemic period. In fact, the facility failed to meet its PAR Levels 15% of the days during the third quarter of 2019 by an average of nearly 60 nursing hours per day (*see* Rhody Aff. ¶ 25).

2. Respondents Operated the Nursing Homes with Woefully Insufficient Staffing During the Peak-Pandemic Period

227. The deficient staffing levels with which Respondents operated the Nursing Homes before the pandemic left the Nursing Homes even more unprepared to adequately care for their residents during the peak months of the pandemic. Because Centers repeatedly and persistently understaffed the Nursing Homes, when their employees became ill or were quarantined during the pandemic, Centers's insufficient staffing model snapped.

228. Staffing at Holliswood was threadbare during the Peak-Pandemic Period.

a. CNAs reported having to care for 12 to 14 residents by themselves, when most facilities staff one CNA for every eight residents (Det. Bates Aff. ¶¶ 14, 89).

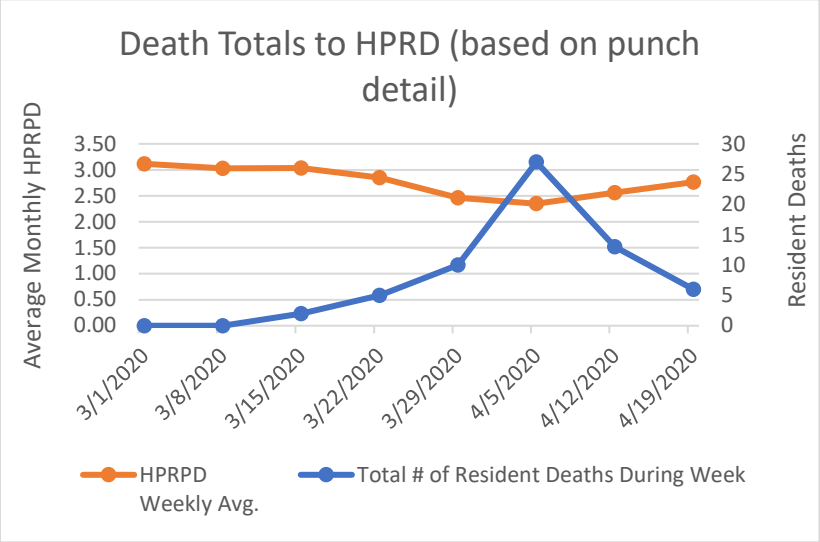
b. Though most facilities staff 1 LPN for every 20 residents, on March 30, 2020, the ratio for LPNs was in fact 1 LPN for 60 residents on "most units" at Holliswood (Det. Bates Aff. ¶ 89; Pettigrew Aff. ¶ 30, Exh. 24).

229. There were many shifts when there were no RNs at Holliswood, or just one RN in the building when two were assigned, or RNs operating at half of the staff assigned to the shift (Rhody Aff. ¶ 17).

230. Based on Holliswood's payroll and timecard records for RNs, LPNs, and CNAs, Holliswood provided on average 2.78 HPRD in March 2020, 2.63 HPRD in April 2020, and 3.01 HPRD in May 2020 through June 11, 2020 (Rhody Aff. ¶ 9), all falling well below the NYS Staffing Minimum of 3.5 and the CMS Threshold of 4.1 HPRD.

231. These documents show Holliswood's lowest staffing levels, a mere 2.35 HPRD, occurred during the week when the most residents died. During the week of April 5, 2020, when staffing was at its low, a shocking 27 residents died, as depicted below:

Holliswood's Lowest Staffing Levels Coincided with the Week of Highest Deaths



(Rhody Aff. ¶ 10).

232. Centers, Rozenberg, and Holliswood's Operator persistently failed to operate Holliswood with sufficient staffing to provide required care. The effects of such failure manifested themselves most acutely during the first two weeks of April 2020 (Rhody Aff. ¶ 10), but inadequate staffing and the resulting inability to deliver adequate care carried throughout the entirety of the Peak-Pandemic Period.

233. From March 1, 2020 through May 31, 2020, Holliswood failed to maintain enough RNs, LPNs, or CNAs to meet the PAR Levels set by Centers on approximately 72% of all shifts and there were multiple occasions where Holliswood had *half* or *fewer than half* the amount of licensed staff (LPNs and RNs) required by Centers's own PAR Levels (Rhody Aff. ¶ 20). The following examples are illustrative:

a. On March 29, 2020, only 1 RN was present for the day shift, when 2 were required.

b. On April 4, 2020, , only 1 LPN worked the overnight shift, when 7 LPNs were required.

c. On April 5, 2020, no RNs were present for the day shift when 2 were required.

d. On April 5, 2020, and April 8, 2020, only 3 LPNs worked the overnight shift when 7 were required.

e. On April 10, 2020, only 2 RNs worked during the day shift when there should have been 6 RNs working.

f. On April 11, 2020, during the day shift, there were no RNs when there should have been 2.

g. On April 10, 2020, and April 18, 2020, during the evening shift, only 6 LPNs worked when 12 were required.

(Rhody Aff. ¶ 20).

234. Respondents were aware that they were operating Holliswood with insufficient staffing during the peak pandemic. Nursing staff complained to Holliswood's management throughout the first wave of the pandemic about "working short" and being overworked (Det. Bates Aff. ¶ 45). The Regional Nurse supervising Holliswood—a Centers employee—stated that she knew nursing staff members were fatigued and burnt out, and staff worked double shifts to compensate for short staffing (Flanagan Tr. at 182-84).

235. Respondents Centers, Rozenberg, and Sicklick, along with other Centers executives, were apprised of Holliswood's woefully deficient staffing levels in March and April 2020, even as the number of COVID-19 infections and deaths continued to rise:

a. On March 20, 2020, Centers Chief Nursing Officer Hendrix wrote to Rozenberg, Abramchik, and Sicklick, among others at Centers, that Holliswood had 22 suspected COVID-19 cases, and had "significant staffing issues," such as "supervisors calling out" and "[d]epartment heads refusing to go on unit," that the Centers Regional Nurse assigned to

Holliswood was "on site" to provide support, and an additional floating DON would have to be pulled from another location for further support (Pettigrew Aff. ¶ 31, Exh. 25).

b. On March 29, 2020, Holliswood's Administrator wrote to Sicklick, among others at Centers, that a supervisor "overheard a lot of murmuring" about staff calling out due to "lots of complaints" about "staff shortage[s]" and a "shortage of gowns." He continued that "all c.n.a's [sic] on the 3rd floor (where most of the covid cases are) called out" (Pettigrew Aff. ¶ 32, Exh. 26).

236. On March 30, 2020, as Holliswood's insufficient staffing levels reached a crisis level, Holliswood's Administrator wrote to Abramchik and Sicklick to plead for higher compensation for supervisors, citing dangerous staffing ratios for LPNs and nurse managers, and increased strain from caring for residents with greater needs during COVID-19:

> "…with over 70 suspected cases in Holliswood," "many extra assessments, orders and care plans that need to get done," "the Unit managers are staying much longer than expected." "We are short 3 RN's [sic] today . . . and the 3rd floor is short an LPN (most units it is 60 residents for 1 LPN) . . . "

(Pettigrew Aff. ¶ 30, Exh. 24).

237. During this time, all staff were working at appreciable risk to their own health; vaccines were not yet available and PPE was in short supply.

238. Against this backdrop, the Administrator pleaded with Centers to pay RNs an hourly rate for additional hours worked beyond their shifts, noting that some RNs were stretched to double their normal capacity (*see* Pettigrew Aff. ¶ 30, Exh. 24; ¶ 33, Exh. 27). Centers executives, including Abramchik, Gittleson, Gross, and Wolff deliberated. Gittleson responded: "I think your [sic] setting a bad precedent. I'd rather give them a one-time bonus" (Pettigrew Aff. ¶ 33, Exh. 27). Gross similarly responded: "slippery slope . . . I would say he should bonus anyone who is working extra hard every so often" (Pettigrew Aff. ¶ 34, Exh. 28).

239. Abramchik eventually relented and agreed to pay RN unit managers for extra hours when they worked late (*see* Pettigrew Aff. ¶ 30, Exh. 24). This gesture, however, ultimately inured to Respondents' benefit, as he expressly conditioned the increased pay on having an RN stay late "to help with admissions" (*id.*). Without an RN—the only type of nurse who could process and assess new residents—Centers could not admit new residents, and without new residents, revenue would decrease.

240. Holliswood staff also kept Centers management informed of the dire staffing shortages at the facility in real time through WhatsApp messages and text messages, including the following:

a. 3/29/2020: On a Holliswood supervisors WhatsApp thread including Holliswood's RNs, DON, ADON and the Centers Regional Nurse overseeing Holliswood, someone[51] exclaimed, "[t]here's only 10 cnas [sic] for the whole building"; "no one here wants to work tomorrow we already very short." The thread continues, "[w]e are in survivor mode here." *See* Pettigrew Aff. ¶ 35, Exh. 29 at 105-106; Flanagan Tr. at 331-335.

b. 4/5/2020: A WhatsApp thread involving the Centers Regional Nurse supervising Holliswood reported that "only 3 LPN[s] are scheduled to work tonight . . . Only one . . . [is actually] working tonight because the rest didn't show up. Only 1 LPN in the whole building and he worked a double." *See* Pettigrew Aff. ¶ 35, Exh. 29 at 104[52].

c. 4/5/2020: "We only had one LPN show up to work last night . . . 11-7 [overnight shift] supervisors called out. It's getting crazy . . . Dropping like flies." *See* Pettigrew Aff. ¶ 36, Exh. 30 at 7 [53].

d. 4/19/2020: "No nurse on first floor again"; "One nurse can't work alone on 3…" (*See* Pettigrew Aff. ¶ 35, Exh. 29 at 100).

[51] The record of WhatsApp messages from Centers Regional Director of Clinical Services Kathleen Flanagan's cellular telephone provided by Holliswood displayed the messages and their dates and times but not the names of individuals who sent each message.
[52] On the night of April 5, 2020, Holliswood less than 50% of the total number of LPNs required to work that shift at Holliswood did so (Rhody Aff. ¶ 20).
[53] The record of text messages from Centers Regional Director of Clinical Services Kathleen Flanagan's cellular telephone provided by Holliswood displayed the messages, and their dates and times, and the name or telephone number of the person(s) who Flanagan was messaging, but failed to indicate which individual was the sender or receiver of each text message.

241. Centers knew that the threadbare nursing staff at Holliswood could not provide all the necessary care for residents, requiring them to triage and ration services based on staff availability (Flanagan Tr. at 102, 203-04; Ramos Tr. at 139):

a. When asked how residents received their medication during certain shifts in April 2020, when staffing records reveal that not a single LPN was on the floor, Holliswood's DON testified that Holliswood considered "medication holidays" or "decid[ed] to reschedule medications so that we were able to book medication administration times during the timeframes when we had the least amount of challenges to have our nursing staff" (Ramos Tr. at 141-42).

b. Showers were eliminated or rescheduled (Ramos Tr. at 139-40; *see also*, Salvio Aff.; Bates Aff., ¶ 268).

c. Instead of turning and positioning residents within the acceptable range of every two to four hours, Holliswood's DON testified that Holliswood went to the "highest spectrum" of "what is considered acceptable" (Ramos Tr. at 140-41).

242. The staffing shortages at Holliswood during the height of the pandemic also forced the already overburdened nursing staff to take on additional tasks, wholly unrelated to direct resident care, such as disinfecting resident rooms (*see* Det. Bates Aff. ¶ 60). Similarly, overworked RNs and LPNs resorted to providing personal care to residents, a task traditionally done by CNAs, because there were not enough CNAs (Det. Bates Aff. ¶ 61).

243. Martine Center's residents also suffered due to insufficient staffing during the peak of the pandemic, including in the following ways:

a. Martine Center's staffing crisis grew during late March and April 2020. On March 26, 2020, the Martine HR Director noted that she was doing her "very best" but there were many holes in the staffing schedule for the upcoming weekend, including 35 unfilled LPN and CNA shifts over those three days (*see* Pettigrew Aff. ¶ 39, Exh. 33).

b. On April 5, 2020, the Martine DON announced to Centers that "Martine Center is in official state of staffing emergency"; only 11 CNAs worked the day shift instead of the 20 that were scheduled, and only 5 nurses worked instead of the 10 that were scheduled (*see* Pettigrew Aff. ¶ 40, Exh. 34).

c. On April 7, 2020, the Martine DON again e-mailed Centers regarding the "Staffing Emergency," noting that Martine Center was staffed below its PAR levels. She gave examples of certain shifts, units, and particular positions that were staffed very low. Hendrix wrote back that "***Senior Leadership*** has requested Staffing emergencies not be 'Emailed'" (*see* Pettigrew Aff. ¶ 41, Exh. 35).

d. On April 8, 2020, the Martine ADON asked in a group chat consisting of Martine Nursing supervisors and the DON, "[i]s there staff to send from other buildings? Residents are threatening to call the police" (Pettigrew Aff. ¶ 42, Exh. 36).

e. On April 15, 2020, in the same group chat, the Martine DON wrote: "[i]ts skeleton staff, nobody has time to process & we have no staffing on all levels" (Pettigrew Aff. ¶ 43, Exh. 37).

f. On April 28, 2020, the Martine DON reported to Centers, "we need all the help we could get," and that "Martine has not yet achieved par level staffing to the present time. Ms. Heidi [Hendrix], please help in getting this into fruition" (Pettigrew Aff. ¶ 44, Exh. 38).

g. On May 8, 2020, the Martine DON notified Centers about DOH surveyors contacting her. Hendrix relayed the e-mail to another Centers executive stating that the surveyors were not happy with the staffing levels (*see* Pettigrew Aff. ¶ 45, Exh. 39).

h. *See also* Pettigrew Aff. ¶¶ 46-47, Exhs. 40-41.

244. Due to the severe understaffing at the facility during the first wave of the pandemic, the staff at Martine Center was overwhelmed and demoralized (Eusebio [6/24/21] Tr. at 216-17). In fact, working at Martine Center during the height of COVID-19 was one of the "worst periods of [one CNA's] life" (Det. Olsen Aff. ¶ 14). The Martine ADON had such loyalty to her colleagues that she refused to stop working at Martine Center—even though she, herself, was displaying symptoms of COVID-19—because she felt like she was abandoning them in a time of such short staffing (*see* Pettigrew Aff. ¶ 48, Exh. 42; *see also* Det. Olsen Aff. ¶ 16).

245. Critical staffing shortages also persisted at Buffalo Center in April 2020:

a. On April 27, 2020, "there were a ton of issues with staff/staffing over the weekend . . . We had critical staffing through the entire weekend" (*see* Pettigrew Aff. ¶ 49, Exh. 43).

3. Despite Known Staffing Shortages, and the Concomitant Resident Harm, Respondents Caused the Nursing Homes to Continue Accepting New Resident Admissions to Increase Revenue, and Misrepresented Staffing Levels to DOH

246. Respondents Centers, Rozenberg, and the Nursing Homes' Operators repeatedly and persistently operated the Nursing Homes with insufficient staffing levels that increased the incidence of neglect and caused harm to their residents. Despite this, Respondent Centers directed the Nursing Homes to continue admitting residents for whom the Nursing Homes could not provide requisite care. Centers did so to enable the Nursing Homes to increase their revenue, which is primarily accomplished through new resident admissions. Disregarding the law and the needs of existing residents and staff, Rozenberg and Centers continued this mandate even at the height of the pandemic, in repeated violation of their duty to limit the Nursing Homes' census only to residents for whom they could provide required care.

247. Centers, through its Central Admissions Department, controls admissions to the Nursing Homes. Central Admission Specialists—what Centers calls the employees in Central Admissions—review hospital referrals to determine whether a resident being discharged is a candidate for a Centers-affiliated nursing home, including the Nursing Homes (Pompee Tr. at 64, 68-69)[54]. These specialists are not New York State licensed clinicians (Pompee Tr. at 20-21).

248. The Nursing Homes' employees, including their administrators, do not have the authority to stop admissions at the Nursing Homes. Only Centers executives, and sometimes only

[54] On April 12, 2022, Centers Central Admissions Specialist Tisch Pompee testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of such testimony is hereto annexed.

Centers COO Abramchik himself, can decide that the Nursing Homes will halt admissions (*see* Pettigrew Aff. ¶ 51, Exh. 45 at 91-92; Topper Tr. at 100-01; Weisz [4/27/2022] Tr. at 102-109) [55].

249. Between January 1, 2019 and December 31, 2021, Martine Center never stopped accepting admissions for more than a few days (*see* Winslow Aff. ¶ 44-45), even though it was unable to provide sufficient care to its existing residents for many months during that period. As Martine Center's staffing levels worsened during the Peak-Pandemic Period, Martine Center's DON and ADON urged Centers to halt new admissions, because adding more residents would spread the already overworked staff even thinner and further decrease the care provided to existing residents that Martine was already neglecting. Centers denied Martine's efforts to curb admissions. This is unsurprising as Respondents' conduct, which prioritized up-front profit taking over their legal duties to provide resident care and sufficient staffing, was motivated solely by avarice.

250. Examples of Martine Center staff's pleas to stop accepting new admissions include:

a. On February 21, 2020, the DON noted, "[w]e already have 6 planned admissions today. This is way too much in 1 day. We want all new admits come in safely & not missed [sic] anything so it does not result to unnecessary AMA & complaints. Please understand especially weekend staffing is a big challenge at this time. Don't get me wrong. We welcome admissions but it has to be safe for all of us. Please ensure we have all equipment ordered before they come" (*see* Pettigrew Aff. ¶ 51, Exh. 45 at 41).

b. On April 7, 2020, the Martine ADON asked, "[i]s everyone aware of the staffing here? Of the 10 nurses we are suppose[d] to have we have 4, we don't even have a nurse on every unit!" Centers Central Admission stated that they would hold off admissions until the next day, and the Martine ADON stated, "we are in a staffing crisis beyond our usual with positive cases in the facility" (*see* Pettigrew Aff. ¶ 51, Exh. 45 at 90).

[55] On May 11, 2022, Centers former Central Admissions Supervisor Akiva Topper testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of such testimony is hereto annexed.

c. On April 8, 2020, the DON wrote to "Martine Admissions," "please cancel admissions today. We have no nurses on 2 units on day shift. Martine is extremely short with nurses. CNAs are also very short on the units." The Martine ADON responded: "At this point! We need a diversion, we have no one to care for these residents. This is horrible." A Centers Admission Specialist rebuffed these requests, reminding the DON that only Centers higher-level staff could agree to call off new admissions, and even then, they "would have to call Amir [Abramchik] to get that blessing" (*see* Pettigrew Aff. ¶ 51, Exh. 45 at 91-92).

d. On April 13, 2020, the DON indicated she asked to "suspend admissions coz [sic] I see that they are sending 2 today. This building is falling apart." The Martine ADON responded, "I can't believe they are still trying to send admissions when everyone is dieing [sic]" (Pettigrew Aff. ¶ 24, Exh. 18; ¶ 48, Exh. 42).

e. On April 14, 2020, the DON wrote to the "Martine Admissions" group chat, "I have no RNS this evening & I have 4 floors without nurses this evening. I'm out sick today including all 3 RN Managers. We have no nurses. Always short 2-3 nurses & floors every shift. We can't handle additional loads right now." The Centers Admission Specialist responded that she was sorry but she had already set up four admissions for that day (*see* Pettigrew Aff. ¶ 51, Exh. 45 at 98-99).

f. On April 15, 2020, the Martine ADON shared, "I can't begin to wrap up today and the amount of calls from the DOH questioning staffing, deaths in facility, why are admission being accepted when there are units with out [sic] nurses, the lack of documentation to justify cares are even being provided, how do we know residents are being fed etc." Earlier in the day, she also informed the DON, Administrator, and Centers that she had talked to Admissions and they were not aware of Martine Center's staffing crisis. The Martine ADON then asked that Admissions be advised that they only have one nurse for the entire evening shift (*see* Pettigrew Aff. ¶ 55, Exh. 49; ¶ 107, Exh. 101).

g. On April 16, 2020, a Centers Admission Specialist reported that she had five admissions coming that day. The DON responded that "[i]t's not safe to take in 5 new admits in 1 evening" (*see* Pettigrew Aff. ¶ 51, Exh. 45 at 102).

251. On April 1, 2020, Martine Center had an end-of-day census totaling 195 residents, which was close to the facility's full capacity of 200. Between April 2, 2020, and April 8, 2020, Martine Center logged 15 discharges, including eight in-house deaths, and there were no admissions to the facility. However, on April 9, 2020, Martine Center again began to accept

admissions. Between April 9, 2020, and April 29, 2020, Martine Center accepted 44 admissions (33 new admissions and 11 re-admissions). On several occasions during this time, Martine Center admitted up to four new residents in a single day (Winslow Aff. ¶ 44-46).

252. Martine Center's Administrator opposed new admissions, yet Centers forced Martine Center to continue accepting new residents (Weisz [4/27/22] Tr. at 109).

253. Respondent Centers's push for Martine Center to accept new admissions, despite lacking sufficient staff to care for its existing residents, reflected Centers's attempt to offset the facility's drop in census—and revenue—during this time, due to resident transfers to the hospital and deaths. Centers's response to residents' suffering and death, and the woeful staffing crisis at Martine, was to continue to disregard its State and federal duties and require Martine to increase admissions to ensure more revenue.

254. Martine Center's staffers were not the only ones concerned about the continued admission of residents. Indeed, DOH also raised concerns about Martine Center's continued admissions in the face of deficient staffing, and such concerns were reported to Centers. Centers, however, still required Martine Center to keep taking admissions.

255. On April 16, 2020, DON Eusebio sent two separate e-mail summaries to Centers Chief Nursing Officer Hendrix, regarding DOH inquiries. Specifically, DOH had inquired whether Martine Center's staffing was sufficient to handle all resident needs and questioned why Martine Center continued to accept new admissions with such insufficient levels of staffing. Despite raising the impassioned concerns and objections referenced above, in her emails to Hendrix, Eusebio reported having "confidently affirmed [to DOH] that facility is able to care for in house residents despite staffing challenges" and is able to bring in admissions because it "has a dedicated RN [supervisor] per diem [employee] who comes and completes ALL admissions from

beginning to end including care plans and CNA Tracker" (*see* Pettigrew Aff. ¶ 58, Exh. 52). In response, Hendrix commended Eusebio for having done a "FANTASTIC Job" during her meeting with DOH (*id.*). Eusebio further explained that, although not all CNA documentation had been completed, "providing care was top priority and documentation was secondary although it was also important"[56] Significantly, Eusebio reported that DOH had requested staffing schedules for certain floors and shifts, but assured Hendrix that the "staffing scheduler printed only 2nd floor schedule removing other floors and shifts as *to not draw extra attention on staffing issues*" (*see* Pettigrew Aff. ¶ 57, Exh. 51, [emphasis added]).

256. In other words, Eusebio, the Martine Center DON, intentionally supplied to DOH misleading staffing information to avoid raising DOH's suspicion and to hide that Martine Center was admitting residents for whom it could not adequately care.[57]

257. Not only that, but Eusebio explicitly informed Centers's Chief Nursing Officer that she had misled DOH, yet Centers did nothing to correct this misleading information.

258. The Martine ADON succinctly summed up Centers's philosophy for admissions: "as long as we still have any beds they are going to keep sending admissions" (Oliver Tr. at 183-85).

259. This experience was not unique to Martine Center. Buffalo Center similarly continued to accept admissions despite its poor staffing conditions. Even during the early wave of the pandemic, which was marked by insufficient staffing levels, and a further loss of staff due to COVID-19 illness and concerns, Respondents required Buffalo Center to continue to admit new

[56] The effect of insufficient staffing on a facility's ability to properly document care, such as CNA documentation is discussed in § VI[H].
[57] DOH did not cite Martine Center for its admissions practices or staffing levels at this time, which is not surprising given that Eusebio and Centers misled DOH about staffing levels.

residents. During the Peak-Pandemic Period, from April 20 to 27, 2020, Buffalo Center admitted 23 new residents (O'Leary Aff. ¶ 93).

260. Centers's repeated decisions to force the Nursing Homes to continue accepting admissions regardless of whether they could adequately care for the new residents resulted in Buffalo Center maintaining a relatively stable monthly census from January 2020 through July 2021, ranging from a high of 191 in March 2020 to a low of 165 in May 2020, even though there was a 45% increase in deaths from the 2018/2019 average to 2020 (O'Leary Aff. ¶ 54, 66).

261. The pattern was strikingly similar at Holliswood Center, where Respondents were operating with such woefully deficient staffing levels that the Regional Nurse overseeing Holliswood Center described it as "uncharted times," and compared it to a "war zone" (Flanagan Tr. at 203-05). During the Peak-Pandemic Period, Holliswood was so short-staffed that its direct care staff was forced to triage care and documentation thereof. Nevertheless, similar to Buffalo Center and Martine Center, Respondents Centers and Rozenberg caused Holliswood to continue to admit residents during the Peak-Pandemic Period (*see* Rhody Aff. ¶ 32), which only served to exacerbate its existing staffing crisis and neglect of residents.

262. In the early days of the pandemic, Centers purportedly took staffing levels into account when determining whether Holliswood was in a position to accept new admissions. Notably, on March 24, 2020, Centers's Chief Nursing Officer Hendrix advised Centralized Admissions Supervisor Topper and Director of Finance Gross that she spoke with Holliswood's Administrator, the Regional Nurse overseeing Holliswood, and a floating DON, and "they are OK with admitting [new residents]. Staffing is OK and they have ~3 Nurse Practitioners." *See* Pettigrew Aff. ¶ 59, Exh. 53; *see also* Flanagan Tr. at 314-16; 320-21; Liff Tr. at 71-74.

263. On that date, across all shifts, there were a total of 80 CNAs, 28 LPNs and eight RNs at Holliswood caring for 312 residents (Rhody Aff. ¶ 14). Regional Nurse Flanagan opined that these staffing levels were sufficient such that new residents could be admitted, noting that against a census of 312, a total of 80 CNAs was "pretty good," while 28 LPNs was a "little low," and eight RNs was "okay." Flanagan Tr. at 330-32.

264. Five days later, however, Holliswood's staffing levels decreased considerably. On March 29, 2020, across all shifts, Holliswood had a total of 63 CNAs, 22 LPNs and four RNs against a census of 309 (Rhody Aff. ¶ 14). As noted above, by this date, the staffing situation at Holliswood was dire, prompting a staffer to report that Holliswood was in "survivor mode." *See* Pettigrew Aff. ¶. 35, Exh. 29 at 105. At this time, however, Centers's purported concerns about the adequacy of staffing evaporated.

265. Despite Holliswood's already deficient staffing levels and the attendant concerns that were communicated to Centers, Flanagan was unaware of any discussions by or between Holliswood and Centers personnel on or about March 29, 2020, regarding whether there was sufficient staffing to admit new residents (Flanagan Tr. at 337-39). Indeed, it appears that the aforementioned email exchange between Hendrix, Topper, and Gross on March 24th was the *last* assessment of staffing made by Centers and Holliswood as it pertained to new admissions (*id.*). Even with these considerably lower staffing levels, and a precipitously climbing death toll, Holliswood and Centers continued to admit new residents—including during the week of April 5, 2020, when Holliswood suffered some of its lowest staffing levels and the most resident deaths (Rhody Aff. ¶¶ 32-33).

266. As noted above, Holliswood suffered its most severe staffing shortages during the first two weeks of April 2020. Between April 5 and April 10, the second week of the month, 24

Holliswood residents died from COVID-19 (Rhody Aff. ¶ 10). Seven of those deaths occurred on April 5 (*id.* at ¶ 33), a day when Holliswood was severely understaffed and, with the exception of RNs on the 11:00 p.m. to 7:00 a.m. shift, PAR Levels were not met for any discipline on any shift:

Holliswood's Most Severe Staffing Shortages Occurred During the First Two Weeks of April 2020

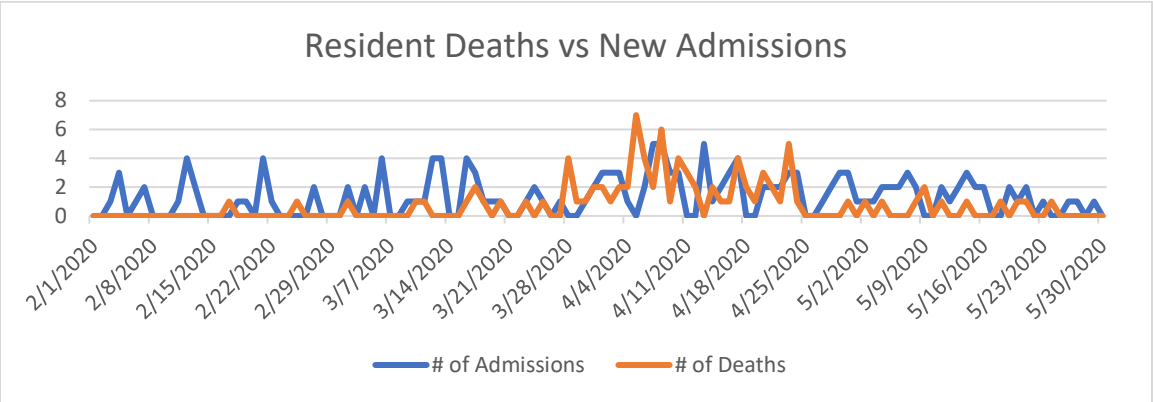
Discipline	Shift	Par Level	# of Staff Worked	Staff Shortfall
CNA	7am – 3pm	33	24	9
LPN	7am – 3pm	12	8	4
RN	7am – 3pm	2	0	2
CNA	3pm - 11pm	27	18	9
LPN	3pm - 11pm	12	8	4
RN	3pm - 11pm	2	1	1
CNA	11pm - 7am	17	12	5
LPN	11pm - 7am	7	3	4
RN	11pm - 7am	1	1	0

(*See* Rhody Aff. ¶ 21).

267. Centers could have halted all admissions at this point but chose not to do so because it prioritized revenue over caring for its residents. Instead, in the face of staffing deficiencies and mounting deaths, Centers caused Holliswood to continue to admit new residents (see Rhody Aff. ¶ 33). Despite the staffing crisis at Holliswood around this time, the decision to refuse new admissions was to be made on a case-by-case basis, and *only* in the event that there was a shortage of RNs—the individuals necessary to process admissions. A shortage of CNAs and LPNs, however, was not a basis for refusing to admit new residents (Liff Tr. at 95-96). In the following days, between April 6 and 10, Holliswood continued to face sub-par staffing levels in all disciplines, *including RNs* (Rhody Aff. ¶ 33). Holliswood nonetheless admitted 18 new residents, while an additional 17 residents died (*id.*). In the chart below, the number of residents who died

each day during this period (orange) is depicted with the number of residents admitted on those same days (blue):

In the Face of Low Staffing Levels, Holliswood Continued to Fill its Beds as Residents Died



Id.

268. During the Peak-Pandemic Period, DOH's March 25, 2020 Advisory prohibited nursing homes from refusing to admit new residents *solely* on the basis of a confirmed or suspected COVID-19 diagnosis.[58] It did not, however, otherwise abrogate the duty of nursing homes to only admit those residents for whom they could provide adequate care (Flanagan Tr. at 344-46; *see also* Ramos: 192). Indeed, Centers retained the authority to direct Holliswood to refuse new admissions (Flanagan Tr. at 344-46), but Centers did not stop the admissions even as staff called out sick and residents suffered, were neglected, infected, and died.

269. Respondents Centers, Rozenberg, and the Operators of Martine Center, Buffalo Center, and Holliswood Center repeatedly and persistently directed the Nursing Homes to accept new residents when staffing was dangerously low, in violation of 10 NYCRR § 415.26 and 42

[58] March 25, 2020 DOH "Advisory: Hospital Discharges and Admissions to Nursing Homes" (*see* Pettigrew Aff. ¶ 56, Exh. 50).

CFR § 483.25, which require nursing homes to "accept and retain only those nursing home residents for whom they can provide adequate care."

4. During the Post-Peak Period, Respondents Centers, Rozenberg, Hagler, and the Nursing Homes' Owners and Operators Continued to Cut Staffing at the Nursing Homes, Again Prioritizing Their Up-Front Profit Taking

270. The tragic outcomes suffered by the Nursing Homes' residents should have served as a wake-up call to Respondents. Sadly, that did not happen. Rather than learning from the experience of the Peak-Pandemic Period and boosting staffing, Respondents doubled down on their callousness by cutting the Nursing Homes' staffing budgets, while forcing them to continue payin inflated rents and sham management fees to Related Parties, which served to conceal their continued extraction of millions in up-front profits (*see* VIII[A],[B][2] below).

271. For example, Martine Center failed to meet its PAR Levels nearly 21% of the days during the third and fourth quarters of 2021 by an average of over 32 nursing hours per day (*see* Rhody Aff. ¶ 24). Indeed, after the Peak-Pandemic Period, staffing conditions at Martine Center were so deficient that in August 2021, Resident J.F. filed a complaint with DOH because she believed that Martine Center was not sufficiently staffed and that residents were not getting the care they deserved. She specifically cited a lack of care by staff that "has been ongoing for years . . . [that] . . . normally occurs between 11pm-7am shift and occurs at least 2-3 times a week" (J.F. Aff.).

272. Martine Center staffers also contacted outside parties to report the deficient care and horrific staffing at the facility after the peak of the pandemic. On December 13, 2021, a Martine Center CNA, who worked the 7 a.m. to 3 p.m. shift on the third floor, contacted MFCU and reported that, upon arriving at work in the morning, she discovered that there had been no CNAs on the third floor during the prior overnight shift and all the residents were soiled (*see* Det. Olsen Aff. ¶ 100). Specifically, from 11 p.m. on December 12, 2021, to 7 a.m. on December 13,

2021, Martine Center did not have any CNAs working on the third-floor unit nor on the second floor, and had only one CNA working on each of the fourth, fifth, and sixth floors. Martine Center's PAR level for CNAs on this shift was two per floor (*see* Winslow Aff. ¶ 43c).

273. Other staff members described similar instances of neglect at Martine Center due to consistently low staffing. The Martine Center CNA who worked the overnight shift in 2021, as referenced above, observed that Martine Center employed at most two CNAs per unit. According to this CNA, even with two CNAs per unit, it was difficult to complete all the required care as each CAN was responsible for 20 residents, and he admitted that he falsely documented that he performed treatment he did not provide so that he would not be questioned by his supervisor. His employment was terminated when he injured a resident by improperly using a Hoyer lift without the required assistance of a second CNA (*see* Det. Olsen Aff. ¶¶ 42-44).

274. The Post-Peak Period staffing shortages at Martine were not inadvertent or unknown to Respondents. Indeed, the staffing shortages were exacerbated by Respondents' decision to cut the facility's staffing budget in the summer of 2020, which caused the facility to operate with insufficient staffing from July 2020 through the end of 2021.

275. Pre-pandemic, Martine Center's census consistently remained over 190 residents. During the Peak-Pandemic Period, the facility's census dropped to around 170 residents (Winslow Aff. ¶¶ 46). As a result of the lower census, Centers re-evaluated Martine Center's staffing budget and *reduced* staffing levels, effective July and August 2020 (*see* Pettigrew Aff. ¶ 193, Exh. 186 at 3). The staffing reductions were to the dissatisfaction of the on-site staff, as the following evidence demonstrates:

a. On July 17, 2020, the Centers Floating DON assigned to Martine ("Floating DON") messaged Martine's administrator: "shragi Martine cant [sic] afford another one of this [staffing cuts] please." Administrator Weisz responded, "Trust me I know." On July 21, 2020, the Floating DON replied, "shragi

martine already have [sic] so much issues with staffing this cut will be a horror for martine" (*see* Pettigrew Aff. ¶ 60, Exh. 54).

b. On January 17, 2021, Martine's administrator wrote to Centers, urging Centers to increase the nursing budget: "Census went up a lot since the cuts and we need to re-visit the nursing budget. We also have been getting really heavy cases and cannot continue with the current staffing levels" (*see* Pettigrew Aff. ¶ 61, Exh. 55.)

c. Martine's administrator testified under oath that he had pushed back to Centers to try to stop the staffing cuts, but that he "lost the argument to" Abramchik and Centers Director of Finance Gross (Weisz [4/27/22] Tr. at 211-214).

276. Similarly, Holliswood's staffing crisis persisted into the Post-Peak Period and, as at Martine, Centers imposed staffing budget cuts at Holliswood that only worsened the situation. Respondents continued to maximize profits, with which they enriched themselves, at the expense of resident care.

277. In July 2020, Holliswood achieved 3.38 HPRD (Budimir Aff. ¶ 56), which was the highest level attained that year, yet was still lower than both the CMS Threshold and NYS Staffing Minimum. Nonetheless, in that month, Centers cut Holliswood's nursing budget for CNA and LPN staffing by 10% and 7%, respectively (Pettigrew Aff. ¶ 62 Exh. 56 at 6), while continuing to admit new residents during the pandemic (Liff Tr. at 91-93).

278. Despite this low HPRD, Centers chose to reduce the care provided to Holliswood residents by cutting staff. Centers adjusted staffing levels based upon census and directed Holliswood to cut 3 CNAs and 1 LPN from the 7 a.m. to 3 p.m. shift (day shift), 3 CNAs and 1 LPN from the 3 p.m. to 11 p.m. shift (evening shift), and two CNAs from the 11 p.m. to 7 a.m. shift (overnight shift) (*see* Pettigrew Aff. ¶ 19, Exh. 13). Centers also cut the budget for housekeeping in July 2020 by approximately 6% and RN management by approximately 21% in August 2020 (*see* Pettigrew Aff. ¶ 62, Exh. 56 at 6).

279. Having cut the staffing budget, Centers closely monitored Holliswood's staffing levels to strictly enforce that budget. On August 31, 2020, for example, a supervisor in the Centers Workforce Management group noted to Centers management that, "[o]f the facilities whose budgets'[] were adjusted for census, the following are not yet within their new budgets and will be worked on: Holliswood (+3.95)" (*see* Pettigrew Aff. ¶ 22, Exh. 16).

280. Centers management directly pressured Holliswood to stay within the staffing budget Centers set (*see, e.g.*, Pettigrew Aff. ¶ 20, Exh. 14 at 11). Centers was particularly concerned that "Holliswood Center (+6.30) is having difficulty adjusting to the new budgets. [Workforce Management] is working with the facility to assist compliance" (*see* Pettigrew Aff. ¶ 23, Exh. 17). Centers even went so far as to hire a new employee to "focus[] on the downstate facilities, first to help them staff-to-budget, and the [sic] also to strategically help facilities reduce the cost of appropriate staffing" (*id.*).

281. It is particularly telling that Centers chose to hire an employee to prioritize cutting staffing costs when it could have spent that money to hire additional staff to improve residents' lives and lessen the burden on the nurses who worked relentlessly throughout the peak of the pandemic. Instead, Centers's new hire was tasked to "babysit" Holliswood, so Centers could "develop [a] process asap for cracking down on lunch breaks" (*see* Pettigrew Aff. ¶ 63, Exh. 57).

282. On November 11, 2020, Centers Director of Finance Gross and Centers Supervisor of Workforce Management again discussed the need to approach Holliswood about its budget, this time after Holliswood insisted it needed additional staffing due to COVID-19: "Holliswood has confirmed that they are staffing 3 additional CNAs per day (2 on Eve[ning shift] and 1 at night), due to COVID they say. Not aware of any approval; reaching out to Dovid to discuss" (*id.*). In

other words, Holliswood needed Centers's approval to employ a mere three additional CNAs to handle COVID-19-related care issues.

283. As was the predictable consequence of Centers's efforts to lower staffing costs at Holliswood, Holliswood's residents received fewer hours of care. The monthly average HPRD fell from 3.38 in July 2020 to 3.26 in August 2020, to 3.22 in September 2020, and then to 3.12 in October 2020 (*see* Budimir Aff. ¶ 56).

284. Holliswood's staffing crisis persisted well beyond the Peak Pandemic period, and the continued staffing budget cuts imposed on the home by Centers management only exacerbated the situation, as did the continued admissions.

285. When nursing staffing levels approached another peak (albeit still low) of 3.33 HPRD in February 2021 (Budimir Aff. ¶ 56), Centers and Holliswood "course corrected" in March and April 2021 and cut nursing hours. The Centers Supervisor of Workforce Management explained the reductions to Abramchik, Vice President of Strategic and Financial Operations Izzy Wolff, and Centers Director of Finance Gross on February 22, 2021: "Holliswood Center (7.61) had been staffing additional employees as they dealt with COVID in the facility. As they are now COVID-free, this has stopped" (*see* Pettigrew Aff. ¶ 21, Exh. 15).

286. Beginning in March 2021, Holliswood's nursing staffing fell below where it was during the Peak-Pandemic Period, declining for four months straight from 3.33 HPRD in February 2021 to 2.87 in May 2021 (Budimir Aff. ¶ 56). In other words, Holliswood residents received 28 fewer minutes of nursing care per day, on average, in May 2021, than in February 2021, due to Centers's decision to cut Holliswood's direct care staff.

287. Holliswood's nursing HPRD never recovered to exceed 3.00 HPRD through the remainder of 2021 (*id.* ¶ 56), and Holliswood failed to meet its own PAR Levels over 21% of the

days during the third and fourth quarters of 2021 by an average of over 33 nursing hours per day (*see* Rhody Aff. ¶ 26). These staffing levels were even below Holliswood's nursing staffing during the Peak Pandemic period, including in April 2020 (Budimir Aff. ¶ 56), when management acknowledged they had a staffing crisis (*see* VI(E)(2) above).

288. Post-pandemic staffing shortages also persisted at Beth Abraham, as that facility failed to meet its PAR Levels over 24% of the days during the third and fourth quarters of 2021, by an average of over 49 nursing hours per day (*see* Rhody Aff. ¶ 25).

i. Staffing Was So Low at Buffalo Center in 2021 that DOH Cited It with Immediate Jeopardy for Inadequate Staffing Resulting in Resident Harm

289. Respondents' disregard for the well-being of their Nursing Home residents is best exemplified by their response to the IJ issued to Buffalo Center in 2021, which was Buffalo Center's second IJ finding within 13 months.

290. As detailed earlier, the neglect of Buffalo Center's residents continued well after the Peak-Pandemic Period. During this time, Buffalo Center's staffing worsened, as the following examples show:

a. CNA BCE3 was left alone on multiple occasions to provide care for up to 60 residents in the dementia unit. She was unable to shower residents on schedule, and many were left in their beds for an entire day. Those who were supposed to be in the dining room for group monitoring due to choking concerns were left to eat in their beds. BCE3 complained to the Buffalo RN Supervisor. In response, the supervisor threatened to call the "State" to report BCE3 for abandonment if she did not return to her floor, despite the insufficient staffing (Det. Petucci Aff. ¶¶ 36, 39, 41-42).

b. On January 16, 2021, CNA BCE2 and two other CNAs were responsible for over 80 residents in the long-term rehabilitation unit. One of the three CNAs was assigned to one-to-one care, meaning that the CNA was required to stay with an individual resident for the entire shift. The following day, BCE2 worked alone and was responsible for caring for almost 60 dementia residents. This low staffing was consistent at Buffalo Center: BCE2 had been required to care for the entire dementia unit 20 times before the January 17, 2021, incident. On that day, though, working in these conditions led BCE2 to resign (Det. Petucci Aff. ¶ 26).

c. CNA BCE1 had been told by Buffalo Center's Staffing Scheduler that the 4th floor, where she worked, needed five CNAs to be fully staffed, although she thought that number was low. Most of the time when she worked, there were only three to four CNAs, one of whom was assigned to provide one-to-one constant care to a particular resident. On March 6 and March 7, 2021, there were only two CNAs per floor on the evening shifts. The 4th floor was often low on LPNs, too, and during approximately ten shifts BCE1 worked, the 4th floor was entirely without nurses (Det. Petucci Aff. ¶¶ 11-14).

d. A Buffalo area paramedic, who was dispatched on a weekly basis to Buffalo Center over the four years preceding March 2023, only saw staff caring for the resident he was sent to treat on one out of every three occasions. On one occasion, after getting the return of spontaneous circulation in a resident, the paramedic attempted to transport the resident to the hospital but was delayed for several minutes in leaving Buffalo Center because he could not find any staff member to unlock the doors to let them out of the building. The paramedic lost the resident's pulse in the ambulance and the resident was pronounced dead at the hospital. In January 2022, when treating a resident on the second floor, he did not see staff attending to any residents on the floor, and when he finally encountered a staff member on his way out of the building, the staff member told him that the prior shift had left without waiting for relief. Additionally, each time the paramedic went to Buffalo Center, he observed the facility to have an acidic, pungent, "stale urine smell"; was unclean, with garbage all over the floors; and the residents appeared dirty with unwashed clothes and hair, and diapers that appear to have not been changed for a week (*see* Affidavit of Todd Swartz, attached hereto).

291. Based upon these reports of extremely low staffing its impact on the residents, DOH conducted an unannounced survey of the facility from May 1 through May 3, 2021. As a result, Buffalo Center was, for the second time in 13 months, cited with an IJ deficiency, primarily due to its failure to provide sufficient nursing staff to adequately care for its residents (*see* Pettigrew Aff. ¶ 13, Exh. 7 at 1; *see also* [VI][E][4][i], for discussion of April 2020 IJ Finding at Buffalo Center). DOH issued a Statement of Deficiencies to the facility, specifically citing that the lack of nursing staff resulted in the failure to provide residents with care in accordance with individual

care plans (*see* Pettigrew Aff. ¶ 13, Exh. 7 at 16-26). The DOH inspectors observed the following on the dementia unit on the fourth floor:

a. On the May 1st to 2nd overnight shift, Buffalo Center staffed the unit with just one LPN and one CNA, to provide care for 53 residents. There should have been three CNAs (*see id.*).

b. On the May 1st 3:00 pm to 11:00 pm shift, Buffalo Center staffed the unit with only one RN and only two CNAs, plus a third CNA who only worked half the shift (*id.*).

c. A resident who was required to have one-to-one supervision, due to alleged past sexual abuse of other residents, wandered the halls, common areas, and his room alone unsupervised (*id.* at 1-2).

e. Another resident who was required to have supervision when moving through the hallways, based on a history of exit-seeking behaviors, pulled a fire alarm, exited the building and was found walking in the parking lot unsupervised. As per the survey documents, the resident's medical record noted that on five occasions prior to this elopement, the resident had been observed wandering, banging on doors, shaking door handles, and attempting to open exit doors. There were no care plan interventions in place to ensure that the resident was properly supervised to prevent unsafe wandering while providing the least restrictive environment (*id.* at 1-16).

f. A resident requiring the assistance of two caregivers two-person for bed mobility and toileting needs was observed "lying in bed on soiled linens wearing an incontinent brief and a soiled gown . . . covered in a foul-smelling yellow-brown liquid-like substance from their head to their knees . . . with areas of this foul-smelling substance drying on the linens." Approximately 30-40 minutes later, the sole CNA on duty changed the linens on the resident's bed without the assistance of another staff member, in violation of the two-person assistance requirement (*id.* at 21-22).

292. As part of the DOH inspection, the RN Supervisor for the overnight shift conceded that "there have been shifts when only one LPN was scheduled for the entire building and 'staffing is horrible here.'" An LPN admitted that "resident care and incontinent care are not sufficiently, nor provided timely, to residents because there is not enough staff." Another LPN reported that "it was impossible to pass medications and assist the CNA with resident care." Two different CNAs stated that "residents were not transferred out of bed to eat dinner because there was not

enough staff" and "incontinent care was not always provided timely to residents because there was not enough staff" (*See* Pettigrew Aff. ¶ 13, Exh. 7 at 20).

293. After the IJ issued in early May 2021, Buffalo Center acknowledged to DOH that it had a duty to "have sufficient nursing staff" (*see* Pettigrew Aff. ¶ 13, Exh. 7 at 16-17). Buffalo Center also assured DOH that Buffalo Center's Quality Assurance and Performance Improvement Committee had met and that it set "minimum staffing numbers [that] were established based on facility census and resident acuity" (Pettigrew Aff. ¶ 13, Exh. 7 at 18). However, Respondents' purported effort at remediation was short-lived. In July 2021, Buffalo Center's staffing levels fell back to the level it was at immediately before the IJ, averaging 2.9 HPRD in July 2021 (*see* O'Leary Aff. ¶ 69). Moreover, Buffalo Center failed to meet its PAR Levels over 49% of the days during the third and fourth quarters of 2021 by an average of over 117 nursing hours per day (*see* Rhody Aff. ¶ 23).

294. Employees noted that staffing quickly returned to the same dangerously low level it had been prior to the IJ. One fourth-floor CNA stated the increased staffing levels lasted about two months before they reverted to the low levels prior to the IJ. Another fourth-floor staffer estimated that staffing returned to pre-IJ status within a few days after the IJ was lifted in June 2021 (Det. Petucci Aff. ¶¶ 15, 38). Staff underscored the hollow nature of Buffalo Center's purported remediation:

a. On a Sunday day shift in August 2021, LPN BCE5 was the only nurse on the second floor. BCE5 was required to stay past the day shift through the evening shift—an additional eight hours of grueling work—because no other LPNs came to work to relieve her. During the evening shift, she was the only employee on the second floor for two hours because the CNAs had left and there were no other LPNs or RNs present (Det. Petucci Aff. ¶ 52).

b. On two or three weekends in September and October 2021, housekeeper BCE11 was the only worker on the fourth floor at the start of the day shift at 7 a.m. Because there was no nursing staff on the floor, BCE11 had to

oversee the nurse's station and answer call lights. According to BCE11, on each of these occasions, two CNAs came in around 8 a.m., and the nurse did not show up on the floor until after 9 a.m. (*see* Affidavit of Det. O'Neill attached hereto at ¶ 17).

c. Staffing improved at Buffalo Center for about two months after the IJ finding but after that, CNA BCE3 noticed that staffing levels dropped again. Between March and October 2021, BCE3 worked alone on the 4th floor three times. When she worked alone, she could only complete one care task per resident for all of the residents under her care (Det. Petucci Aff. ¶¶ 38-39).

295. Finally, in the wake of the IJ, Buffalo Center's DON intimidated a CNA to forge the signature of a colleague on a safety training record, indicating the colleague had participated in the training session when, in fact, the colleague was not at work the day of the training, and had never attended such training, in an effort to misrepresent to DOH that Buffalo Center was in compliance with its Plan of Correction (Det. Petucci Aff. ¶ 46; Det. O'Neill Aff. ¶ 18).

F. Respondents Centers, Rozenberg, Hagler, and the Nursing Homes' Owners and Operators Repeatedly and Persistently Placed Their Residents at Risk by Failing to Spend Nursing Home Funds to Attract and Retain Qualified Nursing Candidates to the Nursing Homes

296. Although the Nursing Homes are handsomely reimbursed by Medicaid and Medicare for the care they purportedly provide, the Nursing Homes do not pay RNs, LPNs, and CNAs competitive wages, especially given the poor conditions in which they work. Unsurprisingly, because the Nursing Homes operate with insufficient staffing to provide required care, yet continue admissions anyway, and assign overburdened staff more duties than can be completed in a given shift, they have difficulty recruiting and retaining qualified employees, which, in turn, negatively impacts the care their residents receive. Instead of spending Medicaid and Medicare funds to adequately pay and retain qualified staff, Respondents repeatedly and persistently transfer exorbitant concealed up-front profit to Respondents, their family members, and Favored Persons at the expense of resident care.

297. Buffalo Center, for example, has suffered high employee turnover, which flows from Centers's operation of Buffalo Center in a manner that failed to pay competitive salaries and caused insufficient staffing to provide required care.

298. Nursing staff turnover at Buffalo Center was 69.3% for the 12 months prior to June 2023, whereas the statewide average of nursing staff turnover for the same period was 43.8% (*see* O'Leary Aff. ¶ 87).

299. The following chart compares average hourly wages for nursing staff at Buffalo Center; at for-profit nursing homes in Erie County, where Buffalo Center is located; and at for-profit nursing homes statewide:

Hourly Wage Rates at Buffalo Center are Consistently Lower Than Other Nursing Homes

Average Hourly Wage									
	Buffalo Center			Erie County			Statewide For-Profit		
	Aides	LPNs	RNs	Aides	LPNs	RNs	Aides	LPNs	RNs
2018	$ 13.48	$ 21.05	$ 31.80	$ 15.14	$ 22.93	$ 33.79	$ 15.11	$ 23.16	$ 33.88
2020	$ 14.58	$ 22.23	$ 36.15	$ 17.22	$ 25.95	$ 35.91	$ 16.88	$ 26.06	$ 37.27

300. As shown above, hourly wage rates at Buffalo Center are consistently as much as 17% lower than other nursing homes, both across the state and in Erie County (O'Leary Aff. ¶¶ 85-86).

301. Instead of attracting qualified candidates to join its in-house nursing staff, Buffalo Center relies heavily upon agency staff (*see* Det. Petucci Aff. ¶¶ 40, 54, 62).

302. Buffalo Center's directly employed staff noted that agency staff is less effective:

a. LPN BCE9 stated that agency staff is "not vested" in the residents or the building and noted many "do not care." She felt that "many of the staffing issues" at Buffalo Center were due to "the use of agency [employees] and 'tons of call offs,'" or agency employees not showing up to work (Det. O'Neill Aff. ¶ 9).

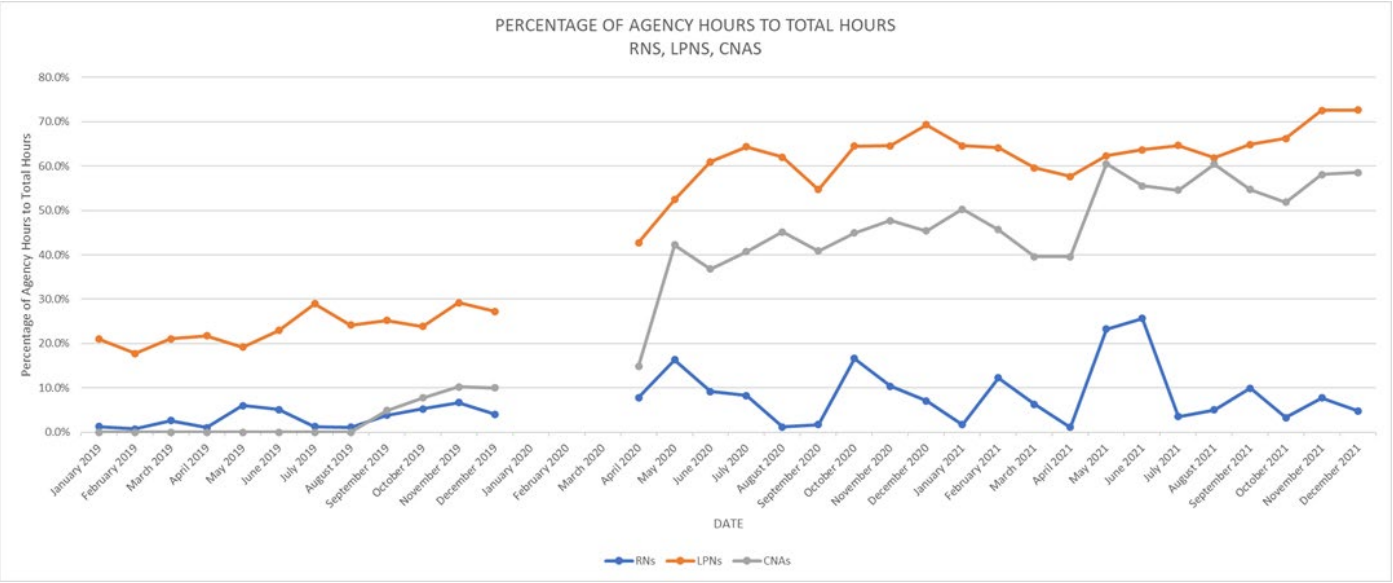
b. LPN BCE5 noted that agency employees have no discipline and seem to make their own schedule, for instance, agency CNAs trickle into work whenever they feel like it on weekend shifts (Det. Petucci Aff. ¶ 54).

c. One CNA noted that Buffalo Center is short-staffed on the weekends when agency staff is not required to work (Det. Petucci Aff., ¶ 19).

d. CNA BCE10 stated that when Buffalo Center is particularly short-staffed, agency staff come in, see how short-staffed the nursing home is, and leave because they refuse to work in those circumstances. BCE10 also said that even those agency staff who do stay often refuse to do certain tasks, leaving it up to the in-house staff, because the agency staff does not care about their work (Det. O'Neill Aff. ¶ 14).

303. Despite the obvious negative impacts on the care of its residents, Buffalo Center increased its reliance upon agency staff from January 2019 to December 2021, as shown in the following graph:

Buffalo Center Relied Heavily on Agency Staff



(O'Leary Aff. ¶ 88).

304. As shown in the graph in orange and grey, respectively, the percentage of hours worked by agency LPNs more than tripled over this period and the percentage of hours worked by

agency CNAs increased sixfold (*see* O'Leary Aff. ¶ 89). Buffalo Center also increased its use of agency RNs during this period, as shown on the graph in blue (*see* O'Leary Aff. ¶ 88).

305. Holliswood also fails to pay direct care employees competitive wages. Holliswood's Administrator testified that Holliswood has "always had a hard time hiring LPNs," an issue that persisted into the Peak-Pandemic Period, and corroborated complaints from LPNs that Holliswood's low pay rate caused potential new hires to refuse job offers from Holliswood (Liff Tr. at 245).

306. Though LPNs perform most of the work on the floors in a nursing capacity, Holliswood's staffing coordinator admitted that it is difficult to hire LPNs because Holliswood's pay rates for LPNs are not competitive with other nursing homes (Arias Tr. at 31-32). LPNs have also complained to union representatives about Holliswood's pay rates (*id.*).

307. When pressed as to why Holliswood's pay rates were lower than the rates paid by other nursing homes, Holliswood's Administrator deflected, stating that LPN and CNA wages are "decided either by the agency or by the union contract" (Liff Tr. at 244-45). However, that statement fails to recognize that the negotiated rate in the contract that governs union employees at Holliswood is a floor, not a ceiling; Holliswood can still offer a rate higher to its employees than this minimum, yet has chosen not to do so.

308. In fact, Holliswood paid even *less* than the rates that they negotiated with the union (Det. Bates Aff. ¶ 96). Certain CNAs received pay of approximately $16 per hour when CNAs were supposed to receive almost $19 per hour under the contracted rate, and certain LPNs received pay of $25 to $26 per hour when LPNs were supposed to receive at least $27-$29 per hour (*id.*). Centers skimped on pay to the Nursing Homes' employees as Centers, Rozenberg, Hagler, and Favored Persons continued to covertly extract millions in up-front profit for themselves from the

Nursing Homes, while the Nursing Homes ignored and violated State and federal laws designed to protect their residents.

309. Management at Holliswood and Centers knew that they were paying below the union contract rates (*id.*). The union contract administrator separately told Holliswood's Administrator about the issue, but the Administrator failed to resolve the problem (*id.*). She later raised the issue directly with Centers executives, including Sicklick (*id*. at ¶ 97).

310. For years, Holliswood's sa;aries and benefits for RNs, LPNs and CNAs measured poorly compared to those of its peers in New York. Based on information that Holliswood submitted to DOH in its financial disclosures, Holliswood spent below the state average on its direct care workers in all years from 2014 (the first full year after Rozenberg purchased the facility) through 2019 (Budimir Aff. ¶¶ 62-64). On average, Holliswood spent approximately 6% less than the state average on direct care workers (*id.*).

G. The Nursing Homes Repeatedly and Persistently Shifted Their Care Duties and Costs to Residents' Families

311. For instance, Buffalo Center's staffing and supervision were so deficient that residents' family members regularly performed the work to care for their resident family members. These family members showed up at the facility often, even daily, to provide their family members assistance with personal care needs, including toileting assistance, turning and positioning, bathing, shampooing, incontinence care, changing diapers, dressing, feeding and drinking, ambulating, and so much more—care that Buffalo Center was legally obligated to provide and which it could have provided if Respondents had adequately staffed the nursing home (*see, e.g.*, Berrie Aff.).

312. Holliswood residents' family members similarly performed personal care for their resident family members, for example:

a. Resident HC9's wife fed him and helped him pour and drink his water when he was dehydrated because he struggled with Parkinson's and Holliswood's staff failed to assist him. She even brought him pureed foods when she visited. During the pandemic, when she could not visit him or bring him food, he lost weight (Det. Bates Aff. ¶¶ 139-40).

b. Resident HC16's family members saw her become "emaciated" because Holliswood did not provide her with food she would eat, did not timely deliver food, and did not help feed HC16, who struggled to do it herself. HC16's daughter continues to have dinner delivered daily, and has fruit, yogurt, and bottled water delivered weekly, because she has anxiety that her mother's health will decline again (Det. Bates Aff. ¶¶ 215-16, 227, 230-32).

313. Family members also have to clean up after the residents to the extent that staff members failed to do so. Resident HC5's daughter threw away dirty diapers filled with feces and urine that were constantly strewn on the floor of HC5's shared bathroom (Det. Bates Aff. ¶ 115).

H. Respondents' Repeated and Persistent Inadequate Staffing at the Nursing Homes Caused the Nursing Homes' Employees to Fail to Document Care

314. All nursing home staff members are required to accurately document all care delivered to each resident, as well as all care that is prescribed but not completed. RNs and LPNs must record the medications they administer on a Medication Administration Record ("MAR") and track treatments they provide on a Treatment Administration Record ("TAR"). CNAs must document that they delivered care, such as oral care, turning and positioning, range of motion exercises[59], toileting, incontinence care, and other services required by the resident's care plan. These records are medically necessary to ensure residents have received timely and appropriate care (*see* Keyser Aff. ¶ 9). In addition, New York law requires that these records be "complete" and "accurately documented." 10 NYCRR § 415.22(a).

315. Medical charts from Martine Center, Buffalo Center, and Holliswood Center show that Respondents Centers, Rozenberg, and the Operators of the Nursing Homes failed to ensure

[59] "Range of motion" exercises are done to preserve flexibility and mobility of the joints on which they are performed (*see* Keyser Aff. ¶ 35).

that staff at the Nursing Homes completed and documented residents' care. The medical records that Respondents produced to Petitioner reflected gaps that indicated that either (1) that the Nursing Homes did not provide residents the care they needed and to which they were entitled; or (2) care was rendered but not documented. The former is consistent with the evidence set forth herein regarding Respondents' neglect of many residents. These failures are due to Respondents' decisions to employ insufficient numbers of staff: the existing direct care staff are stretched too thin. Respondents' failures to document and/or provide care violate New York law. *See* 10 NYCRR § 415.22(a).

316. The following are examples of prescribed care not being provided or documented at Martine Center in April 2020:

a. CNA documentation records for Resident MC10[60] show that, in the first 20 days of April 2020, up to 80% of her required care during the day shift was not documented, including meals, transfers, bed mobility, dressing, ambulation, personal hygiene, range of motion exercises, skin checks/care and bed rail position check (*see* Winslow Aff. ¶ 43a).

b. CNA documentation records for Resident MC9 show that, in the first 20 days of April 2020, up to 70% of required care during the day shift was not documented, including meals, toileting, transfers, bed mobility, dressing, ambulation, personal hygiene, nutrition, skin checks/care, and bed rail position checks (*see* Winslow Aff. ¶ 43b).

317. Buffalo Center had similar failures. A review of 16 Buffalo Center residents' records from January 2019 through October 2021 shows that certain residents' prescribed wound care, turning-and-positioning, and toileting were not documented as having been provided (*see* O'Leary Aff. ¶¶ 55-57).

[60] Within Det. Olsen's Affidavit, Martine Center residents are anonymized and referred to with the prefix "MC" and a number designation.

318. A review of Holliswood residents' records from January 2020 through May 2020 produced by Holliswood also shows that prescribed care was not provided or was not documented. From January 2020 through May 2020, among the 32 residents on the sixth floor, where residents requiring psychiatric and dementia care live, there were hundreds of instances in each month where entries were not documented for administration of medications and nutritional supplements and checks of resident vitals and O2 levels (*see* Rhody Aff. ¶¶ 45-48).

319. The schedule below shows services that were not documented in each month and evidences a significant increase in the failure to document in April 2020 and May 2020. This increase unsurprisingly corresponds to Holliswood's drop in staffing levels at that time (*see* paragraphs VI[E][2] above):

As Holliswood Staffing Levels Dropped, Failures to Document Increased

Category	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	Total
Medication	149	173	119	599	267	1,307
Nutrition/Hydration	61	46	46	268	93	514
Service[61]	21	51	123	459	245	899
Vitamin/Supplement	1	2	2	22	11	38
TOTAL	**232**	**272**	**290**	**1,348**	**616**	**2,758**

(*See* Rhody Aff. ¶ 48).

320. Management at Centers was aware that the Nursing Homes were failing to document the administration of treatment and medication in their records in the manner required.

[61] The "Services" category represents services such as taking vitals or cleaning or changing a feeding tube (*see* Rhody Aff. ¶ 47).

Centers created daily reports that identified all instances where staff failed to document that they provided care and services, which Centers referred to as reports of "missing MARs and TARs."[62] In addition, Centers separately tracked missing "critical MARs," which recorded when particularly critical medications were not documented. Those critical medications include those used to treat pain, seizures, neuropathy, convulsions, schizoaffective disorders, and infections, as well as insulin. Centers also tracked missing TARs for treatments such as wound care, respiratory assessments, vital checks, neurological checks following falls, and appropriate fluid intake or restriction. *See* Rhody Aff. ¶ 45-51.

321. On May 31, 2020, the Director of Clinical Services responsible for overseeing Holliswood asked the Holliswood nursing supervisors to "start addressing the missing MARs and TARs" (*see* Pettigrew Aff. ¶ 65, Exh. 59). The MARs and TARs reflecting the lack of documentation, which were attached to the email, revealed that on a single day, May 29, 2020, staff at Holliswood failed to document 127 orders related to medication administration, including 10 highlighted as "Critical Meds" (*see* Pettigrew Aff. ¶¶ 66, 68, Exhs. 60, 62), and 149 treatment administrations (*see* Pettigrew Aff. ¶ 67, Exh. 61). On May 30, 2020, staff at Holliswood failed to document 226 orders related to medication administration, including 34 highlighted as "Critical Meds" (*see* Pettigrew Aff. ¶¶ 69, 38, Exh. 63, 32). Because of these failures, it is impossible to know if these residents received these vital medications and treatments.

[62] MAR stands for Medication Administration Record; TAR, for Treatment Administration Record (*see* Keyser Aff. ¶ 9).

VII. RESPONDENTS ROZENBERG, CENTERS, THE NURSING HOMES' OPERATORS, AND THE NURSING HOMES' OWNERS CONTRIBUTED TO THE SPREAD OF COVID-19 AT THE NURSING HOMES BY REPEATEDLY AND PERSISTENTLY VIOLATING INFECTION CONTROL REGULATIONS

322. Nursing homes are required to establish and maintain an infection control program for the benefit of their residents. The program must be "designed to provide a safe, sanitary, and comfortable environment" for the residents, while helping to "prevent the development and transmission of disease and infection." 10 NYCRR § 415.19. The infection control program must have "written policies and procedures" under which the nursing home "investigates, controls and takes action to prevent infections," defines procedures for isolating residents to prevent the spread of infection; records incidence of infections; and documents corrective actions that the nursing homes takes. (*Id.*)

323. Respondents violated these requirements, resulting in increased risk of infection and death to the Nursing Homes' vulnerable residents. Because Respondents required the Nursing Homes to cut costs at the direction of Centers, such as by operating with minimal staffing levels, the Nursing Homes were primed to fail in controlling infections during the Peak-Pandemic Period.

A. Respondents Repeatedly and Persistently Delegated Authority to Adopt and Enforce Infection Control Policies for the Nursing Homes to Centers in Violation of 10 NYCRR § 600.9

324. Each nursing home in New York State is required to have a "governing authority or operator" recognized by DOH that is "the party responsible for the operation" of the nursing home. 10 NYCRR § 600.9.

325. The governing authority or operator of every nursing home in New York State has a non-delegable duty to "adopt[] and enforce[] policies regarding the operation of the facility," 10 NYCRR § 600.9, including policies regarding infection control.

326. The governing bodies of the Nursing Homes are the Nursing Homes' Operators.

327. Centers is not the Nursing Homes' governing authority or operator; Centers is their management consultant. Despite this more limited role, Centers develops and finalizes clinical policies and procedures, and requires the Nursing Homes to implement those policies, in violation of 10 NYCRR § 600.9. The Nursing Homes Owners' and Operators' unlawful delegation of policymaking to Centers yielded disastrous results at the Nursing Homes during the pandemic.

328. Centers exercised near-total control over the Nursing Homes' infection control policies and procedures during the Peak-Pandemic Period. During this period, Centers created and issued to the Nursing Homes numerous pandemic-specific infection control policies. The corporate head of education at Centers drafted the policies (Flanagan Tr. at 21-22).

329. All four of the Nursing Homes implemented infection control policies and procedures that were created by Centers without input from staff at the Nursing Homes. Beth Abraham and Buffalo Center adopted these policies without any input from their administrators (Blackstein Tr. at 60; Smith Tr. at 21) [63, 64]. Similarly, Martine Center's Medical Director/Attending Physician was not involved in drafting policies or procedures for Martine Center; he testified that he merely read them after they were created (*see* Buddhavarapu Tr. at 69-71; Weisz [3/31/22] Tr. at 46) [65]. Holliswood also implemented the infection control policies and

[63] On May 5, 2022 and May 19, 2022, former Beth Abraham Administrator Moshe Blackstein testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of his testimony is hereto annexed.
[64] On November 24, 2020, Centers Regional Director of Clinical Services Heidi Smith testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of her testimony is hereto annexed.
[65] On December 8, 2020, Martine Center Medical Director and Attending Physician Dr. Rajeskehar Buddhavarapu testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of his testimony is hereto annexed.

procedures that it received from Centers with only facility-specific "tweaks" from the Centers-employed regional-nurse (Liff Tr. at 46).

B. Respondents Failed to Follow Established Infection Control Policies and Guidance During the Peak-Pandemic Period

330. Infection control failures within Centers facilities during the height of the COVID-19 pandemic created a substantial risk of serious harm and death to their vulnerable and elderly residents.

331. Although health alerts regarding COVID-19 were first released in January 2020, Centers did little to prepare for the impending spread of the virus. For instance, Martine Center failed to take simple steps to prepare, including increasing PPE supplies, hiring more staff, and providing adequate COVID-19 related training to its staff (Buddhavarapu Tr. at 139; Oliver Tr. at 135-37; Afrifa [2/11/21] Tr. at 162-63) [66]. The failure of Respondents Centers, Rozenberg, the Nursing Homes' Owners, the Nursing Homes' Operators, and the Nursing Homes to take these simple and expected steps led to exacerbated failures in infection control during the height of the COVID-19 pandemic, which created a greater risk of serious harm and death to their residents.

1. The Nursing Homes Failed to Maintain Dedicated Staff to Care for Residents with COVID-19

332. Under Centers's control, due to insufficient levels of direct care staff, the Nursing Homes failed to devote separate staffing teams to care for residents who had or were suspected to have had COVID-19 and those residents who did not, in violation of applicable government directives.

[66] On February 11, 2021, and March 9, 2021, Martine Center RN Educator and Infection Preventionist Alex Afrifa testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcripts of his testimony are hereto annexed.

333. Early in the first wave of the pandemic, federal, state, and local governments issued directives to nursing homes that set forth how to protect vulnerable residents while simultaneously caring for individuals infected with COVID-19. DOH issued one such directive on March 13, 2020, which required nursing homes to "not float staff between units" and to "[c]ohort residents with COVID-19 with dedicated [healthcare professionals]."[67] The rationale for this directive was obvious – given the highly communicable nature of the COVID-19 virus, it was critical to separate nursing home staff into two components: those who treated residents with COVID-19, and those who treated residents who did not have COVID-19.

334. Despite this directive, and despite Respondents' total control over the Nursing Homes' infection control policies, Respondents did not direct the Nursing Homes to comply with DOH's directive. Because the Nursing Homes operated with chronically insufficient staffing, even before the pandemic, there were not enough direct care staff members to comply with DOH's directive. As a result, staff members at the Nursing Homes cared for both residents who had COVID-19 and residents who did not, thereby significantly increasing the risk of transmission of the virus to uninfected residents and placing those residents at risk of infection and death.

335. In addition to failing to comply with DOH's directive, Respondents failed to comply with their own internal policies that Centers created for the Nursing Homes.

336. For example, Centers created a policy for Martine Center in March 2020 that states: "Do not float staff between units. Cohort residents with COVID-19 with dedicated [healthcare provider] and other direct care providers" (Pettigrew Aff. ¶ 52, Exh. 46 at 5). But Martine Center failed to create a dedicated COVID-19 unit and failed to segregate its staff for seven weeks, until

[67] DOH, Bureau of Healthcare Associated Infections, Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities (Mar. 13, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/03/acfguidance.pdf (last visited June 27, 2023).

May 8, 2020. Before May 8, 2020, Martine Center's COVID-19-negative residents shared staff with residents who were COVID-19-positive, and positive and negative residents were also housed on the same units (*see* Eusebio [6/24/21] Tr. at 73-74, 90; Weisz [4/27/22] Tr. at 139, 147-51; Pettigrew Aff. ¶ 198, Exh. 191).

337. The Nursing Homes' nursing staff knew that it was important to assign separate groups of staff to care for COVID-19-positive and COVID-19-negative residents, but they did not have the power to do so, because Centers controlled the decision-making for the Nursing Homes. For instance, Martine Center's then-DON Eusebio testified that she knew that having separate staff for infected residents reduced the risk of transmission to uninfected residents, but stated that she did not know why Martine Center did not implement such a policy sooner (Eusebio [6/24/21] Tr. at 89, 92). Despite Centers's control over virtually every aspect of the Nursing Homes' operations, including staffing levels, the Centers Chief Nursing Officer attempted to deflect blame when she accused Martine Center of acting improperly by not having a designated group of staff members dedicated to treating COVID-19 residents earlier (Hendrix Tr. at 186-92).

338. Holliswood also failed to dedicate separate groups of staff to residents with and without COVID-19. When clusters of COVID-19 symptoms started emerging on two floors in March 2020, Holliswood's approach to quarantining was to confine COVID-19-symptomatic residents to their rooms. Due to "challenges of staffing," staff floated throughout these two floors, caring for both symptomatic and asymptomatic residents (Ramos Tr. at 214, 218). Some staff also worked on the two floors with COVID-19-symptomatic residents and then returned to work on their assigned floors to care for asymptomatic residents (Ramos Tr. at 218; Det. Bates Aff. ¶¶ 47-48).

339. Centers Regional Nurse Kathleen Flanagan, who supervised Holliswood, testified that in April 2020, when Holliswood began to isolate symptomatic residents in a back area on each unit, there were times when staff members moved between rooms with asymptomatic and symptomatic residents. Flanagan stated the number of symptomatic residents on a floor did not justify devoting a single caregiver exclusively to their care (Flanagan Tr. at 456-57). Presumably, Centers did not deem it cost-effective to provide proper care. Significantly, Flanagan admitted she could not rule out the possibility that a staff member who cared for symptomatic residents one day would receive a different assignment to care for asymptomatic residents the next day (*id.* at 455).

340. By the middle of May 2020, the many deaths of Holliswood residents exposed the fatal impact of Respondents' decision to employ insufficient numbers of staff – but proper infection control continued to be an afterthought. Due to the widespread prevalence of COVID-19 at Holliswood, and the high number of COVID-19 deaths, on May 5, 2020, DOH conducted facility-wide COVID-19 testing at Holliswood. At that time, DOH directed Holliswood to implement a revised cohorting strategy: DOH directed Holliswood to group residents into cohorts by COVID-19 status and arrange the cohorts next to each other on each floor, marked with designated colors. But even DOH's cohorting system could not achieve the intended effect of using separate groups of staff to care for symptomatic and asymptomatic residents, because Holliswood did not have sufficient staff to create dedicated teams to staff each of the cohorts. Because of Holliswood's insufficient staffing level, staff had to float between cohorts to care for residents (*see* Pettigrew Aff. ¶ 70, Exh. 64; Ramos Tr. at 221-25), likely exposing COVID-19-negative residents to the virus.

341. Holliswood did not create separate teams to care for COVID-19-positive residents at this time because "there [were] multiple staff challenges and the ability to select only certain

staff for one area and not in another area . . . pose[d] [staff] challenges" (Ramos: 223). This violated DOH guidance that required nursing homes to have separate staffing teams for positive and negative residents, as well as CDC guidance dated April 2, 2020, which required nursing homes to "use separate staffing teams for COVID-19 positive residents to the best of their ability" and further required that "staff as much as possible should not work across units or floors" (Pettigrew Aff. ¶ 53, Exh. 47).

342. Further, nursing supervisors did not tell CNAs which residents were COVID-19-positive or COVID-19-negative (*see* Det. Bates Aff. ¶¶ 24, 56, 83). On April 1, 2020, the staffing coordinator at Holliswood's largest staffing agency relayed a complaint to Holliswood's DON and ADON from a CNA who refused to be staffed "after not having been feeling well and was put on a unit with COVID-19 patients and was not given this information by any NS [nursing supervisor]" (*see* Pettigrew Aff. ¶ 64, Exh. 58). In response, the ADON tacitly acknowledged there was no means by which to identify COVID-19 residents: "[t]he whole building is treated as a presumptive building for COVID-19" (*id.*).

343. This problem persisted beyond the Peak-Pandemic Period into September 2020, when COVID-19-positive residents were being transferred from hospitals to Holliswood. CNAs reported not knowing the COVID-19 status of the residents for whom they were assigned to care (Det. Bates Aff. ¶ 24).

2. Martine Center Failed to Properly Implement an Effective Employee Screening Program, Increasing the Risk of COVID-19 Infection to Its Residents and Employees

344. On March 13, 2020, DOH required that all nursing homes suspend visitation and immediately implement health checks for care providers and other staff entering the facility at the beginning of each shift, with the goal of limiting the spread of COVID-19. This requirement applied to all personnel entering the building. DOH guidance further instructed facilities to send

home any staff with COVID-19 symptoms or with a temperature of or exceeding 100 degrees, regardless of whether employees had symptoms when they started work or developed symptoms during their shift.[68]

345. Martine Center began an employee screening program the second week of March 2020. However, there were multiple failures at Martine Center that rendered the screening program ineffective, thereby exposing Martine Center residents and other employees to an increased risk of harm. Those failures included:

a. Martine Center employees used a backdoor to enter and exit the building that Martine Center failed to monitor (*see* Winslow Aff. ¶ 29; Det. Olsen Aff. ¶¶ 21, 29, 59).

b. Martine Center's screening station was frequently left unstaffed, allowing employees, including the DON and even the *Infection Preventionist* to enter through the main entrance without being screened – an issue of which Martine Center was aware, but failed to remedy (Eusebio [6/24/21] Tr. at 111-14, 143-51; *see* Winslow Aff. ¶¶ 27-28).

c. Martine Center knowingly used defective thermometers for six days during the end of March 2020, a problem of which Centers's Chief Nursing Officer was also aware but did not correct (*see* Pettigrew Aff. ¶¶ 72-77, Exhs. 66-71; Hendrix Tr. at 108-12; Eusebio [6/24/21] Tr. at 131-39).

346. Thus, Respondents repeatedly and persistently failed to screen Martine Center employees for COVID-19, as required by law, increasing risks of infection to residents.

3. Martine Center Endangered the Health and Safety of Its Residents by Allowing Two Nurses to Work While Sick with COVID-19

347. Martine Center allowed at least two very sick employees to work in the nursing home, including one who provided direct care to residents while sick.

[68] DOH, Bureau of Healthcare Associated Infections, Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities (Mar. 13, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/03/acfguidance.pdf (last visited June 27, 2023).

348. First, on Friday, April 17, 2020, a Centers's Floating DON[69], emailed her supervisor at Centers, Clinical DON Gemma Moore, who thereafter forwarded the email to Centers Chief Nursing Officer Heidi Hendrix, stating that she: had body pains and a bad headache, was leaving early, and had already spoken with DON Eusebio and Administrator Weisz (*see* Pettigrew Aff. ¶ 78, Exh. 72).

349. The following Monday, April 20, 2020, the Floating DON emailed Moore and Hendrix, stating that she would be leaving Martine Center early to get a COVID-19 test (*see* Pettigrew Aff. ¶ 79, Exh. 73). This email indicates that the Floating DON had returned to Martine Center three days after experiencing COVID-19 symptoms; in addition, and there is no record of the Floating DON being screened for COVID-19 symptoms upon entering Martine Center on April 20 (Winslow Aff. ¶ 24).

350. Later that day, Hendrix emailed the Floating DON to ask how she was feeling. The Floating DON replied, "I am hanging in . . . the headaches and body pain is crazy . . . dry cough started yesterday" (Pettigrew Aff. ¶ 80, Exh. 74).

351. That evening, the Floating DON emailed Moore and Hendrix stating that she had been tested but did not expect results for four to five days; she then asked whether she should return to Martine Center the next day or wait for the results. In that email, the Floating DON also stated that she had no fever but was experiencing shortness of breath, dry cough, body pains, and a headache. Hendrix, the Chief Nursing Officer for all of Centers, asked the Floating DON if she felt like she could work in a mask. The Floating DON replied that she could work, and that she would wear a mask and stay away from the residents (*see* Pettigrew Aff. ¶ 81, Exh. 75).

[69] Centers sends the "Floating DON" to Centers-affiliated nursing homes that need support, such as when a DON position is open or to assist a new DON (*see* Moore [6/3/2021] Tr. at 131; Hendrix Tr.at 259).

352. The next day, April 21, 2020, the Floating DON reported to work at Martine Center. She emailed Hendrix and Moore advising them that Martine's administrator had asked about her symptoms and expressed concern that she could spread COVID-19 at Martine Center. The Floating DON wrote that she had explained to the administrator that Hendrix and Moore had approved her to work because she was fever-free. Hendrix responded via email that she had spoken with the administrator and that the administrator agreed to allow her work with a mask if she stayed off resident units (*see* Pettigrew Aff. ¶ 82, Exh. 76).

353. Unsurprisingly, Chief Nursing Officer Hendrix was evasive when questioned under oath about whether her decision to allow the Floating DON to work violated DOH directives. Nonetheless, Hendrix admitted that allowing the Floating DON to enter Martine Center pending the results of her COVID-19 test "was not in alignment directly" with DOH guidance or Centers policy (Hendrix Tr. at 260-61). Hendrix further admitted that "if we could go back and make a different decision we would have" (*id*. at 269).

354. Martine Center also allowed its ADON to continue coming to work, and for a time, even to work on resident units, while experiencing COVID-19 symptoms. This further demonstrates Martine Center's failure to follow infection control directives. In this instance, such failure ended tragically.

355. In early April 2020, the ADON developed symptoms consistent with COVID-19. She shared the news of her symptoms with her colleagues via WhatsApp messaging, noting that "my freaken [sic] throat hurts!" (*see* Pettigrew Aff. ¶ 83, Exh. 77). On April 13, she did not work, explaining, "I'm sorry guys, I feel horrible like I am abandoning you but I'm not going to make it in today either. If my fever breaks and I am able to drive later I will pack so I can at least be in the building with you. If not I will be in, in the morning, starting Levaquin now" (*see* Pettigrew

Aff. ¶ 48, Exh. 42). Despite these serious symptoms, the ADON worked at Martine Center the next day, on April 14 (*see* Winslow Aff. ¶ 25, Exh. 16). The following day, April 15, the Martine ADON told her colleagues that she was "horrible, [with a] 101.2 [degree fever] and I'm on the protocol…but I feel better than yesterday," *i.e.*, better than on April 14 when she worked at Martine (*see* Pettigrew Aff. ¶ 84, Exh. 78).

356. A few days later, on April 17, the ADON worked at Martine again, and during that shift she sent a voice message to the Assistant Administrator. On this voice message, the ADON was coughing and had trouble speaking. The Assistant Administrator responded that the ADON sounded sick and asked if she was at work. The ADON replied via a WhatsApp message, stating, "Yes, but I'm going home as soon as meds kick in and I'm not dizzy" (*see* Pettigrew Aff. ¶ 85, Exhs. 79a and 79b). The ADON punched out of work for the final time at 12:46 p.m. on April 17 (*see* Winslow Aff. ¶ 26, Exh. 16). She was hospitalized on April 21, and at the hospital she tested positive for COVID-19 (*see* Pettigrew Aff. ¶ 86, Exh. 80; ¶ 108, Exh. 102). On May 1, 2020, the Martine ADON was intubated (Pettigrew Aff. ¶ 87, Exh. 81). She died less than two weeks later.

357. Martine's medical records, including MARs, TARs, and Nursing Notes, show that the ADON worked directly with residents as late as April 10, 2020 (Winslow Aff. ¶ 26).

358. Martine Center management knew that the Martine ADON worked in the building while she was sick and exhibiting COVID-19 symptoms. The DON and Medical Director both noticed that she did not look well and told her to go home and rest (Buddhavarapu Tr. at 186, 252-253; Eusebio [5/20/2021] Tr. at 108-110).

359. By allowing two senior nurses who were exhibiting COVID-19 symptoms to continue working alongside their colleagues and vulnerable residents, Martine Center endangered both its staff members' and residents' lives. Martine Center allowed this serious breach of

infection control protocol because of Martine's short staffing: with so few employees, the absence of even a single experienced nurse meant that more residents would be neglected.

4. The Nursing Homes Failed to Properly Supervise Wandering Residents, Which Increased the Risk that COVID-19 Would Spread Throughout the Facilities

360. Nursing homes are required to supervise residents. Residents who have psychological and/or cognitive conditions, including dementia, are more likely to wander through the nursing home into different units if they do not receive adequate supervision by nursing home staff (*see* Keyser Aff. ¶ 19). The failure of a nursing home to prevent residents from wandering unsupervised is an infection control failure because it allows unmonitored potential exposures across different units at the nursing home. The odds of transmission are increased further if residents with psychological and/or cognitive conditions such as dementia wander unsupervised, because residents with those conditions are less likely to comprehend or fully comply with the masking requirements.

361. During the Peak-Pandemic Period, Holliswood failed to sufficiently staff its fifth and sixth floors, which are for residents diagnosed with psychiatric conditions and/or dementia. Those residents, because of their conditions, struggle with impulse control and have poor safety awareness (Flanagan Tr. at 43-44). These residents presented an increased transmission risk because they tended to refuse COVID-19 testing and thus, their COVID-19 status could not be confirmed (*id*. at 460-61).

362. Holliswood knew that unsupervised resident wandering presented infection control risks. Holliswood's ADON and Infection Control Preventionist believed that residents infected with COVID-19 likely spread it throughout the facility by wandering out of isolation units and failing to comply with masking and social distancing requirements (Floyd Tr. at 151-55). At times, these residents failed to properly mask and observe social distancing because they were cognitively

unable to do so (*id.*). The unique needs of this population made adequate staffing even more important to prevent the spread of COVID-19.

363. Despite these known risks, Holliswood failed to adequately staff these units. Staff reported that two CNAs were responsible for monitoring and redirecting as many as 30 residents on these units who were kept seated together in a hallway (Det. Bates Aff. ¶¶ 18, 65, 80). One staff member explained that because of their behaviors, the residents were "too much to handle" at Holliswood's staffing levels; CNAs needed to interrupt nurses who were providing care to residents to help manage other residents in the hallway (Det. Bates Aff. ¶ 66).

364. Unsurprisingly, residents on these units at Holliswood experienced drastically higher levels of COVID-19 infections and deaths compared to residents on other floors. From January 1, 2020, to May 31, 2020, 84% of residents living on the sixth floor became infected with COVID-19, compared to 39% of residents throughout the building (Rhody Aff. ¶ 43). On the sixth floor, 36% of residents died from COVID-19, compared to the building-wide average of 16% (*id.* ¶ 44).

365. Similar to Holliswood, during the Peak-Pandemic Period, COVID-19-positive residents with dementia wandered throughout Martine Center unsupervised and into other resident rooms without wearing a mask (*see* Det. Olsen Aff. ¶¶ 55, 67).

5. The Nursing Homes Failed to Adequately Train Staff to Provide Care During the COVID-19 Pandemic

366. Under Respondents' control, the Nursing Homes failed to adequately train their staff, which adversely impacted resident care and decreased the efficiency of nursing staff.

367. Holliswood staff did not receive any infection control training regarding COVID-19 during the first wave of the pandemic except related to mask-wearing (Det. Bates Aff. ¶¶ 30, 58, 77).

368. Similarly, Martine Center provided inadequate COVID-19 training to its employees. Between March 5, 2020, and March 26, 2020, Martine Center conducted COVID-19 trainings. However, as COVID-19 spread throughout Martine between March 27 and April 24, 2020, Martine conducted only two poorly attended trainings.[70] Martine Center finally conducted another COVID-19 training on April 25, 2020, after having failed to educate its staff about guidance and recommendations for best practices released by the CDC, CMS, and DOH during the previous four weeks. By the time Martine Center conducted the April 25 training, the virus had already spread throughout the facility (*see* Winslow Aff. ¶ 30; Pettigrew Aff. ¶ 88, Exh. 82). Martine Center's failure to hold COVID-19 trainings was consistent with its low staffing: the nursing managers, including the RN educator, who would normally conduct those trainings, were required to provide direct care to residents due to insufficient staffing (Afrifa [3/9/21] Tr. at 23). Thus, Martine Center deprived its staff of up-to-date guidance for responding to COVID-19 during the critical first months of the pandemic.

369. Insufficient training also resulted in infection control failures at Buffalo Center, that in turn led DOH to place Buffalo Center in IJ after an April 30, 2020, COVID-19 Focus Survey.[71]

370. At the April 30 Focus Survey, DOH surveyors observed Buffalo Center staff members floating between the rooms of COVID-19-positive and -negative residents, without changing PPE or without any PPE at all, contrary to DOH directive/guidance. Though masking was required, the DOH survey team also observed several Buffalo Center staff, including the

[70] On April 3, 2020, there was a handwashing and PPE training, which 15-17 staff members attended. On April 21, 2020, there was a training conducted by the administrator regarding COVID-19 notifications to families, which was attended by 6 staff members.
[71] A Focus Survey concentrates on a limited aspect or aspects of nursing home operations. In this case, DOH's survey focused on Buffalo Center's infection control procedures as they relate to COVID-19.

ADON, either not wearing masks or not wearing them appropriately. A DOH surveyor also observed a CNA and a member of the housekeeping staff violating infection control protocols. The housekeeping staff member had never participated in infection control training at the facility because such trainings were held after her regular work hours. She also did not receive *any* PPE from Buffalo Center until after DOH inspectors spoke to her about improper infection control procedures on the day of the survey (*see* Pettigrew Aff. ¶ 117, Exh. 111; Det. Petucci Aff. ¶ 70).

C. Some Nursing Staff Were Forced to Wear Garbage Bags Instead of Gowns, Because Respondents Failed to Distribute Sufficient PPE, Which Increased the Risk of Transmission of COVID-19 at the Nursing Homes

371. Holliswood Center and Martine Center failed to provide staff with sufficient PPE, specifically gowns, during the height of the COVID-19 pandemic. This created an increased risk of transmission of the virus and compounded the infection control risk of having staff float between COVID-19 positive and negative residents, described above.

372. Early in the pandemic, Holliswood had a dire need for gowns, a fact known by Holliswood's Administrator and by Centers management (*see* Pettigrew Aff. ¶ 89, Exh. 83). Indeed, the Centers Director of Purchasing apologized for the "hardship the shortage has caused" and promised to send more gowns (Pettigrew Aff. ¶ 92, Exh. 86). Yet, days later, staff continued to complain about the lack of PPE, specifically gowns, and at least one CNA refused to report to work until Holliswood could provide proper PPE (*see* Pettigrew Aff. ¶ 91, Exh. 85; Det. Bates Aff. ¶¶ 102-06).

373. In late March 2020, Centers and Holliswood adopted extended wear and re-use procedures that required staff to wear the same facemask and gown for repeated close encounters with multiple residents (Liff Tr. at 200, 203-05; Ramos Tr. at 252-54). Since Holliswood provided just one reusable gown to wear for the day, staff wore the same layer when caring for all of their assigned residents—both COVID-19-positive and -negative residents (Liff Tr. at 204). Centers

demanded "strict adherence" to these rationing strategies, at least for facemasks (*see* Pettigrew Aff. ¶ 93, Exh. 87) and Holliswood staff complied, even as they floated between residents with COVID-19 symptoms and those without (Det. Bates Aff. ¶ 55).

374. In March and April 2020, Holliswood staff was not expected to wear gowns unless they were caring for residents with COVID-19 symptoms (Floyd Tr. at 212-13). But because Holliswood did not conduct mass testing of its residents until early May 2020, which revealed many asymptomatic COVID-19 cases among Holliswood residents, this policy likely resulted in staff unknowingly providing care to both COVID-19-positive and -negative residents alike without wearing a gown.

375. Despite these rationing measures that Centers imposed on Holliswood, Holliswood still did not have enough gowns for its staff. Because of this, some CNAs resorted to wearing plastic garbage bags as gowns (*see* Det. Bates Aff. ¶ 28, 38, 54).

376. The gown reuse policy that Centers imposed on Holliswood violated applicable CDC guidance. CDC guidelines allowed for the extended use of gowns as a crisis strategy only if (1) a nursing home properly cohorted its residents with COVID-19 and (2) the gown was worn to care for residents known to be infected with the same disease.[72] At Holliswood, however, COVID-19-positive residents were not cohorted until mid-May 2020. And even after May 2020, staff continued to float between COVID-19-positive and COVID-19-negative residents.

377. During the beginning of the pandemic, Holliswood staff was also expected to wear the same surgical mask for multiple days or until it was torn or soiled, and to wear one N95 mask for a week, unless it was visibly soiled or torn (Liff Tr. at 205-207, 209; Floyd Tr. at 209; Det.

[72] CDC, Strategies for Optimizing the Supply of Isolation Gowns, updated January 21, 2021.

Aff. ¶ 26, 50)[73]. Because Holliswood's residents were not cohorted by COVID-19 status and staff members floated between COVID-19-positive and -negative residents at that time, these policies increased the risk of infections among Holliswood's staff and residents.

378. Holliswood's managers knew that these PPE practices were unsafe:

a. The DON testified that "we knew how PPE should be utilized and now there had to be a change in how we had to use it . . . [I]t was hard to switch off as a nurse. As an educator to educate someone that you change the mask in and out of every patient's room to saying, 'Hey, you got to keep your mask on for the day or you to have to keep it in the bag'" (Ramos Tr. at 250).

b. Similarly, the ADON and Infection Preventionist testified: "If I'm going to go in [a resident's] room and you have some type of airborne issue going on, all that breathing and all those droplets are going to get on my clothing. So why on earth would you want me to wear that in another room with someone who is sick who may have pneumonia or cardiovascular disease who would be susceptible to . . . having an issue . . ." (Floyd Tr. at 188).

379. Holliswood ADON Floyd also served as Holliswood's Infection Control Preventionist. Floyd was frustrated by the way that Centers handled its infection control policies and believed that "no one cares what I think" (Floyd Tr. at 187). Centers established Holliswood's infection control procedures without "deal[ing] with me" so there were many things she "can say that should have happened that didn't happen" (Floyd Tr. at 44, 187, 196-97).

380. Martine Center suffered similar shortages of PPE, especially gowns, during the Peak-Pandemic Period. These shortages likely exacerbated the spread of COVID-19 throughout the nursing home. Martine Center direct care staff were provided a single gown that they were required to wear for an entire shift or for as long as several days (*see* Det. Olsen Aff. ¶¶ 55, 67, 101). During the Peak-Pandemic Period, Martine Center staff washed used gowns and had to reuse

[73] On April 14, 2021, Holliswood Assistant DON/Infection Control Preventionist Alesia Floyd testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of her testimony is hereto annexed.

them the next day (*see* Det. Olsen Aff. ¶ 67). Because Martine Center floated staff between resident rooms regardless of COVID-19 status, the reusing of gowns increased the potential for spread of COVID-19 throughout the facility (*see* Det. Olsen Aff. ¶¶ 47, 93).

D. Respondents Centers, Rozenberg, and Holliswood's Operator Delayed Free Testing of Staff for COVID-19 and Instead Paid for Slower Results from a Related Party Laboratory – Prioritizing Their Financial Interest Above Resident Health

381. By April 2020, Centers knew that COVID-19-positive staff at Holliswood was caring for residents but ignored the risk. In late April 2020, after facility-wide staff testing at two Centers-affiliated nursing homes in New Jersey, Centers learned that as many as sixty staff members tested positive at those nursing homes, despite very few having exhibited symptoms (Flanagan Tr. at 242-45, 371). Rather than anticipating and preparing for a similar situation at Holliswood, the Regional Nurse at Centers buried her head in the sand, stating she believed that the height of the pandemic had passed at Holliswood (Flanagan Tr. at 372-73).

382. Indeed, Holliswood did not begin testing its staff for COVID-19 until New York State mandated twice-weekly testing of staff at nursing homes in an executive order dated May 10, 2020[74] (Floyd Tr. at 116; Liff Tr. at 155). However, while this executive order required nursing homes to submit a plan for testing by May 13, 2020, and a certificate of compliance by May 15, 2020, Holliswood was "not in compliance" with the order and did not begin any staff testing until May 20, 2020, weeks after Centers knew the New Jersey testing results (Liff Tr. at 155).

383. From the time the May 20 test results became available, through early June, at least 29 Holliswood staff members tested positive for COVID-19 (*see* Pettigrew Aff. ¶ 94, Exh. 88; Liff Tr. at 175-76). Some staff members had been working in the facility for up to 10 to 12 days with

[74] New York Executive Order 202.30, Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency (May 10, 2020), https://dmna.ny.gov/covid19/docs/all/EXEC_COVID19_ExecutiveOrder202.30_051020.pdf (last visited Nov. 20, 2022).

COVID-19 while awaiting their test results, potentially transmitting the virus to residents and other staff members during this period (*id.*). The Administrator attributed the lag to MedLabs Diagnostics ("MedLabs") "taking longer than expected" to process test results due to the "enormous amount of labs to process" (Liff Tr. at 176). MedLabs is owned by Rozenberg[75] so, given Centers's control of Holliswood, its decision to use MedLabs to process COVID-19 test results, despite its strikingly long processing delays, is unsurprising (*see* Budimir Aff. ¶ 29; Exh. 49e, 49h, 49u). Indeed, MedLabs also contracted with other Centers-affiliated nursing homes to process staff COVID-19 tests (Liff Tr. at 166), and those nursing homes also faced similar delays to receive results (*see*, *e.g.*, Pettigrew Aff. ¶ 95, Exh, 89).

384. Once COVID-19 rapid tests became available, Holliswood allowed staff to enter resident units before the test results were available – even though the tests only took roughly 15 minutes to show results (*see*, *e.g.*, Det. Bates Aff. ¶ 32). This decision allowed nursing staff to care for residents while they were unknowingly infected with COVID-19. One CNA recounted an instance when Holliswood sent him to work on his floor before his test results were available. After about fifteen minutes, he was called down from his floor and heard that he had tested positive for COVID-19. Other staff members similarly tested positive for COVID-19 but were working on their respective floors while they awaited those rest results (*id.*).

385. Shockingly, Centers and Holliswood intentionally declined earlier, free COVID-19 testing from DOH in favor of using the Rozenberg-controlled laboratory that gave delayed results. On May 4, 2020 – more than two weeks before Holliswood finally started testing its staff – DOH

[75] MedLabs Diagnostics is the "d/b/a" name for Centers Lab NJ, LLC, which is a wholly-owned subsidiary of Centers Agency LLC d/b/a Centers Laboratory, which is owned by Rozenberg.

offered to test Holliswood's staff for free to assess the number of staff members who were infected with COVID-19.

386. However, Centers *refused* to permit DOH to test Holliswood's staff. The Centers Regional Nurse responsible for overseeing Holliswood "talked [DOH] off of staff testing" (Pettigrew Aff. ¶ 36, Exh. 30 at 2; Flanagan Tr. at 405). The Chief Nursing Officer at Centers cheered this result: "[Flanagan] talked [DOH] out of testing employees this week . . . Whew" (Pettigrew Aff. ¶ 97, Exh 91). Incredibly, when pressed under oath, the Centers Regional Nurse who dissuaded DOH from testing Holliswood's employees could not remember her reason for doing so (Flanagan Tr. at 405). It is likely that Holliswood and Centers feared further absences that would inevitably result from employees testing positive, which would further exacerbate the staffing challenges. A Holliswood staff member alluded to this in a WhatsApp group chat with the Holliswood Administrator, noting on May 10, 2020, "[t]he twice a week testing of all health care employees is going to be crippling" (Pettigrew Aff. ¶ 98, Exh. 92 at 7).

387. Moreover, Holliswood's Administrator went further to prevent MedLab's test results from reaching employees. On May 27, 2020, he wrote to MedLabs's COO that "the lab is calling covid positive employees" (Pettigrew Aff. ¶ 99, Exh. 93). The administrator asked MedLabs to stop contacting employees directly, writing: "Can you please have them not call anyone because if they call without us being aware, then it'll be very hard to find staffing" (*id.*).

388. On June 5, 2020, Centers flagged that Holliswood had some of the lowest levels of staff testing among all Centers-affiliated nursing homes (Pettigrew Aff. ¶ 100, Exh. 94). By June 5, Holliswood had tested only 82% of its staff at least once, even though DOH had required twice-weekly testing of all staff since mid-May (Pettigrew Aff. ¶ 100, Exh. 94). When asked how that

happened, Holliswood's administrator self-servingly testified that he "couldn't figure it out" and attributed the delay in initiating staff testing to "human error" (Liff Tr. at 164).

389. Despite many errors and delays, Centers continued to send Holliswood's staff tests to MedLabs. At times, MedLabs falsely informed Holliswood's employees that they had tested positive because MedLabs had confused their names (Liff Tr. at 169-171). As noted above, MedLabs told Holliswood's administrator that, due to the enormous number of labs to process, the turnaround time would be longer than expected; indeed, there were delays of up to 12 days between the time that staff members took their tests and were told their results in late May and early June 2020. And the administrator's insistence that MedLabs show him proof of positive results before contacting staff members with results introduced further delays in delivering results (Liff Tr. at 168-70). These issues continued into at least February 2021, as exemplified by an email between Centers's Finance Director and its Corporate Director of Education and Clinical Practice, on which Centers Chief Nursing Officer was copied, in which they discussed the lab "report[ing] positives that came back negative" at multiple Centers-affiliated nursing homes, including Holliswood (Pettigrew Aff. ¶ 102, Exh. 96).

390. Centers employees complained about issues with MedLabs months after the Peak-Pandemic Period, noting in December 2020, for example, MedLabs had "no record from the lab that they received [a swab]" from employees that a nursing home had recorded as having been swabbed (Pettigrew Aff. ¶ 103, Exh. 97).

391. Despite MedLabs's repeated errors and delays, which increased risk to residents, it is unsurprising that Respondents caused Holliswood to continue using MedLabs for COVID-19 testing. Using MedLabs ultimately inured to the financial benefit of the common owner of Holliswood, Centers and MedLabs: Kenneth Rozenberg.

E. Respondents Ignored Risks of Resident Harm by Delaying Testing Holliswood Residents for COVID-19

392. In addition to delaying staff testing, Centers and Holliswood also delayed resident testing. By the third week of April 2020, managers at Holliswood and at Centers knew that many more Holliswood residents were COVID-19 positive than those showing symptoms (Flanagan Tr. at 355, 359-60; Liff Tr. at 148). Nevertheless, Centers and Holliswood failed to take any measures to determine the actual positivity rate among residents or to increase staffing to care for residents who would become sick.

393. When Centers tested all residents at two New Jersey Centers-affiliated nursing homes, eight to ten residents at each nursing home were symptomatic with COVID-19, but 120 residents tested positive for COVID-19 in one nursing home and 90 tested positive in the other (Flanagan Tr. at 242-43). According to the Centers Regional Nurse, "as a company and as individuals who ran facilities, everyone was shocked and concerned" (Flanagan Tr. at 242-43). Moreover, she anticipated that Holliswood would similarly have more positive cases than individuals presenting symptoms (Flanagan Tr. at 359-60).

394. Yet, Centers and Holliswood did not try to test residents (Flanagan Tr. at 360, 363). Holliswood did not increase its staffing at the time, in anticipation of what was to come, nor did anyone at Centers or Holliswood reach out to any government agency to request testing at Holliswood (Flanagan Tr. at 362-63).

395. In fact, the Centers COVID-19 Task Force ill-advisedly instructed the facilities to refrain from testing residents, as evidenced by a message included in a Holliswood WhatsApp chat[76] on March 30, 2020, stating, "As per DOH no more testing in nursing homes- anyone with

[76] This WhatsApp message was written by either the Centers Regional Nurse, the Holliswood Administrator, or the Holliswood DON (*see* Flanagan Tr. at 348-49).

respiratory or fever is presumed positive for COVID…The tests need to be conserved for the community." Centers Regional Nurse overseeing Holliswood interpreted this as an instruction to not test their residents until testing kits were available (Flanagan Tr. at 3481-53; Pettigrew Aff. ¶ 35, Exh. 29 at 105).

396. This message was misleading, as DOH had not issued any such prohibition against testing residents.[77] Yet, following Centers's directive, Holliswood tested very few residents for COVID-19 during the Peak-Pandemic Period. From March 27, 2020, to May 4, 2020 – the day prior to DOH's facility-wide testing at Holliswood – Holliswood did not test *any* residents for COVID-19 (*see* Rhody Aff. ¶¶ 36, 37).

397. Management at Centers and Holliswood claim that their failure to test residents was due to the scarcity of test kits during the Peak-Pandemic Period (Flanagan Tr. at 349-50, 360-61; Liff Tr. at 149-51). But their actions reveal a different explanation: they did not try to get tests for their residents. In fact, Holliswood's administrator contacted only a single laboratory, Centers Lab, for additional tests (Liff Tr. at 122). Unsurprisingly, like MedLabs, Centers Lab is owned by Kenneth Rozenberg (*see* Budimir Aff. ¶ 29; Exh. 49e, 49u).

398. By May 4, 2020, DOH became adamant that it would test all residents at Holliswood (*see* Pettigrew Aff. ¶ 36, Exh. 30 at 2). Centers Regional Nurse Flanagan felt "nervous" about DOH testing residents because of the number of COVID-19 positives it would identify, based on the results from the two Centers facilities in New Jersey (Flanagan Tr. at 359-60). Holliswood's administrator similarly noted that "[w]e knew that there were residents that

[77] DOH, Bureau of Healthcare Associated Infections, Health Advisory: Respiratory Illness in Nursing Homes and Adult Care Facilities in Areas of Sustained Community Transmission of COVID-19 (March 21, 2020) https://coronavirus.health.ny.gov/system/files/documents/2020/03/22-doh_covid19_nh_alf_ilitest_032120.pdf (last visited 2/15/2023).

would be asymptomatic . . . We knew going in, when they came into test, that there were going to be a high amount of room changes . . . because of the amount of positive tests that are going to come back" (Liff Tr. at 148).

399. Unsurprisingly, DOH's facility-wide testing on May 5, 2020, confirmed that COVID-19 was rampant at Holliswood. Though only 15 residents were symptomatic, 75 out of the 232 residents tested were COVID-19-positive[78] (*see* Pettigrew Aff., ¶ 70, Exh. 64; ¶ 105, Exh. 99; Rhody Aff. ¶¶ 35-37).

400. Once Holliswood received the results of DOH's resident tests, Holliswood, at the direction of DOH, moved 123 residents (approximately 41% of its census) to different rooms in the facility to cohort the residents by their COVID-19 status (*see* Rhody Aff. ¶ 41). This was Holliswood's first large-scale effort to separate residents based upon their COVID-19 status (*see* Rhody Aff. ¶¶ 38-41) and was done under DOH and CDC oversight (Pettigrew Aff. ¶ 70, Exh. 64).

F. Choosing to Profit Instead of Protecting Resident Health, Centers Caused Holliswood to Reject Free Testing for Residents so that a Rozenberg- Controlled Laboratory Could Get Paid to Provide Poor Testing

401. On May 29, 2020, the New York City Department of Health and Mental Hygiene ("DOHMH") offered Holliswood free, weekly COVID-19 testing for all residents whose DOH test results were negative or indeterminate, until there were no residents newly testing positive. The program was designed to "support your facility in ongoing prevention and control efforts in the midst of COVID-19" (*see* Pettigrew Aff. 106, Exh. 100). Stunningly, Holliswood refused DOHMH's offer. After consultation with Centers Vice President of Strategic and Financial Operations Wolff, Holliswood used Centers Lab to test its residents (Liff Tr. at 127-29). Centers

[78] An additional 65 residents refused testing (*see* Pettigrew Aff., ¶ 70, Exh. 64; ¶ 105, Exh 99).

Lab, owned by Kenneth Rozenberg, charged Holliswood money for testing, in contrast with DOHMH's free testing offer.

402. Holliswood's administrator claimed that the decision to pay Centers Lab instead of accepting free testing was based on the preexisting relationship between Centers, Holliswood, and Centers Lab, and on the assumption that Centers Lab could handle the volume (*id.*).

403. That assumption was wrong. Centers Lab, like MedLabs, had significant delays in processing tests and in sending Holliswood the results. Holliswood's administrator complained to Centers management about such delays. On October 30, 2020, Holliswood's administrator and the Centers Regional Nurse responsible for overseeing Holliswood exchanged text messages noting that the delays were "r[i]diculous" and highlighting that they "still hav[e] 15 second floor results not in" (Pettigrew Aff. ¶ 36, Exh. 30 at 13). The Regional Nurse acknowledged that there were regular delays with Centers Labs of approximately two days beyond the turnaround time directed by DOH (Flanagan Tr. at 390-91).

404. Centers Lab's delays and errors continued throughout 2020. On November 15, 2020, the Centers Regional Nurse Flanagan notified Centers Chief Nursing Officer Hendrix of another error and stated that Centers Lab had sat on a positive test result for multiple days without informing the facility (Pettigrew Aff. ¶ 36, Exh. 30, at 1). Hendrix notified Abramchik, writing: "[Flanagan] just now notified me of another lab situation at Holliswood. . . Positive on Friday . . . [S]he said the Facility was not called . . . result not faxed . . . or uploaded . . . omg" (Pettigrew Aff. ¶ 109, Exh. 103 at 3).

405. Despite the slow turnaround times and errors by Centers Lab for nearly six months, Holliswood did not seek other labs to conduct its resident testing (Liff Tr. at 122).

406. By choosing to work with Centers Lab, a related party, Holliswood failed to test its residents as frequently, extensively, and cost-effectively as it could have, had it accepted DOHMH's offer of free testing. In so doing, Respondents Centers, Rozenberg, Holliswood's Operator and Owners repeatedly and persistently violated 10 NYCRR § 415.20 by failing to ensure that laboratory services met the needs of the nursing home residents, including by failing to ensure the quality and timeliness of such services.

* * *

407. For the reasons discussed above, Respondents' infection control policies and procedures, and the implementation and enforcement of them in the Nursing Homes, were woefully inadequate, thereby failing to protect residents and staff members from exposure to COVID-19. Respondents' repeated failures to establish and maintain a robust infection control program violated 10 NYCRR § 415.19.

VIII. RESPONDENTS REPEATEDLY AND PERSISTENTLY COMMITTED FRAUD AND ILLEGALITIES BY POCKETING MEDICAID AND MEDICARE PAYMENTS THAT WERE MEANT TO PROVIDE CARE TO THE NURSING HOMES' RESIDENTS

408. While residents of the Nursing Homes suffered and frontline staff chronically worked short-handed and, at times, without vaccines or sufficient PPE, Respondents repeatedly prioritized their up-front profit taking by diverting millions of dollars to themselves from the Nursing Homes that were meant for resident care. As described below, Respondents took these funds by engaging in repeated and persistent fraud and illegality.

409. Respondents siphoned money from the Nursing Homes using multiple fraudulent and illegal schemes. Respondents caused the Nursing Homes to: enter Related-Party[79] lease

[79]As discussed below, Nursing Homes are required to file Cost Reports with DOH. The Cost Report and the instructions thereto also require, at several points, the disclosure of "related

agreements with inflated rents; enter Related-Party loans with exorbitant interest rates; transfer money out of the Nursing Homes to other Centers-affiliated nursing homes at no benefit to the Nursing Homes; utilize Related-Party vendors that provided no substantial goods and/or services; pay "salaries" to owners for "no show" jobs.

410. Respondents used these schemes to take "up-front profits," despite violating State and federal laws in failing to deliver adequate care to the Nursing Homes' residents and hid their profit-taking and Related-Party transactions from DOH.

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companies"—companies with which the Operator has "Non-Arm's Length Arrangements," as defined by Schedule 16:

> An arrangement between the operator of a facility and an organization related to the 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.

(*See* Budimir Aff. ¶ 12).

There is also a similar definition of "related organization" contained in 10 NYCRR § 451.229: "[a]n entity which, to a significant extent, is under common ownership and/or control with, or has control of or is controlled by, the provider. An entity is deemed to control another entity if it has a significant ownership interest in the other, or if it has the power, whether or not exercised, to influence directly or indirectly the activities or policies of the other."

Finally, in a Dear Administrator Letter issued by DOH on January 26, 2018, DOH noted that "related party expenses are those provided by any company in which the operator(s) of the nursing home have ownership and/or a direct financial interest" (Pettigrew Aff. ¶ 118, Exh. 112 at 7).

Throughout this Petition, a company that meets the above definitions will be referred to as a "Related Party," and multiple such companies, as "Related Parties."

A. Respondents Repeatedly and Persistently Committed Fraud by Causing the Nursing Homes to Enter Collusive and Unnecessary Real Estate Transactions, Generating Millions of Dollars of Profit for Rozenberg and Hagler

411. Respondents' real-estate fraud begins with a simple ownership structure. There are two corporate entities involved in every nursing home that Rozenberg owns in New York: the Operator, a company that owns the operations of the nursing home, and the Landlord, a company that owns the nursing home's real property, including the building itself and the land on which it sits. For every nursing home that Rozenberg owns in New York, Rozenberg majority owns the operations company and is the Operator, and Hagler majority owns the real estate company and is the Landlord (Hagler Tr. at 73).

412. As discussed below, Hagler and Rozenberg colluded and caused the Nursing Homes to pay inflated "rent" to Hagler that was far above the expenses incurred or efforts expended by the Landlords and that took a substantially higher proportion of the Nursing Homes' revenues than the statewide average rent-to-revenue ratio paid by for-profit nursing homes.

413. To serve their personal financial interests, Rozenberg and Hagler also caused the Nursing Homes to take (or be obligated to fund) Related-Party loans with exorbitant interest rates to finance their purchases of certain Nursing Homes. Other times, Rozenberg and Hagler caused the realty companies to take commercial loans with principal amounts that were higher than necessary to acquire the Nursing Homes, leaving the Nursing Homes to repay that debt while Rozenberg and Hagler pocketed the excess proceeds.

414. Through each of these schemes, Rozenberg and Hagler fraudulently siphoned funds from the Nursing Homes without regard to resident care.

1. Respondents' Real Estate Frauds at Holliswood

i. Respondents Rozenberg, Hagler, Centers, and Holliswood's Operator and Owner Caused Holliswood to Enter Collusive and Fraudulent Real Estate Arrangements for Their Own Benefit

415. Rozenberg, who owns and operates Holliswood through Hollis Operating Co., and Hagler, who owns Holliswood's Landlord, Hollis Real Estate Co., caused these entities to enter Related-Party transactions that required Holliswood to pay the Landlord millions of dollars in inflated expenses.

416. Hagler owns 90% of Hollis Real Estate Co., with Mordechai "Moti" Hellman owning the remaining 10%. Centers performs the bookkeeping for Hollis Real Estate Co. and Hagler personally prepares Hollis Real Estate Co.'s taxes (Hagler Tr. at 19-22, 181-82).

417. On November 1, 2010, Rozenberg and Hagler entered into purchase agreements to acquire Holliswood and its real estate from its former owner and landlord. Hagler, through Hollis Real Estate Co., paid Holliswood's former landlord $5.5 million for the option to purchase the real property for $28,098,000, and Rozenberg, through Hollis Operating Co., agreed to purchase Holliswood's operations for the difference between the facility's assets and liabilities (*see* Budimir Aff. ¶¶ 80; Exh. 16, 47, 48).

418. The next day, on November 2, 2010, Rozenberg issued a note to Hollis Real Estate Co. for $5.5 million, obligating Hollis Real Estate Co. for the cost of the option to purchase the real property (Budimir Auditor Aff. at ¶ 80; Exh. 46). This note will be referred to as the "Holliswood Option Loan."

419. Once Rozenberg and Hagler took control of Holliswood, they required Holliswood to pay its Landlord an amount of purported rent that soared well beyond the rent that Holliswood had paid prior to the acquisition (*see* Budimir Aff. at ¶ 84).

420. On April 23, 2012, Rozenberg and Hagler executed an amended lease that set the rent at $2,522,312 per year, which was over $1 million per year more than Holliswood was paying its landlord at the time, and more than Holliswood would have paid its former landlord for another three and a half years, under its prior lease (*see* Budimir Aff. ¶ 85; Exh. 45e).

421. Three days later, on April 26, 2012, in connection with the purchase of the facility, Rozenberg applied to DOH for a CON to operate Holliswood. This application included the recently executed lease (Budimir Aff. at ¶ 86; Exh. 16, 45e).

422. As discussed earlier, DOH, through the PHHPC, reviews all CON applications prior to a change of ownership at an existing nursing home (*see* O'Leary Aff. ¶ 19).

423. On December 6, 2012, the PHHPC contingently approved Holliswood's CON application and issued a report on the representations contained therein, noting the following:

a. Hollis Real Estate Co. was 100% owned by Daryl Hagler; [80]

b. Hollis Real Estate Co. would acquire the facility's property;

c. Holliswood and Hollis Real Estate Co. entered into a triple net lease agreement,[81] dated April 23, 2012, which set the rent at $2,522,312 per year; and

[80] Although the CON approving Rozenberg's acquisition of Holliswood listed Hagler as Hollis Real Estate Co.'s sole owner, Hagler testified that he believed, but could not be sure, that Hellman owned 10% of Hollis Real Estate Co. when it purchased the land underlying Holliswood (Hagler Tr. at 19-20, 181-82). Hellman's ownership interest is supported by the fact that Hellman has received equity distributions from Hollis Real Estate Co. from 2013 to the present (*see* Budimir Aff. ¶¶ 45, 78, 79). Hagler also testified that "there must be" documents evidencing Hellman's ownership (Hagler Tr. at 181-82, 198-205). However, counsel has yet to identify or produce any documents describing Hollis Real Estate Co.'s prior to 2017 (Pettigrew Aff. ¶ 135, Exh. 129). As an additional inconsistency, materials the Holliswood Bridge Loan state that Hagler owns 99% of Hollis Real Estate Co. with his son, Jonathan Hagler, owning the remaining 1%, even though Hagler testified that Jonathan Hagler does not have any interest in the entity (*see* Budimir Aff. ¶ 45, Exh. 40a; Hagler Tr. at 241).

[81] As a triple net lessee, Holliswood is responsible for paying all the expenses of the property, including real estate taxes, building insurance, and maintenance.

d. "The lease arrangement is a non-arm's length agreement. The applicant has submitted an affidavit attesting to the relationship between the Landlord and operating entity."

(Budimir Aff. ¶ 87, Exh. 16).

424. On May 7, 2013, Holliswood Operating Co. and Hollis Real Estate Co. closed on a 12-month, $30 million bridge loan (a short-term loan) at an interest rate of 6.25% from Greystone Funding Corporation ("Greystone"), a real estate lending, investment, and advisory company (the "Holliswood Bridge Loan"). Holliswood Operating Co. and Hollis Real Estate Co. then exercised Hagler's option to acquire Holliswood and its real property. Under the terms of the Holliswood Bridge Loan, Hollis Real Estate Co. paid Greystone a total of $2,369,637 in interest, insurance, tax, and replacement reserve expenses from May 2013 through May 2014. Hollis Real Estate Co. and Greystone then began the process of applying for a loan insured by the United States Department of Housing and Urban Development ("HUD") to refinance the Holliswood Bridge Loan (*see* Budimir Aff. at ¶ 80, Exh. 38a, 40a, 40b).

425. As part of Greystone's underwriting for the HUD-insured loan, Greystone set a minimum annual rent that Holliswood Operating Co. would be obligated to pay to Hollis Real Estate Co. Greystone used a debt service coverage of 145% of the total debt service,[82] resulting in a minimum annual rent of $4,864,509. However, the typical debt service coverage for skilled nursing facility loans is only 105% of the total debt service (*see* Budimir Aff. ¶¶ 88-89, Exh. 41a).

426. On March 4, 2014, HUD issued a commitment letter agreeing to insure the loan, with certain conditions. Condition #15 in the letter inaccurately states that the minimum annual

[82] In this context, debt service coverage ensures that the minimum annual rent is sufficient to cover the debt service on the loan. According to HUD agreements, debt service is comprised of the sum of annual principal and interest payments; annual mortgage insurance premium; annual deposit to reserve for replacement; annual property insurance; and annual property taxes. Thus, HUD requires that the minimum annual rent is high enough to cover these costs.

rent of $4,864,509 represents 105% of debt service coverage, when, in fact, that amount actually represents *145%* of debt service coverage (*see* Budimir Aff. ¶ 89, Exh, 39d). HUD's reference to 105% of debt service coverage is inaccurate, and reflects that Greystone may have erred in originally calling for a total debt service coverage of 145% ($4,865,509) and that HUD relied on Greystone's inaccurate statement by adopting Greystone's minimum rent amount. HUD, though, apparently mistakenly characterized that rent amount as 105% debt service coverage, which is the industry standard.

427. On May 14, 2015, Greystone submitted a request to HUD to amend certain conditions, including that HUD remove the condition that the annual lease must be 105% of the debt service coverage. Greystone explained its request to remove this condition by noting that the rent only needs to be sufficient to maintain the project and meet project expenses, in accordance with HUD requirements. Budimir Aff. at ¶ 91, Exh. 39a. Notably, removal of this condition would allow Hollis Real Estate Co. to claim there is a higher minimum rent requirement, which would narrow the gap between the minimum rent and the rent Hollis Real Estate Co. actually charged, thereby obscuring the amount by which the rent is inflated.

428. On May 16, 2015, Greystone again wrote to HUD to revise its amendment requests, including lowering the minimum annual rent from $4,864,509 to $2,966,399 based on a lower interest rate, updated escrow calculations for taxes and insurance, and 105% debt service coverage (*see* Budimir Aff. ¶ 91, Exh. 39b).

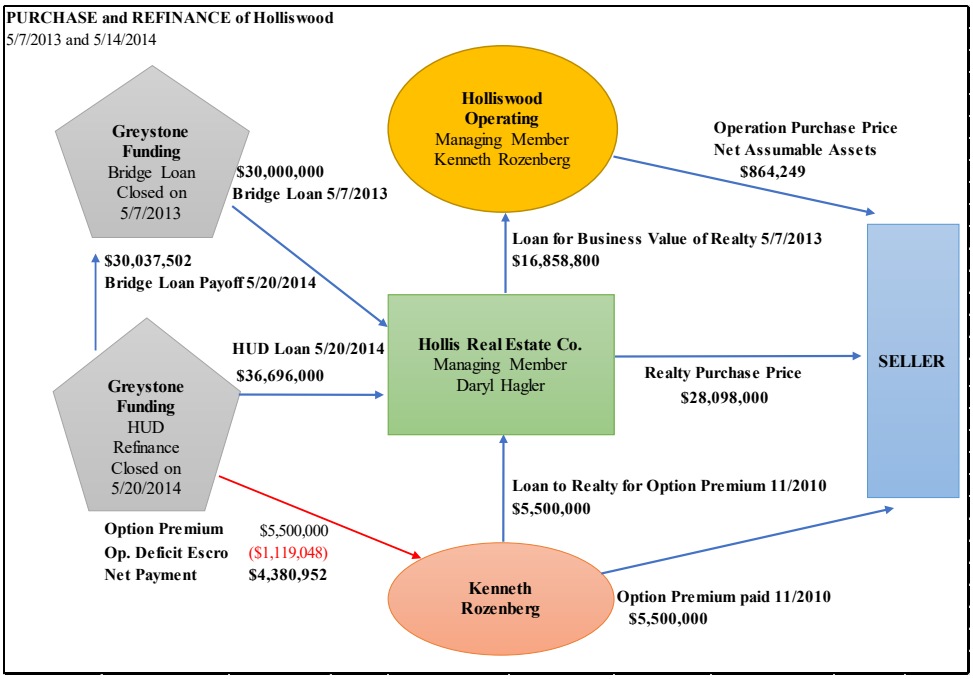
429. On May 20, 2014, Hagler, through Hollis Real Estate Co., closed on a $36,696,000 HUD-insured loan from Greystone (the "Holliswood HUD Loan").[83] Respondents used the

[83] As part of the Holliswood HUD Loan, Hagler executed an agreement with HUD titled, "Healthcare Regulatory Agreement – Borrower." Section 11(b) of that agreement states that, the

proceeds of the Holliswood HUD Loan to pay off the Holliswood Bridge Loan ($30 million plus interest) and to satisfy the Holliswood Option Loan ($5.5 million owed to Rozenberg) (Budimir Aff. ¶ 81, Exh. 41b, 41c).

430. On the same day, HUD issued an acceptance of the revised amendment lowering the minimum annual rent to $2,966,399 (*see* Budimir Aff. ¶ 92, Exh. 39c).

431. By adding the Holliswood Option Loan to the principal balance of the Holliswood HUD Loan, Respondents indebted Holliswood for the $5.5 million Rozenberg purportedly lent to Hollis Real Estate Co. under the Holliswood Option Loan, which was then paid to Rozenberg through the proceeds from the Holliswood HUD Loan (*see* Budimir Aff. ¶¶ 80-81; Budimir Exh. 41a, 41b, 46). The following chart diagrams the structure of Respondents purchase and refinancing of Holliswood:



"Borrower shall not engage in any business or activity, including the operation of any other project or other healthcare facility, or other ancillary business, or incur any liability or obligation not in connection with the Project." However, Hollis Real Estate Co.'s financial statements indicate "staffing agency" revenue and expenses, seemingly in violation of such clause.

432. Starting in July 2014, Hollis Real Estate Co. began to make monthly payments of between approximately $215,000 and $235,000 to service the Holliswood HUD Loan (*see* Budimir Aff. ¶ 93).

433. As they did with the Holliswood Bridge Loan, Hagler and Rozenberg placed the burden to pay off the Holliswood HUD Loan squarely on Holliswood's shoulders. Indeed, for HUD to back the loan, Hollis Real Estate Co. had to demonstrate that it has a lease with Holliswood, pursuant to which Holliswood would make monthly payments. Moreover, Holliswood's rent payments were the primary source of income for Hollis Real Estate Co.

434. On the day the Holliswood HUD Loan closed, Rozenberg and Hagler collusively executed two amended leases that were inconsistent with each other. The first set an initial minimum annual rent of $4,864,509 (based on a debt service coverage of 145%) as originally contemplated by the Holliswood HUD Loan. The second lease set a minimum annual rent of $2,966,399 as approved by HUD. Rozenberg and Hagler exercised their control over Holliswood and chose to enforce the lease with the *higher* rent minimum (the "Holliswood May 2014 Lease"), even though the rent minimum had been lowered by HUD (*see* Budimir Aff. ¶ 92; Budimir Exh. 45a, 45b, 42b, 42f).

435. By enforcing the new, more onerous lease, Hagler and Rozenberg increased Holliswood's minimum annual rent by nearly 93% above the rent that Rozenberg certified to DOH on the CON application in 2012, and by nearly 64% over the minimum rent set in the Holliswood HUD Loan. This new minimum annual rent was nearly $2.7 million more than Holliswood would have had to pay its former landlord in 2014. And that money was paid to Hagler's benefit (*see* Budimir Aff. at ¶ 83, 92).

436. Furthermore, Holliswood's steep rent had no relationship to any expense or effort expended by the Operator and/or the Landlord. Rather, the rent paid by Holliswood to Hollis Real Estate Co. is the result of collusive, non-arm's-length negotiations between Rozenberg and Hagler (*see* Budimir Aff. Exh. 16), two longtime business partners and friends who had done business together for over 20 years (Hagler Tr. 15-16). As discussed above, for every nursing home that Rozenberg owns in New York State, Hagler owns the underlying real estate. Indeed, Rozenberg even characterized the lease arrangement to DOH as "a non-arm's length agreement" (Budimir Aff. ¶ 12; Exh. 16). Unsurprisingly, Hagler characterized the "negotiations" to determine the rent at Holliswood simply as conversations between himself and Rozenberg, using a so-called "formula" that they came up with together (Hagler Tr. at 191-96). He noted that they used the same process to set the rent at the other Nursing Homes (*see id.*). Rozenberg also agreed to be jointly and severally liable, in his individual capacity, for Hollis Real Estate Co.'s obligations under the Holliswood Real Property Purchase Agreement (*see* Budimir Aff. ¶ 80, Exh. 48).

437. Holliswood and Hollis Real Estate Co. are deeply intertwined. For instance, they share financial services resources. Hollis Real Estate Co.'s bookkeeping is done by Centers (Hagler Tr. at 19-22), and its accountant also provides accounting services to the Nursing Homes and other entities and individuals associated with Centers. In addition, one of Holliswood's commercial banks has even addressed correspondence to Hagler at Hollis Operating Co., even though on paper Hagler has no role at Hollis Operating Co. (*see* Pettigrew Aff. ¶ 110, Exh. 104).

438. Additional transfers between Respondents demonstrate that the paper division between entities controlled by Rozenberg and those controlled Hagler is a fiction they use to hide their collusive dealings. From 2012 to May 7, 2013, Hollis Real Estate Co. paid Rozenberg over $1.5 million. This payment is evidence of Respondents' collusion because, during that period,

Hollis Real Estate Co. had no operations or real estate holdings, and because Rozenberg had, and has to this day, no documented ownership interest or role in Hollis Real Estate Co. (*see* Budimir Aff. ¶ 78).

439. Using the non-arm's-length relationship between Holliswood and its landlord, Hagler and Rozenberg have required Holliswood to repeatedly pay Hagler's company inflated rents that are disconnected from any expense or effort incurred by Hollis Real Estate Co. These rents are far above what other nursing homes paid for rent in New York State.

440. First, Holliswood's annual minimum rent greatly exceeds the amount Hollis Real Estate Co. needs to cover the debt service on the Holliswood HUD Loan and other property expenses, including real estate taxes:

Holliswood's Falsely Inflated Rent Payments

Year	Minimum Annual Rent Charged to Holliswood	Debt Service on HUD Loan & Property Expenses Paid by Hollis Real Estate Co.	Hollis Real Estate Co.'s Profit
2014	$4,864,509	$2,471,430	$2,393,079
2015	$4,864,509	$2,803,220	$2,061,289
2016	$4,864,509	$2,772,144	$2,092,365
2017	$4,864,509	$2,790,805	$2,073,704
2018	$4,864,509	$2,763,091	$2,101,418
2019	$4,864,509	$2,722,886	$2,141,623
2020	$4,864,509	$2,673,782	$2,190,727
Total	**$34,051,563**	**$18,997,358**	**$15,054,205**

(Budimir Aff. ¶ 93).

441. As the above chart shows, the Holliswood May 2014 Lease guaranteed Hollis Real Estate Co. a minimum profit each year of approximately $2 million above the amounts it owes on the Holliswood HUD Loan and for any property expenses – in other words, approximately $2

million in net income per year. Hagler admitted this, testifying that any money that Holliswood pays to Hollis Real Estate Co. in rent beyond that required to pay down the loan is "money I take out" (Hagler Tr. at 157-59, 229-30).

442. Second, on its Cost Reports, Holliswood reported rent expenses far higher than the statewide average for nursing home rents. The table below compares Holliswood's annual rent to its annual revenue, both as reported on Holliswood's Cost Reports, to determine the "rent-to-revenue ratio," or the percentage of its annual revenue that it spends on rent. The table then compares that ratio to the average rent-to-revenue ratio for all nursing homes in New York State, per year. Finally, the chart includes a calculation of the yearly difference between Holliswood's reported rent expense and what it would have paid in rent if its rent-to-revenue ratio had been the statewide average:

Holliswood's Rent Payments Exceed the State Average

Year	Holliswood's Rent Expense	Holliswood's Yearly Revenue	Holliswood's Rent-to-Revenue Ratio	NYS Average Rent-to-Revenue Ratio	Difference Between Holliswood Rent and Average Ratio
2014	$ 6,350,000	$ 39,614,813	16.03%	6.38%	$3,822,575
2015	$ 7,850,000	$ 39,958,119	19.65%	6.86%	$5,108,873
2016	$ 7,617,028	$ 40,141,639	18.98%	7.69%	$4,530,136
2017	$ 5,398,905	$ 37,733,000	14.31%	8.28%	$2,274,613
2018	$ 4,892,677	$ 38,673,175	12.65%	8.65%	$1,547,447
2019	$ 4,908,462	$ 41,097,854	11.94%	9.05%	$1,189,106
2020	$ 4,913,888	$ 40,004,117	12.28%	10.62%	$665,451
Total	**$41,930,960**				**$19,138,201**

(*See* Budimir Aff. ¶ 96).

443. Thus, from 2014 through 2020, Holliswood's rent expenses were approximately $19 million greater than what they would have been if its rent-to-revenue ratio had been at the

state average. Had Hollis Real Estate Co. charged rent commensurate with the state average, that rent would have been 45% lower than, or nearly half of, what it in fact charged.

444. Third, the Operator and Landlord's collusive relationship is further evidenced by the fact that Holliswood claims to be in arrears to Hollis Real Estate Co. by tens of millions of dollars. Despite its bank records reflecting transfers amounting to $36,716,389, from 2014 through 2020, Holliswood claims on its financial statements, that it still owes Hollis Real Estate Co. approximately $19.5 million in back rent, which is nearly 50% of the total rent expense stated on the Cost Reports during that period (Budimir Aff. ¶¶ 76, 97). During this time, Hollis Real Estate Co. has continually met its debt service obligations and paid its other property expenses (Budimir Aff. ¶ 94), and thus, Holliswood could have paid the HUD-approved rent of $2,966,399 without going into arrears. Thus, the accrual of back rent is merely another indication that Holliswood's reported rent expense has no substantial business purpose, and any back rent represents nothing more than a future windfall to Hagler.

ii. Rozenberg and Hagler Caused Holliswood to Enter a Related-Party Loan that Provided No Benefit to Holliswood

445. As part of the Holliswood Real Property Purchase Agreement, Hagler and Holliswood's former landlord agreed that the value of the $28,098,000 purchase price and the $5.5 million option should "be allocated forty percent (40%) to the Building and the Land and sixty (60%) to the Business" (*see* Budimir Aff. ¶ 99, Exh. 48). In other words, 40% of the purchase price and the option was attributed to the building and land, and 60% was attributed to the business value of the real estate, based on Holliswood's operation as a nursing home.

446. On May 7, 2013, the same day that Hollis Operating Co. and Hollis Real Estate Co. closed on their acquisitions of Holliswood and its real property, Hollis Real Estate Co. indebted Hollis Operating Co. under the terms of an unsecured loan for $16,858,800 (the "Holliswood

Unsecured Loan"), which is exactly 60% of the $28,098,000 purchase price that Hollis Real Estate Co. paid to acquire Holliswood's real property.[84] The purpose of the Holliswood Unsecured Loan was to enable Rozenberg to purchase, over time, the business value of the real estate, with interest.[85] However, Holliswood never received any tangible proceeds from this loan (Budimir Aff. ¶ 99).

447. Thus, Holliswood was required to fund Hagler's acquisition of Holliswood's real property (including the land and the business value of such) through its rent payments. And yet, at the same time, Holliswood was required to pay Hollis Real Estate Co., with interest, to fund the transfer of the business value of the real property to Rozenberg. In effect, Holliswood was required to pay twice for the business value of the real property: first, for Hagler to purchase it (through the rent) and second, for Rozenberg to purchase it from Hagler (through repayment of the Holliswood Unsecured Loan). In addition, Holliswood was obligated to pay interest to Hollis Real Estate Co. under the Holliswood Unsecured Loan, which diverted additional money from Holliswood to benefit Hagler. As such, the Holliswood Unsecured Loan unnecessarily drained funds from Holliswood without providing any benefit to Holliswood or its residents.

448. The harm to Holliswood caused by Rozenberg and Hagler's collusive financing arrangements is evidenced by the difference between the amounts Rozenberg and Hagler paid to

[84] Although the Holliswood Unsecured Loan document itself states that the loan principal is $16,850,800, Holliswood's 2013 financial statement and the payment schedule for the Holliswood Unsecured Loan both list the loan principal as $8,000 higher, at $16,858,800, which is exactly 60% of the $28,098,000 purchase price. Holliswood has also made interest and principal payments consistent with the higher loan amount of $16,858,800 (Budimir Aff. ¶¶ 98-99).

[85] The Holliswood Unsecured Loan required Holliswood to make interest-only payments at 6.5% for the first year. After the first year, the interest rate changed to 5% per year, along with repayments of the principal (Budimir Aff. ¶ 99, Exh. 37).

Holliswood's former owner and landlord, and the amount Holliswood was obligated to pay to cover those acquisitions.

449. Rozenberg paid Holliswood's former owner $864,249 to acquire Holliswood's operations under the Holliswood Facility Purchase Agreement, and Hagler paid Holliswood's former landowner $33,598,000 to purchase Holliswood's real property[86] (Budimir Aff. ¶ 80, Exh. 16, 47, 48). Thus, together Rozenberg and Hagler paid $34,462,249 to acquire Holliswood and its real property (*see* Budimir Aff. ¶ 80, Exh. 16, 47, 48).

450. However, to facilitate their up-front profit-taking from Holliswood, Rozenberg and Hagler caused Holliswood to incur $53,554,800 in debt to cover Rozenberg and Hagler's acquisition costs: Hagler added $5.5 million to the Holliswood HUD Loan to pay off the Holliswood Option Loan; Hagler used $28,098,000 from the Holliswood Bridge Loan, which was incorporated into the Holliswood HUD Loan, to purchase Holliswood's real property; Hagler and Rozenberg obligated Holliswood to pay costs associated with closing the Holliswood HUD Loan; and Rozenberg obligated Holliswood to pay $16,858,800 to purchase the business value of Holliswood's real property from Hagler (Budimir Aff. ¶¶ 99-100).

451. Hollis Real Estate Co.'s financial statements show that, from 2014 through 2020, it charged Holliswood over $7.1 million total on this related-party loan, of which nearly $5.8 million was interest, as shown in the following table:

[86] This amount is comprised of $5.5 million for the option contract plus $28,098,000 for the purchase price.

Year	Principal	Interest	Total	Principal Year-end Balance
2014	$105,183	$947,000	$1,052,183	$16,753,617
2015	$187,591	$833,421	$1,021,011	$16,566,026
2016	$197,188	$823,823	$1,021,011	$16,368,838
2017	$207,277	$813,735	$1,021,011	$16,161,561
2018	$217,882	$803,130	$1,021,011	$15,943,679
2019	$229,029	$791,983	$1,021,011	$15,714,651
2020	$240,746	$780,265	$1,021,011	$15,473,904
Total	**$1,384,896**	**$5,793,357**	**$7,178,249**	**$15,473,904**

(Budimir Aff. ¶ 101, Exh. 42f).[87]

452. Going forward from 2020, under this repayment schedule, not only does Holliswood have to pay Hollis Real Estate Co. $15,473,904 in principal, but Holliswood will also have to pay Hollis Real Estate Co. several million dollars in interest.

453. While testifying under oath, Hagler purported not to remember why he made the Holliswood Unsecured Loan or for what purpose the money was used (Hagler Tr. at 232). Hagler also had "no idea" if he has been repaid at all (Hagler Tr. at 236-37). But Hagler remembered that he never had a discussion with Rozenberg about spending the loan proceeds on resident care (Hagler Tr. at 240-41).

iii. Holliswood's Inflated Rent and Related Party Loan Payments Facilitated Up-Front Profit Taking by Hagler and Hellman

454. In addition to the millions of dollars in payments from Holliswood to Hollis Real Estate Co. under the Holliswood Unsecured Loan, Holliswood's purported "rent" was padded so far beyond what was necessary to pay either the Holliswood Bridge Loan or the Holliswood HUD

[87] A fuller analysis of the Holliswood Unsecured Loan could not be completed because counsel for Hollis Real Estate Co. initially objected to producing the necessary records as irrelevant. Upon further discussions between counsel and MFCU, counsel noted he would confer with Hollis Real Estate Co. on the issue, but, ultimately, did not produce the requested records. Pettigrew Aff. ¶ 135, Exh. 129). This baseless objection hampered Petitioner's investigation and, incredibly, Hagler consistently claimed he did not know basic details regarding the Holliswood Unsecured Loan (Hagler Tr. at 230-41).

Loan, that it could not have had any purpose other than to serve as a means by which to covertly transfer funds directly from Holliswood to Hagler and to Hollis Real Estate Co.'s 10% owner, Hellman.

455. Of the $37,938,389 that Holliswood paid to Hollis Real Estate Co. from 2013 through 2020, a total of $17,077,512 was transferred directly to Daryl Hagler and Hellman:

Year	Deposits by Holliswood to Hollis Real Estate Co.	Withdrawals by Daryl Hagler	Withdrawals by Moti Hellman	Total Withdrawals
2013 [88]	$1,222,000	$0	$0	$0
2014	$3,529,150	$0	$250,012	$250,012
2015	$4,803,220	$1,755,000	$195,000	$1,950,000
2016	$5,772,504	$2,700,000	$300,000	$3,000,000
2017	$6,791,309	$3,600,000	$400,000	$4,000,000
2018	$5,528,288	$2,700,000	$300,000	$3,000,000
2019	$5,220,636	$2,241,000	$249,000	$2,490,000
2020	$5,071,282	$2,148,750	$238,750	$2,387,500
Totals	**$37,938,389**	**$15,144,750**	**$1,932,762**	**$17,077,512**

(*See* Budimir Aff. ¶ 79).

456. The transfers to Hagler and Hellman represent over 45% of every dollar Holliswood paid to Hollis Real Estate Co. (Budimir Aff. ¶ 79). Put differently, almost half of the money Holliswood paid to Hollis Estate Co. ended up in the pockets of Hagler and Hellman. Instead of using $17 million to comply with their legal duties to pay for appropriate care and sufficient nursing staff at Holliswood, Respondents Rozenberg, Hagler, Centers, and Holliswood's Operator and Owners violated those duties, and ensured that the money solely benefited Hagler and Hellman.

[88] The accounting for 2013 rent and withdrawals begins on May 7, 2013 with Rozenberg and Hagler's acquisition of Holliswood and its real property.

457. In exchange for the over $15 million Hagler personally took from Hollis Real Estate Co., he performed no services as the landlord. In fact, when Hagler becomes the landlord for a nursing home, he takes "no action whatsoever" (Hagler Tr. at 156-57). He does not even view the building or the land he has acquired (*id.*). Rather, he solely relies on One70 Group, a Centers affiliate, to determine if the property is safe and well maintained (*id.*). Hagler's day-to-day obligations as a landlord amount to "almost nothing" (*id.* at 22-25, 28-30).

458. Similarly, Hellman has no day-to-day role at Hollis Real Estate Co. and performed no work on behalf of the entity (*id.* at 243-44).

459. The above-described self-dealing between Rozenberg and Hagler is not unique to Holliswood, but rather, is part of a pattern of conduct Rozenberg and Hagler engage in at the Nursing Homes to the detriment of resident care.

2. Respondents' Real Estate Frauds at Martine Center

i. Respondents Rozenberg, Hagler, Centers, and Martine Center's Operator and Owners Financed Their Purchase of Martine Center Through Self-Dealing Loans with Inflated Interest Rates, Which They Did Not Disclose to DOH

460. As with Holliswood, Respondents split ownership of Martine Center into two distinct limited liability companies: Schnur Associates is the Operator of Martine Center and Light Property Holdings II Associates LLC ("Light Property II") is its Landlord. At the time of purchase, Schnur Associates was 98% owned by Light Operational Holdings; Light Operational Holdings currently owns 65% of Schnur Associates.[89] Rozenberg is Light Operational Holdings's 95% owner, and, as of July 2022, he also directly owns a 4% interest in Schnur Associates (Winslow Aff. ¶ 48-52; 77).

[89] Light Operational Holdings was the 98% owner of Schnur Associates at the time of purchase. Effective January 1, 2019, its ownership share of Schnur Associates decreased to 65% (Winslow Aff. ¶¶ 48-52).

461. Hagler owns 99% of Martine Center's Landlord, Light Property II. Jonathan Hagler owns the remaining 1%. Light Property II leases the land, building, and non-moveable equipment where Martine Center is located to Schnur Associates, where Schnur Associates operates Martine Center (Winslow Aff. ¶ 77).

462. On February 19, 2016, Schnur Associates and Light Property II entered into agreements with Martine Center's former owner and landlord to purchase Martine Center's operations for $12,454,400 and the real property for $10,000,000 (Winslow Aff. ¶ 79).

463. As with the other Nursing Homes, Rozenberg had to secure approval from DOH through the CON application process to get the license to operate Martine Center.

464. In February 2016, Schnur Associates submitted a CON application for Martine Center to DOH, signed by Rozenberg. The CON application states that Respondents would purchase Martine Center with the following funds:

- a deposit of $2,100,000;
- a loan for $7,765,500 at 5% interest for 10 years, with balloon final payment;[90] and
- member equity contributions of $2,588,900

(Winslow Aff. ¶¶ 79-80).

465. Schnur Associates submitted a bank loan commitment letter, dated April 20, 2016, from Greystone to DOH with its CON application. The letter indicates that Greystone approved Schnur Associates for a loan of $7,765,500, with an interest rate that fluctuated at LIBOR plus 2.9 basis points[91] (Winslow Aff. ¶ 81).

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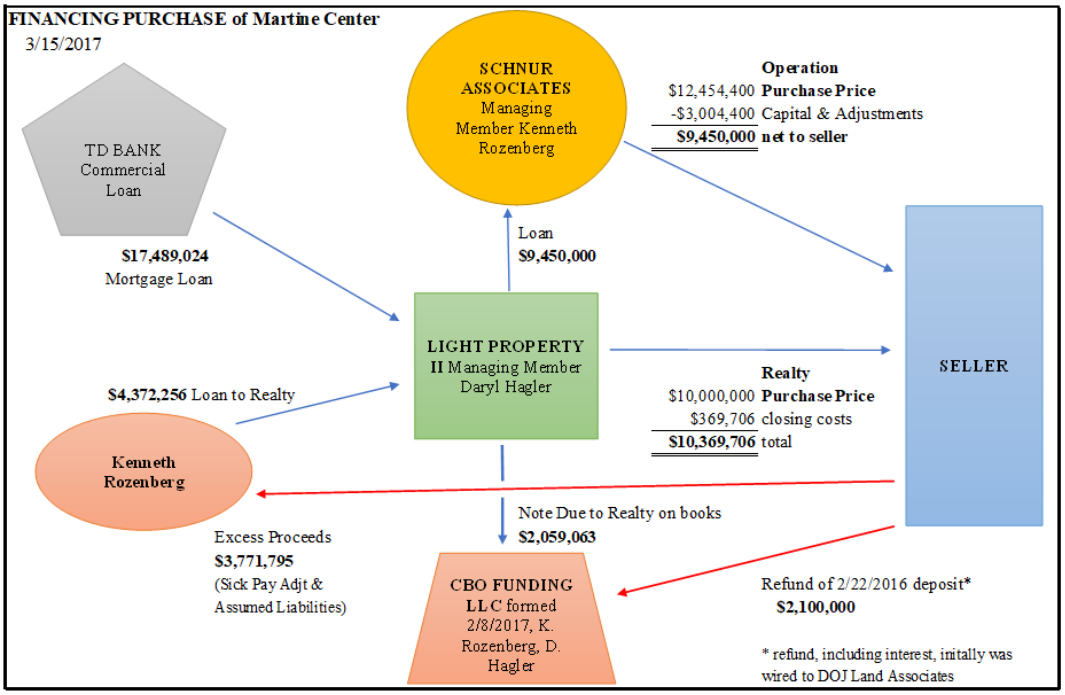
[90] A balloon payment is a larger-than-usual, one-time payment at the end of a loan term (Winslow Aff. ¶ 80).

[91] LIBOR stands for the London Interbank Offered Rate. LIBOR was the benchmark interest rate that banks used when lending money to other banks in the international interbank market for short-term loans (Winslow Aff. ¶ 81).

466. Schnur Associates submitted another commitment letter to DOH during the CON process, dated April 25, 2016, stating that Rockland Capital Funding, LLC ("Rockland Capital") had approved a working capital loan to Schnur Associates of $1,678,233 at an interest rate of 5% over five years. This loan commitment was meant to fund Martine Center's operations after Schnur Associates acquired it. The Rockland Capital letter was signed by Beverly Schiffer, who was Hagler's wife at the time. Rockland Capital was incorporated in 2006 using Hagler's home address (Winslow Aff. ¶ 82).

467. On June 2, 2016, DOH approved Schnur Associates' CON application for Martine Center (Winslow Aff. ¶ 83).

468. After DOH approved Schnur Associates' CON application, Schnur Associates and Light Property II did not fund their purchases using the funding sources they submitted to DOH. Instead, they closed on their acquisitions using self-dealing loans with inflated interest rates. The following chart shows the structure of the purchase:



(Winslow Aff. ¶ 94).

469. First, on March 15, 2017, Light Property II secured a mortgage from TD Bank for $17,489,024 at an interest rate of LIBOR plus 2.9% (the "TD Bank-Light Property II Loan"). Schnur Associates, Light Operational Holdings, Rozenberg, and Hagler were all guarantors on the loan (Winslow Aff. ¶ 87).

470. As part of the TD Bank-Light Property II Loan, Light Property II was required to keep all of its accounts at TD Bank. Light Property II had opened an account at TD Bank on May 13, 2016, before it received DOH's final approval on its CON application. Prior to its acquisition of Martine Center's property, Light Property II's TD Bank account did not have any activity (Winslow Aff. ¶ 88). Thus, Hagler and Rozenberg had begun working toward securing the TD Bank-Light Property II Loan while their CON application was pending, without amending the CON application to disclose the true source of the funds.

471. Second, also on March 15, 2017, Rozenberg personally loaned $4,372,256 to Light Property II (the "Rozenberg-Light Property II Loan"). According to Light Property II's annual financial statements, this loan from Rozenberg did not have any interest or repayment terms and was payable to an "unrelated party." However, the note contradicts the financial statements: the note states that it has an annual interest rate of 7% and is due in 5 years. Yet, Light Property II's annual financial statements from 2017 through 2020 note that "[t]he Company does not anticipate making any repayments during" that year (Winslow Aff. ¶¶ 89, 98).

472. Thus, between the TD Bank-Light Property II Loan and the Rozenberg-Light Property II Loan, Light Property II obtained loans totaling $21,861,280.

473. Light Property II then loaned its related-party tenant, Schnur Associates, $9.45 million based on a promissory note dated March 15, 2017 (the "Light Property II-Schnur Note"). This promissory note initially had a 4-year term with a 12% interest rate, which equated to

approximately $90,000 in monthly interest and a final balloon payment of $7.9 million. The Light Property II-Schnur Note was amended after ten months; the amendment reduced the interest rate to 4% (for approximately $28,000 in monthly interest), extended the term by one year, and lowered the final balloon payment to $7.5 million (Winslow Aff. ¶ 84).

474. Prior to closing, Schnur Associates agreed to certain closing adjustments with Martine Center's former owner. As result, Schnur Associates only paid $9.45 million at closing. Schnur Associates paid this amount with the funds it obtained from the Light Property II-Schnur Note (Winslow Aff. ¶ 84).

475. Had Rozenberg not loaned $4,372,256 to Light Property II through the Rozenberg-Light Property II Loan, Rozenberg could have used those funds directly in his acquisition of Martine Center rather than causing Schnur Associates to enter the Light Property II-Schnur Note, and Martine Center would not have had to pay any interest whatsoever on that $4.3 million. This would have saved Martine Center approximately over $1 million from 2017 to 2021, which it could have spent on patient care (*see* Winslow Aff. ¶ 155). Instead, Rozenberg and Hagler used the collusive loans between Rozenberg, Light Property II, and Schnur Associates, to siphon off the interest and enrich themselves through another fraudulent scheme at the expense of Martine Center and its residents.

476. Moreover, had Rozenberg funded his acquisition directly through a commercial lender rather than through the Light Property II-Schnur Note, Martine Center would have saved hundreds of thousands of dollars in interest expenses. For the first ten months of the Light Property II-Schnur Note, Schnur Associates paid more than $900,000 in interest on the note – money that it paid out of the nursing home operating account. In contrast, during 2017, the interest rate on the TD Bank-Light Property II Loan fluctuated between 3.81% and 4.26%. Had Schnur Associates

paid the same interest rates, instead of the absurdly inflated 12% it paid to Light Property II, it would have saved Martine Center around $600,000 (Winslow Aff. ¶¶ 85, 150). Thus, by engaging in an unnecessary and collusive loan, Rozenberg allowed Hagler's company to pocket more than half a million dollars that Martine Center should have spent on resident care, in less than one year.

477. After the Light Property II-Schnur Note, Light Property II still had $12,411,280 remaining from the combined proceeds of the TD Bank-Light Property II Loan and the Rozenberg-Light Property II Loan. Light Property II used $10,369,706 of that amount to pay the total closing costs for its acquisition of Martine Center's real property. Light Property II then issued a note to CBO Funding, LLC ("CBO Funding") for $2,059,063 (the "Light Property II-CBO Funding Note") (Winslow Aff. ¶ 90).

478. CBO Funding is another company owned by Rozenberg and Hagler (*see* Winslow Aff. ¶ 92) that exists for the purpose of making loans and/or investments to other associates and entities (including Rozenberg-owned nursing homes). CBO Funding thus generates additional profit for Rozenberg and Hagler (Hagler Tr. at 50-54). CBO Funding has no employees; in fact, Centers does its bookkeeping (Hagler Tr. at 50-54).

479. By borrowing the additional $2,059,063 for the Light Property II-CBO Funding Note, Light Property II added additional debt that had to be repaid by Martine Center because Martine Center's rent payments were the sole source of income for Light Property II and Light Property II used those rent payments to cover the debt service on the TD Bank-Light Property II Loan and the Rozenberg-Light Property II Loan. In sum, Martine Center bore the ultimate burden of the Light Property II-CBO Funding Note without receiving any of its benefits; rather, all the benefits from the Light Property II-CBO Funding Note flowed to Rozenberg and Hagler. Had Light Property II not borrowed the additional $2,059,063 that it then loaned to CBO Funding,

Martine Center would not have had to pay the principal and interest repayments of this debt, which it paid through its monthly rent payments, and could have paid less in rent, thereby saving Martine Center additional funds from 2017 to 2022 that could have been spent on resident care.

480. As discussed in §§ VIII(A)(2)-(3) below, Rozenberg and Hagler acquired both Martine Center and Beth Abraham on the same day, because the two facilities had the same former owner. As part of the joint closing, Rozenberg transferred $15,852,000 to the title company ($11,479,744 loan to Light Property and $4,372,256 loan to Light Property II) as part of the purchases, and thereafter received $16,382,910 back from the title company at closing on behalf of Beth Abraham and Martine Center. This returned amount, representing the purported closing adjustments as agreed to by the parties, was transferred to Rozenberg's personal account. In the end, the title company transferred Rozenberg $530,910 *more* than Rozenberg paid to the title company for the acquisitions. At closing, Rozenberg transferred that amount to CBO Funding (Winslow Aff. ¶¶ 95-96). Therefore, after the closing was completed, Rozenberg more than recouped the proceeds that he had provided towards the purchase of Beth Abraham and Martine Center, in addition to holding the $4.3 million Rozenberg-Light Property II Loan and the $11.4 million Rozenberg-Light Property Loan, discussed below.

ii. Respondents Forced Martine Center to Pay the Extra Interest After Refinancing a Loan for Hagler's Benefit

481. Respondents' pattern of repeated and persistent fraud involving collusive loans continued at Martine Center when they refinanced the TD Bank-Light Property II Loan with a HUD-backed mortgage from Greystone, in February 2020.

482. Although the TD Bank-Light Property II Loan principal was $17,489,024, the principal for Light Property's HUD-backed loan was $26,223,500 (the "Martine Center HUD

Loan"). The Martine Center HUD Loan carries an interest rate of 2.94% and has a 35-year term (Winslow Aff. ¶¶ 87, 99).

483. The Martine Center HUD Loan proceeds were distributed as follows:

- $14,077,744 to TD Bank to pay off the remainder of the TD Bank-Light Property II Loan;
- $3,282,382 to escrow as a reserve for future property expenses and to pay for repair work;
- $1,554,484 to Light Property II as purported reimbursement for capital improvements performed in 2018 and 2019;
- $6,580,108 to Rozenberg to repay the Rozenberg-Light Property II Loan; and
- $728,782 for other disbursements.

(Winslow Aff. ¶¶ 99-100).

484. The $6,580,108 payment to Rozenberg is the repayment of the Rozenberg-Light Property II Loan at a 7% interest rate. As discussed in § VIII(A)(2)(ii) below, it appears that Rozenberg had already been repaid on the Rozenberg-Light Property II Loan when Rozenberg closed on the Martine Center acquisition five years earlier, in 2017. Thus, it appears that Rozenberg was repaid twice on the Rozenberg-Light Property II Loan: once at Martine Center's closing and again, with interest, from the proceeds of the Martine Center HUD Loan (Winslow Aff. ¶¶ 98; 100).

485. To the extent that the Martine HUD Loan accounted for the unnecessary second repayment to Rozenberg, this caused the loan amount to increase, which, in turn, increased the minimum lease amount. This increase benefitted Hagler, at the expense of Martine Center residents.

iii. Respondents Chose to Defer Martine Center's Rent Payments to Hagler While Making Payments on a Note for Hagler's Benefit, Thereby Allowing Hagler to Pocket Lump Sum Payments

486. In addition to taking out non-arm's-length loans to benefit Rozenberg and Hagler while burdening Martine Center with the inflated interest and debt payments, Rozenberg, Hagler, Centers, Light Property II, and Martine Center's Operator and Owners further committed fraud by causing Martine Center to sign an inflated Related-Party lease with Light Property II, which drained additional funds from Martine Center and covertly transferred them to Hagler's company for his personal benefit.

487. On February 19, 2016, Rozenberg and Hagler caused Schnur Associates and Light Property II to execute a lease agreement for Martine Center's land and building, with a minimum annual rent of $1,900,000 plus additional payments for insurance, taxes, maintenance. The lease commenced on March 15, 2017, when Respondents acquired Martine Center and its real property. Rozenberg signed the lease on behalf of Schnur Associates, and Hagler signed on behalf of Light Property II (Winslow Aff. ¶ 102).

488. Respondents submitted the Martine lease to DOH as part of Martine Center's CON application, along with an affidavit stating that the "non-arm's length agreement [between Schnur Associates and Light Property II] reflect[s] a reasonable lease amount to account for the long-term viability of the operation of the nursing home as well as the debt service and real estate tax amounts that will be owed on the property . . . [therefore] the lease amount is appropriate under the circumstances of this transaction" (Winslow Aff. ¶ 103). But this was not true.

489. HUD's commitment letter for the Martine Center HUD Loan notes an annual minimum rent of $1,823,000, which would cover 105% of the debt service (Winslow Aff. ¶ 107).

490. From 2017 to 2021, Schnur Associates' financial statements include rent expenses to its landlord, Light Property II, totaling $10,240,789. As of the end of 2021, Schnur Associates

had paid $5,747,661 in rent, leaving $4,493,128 in unpaid back rent. Several of the notes to the financial statements indicate that the Hagler-owned landlord company consented to the deferral of rent payments (*see* Winslow Aff. ¶¶ 105-06; 108-09). The amount of unpaid back rent represents approximately 44 percent of Martine Center's total rent obligation (Winslow Aff. ¶ 106). Thus, Martine Center's stated rent expense (practically double the amount of money needed for the landlord to pay its mortgage) is plainly inflated.

491. During this same period, Schnur Associates also paid Light Property II $4,062,489 to service the inflated interest on the $9.45 million Light Property II-Schnur Note, which Rozenberg used to finance his acquisition of Martine Center (Winslow Aff. ¶ 109). This was another source of money flowing from Martine Center to Hagler-owned Light Property II. And, had Rozenberg and Hagler not colluded to use the Light Property II-Schnur Note to inflate Martine Center's debt, Martine Center could have paid approximately 90% of its inflated rent, lessening the debt accruing on its books.

492. Hagler profited enormously from his collusive real estate dealings with Rozenberg. Between 2020 and April 2022, Hagler transferred $3,235,000 from Light Property II to his personal bank account. Specifically, in January 2020, Hagler transferred $500,000 from Light Property II into his personal account. In January 2021, Hagler transferred $500,000 from Light Property II into his personal account. And in January 2022, Hagler transferred $2,235,000 into his personal account (*see* Winslow Aff. ¶¶ 109-11, 152).

493. Between March 2017 and April 2022, Schnur Associates transferred $10,117,714 to Light Property II. Light Property II, in turn, then transferred $6,681,661 to TD Bank to pay the TD Bank-Light Property II Loan and $146,092 to Greystone to pay the Martine Center HUD Loan (*see* Winslow Aff. ¶ 111). Thus, the $3,235,000 that Hagler transferred from Light Property II to

his personal bank account represents 32% of every dollar Martine Center paid to Light Property II.

494. Meanwhile, residents at Martine Center were being neglected and suffering, and overburdened staff members at Martine Center were working under the poor working conditions that Centers and Rozenberg had created, and from which Hagler profited.

3. Respondents' Real Estate Frauds at Beth Abraham

i. Respondents Financed Their Purchase of Beth Abraham Through Self-Dealing Loans with Inflated Interest Rates, Which They Failed to Disclose to DOH

495. Rozenberg and Hagler's purchase, financing, and exploitation of Martine Center must be evaluated alongside its purchase of Beth Abraham, because they bought both nursing homes from the same seller on the same day (*see* Winslow Aff. ¶ 89; 95).

496. As they did with the other Nursing Homes mentioned above, Rozenberg and Hagler split the purchase of Beth Abraham into two discrete entities. Rozenberg purchased Beth Abraham's operations through Abraham Operations (Waldropt Aff. ¶ 11). The 98% owner[92] of Abraham Operations is Light Operational Holdings (Waldropt Aff. ¶ 11), which is also the majority owner of Schnur Associates (Winslow Aff. ¶ 48-52). Hagler purchased Beth Abraham's real property through Light Property, a company also owned 99% by Hagler and 1% by Jonathan Hagler (Budimir Aff. ¶ 29; Hagler Tr. at 131).

497. On February 19, 2016, Abraham Operations and Light Property entered into agreements with Beth Abraham's former owner and landlord to purchase Beth Abraham's operations for $30,305,600 and the real property for $25 million (Waldropt Aff. ¶ 12).

[92] Initially Sicklick was a 2% member, but he transferred his membership to Beth Rozenberg in 2018 (Waldropt Aff. n.2). Thereafter, in or about April 2023, the 2% ownership interest was transferred to Rivka Rozenberg (Budimir Aff. Exh. 62).

498. As he had for the other Nursing Homes mentioned above, Rozenberg had to secure approval from DOH through the CON application process to close on the purchase of Beth Abraham (Waldropt Aff. ¶ 13).

499. In February 2016, Rozenberg submitted a CON application for Beth Abraham to DOH. In support of the CON application, Abraham Operations submitted the following proposed financing narrative to fund the $30,305,600 purchase price for the operations:

- $6,301,400 would be raised through equity contributions by members of Abraham Operations;
- $5.1 million would come from a deposit already paid by Abraham Operations; and
- $18,904,200 would be provided through a bank loan from Greystone, with Kenneth Rozenberg as the Guarantor, at an interest rate of approximately 5%.

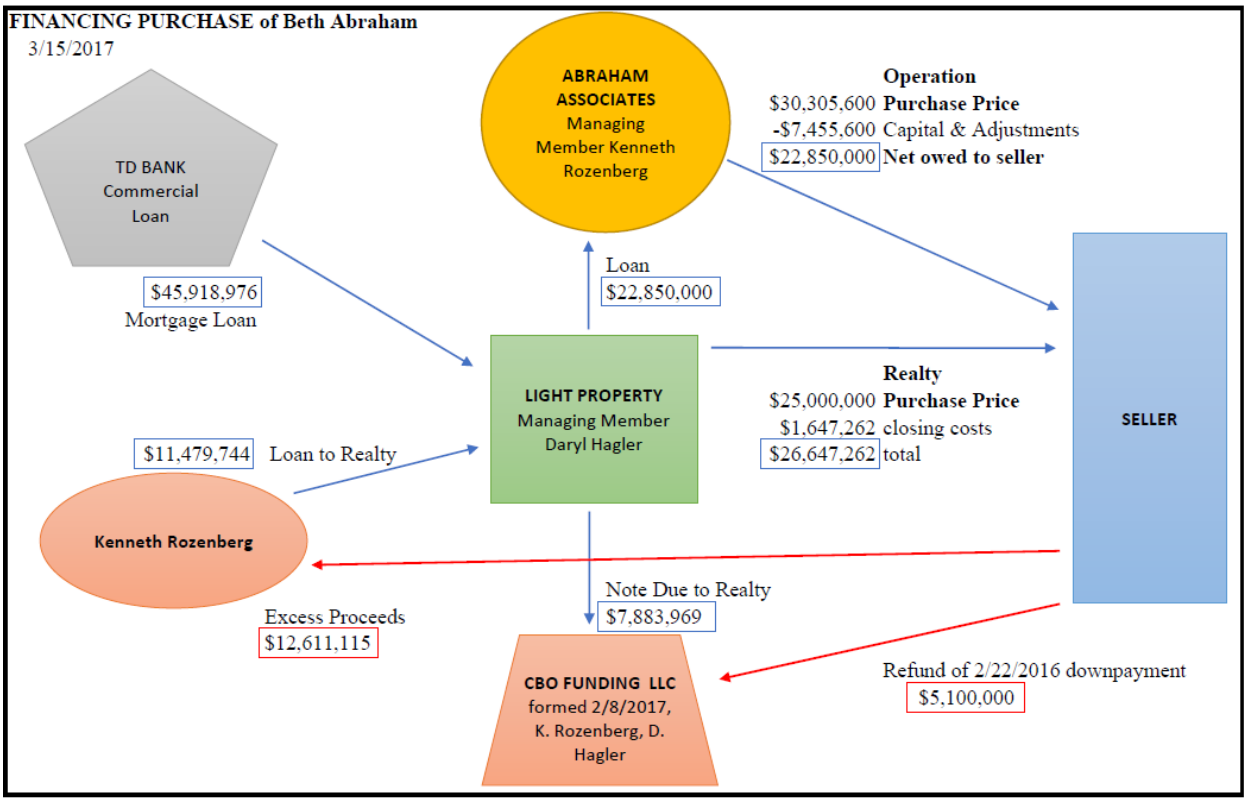
(Waldropt Aff. ¶ 13).[93]

500. The $25 million purchase of the real property would also be funded through a Greystone loan at the interest rate of 5% (Waldropt Aff. ¶ 14).

501. On June 2, 2016, DOH approved Abraham Operations' CON application for Beth Abraham (Waldropt Aff. ¶ 15).

502. However, as with Martine Center, Abraham Operations did not follow the funding narrative it submitted to DOH. Instead, on March 15, 2017, Abraham Operations and Light Property closed their acquisitions using the same structure of multiple self-dealing loans with inflated interest rates that Schnur Associates and Light Property II used for Martine Center, as shown in the following chart:

[93] Like with Martine Center, Abraham Operations also notified DOH of its intention to obtain a working capital loan of $4,463,841 from Rockland Capital at an interest rate of 5% over five years. As with Martine Center, the familial relationship between Hagler and Rockland Capital was not disclosed as part of the Beth Abraham CON process. *See* Waldropt Aff. n.5.



(*See* Waldropt Aff. ¶¶ 16-22).

503. Similar to Martine Center's acquisition, on March 15, 2017, Light Property took out a loan of $45,918,976 from TD Bank at an interest rate of LIBOR plus 2.9% (the "TD Bank-Light Property Loan") and an $11,497,744 loan from Rozenberg (the "Rozenberg-Light Property Loan").

504. According to Light Property's yearly financial statements from 2017 to 2020, the Rozenberg-Light Property Loan did not have any interest or repayment terms and was payable to an "unrelated party." However, the note itself states that it has an annual interest rate of 7% and is due in five years. Light Property's annual financial statements from 2017 to 2020 do not show any repayments on the Rozenberg-Light Property Loan, and each year's financial statement notes that "[t]he Company does not anticipate making any repayments during" that year (*see* Waldropt Aff. ¶ 17).

505. Light Property used $26,647,262 of the proceeds from these loans to acquire Beth Abraham's real property, including paying closing costs (*see* Waldropt Aff. ¶ 18).

506. Light Property also used the loan proceeds it received to lend $22,850,000 to its Related-Party tenant, Abraham Operations (the "Light Property-Abraham Operations Note"). This promissory note initially had a 5-year term with a 12% interest rate, which equated to approximately $229,630 in monthly interest charges. In 2017, Beth Abraham paid $685,500.03 in principal and $2,181,489.51 in interest on the Light Property-Abraham Operations Note. The Light Property-Abraham Operations Note was amended and the interest rate dropped to 4%, as of January 1, 2018 (*see* Waldropt Aff. ¶¶ 19-20).

507. Prior to closing, Abraham Operations agreed to certain closing adjustments with Beth Abraham's former owner. As result, Abraham Operations only paid $22.85 million at closing. The entire amount of money Abraham Operations used to pay that purchase price came from the Light Property-Abraham Operations Note (*see* Waldropt Aff. ¶ 21).

508. Had Rozenberg not loaned $11,497,744 to Hagler through the Rozenberg-Light Property Loan, Rozenberg could have used *those* funds directly in Beth Abraham's acquisition of Beth Abraham. Had he done so, Beth Abraham could have borrowed less under the Light Property-Abraham Operations Note, and Beth Abraham would have had a lower interest expense by approximately $2,755,566 (*see* Waldropt Aff. ¶ 23).

509. Had Rozenberg funded his acquisition directly through a commercial lender rather than through the Light Property-Abraham Operations Note, it would have saved Beth Abraham hundreds of thousands of dollars in interest expenses. From March 2017 through December 2017, Beth Abraham owed $2,181,489.51 in interest on the Light Property-Abraham Operations Note. During that same period, the interest on the TD Bank-Light Property Loan was approximately 4%.

Had Abraham Operations paid the same interest rate, it could have saved Beth Abraham around $1,454,326 (*see* Waldropt Aff. ¶ 24). Thus, by causing Abraham Operations to take on a Related-Party loan with an inflated interest rate, the Light Property-Abraham Operations Note, Respondents Rozenberg, Hagler, Centers, and Beth Abraham's Operator and Owners cost Beth Abraham more money, leaving fewer dollars to be spent on resident care, while enabling Hagler to siphon significant up-front profit out of Beth Abraham in less than one year through inflated interest payments.

510. As discussed above, Light Property used the remainder of the loan proceeds it received to issue a note to CBO Funding, a party controlled by Rozenberg and Hagler, for $7,883,969 (the "Light Property-CBO Funding Note") (Waldropt Aff. ¶ 25).

511. Just as with Martine Center, by borrowing the additional $7,883,969 for the Light Property-CBO Funding Note, Light Property added additional debt that had to be repaid by Beth Abraham because Beth Abraham's rent payments were the sole source of income for Light Property and Light Property used those rent payments to cover the debt service on the TD Bank-Light Property Loan and the Rozenberg-Light Property Loan. In sum, Beth Abraham bore the ultimate burden of the Light Property-CBO Funding Note without receiving any of its benefits, which all flowed to Rozenberg and Hagler. Had Light Property not borrowed the additional $7,883,969 that it then loaned to CBO Funding, Beth Abraham would not have had to cover the principal and interest repayments of this debt, which it paid through its monthly rent payments, and could have paid less in rent, thereby saving Beth Abraham additional funds from 2017 to 2022 that could have been spent on resident care.

512. On July 6, 2020, Light Property applied for a HUD-backed loan through Greystone to refinance the TD Bank-Light Property Loan. That application is still pending (Waldropt Aff. ¶ 26).

ii. Hagler Profited Greatly from Beth Abraham's Related-Party Loans and Inflated Rent Payments

513. In addition to causing Beth Abraham to take out Related Party loans, Rozenberg and Hagler caused Beth Abraham to enter into a Related-Party lease with Light Property, which further facilitated Rozenberg and Hagler's transfer of up-front profit from Beth Abraham to Light Property for Hagler's benefit.

514. On December 31, 2015, Rozenberg and Hagler executed two leases between Abraham Operations and Light Property. One lease had a $6 million annual minimum rent plus additional expenses. Beth Abraham submitted this lease to DOH with its CON application. Beth Abraham's CON application and approval documents contain the same language regarding the related-party relationship and rent comments as in Martine Center. The second lease, also executed on December 31, 2015, had a $1.3 million annual minimum rent plus additional expenses (*see* Waldropt Aff. ¶ 68).

515. On January 1, 2018, Rozenberg and Hagler caused Beth Abraham to enter into an amended lease with Light Property, with a $2.6 million annual minimum rent (*see* Waldropt Aff. ¶ 69).

516. According to Beth Abraham's 2021 Cost Report, its annual rent is $6 million – the amount on the original lease. However, there is no mention of a lease amendment for that amount in the 2021 Cost Report (whereas the amended lease was disclosed in the 2018 Cost Report) (*see* Waldropt Aff. ¶ 70).

517. From 2017 to 2021, according to Abraham Operations' financial statements, Beth Abraham's total rent obligation to its landlord, Light Property, was $23,164,229.67, of which it paid $17,216,056.64, leaving $5,948,173.03 in unpaid back rent. Thus, Abraham Operations' back rent is approximately 26% of its total rent obligation (*see* Waldropt Aff. ¶ 71).

518. During this same period, Abraham Operations paid Light Property $9,817,765.02 to service the unnecessary, inflated Light Property-Abraham Operations Note. Had these funds instead been used to pay rent, Beth Abraham would not owe any back rent (*see* Waldropt Aff. ¶ 72), and instead Beth Abraham would have had a surplus of $3,869,591.99 to spend on resident care.

519. From 2020 through April of 2022, Hagler transferred $9,960,000 from Light Property to his personal account. In 2020, Hagler transferred $1 million from Light Property into his personal account. In 2021, Hagler transferred $2.5 million from Light Property into his personal account. In 2022, Hagler transferred $6,460,000 into his personal account. *See* Waldropt Aff. at ¶ 73.

520. In total, from 2017 through April 2022, Abraham Operations transferred $27,860,073 to Light Property. Light Property then transferred $17,827,676 to TD Bank to pay down the TD Bank-Light Property Loan (*see* Waldropt Aff. ¶ 74). Thus, the $9,960,000 that Hagler transferred from Light Property to his personal bank account represents about 36% of every dollar Beth Abraham paid to Light Property (Waldropt Aff. ¶ 74), which shows how Respondents transferred up-front profit out of Beth Abraham far in excess of any expense incurred or effort expended on Beth Abraham's behalf—all while Rozenberg, Hagler, Beth Abraham's Owners and Operators, and Centers violated State and federal laws designed to protect Beth Abraham's residents.

521. Meanwhile, residents at Beth Abraham were being neglected and suffering, and overburdened staff members at Beth Abraham were working under the poor working conditions that Centers and Rozenberg created, and from which Hagler profited.

4. Respondents' Real Estate Frauds at Buffalo Center

i. Rozenberg and Hagler Caused Buffalo Center to Take Out Mortgages with Inflated Principals, Which Benefited Hagler, and Caused Buffalo Center to Pay Unnecessary Debt Service Expenses

522. Like with the other Nursing Homes, Rozenberg and Hagler split the purchase of Buffalo Center into two nominally separate entities. Rozenberg purchased Buffalo Center's operations through Delaware Operations, which is 90% owned by Rozenberg and 10% owned by Sicklick. Hagler purchased Buffalo Center's real property through Delaware Real Property, a company of which he owns 99% of and Jonathan Hagler owns 1% (O'Leary Aff. ¶¶ 8-9).

523. On August 30, 2013, Rozenberg and Hagler caused Delaware Operations to enter into an agreement to purchase Buffalo Center's operations for $10 plus an assumption of its debts and caused Delaware Real Property to enter into an agreement to purchase the real property where Buffalo Center is located for $5 million (O'Leary Aff. ¶ 10).

524. On December 16, 2015, Rozenberg and Hagler closed on their acquisitions. At closing, Buffalo Center's operations had approximately $3 to $4 million in debt, which Delaware Operations assumed (O'Leary Aff. ¶ 10).

525. To finance their acquisitions, Delaware Operations and Delaware Real Property jointly took out a two-year bridge loan from Greystone for $18,408,000 with interest-only repayment at a minimum of 6.75% annual interest (the "Buffalo Center Bridge Loan"). Delaware Real Property used only $5,772,803.85 of the Buffalo Center Bridge Loan proceeds to purchase the facility, which included the $5,000,000 purchase price, closing costs, and a tax credit to the seller and received a credit from the seller of $1,469,844.52, along with a return of its $100,000

deposit. Therefore, after Buffalo Center was purchased, there were still $14,205,040.67 in additional proceeds from the Buffalo Center Bridge Loan that were not needed for the purchase of the facility (O'Leary Aff. ¶¶ 11, 12).

526. Buffalo Center suffered as a result of Hagler and Rozenberg causing the Buffalo Center Bridge Loan to be inflated by $14.2 million over the cost to purchase the facility because Buffalo Center's rent payments were the sole source of income for Delaware Real Property, and Delaware Real Property used Buffalo Center's rent payments to cover the interest payments on the Buffalo Center Bridge Loan. Buffalo Center spent more money to cover the interest than necessary to acquire the property, because the principal was unnecessarily inflated (*see* O'Leary Aff. ¶ 12).

527. Maximizing the loan proceeds from the Buffalo Center Bridge Loan was a calculated move on the part of Hagler and Rozenberg, according to an email between Greystone employees prior to closing on the Buffalo Center Bridge Loan, which also showed that Hagler and Rozenberg already had plans for the additional proceeds of the loan. The email reads, in part, "[b]orrower request is to borrow as much as we anticipate the HUD takeout to be. $5M of which will be used to fund the purchase price. The principals will deposit the balance in an account that they will not touch until we can go to HUD" to refinance the bridge loan into a new mortgage. The email ended by saying, "[p]rinciples would be interested in entering into an agreement with us that would allow us to use the capital in that account for a[n] 8% return on the money" (Pettigrew Aff. ¶ 111, Exh. 105). Thus, Respondents purposefully increased the Buffalo Center Bridge Loan principal with the intention to refinance the entire loan with a HUD-backed mortgage in two years.

528. Respondents' avarice did not stop there. Rather than have the remaining $14.2 million sit in an account for two years, curiously, within one year of Delaware Real Property receiving these loan proceeds, its financial statements reflected that it had a $13 million "deficit in

equity." This deficit in equity was due, in large part, to Hagler causing National Granite Title Company to transfer $9.3 million of the $14.2 million to Capital Mezz Funding II ("Capital Mezz"), a company affiliated with Greystone. Capital Mezz credited the $9.3 as a loan from Hagler, not Delaware Real Property, and had a fixed interest rate began at 8% but jumped to 10% in 2018 (the "Hagler-Capital Mezz Loan") (O'Leary Aff. ¶ 14). In so doing, Hagler directly profited from Respondents having taken out more money than they needed to finance the acquisition of Buffalo Center.

529. Hagler, not Delaware Real Property or Buffalo Center, profited from the lending of this money. Specifically, from December 17, 2015, to December 31, 2021, Capital Mezz paid $5,009,260 in interest on the Hagler-Capital Mezz Loan directly into Hagler's personal account (*see* O'Leary Aff. ¶ 14). Even though Buffalo Center was a signatory to the Buffalo Center Bridge Loan and Buffalo Center alone shouldered the burden of repaying the Buffalo Center Bridge Loan through its rent payments to Delaware Real Property, Buffalo Center reaped no benefit from taking out $9.3 million more than was needed to finance the property's acquisition. Simply put, Hagler personally reaped the benefit of the Hagler-Capital Mezz Loan by collecting millions of dollars in interest, while Buffalo Center paid an inflated rent to cover the interest payments on the Buffalo Center Bridge Loan mortgage, which in turn reduced the amount of money that Buffalo Center had to support resident care.

530. Shortly after closing, on January 2, 2016, Hagler provided a personal loan to Delaware Real Property for $5 million with a 7% interest rate (the "Hagler-Delaware Real Property Loan"), which Delaware Real Property used to pay off $3.5 million in Medicaid bed taxes that had accrued under the previous owner and to avoid potential liens on the property (*see* O'Leary Aff. ¶ 15).

531. In October 2018, Delaware Operations and Delaware Real Property refinanced the Buffalo Center Bridge Loan. On that date, Delaware Real Property closed on a $28,972,100 HUD-insured mortgage through Greystone with 4.2% annual interest and a 35-year term (the "Buffalo Center HUD Loan").[94] Delaware Real Property used the proceeds from the Buffalo Center HUD Loan to pay off the Buffalo Center Bridge Loan, to pay approximately $3.6 million owed on the Hagler-Delaware Real Property Loan, and to establish an escrow account for non-critical repairs (*see* O'Leary Aff. ¶¶ 16, 17).

532. Again, by borrowing more principal than was needed under the Buffalo Center Bridge Loan and paying it off using the Buffalo Center HUD Loan, Respondents Rozenberg, Hagler, Centers, Delaware Operations, Buffalo Center's Owners, and Delaware Real Property caused Buffalo Center to pay higher rents than were necessary for Delaware Real Property to pay down its debt. Through this arrangement, Respondents Rozenberg and Hagler orchestrated a system that cost Buffalo Center (by raising its lease payments to enable Delaware Real Property to repay the inflated Bridge Loan, although Hagler lent most of that money out) but benefited Hagler (who profited from the interest on the Hagler-Capital Mezz Loan).

533. Even after the Buffalo Center HUD Loan closed, Hagler continued to receive interest payments from Capital Mezz on the Hagler-Capital Mezz Loan, which was funded from the excess proceeds of the Buffalo Center Bridge Loan. Two days after the Buffalo Center HUD Loan closed, the interest on the Hagler-Mezz Loan increased from 8% to 10%. In 2021, Hagler

[94] Similar to Holliswood, as part of the Buffalo Center HUD Loan, Hagler executed an agreement with HUD titled, "Healthcare Regulatory Agreement – Borrower." Section 11(b) of that agreement states that, the "Borrower shall not engage in any business or activity, including the operation of any other project or other healthcare facility, or other ancillary business, or incur any liability or obligation not in connection with the Project." However, Delaware Real Property's financial statements indicate that it had revenue and expenses for housekeeping and/or staffing services, seemingly in violation of such clause.

received over $930,000 in interest on the Hagler-Capital Mezz Loan (*see* O'Leary Aff. ¶¶ 14, 18). Despite using the Buffalo Center HUD Loan proceeds to pay off the Buffalo Center Bridge Loan and raising Buffalo Center's rent to sustain the additional borrowing costs, at least through the end of 2021, Hagler continued to receive interest payments totaling just under $1 million per year on the Hagler-Capital Mezz Loan.

ii. Rozenberg and Hagler Caused Buffalo Center to Pay Inflated Rent Pursuant to Related-Party Leases with Delaware Real Property, for Hagler's Benefit

534. Like they did for the other Nursing Homes, Rozenberg and Hagler entered into Related-Party leases that caused Buffalo Center to pay Hagler millions of dollars in inflated rent expenses. The amount of rent Delaware Real Property charged Buffalo Center is far beyond any bona fide expense and created a fraudulent vehicle for Hagler to extract significant up-front profit, to the detriment of resident care, and while Rozenberg, Hagler, Centers, and Buffalo Center's Operator and Owners ignored and violated state and federal laws requiring Buffalo Center to provide required care and operate with sufficient staffing to deliver it.

535. In 2014, Jeremy and Meryl Strauss submitted a CON application to DOH seeking permission to purchase Buffalo Center. Their application included a lease agreement, dated April 2, 2014, representing that Buffalo Center's annual rent would be $600,000 (*see* O'Leary Aff. ¶¶ 22, 24-25).

536. During the CON process, the Strauss' CON application was amended to substitute Rozenberg and Sicklick as the new proposed owners (*see* O'Leary Aff. ¶ 24).

537. On September 2, 2015, DOH approved Delaware Operation's CON for Buffalo Center, including the initial lease with an annual rent of $600,000 (*see* O'Leary Aff. ¶ 30).

538. However, on December 16, 2015, the same day Rozenberg and Hagler closed on the financing for their acquisitions of Buffalo Center and its real property, Rozenberg and Hagler

executed a new lease, which set the annual rent at $2 million (the "December 2015 Lease"). The December 2015 Lease charged a rent 233% greater than the rent that DOH approved with the CON application (*see* O'Leary Aff. ¶ 31). In other words, after receiving DOH approval, Respondents more than doubled Buffalo Center's rent, without disclosing the increase.

539. Respondents chose to charge Buffalo Center far more than necessary to cover the debt service on the Buffalo Center Bridge Loan. For the Buffalo Center Bridge Loan, Greystone prepared underwriting documents noting that the current lease terms include a $600,000 annual rent—the same amount disclosed in Delaware Operation's CON application (*see* O'Leary Aff. ¶¶ 25, 30)—with no annual rent increases (*see* O'Leary Exh. 7 at 8). The fact that the underwriting documents include this lower rent show that Greystone, as the lender, was satisfied with that rent. But Respondents were not satisfied and instead chose to covertly funnel money away from resident care into Hagler's pockets.

540. On October 30, 2018, Rozenberg and Hagler caused Buffalo Center and Delaware Real Property to enter into a new lease as part of the process of obtaining the Buffalo Center HUD Loan. This lease set the minimum annual rent at $2,350,987. This rent level was listed in both Greystone's underwriting and HUD's commitment letter as the minimum annual rent to support 105% of the debt service (*see* O'Leary Aff. ¶ 32).

541. Rozenberg and Hagler used the HUD loan process to justify the even higher rent. First, as noted above, Buffalo Center's rents were the only source of revenue to service the Buffalo Center HUD Loan, which included paying for the $9.3 million that Hagler loaned back to Greystone—a sum from which Hagler was already profiting, with Greystone's interest payments to him.

542. Second, because Rozenberg and Hagler increased Buffalo Center's HUD Loan principal by approximately $10.5 million above the Buffalo Center Bridge Loan, HUD required a higher minimum rent to cover the debt service than it would have, had Respondents not increased the principal on the loan (*see* O'Leary Aff. ¶¶ 11,16, 32).

543. On June 1, 2020, Rozenberg and Hagler amended the lease a second time and set the new minimum annual rent even higher, at $2,750,000 (*see* O'Leary Aff. ¶ 33).

544. Unsurprisingly, Buffalo Center's rent-to-revenue ratio is significantly higher than the statewide average rent-to-revenue ratio, as detailed in the below chart:

Year	Buffalo Center Operating Revenue	Buffalo Center Rent Expense	Buffalo Center Rent to Revenue Ratio	Statewide Rent to Revenue Average	Rent Expense Above State Average
2016	$15,052,665.00	$2,067,628.00	13.74%	7.69%	$910,078
2017	$18,553,616.00	$3,044,547.00	16.41%	8.28%	$1,508,308
2018	$21,390,865.00	$2,540,582.00	11.88%	8.65%	$690,272
2019	$22,265,400.00	$3,698,126.00	16.61%	9.05%	$1,683,107
2020	$22,872,450.00	$3,390,283.00	14.82%	10.62%	$961,229
Total	**$100,134,996.00**	**$14,741,166.00**	**14.72%**	**8.28%**	**$5,752,994**

See O'Leary Aff. ¶¶ 38-39.

545. Thus, from 2016 through 2020, Buffalo Center's rent expenses were approximately $5.7 million greater than what they would have been if Buffalo Center's rent-to-revenue ratio had been at the state average (*see* O'Leary Aff. ¶ 40). The elevated rents that Rozenberg and Hagler caused Buffalo Center to pay to Delaware Real Property, through their collusive relationship, significantly decreased the amount of funds available for Buffalo Center to spend on care,

preventing the nursing home from increasing staffing, making necessary repairs, sanitizing dirty rooms and equipment, and buying adequate PPE and other supplies.

iii. Rozenberg and Hagler Repeatedly and Persistently Took Up-Front Profits from Buffalo Center Through Their Use of Inflated Related-Party Leases and Loans

546. As with the other Nursing Homes, Hagler (and therefore, Rozenberg, given their partnership) is the ultimate beneficiary of the Related-Party leases and loans between Buffalo Center and Delaware Real Property.

547. In total, from December 2018 through March 2022, Respondents Rozenberg, Hagler, Centers, Delaware Real Property, and Buffalo Center's Operator and Owners caused Buffalo Center to transfer $11,983,484 to Delaware Real Property. Delaware Real Property also received $2,056,494 related to the Buffalo Center HUD Loan and $1,343,984 from another account associated with Delaware Real Property. In total, Delaware Real Property received at least $14 million from its role as Buffalo Center's Landlord. During that period, Hagler moved $8,295,000 from Delaware Real Property's bank account into his personal bank account. Put differently, Hagler sent approximately 69 cents of every dollar paid by Buffalo Center to Delaware Real Property for rent to his personal accounts at Charles Schwab and Popular Bank. Hagler's excessive profiteering demonstrates that Buffalo Center's rent is disconnected from any legitimate expense or effort. As a result of Respondents' choice to divert these funds to Hagler, Buffalo Center was deprived of nearly $8.3 million that Respondents should have used to provide resident care.

* * *

548. The ownership and operation of a nursing home in New York is heavily regulated with the primary goal of ensuring that the nursing home owners provide high levels of care to

residents, while not extracting profits above certain limits.[95] Instead of complying with their legal obligation to provide care to the vulnerable, Respondents drained money from the Nursing Homes directly into Hagler's pockets through Related-Party leases and loans. Hagler reaped millions of dollars in profits from the Nursing Homes due to his relationship with Rozenberg, while doing little to no work.

549. During the pandemic, as the Nursing Homes' residents suffered and died, frontline nursing staff worked without adequate support and resources, and nursing home industry groups demanded that New York State maintain Medicaid funding levels and even "provide additional needed financial resources to address the unprecedented costs" of the pandemic, (Pettigrew Aff. ¶ 112, Exh. 106). Respondents continued to repeatedly and persistently commit fraud, as they directed the Nursing Homes to transfer millions of dollars to Hagler through inflated Related-Party leases and loans. Respondents further committed fraud by orchestrating these transfers without fully disclosing them to DOH, as discussed below.

B. Respondents Repeatedly and Persistently Committed Fraud and Illegalities by Extracting Funds from the Nursing Homes Through Related-Party Transactions

550. Not only did Respondents cause the Nursing Homes to pay down inflated mortgages through their "rent" obligations—which were thus likewise inflated—as described above, but Respondents further looted from the Nursing Homes by repeatedly and persistently causing them to enter into various Related-Party transactions—a majority of which had no substantial business purpose or discernable benefit to the Nursing Homes—with entities owned or controlled by the Nursing Homes' owners, Centers executives, and/or their family members.

[95] The "special obligation" even impacts nursing home landlords. New York law imposes special rules on that nursing home leases, which differentiate nursing home landlords from traditional landlords. *See* 10 NYCRR §§ 600.2(d), (e).

551. Through repeated and persistent Related-Party transactions, Respondents caused the Nursing Homes to transfer money to other Centers-affiliated nursing homes and caused the Nursing Homes to pay entities owned and/or controlled by Centers's owners and executives for which the Related-Party entities provided little to no services to the Nursing Homes. As a result, Respondents siphoned money out of the Nursing Homes into their personal bank accounts.

552. Furthermore, because these payments were structured as Related-Party transactions, Respondents should have disclosed them to DOH (*see* § [VIII][D] below).

553. Respondents also should have accounted for these Related-Party transactions as equity withdrawals pursuant to DOH regulations and sought DOH approval to make the transfers where required by law (*see* § VIII[E] below).

554. Respondents neither disclosed these fraudulent Related-Party transactions nor sought approval from DOH for the transfers. Respondents thus deceptively used these Related-Party transactions as an end run around DOH's regulatory scheme, which is intended to prevent nursing home owners from withdrawing large amounts of money from facilities without prior approval.

1. Respondents Repeatedly and Persistently Took Millions of Dollars from Holliswood Center and Buffalo Center Through Fraudulent No-Interest Loans Made to Other Centers-Affiliated Nursing Homes

555. Publicly, Centers represents that each Centers-affiliated nursing home is independently owned and operated. However, the reality is much different: Respondents Rozenberg, Hagler, and Centers controlled and used the Nursing Homes as piggy banks for their own benefit, including by directing the Nursing Homes to transfer funds to other Centers-affiliated nursing homes, at no benefit to the Nursing Homes, while they ignored and violated State and federal laws requiring the Nursing Homes to provide required care and operate with sufficient staffing to deliver it.

556. The Nursing Homes' accounting documents characterize these transfers to other Centers-affiliated nursing homes as "loans and exchanges." However, unlike legitimate loans, these loans are not well-documented, and instead frequently are just noted as "loans and exchanges" in the Nursing Homes' books. And these loans are rarely repaid in full and do not carry interest.

557. Yet, as described above, when Rozenberg and Hagler were the beneficiaries of loans, including sham Related-Party loans, they forced the Nursing Homes to repay the loans in full and with interest. This contrast makes sense in the context of Respondents' fraud: Rozenberg and Hagler charged interest when they pocketed those interest payments but had no incentive to do so when the loans were between two nursing homes under their control.

558. These transfers from Holliswood and Buffalo Center to other Centers-affiliated nursing homes deprived Holliswood and Buffalo Center of funds for resident care and, in some cases, supported nursing homes located in other states—and whose care is paid for by other states' Medicaid programs.

559. These transfers also allowed Centers to move money from highly profitable facilities to other facilities, potentially to avoid DOH's equity withdrawal regulations.

560. By causing the Nursing Homes to make these transfers, Respondents repeatedly and persistently committed fraud and conversion, and repeatedly and persistently violated Executive Law § 63-c.

i. Respondents Caused Holliswood Center to Transfer $10,034,510 to Other Centers-Affiliated Nursing Homes, Without Any Benefit to Holliswood or Its Residents

561. As evidenced by Holliswood's bank records from 2017 through 2021, Respondents Rozenberg, Centers, and Holliswood Center's Owners and Operator caused Holliswood Center to transfer $10,034,510 to other Centers-affiliated nursing homes without any benefit to Holliswood.

Holliswood's trial balances from 2017 through 2020 characterize these transfers as "loan(s) and exchange(s) (asset)."[96] Similarly, Holliswood's 2020 general ledger characterizes the transfers that occurred that year as "loans and exchanges" (Budimir Aff. ¶ 125). However, these transfers do not benefit Holliswood Center. Indeed, as evidenced by the aforementioned bank records, not only did Holliswood not profit from these purported loans, Holliswood was only repaid in full on 6 out of 21 of the purported loans. Moreover, when Holliswood was repaid, it was not repaid with interest and was thereby deprived of the time value of those funds.

562. All of the purported "loan" transfers, from 2017 through 2021, are set forth in the table below, which shows amounts taken from Holliswood in red and amounts returned to Holliswood in black:

Centers Facility	Amount Transferred from Holliswood	Amount Returned to Holliswood as of 2/23/21	Net Loss to Holliswood
Abraham Operations	($4,171,979)	$2,603,755	($1,568,224)
Amsterdam Nursing Home	($2,197)		($2,197)
Bannister Operations	($550,000)		($550,000)
Brooklyn Center	($500,000)		($500,000)
Bushwick Center	($5,485)		($5,485)
Carthage Center	($201,090)	$201,090	$0
Ellicott Center	($20,363)		($20,363)
Fulton Center	($50)		($50)
Glens Falls Center	($300,820)	$300,820	$0
Granville Center	($196,397)	$193,397	($3,000)
Martine Center	($503,723)	$415,962	($87,761)
Minoa LLC	($183,867)	$183,867	$0
New Paltz Center	($181,018)	$181,018	$0
Oceanview Nursing	($8,782)		($8,782)
Prospect Park Operating	($1,250,000)		($1,250,000)
Richmond Center	($10,341)	$9,436	($905)
Schenectady Center	($511,492)	$511,492	$0
Shady Acres Operations	($350,000)		($350,000)

[96] MFCU only has available to it Holliswood's trial balance records through 2020.

Troy Center	($186,906)	$186,906	$0
Washington Operations	($550,000)		($550,000)
Waterfront Operations	($350,000)		($350,000)
Totals	**($10,034,510)**	**$4,787,743**	**($5,246,767)**

(Budimir Aff. ¶ 125).

563. In other words, Respondents removed over $10 million from Holliswood in a 5-year period to support other nursing homes under their control, instead of causing Holliswood to spend the money to care for Holliswood's residents as required by law.

564. Respondents' only documentation of these "loans" is four promissory notes from Hollis Operating Co. to CBO Lending (*see* Pettigrew Aff. ¶ 113, Exh. 107; ¶¶ 131-134, Exhs. 125-128). CBO Lending is not a separate legal entity but is merely a d/b/a that Centers uses for "intercompany loans" between Centers-affiliated nursing homes (Hagler Tr. at 42-44). When "one company is in need of cash and one company has it . . . it gets lent to the other company, and it gets paid back" (*id*. at 42-43). Hagler signed all four promissory notes from Hollis Operating Co. on behalf of CBO Lending. None of the four promissory notes states that the loans carry interest (*see* Pettigrew Aff. ¶¶ 131-134, Exhs. 125-128).

565. Instead of using these apparently surplus funds generated by Holliswood to support resident care or raise staffing levels at Holliswood, Respondents caused Holliswood to transfer the funds to other Centers-affiliated nursing homes, to serve the interests of Rozenberg, Hagler, and their businesses. Such acts constitute conversion, which is an Unacceptable Practice, as per 10 NYCRR 515.2(b)(4), and repeatedly and persistently violated Executive Law 63-c.

ii. Respondents Caused Buffalo Center to Transfer $4,840,000 to Centers-Affiliated Nursing Homes in Other States Without Any Benefit to Buffalo Center or Its Residents

566. Between 2018 and 2019, Respondents Rozenberg, Centers, and Buffalo Center's Owners and Operators caused Buffalo Center to transfer $4,840,000 to five Centers-affiliated nursing homes without any benefit to Buffalo Center, as demonstrated in the table below, which shows amounts taken from Buffalo Center in black and amounts returned to Buffalo Center in red:

Centers Facility	Amount Transferred from Buffalo Center	Amount Returned to Buffalo Center	Net Loss to Buffalo Center
Overland Park (Kansas)	($2,500,000)	-	($2,500,000)
Wichita Center (Kansas)	($860,000)	$500,000	($360,000)
Topeka Center (Kansas)	($730,000)	$730,000	$0
Bannister Center (Rhode Island)	($650,000)	-	($650,000)
Kingston Center (Rhode Island)	($100,000)	-	($100,000)
Total	**($4,840,000)**	**$1,230,000**	**($3,610,000)**

(*See* Affidavit of Senior Auditor-Investigator Giacoia Aff. ¶ 20)

567. In other words, Respondents took over $4.8 million from Buffalo Center in a 4-year period to support other nursing homes under their control, instead of spending the money to care for Buffalo Center's residents as required by law.

568. Only 25% of the funds transferred out of Buffalo Center had been returned to Buffalo Center as of March 2022. Buffalo Center's purchase journal categorizes these transfers as "loans and exchanges." Based on the repayment by Topeka Center, for example, of the exact amount it received, it appears these "loans" are interest free (Giacoia Aff. ¶ 28).

569. Respondents transferred funds from Buffalo Center – which derives most of its revenue from New York State's Medicaid program – to Centers-affiliated nursing homes in other states. Specifically, Wichita Center, Topeka Center, and Overland Park are nursing homes located

in Kansas that are managed by Centers and owned by Centers owners, executives, and/or their family members (Giacoia Aff. ¶¶ 21, 23-25). Similarly, Bannister Center and Kingston Center are nursing homes located in Rhode Island that are managed by Centers and owned by Centers owners, executives, and/or their family members (Giacoia Aff. ¶¶ 21, 26-27).

570. Buffalo Center had transferred nearly $5 million to these facilities, and as of March 2022, nearly $3.6 million had not been returned (Giacoia Aff. ¶ 20). Therefore, Centers used New York State's Medicaid money – money that the State expends to care for New Yorkers – to benefit their businesses in other states, instead of using the money to care for Buffalo Center's residents as required by law.

2. Respondents Caused the Nursing Homes to Pay Millions of Dollars to Related Parties for Purported Goods or Services that Were Not Provided, to Extract Up-Front Profit

571. In addition to funneling money from Holliswood and Buffalo Center to other Centers-affiliated nursing homes, Respondents also unlawfully and fraudulently extracted up-front profit from the Nursing Homes by causing them to pay sham invoices from companies owned or controlled by the Nursing Homes' owners, Centers's owners, and/or their family members, for goods and/or services that were not delivered or provided.

572. The Nursing Homes' administrators have no discretion or authority to retain third-party vendors (Liff Tr. at 29; Blackstein Tr. at 290; Weisz [3/31/22] Tr. at 114-115). Instead, Centers controls the selection and payment of vendors that are supposed to provide goods or services for the Nursing Homes (Liff Tr. at 29). Inevitably, Centers selects and pays Related-Party vendors.

573. By causing the Nursing Homes to enter into collusive arrangements with Related-Party vendors, Respondents ensured the transfer from the Nursing Homes of millions of dollars in up-front profit into the pockets of Centers's owners and executives and their family members—

even as Respondents violated the Nursing Homes duties under State and federal law. Thus, there was no disinterested party to monitor whether the goods and services were actually provided, nor any possibility that a vendor's poor service could lead to the termination of its arrangement—because Respondents were negotiating with themselves.

574. These Related-Party arrangements disincentivize Centers and the Nursing Homes from negotiating the best price because Respondents profit by overcharging the Nursing Homes and/or by charging the Nursing Homes for goods and services that the Related-Party vendors do not actually provide. Consequently, Respondents' use of these Related-Party vendors to provide purported goods and services to the Nursing Homes is an easy way to conceal the siphoning of funds from the Nursing Homes without Rozenberg or Hagler having to withdraw money directly from the Nursing Homes as equity in a way that requires transparency.

i. Respondents Caused the Nursing Homes to Pay Over $3.3 Million to BIS Funding, a Company Owned by Hagler, for Purported Goods and Services that Were Not Provided

575. BIS Funding Capital, LLC ("BIS Funding") is an entity that purports to centralize costs for Centers-affiliated nursing homes to help them obtain competitive prices for technology goods and services (Garritano Tr. at 306-08).[97] Hagler is the 99% owner of BIS Funding; his adult son, Jonathan Hagler, owns the remaining 1% of BIS Funding (Hagler Tr. at 30).

576. In reality, BIS Funding is another entity through which Respondents Rozenberg and Hagler siphon up-front profit out of the Nursing Homes. Though Hagler and his son own BIS Funding, Centers maintains BIS Funding's books and records (Hagler Tr. at 34); BIS Funding has no employees.

[97] On September 14, 2021, Centers Director of Accounting Avi Garritano testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of his testimony is hereto annexed.

577. According to Hagler, BIS Funding provides software-related services to nursing homes and does not provide information technology hardware or equipment (Hagler Tr. at 32). Hagler claimed that BIS Funding receives invoices from the various vendors who provide services to Centers-affiliated nursing homes and bills those amounts back at cost – without any markup or fee – to the respective nursing homes (Hagler Tr. at 31-32).

578. However, no contracts or written agreements exist between the Nursing Homes, or between any Centers-affiliated nursing home in New York – and BIS Funding (*see* Pettigrew Aff. ¶ 141, Exh. 135; ¶ 142; Hagler Tr. at 33).

579. Nevertheless, from October 2019 through July 2021, 57 nursing homes, including over 45 Centers-affiliated nursing homes (including the Nursing Homes), paid BIS Funding approximately $17.2 million. Yet, BIS Funding spent merely $4.5 million on information technology, software, or communications expenses (*see* Waldropt Aff. ¶¶ 77-78). Thus, either BIS Funding did not provide the goods and/or services it billed for, or it charged these nursing homes an exorbitant mark up.

580. The only documents memorializing the purported goods or services BIS Funding allegedly delivered to or performed at the Nursing Homes are invoices with generic descriptions, such as "Custom Software Development" and "Major Moveable Equipment Purchases." Some BIS Funding invoices are marked "management fees," and other invoices have blank descriptions (*see* Waldropt Aff. ¶ 79). Centers employees generated these generic invoices (Garritano Tr. at 314-15).

581. From September 2019 through April 2022, the Nursing Homes alone paid BIS Funding over $3.3 million.

582. From September 2019 through April 2022, BIS Funding invoiced Holliswood for $1,112,620.42 in purported goods and services:

Invoice Description	Amount Billed
Software Developing Staffing	$301,846.76
Custom Software Development	$196,355.63
Software Rental Fees	$194,876.15
Computer Rental	$176,077.02
Major Moveable Equipment Purchases	$101,198.38
Management Fees	$97,101.46
Blank	$45,165.02
Total	**$1,112,620.42**

(Rhody Aff. ¶ 91). BIS Funding's invoices to Holliswood contain no additional detail beyond the descriptions listed in the above chart (*id.*).[98] Of the total amount reflected on the invoices, Holliswood had paid BIS Funding $960,598.94 as of April 2022 (Rhody Aff. ¶ 90).

583. From January 2019 through April 2022, Beth Abraham transferred $1,308,216 to BIS Funding (Waldropt Aff. ¶ 76). Again, BIS Funding produced only generic invoices that purported to justify that amount in goods and/or services purportedly provided to Beth Abraham.

584. The veracity of the BIS Funding invoices issued to Beth Abraham is undercut by Beth Abraham's former administrator, who testified that he had never heard of BIS Funding and could not name any service it provided (Blackstein Tr. at 292-98)

[98] A complete analysis of the goods and services that BIS Funding purportedly provided to Holliswood could not be performed because counsel for BIS Funding objected to producing the necessary records as "irrelevant, overly broad, unduly burdensome, duplicative, and palpably improper" (Pettigrew Aff. ¶ 114, Exh. 108, ¶ 141, Exh. 135; ¶ 142). Because this baseless objection hampered Petitioner's investigation, BIS Funding should be precluded from introducing any evidence of services purportedly rendered to the Nursing Homes.

585. From September 2019 through March 2022, BIS Funding billed Buffalo Center over $750,000:

Invoice Description/Invoice Item	**Amount**
Software Developing Staffing	$210,202.76
Software Rental Fees	$146,844.54
Computer Rental	$105,308.32
Custom Software Development	$74,466.18
Major Moveable Equipment Purchases	$72,605.38
Management Fees	$71,634.60
Unknown/Blank	$37,531.85
Software Developing	$36,641.85
Grand Total	**$755,235.48**

Of that total, Buffalo Center paid BIS Funding $690,498 (Giacoia Aff. ¶¶ 41-42).

586. According to Martine Center's cash disbursement journal, between October 2019 and December 2020, Martine paid BIS Funding $345,000 (*see* Winslow Aff. ¶ 125). According to the invoices that BIS Funding produced, between September 2019 and January 2021, BIS Funding billed Martine Center a total of $347,505 for purported goods and/or services. BIS Funding's invoices contained generic descriptions, such as computer rental, custom software development, major moveable equipment purchases, software developing staffing, software rental fees, and management fees. The management fees were billed in a single BIS invoice dated December 31, 2019, and totaled $79,226 (*see* Winslow Aff. ¶ 126).

587. As with Beth Abraham, Martine Center's Administrator testified that he had never heard of BIS Funding nor did he believe that BIS Funding provided any services to Martine Center (Weisz [3/31/22] Tr. at 117-18).

588. Even though BIS Funding's invoices mention "Computer Rental" and "Major Moveable Equipment Purchases," Hagler testified that BIS Funding does not supply physical computers or equipment (Hagler Tr. at 32).

589. The false and/or fraudulent nature of the BIS Funding invoices is further illustrated by the fact that the Nursing Homes were paying another vendor for IT services, HOCS Consulting, in addition to paying BIS Funding purportedly for the same services.

590. While BIS Funding charged the Nursing Homes for "management fees" related to IT services, the Nursing Homes also paid Centers for managing their IT services (*see* Budimir Aff. ¶ 25, f.n. 5, Exh. 1a to 1d).

591. The Nursing Homes also paid a third company, HOCS Consulting, to provide IT support. According to HOCS Consulting's website, the information technology company provides "everything from servers, virtualization, remote access, backup, cyber-security, all the way down to printers and keyboards not working and everything in between."[99] In addition to contracting with the Nursing Homes for these services, HOCS Consulting also provides IT services to Centers itself (Garritano Tr. at 126-27).

592. From January 2019 through December 2020, Martine Center paid HOCS Consulting $42,058 for major moveable equipment and an additional $6,242 for other services, supplies, and minor equipment. During this time, Martine Center also paid Hewlett Packard

[99] HOCS Consulting, About Us, https://www.hocsinc.com/about-us (last visited Nov. 29, 2022).

$38,568 for a business lease agreement for hardware installed by HOCS Consulting (*see* Winslow Aff. ¶¶ 130-31).

593. Similarly, Beth Abraham paid $78,376 to HOCS Consulting from 2019 to March 2022 (Waldropt Aff. ¶ 80); Holliswood paid HOCS Consulting $101,963.89 from 2019 to 2021 (Rhody Aff. ¶ 95); and Buffalo Center paid HOCS Consulting $13,343 in 2019 (Giacoia Aff. ¶ 43).

594. During the period when the Nursing Homes paid BIS Funding for the purported services reflected on the BIS Funding invoices, BIS Funding transferred over $3.5 million to Hagler's personal bank account (*see* Waldropt Aff. ¶ 77).

595. The Nursing Homes' payments to BIS Funding were merely another conduit for Daryl Hagler to covertly siphon funds out of the Nursing Homes as up-front profit for his personal benefit to the detriment of the Nursing Homes' residents and staff.

ii. Respondents Caused the Nursing Homes to Pay Over $2.3 Million to Skilled Staffing, a Company Owned by Rozenberg's Daughter, for Management and Consulting Services that Were Not Performed

596. Respondents caused the Nursing Homes to pay another Related Party, Skilled Staffing, a staffing agency majority owned by Kenneth Rozenberg's daughter, Shoshana Areman,[100] for spurious "management" and "consulting" services. These funds were then paid out to Respondents, Centers executives, and their families, even though those recipients had no connection to Skilled Staffing. Respondents' use of Skilled Staffing to drain more up-front profit from the Nursing Homes worsened resident care at the Nursing Homes.

[100] Records produced by M&T Bank for a Skilled Staffing bank account list Elisabeth Farkas as the 100% owner of Skilled Staffing, as of November 16, 2017 (Giacoia Aff. ¶ 33). However, a Paycheck Protection Program loan application for Skilled Staffing dated May 22, 2020, lists Shoshana Areman as its 82% owner and Farkas as its 18% owner (*see* Budimir Aff. ¶ 29, Exh. 49s).

597. From December 2017 to October 2021, Skilled Staffing received approximately $38.5 million, more than 90% of which came from Centers-affiliated nursing homes. These payments were not exclusively for staffing. In fact, from 2018 through 2020, Centers-affiliated nursing homes paid $5.6 million to Skilled Staffing for "consulting" or "management" services (Giacoia Aff. ¶¶ 35-37). The Nursing Homes, of course, also pay Centers for consulting and management. These duplicative payments, like with BIS Funding, are evidence that the payments were not made in exchange for any actual service, but were instead a means of transferring money away from resident care to Respondents' pockets.

598. Specifically, under the "Consulting Services Agreements," the Nursing Homes pay Centers to provide the following nursing management and/or consulting services:

- Staffing, including "furnish[ing] sufficient part-time temporary licensed skilled professional staff for the health care activities described herein, and as otherwise required by [the] facility[;]"
- Operational consulting;
- "[S]chedule coordination with Nursing and other departments-managing and monitoring hours, processing hours and payroll, processing of payroll reports, communication of time clock data to all pertinent parties[;]" and
- "Clinical Consulting Services," including providing advice and assistance to the administrative function of the Therapy, Social Services and Nursing Departments, developing operating policies and procedures, rules, and methods of operation appropriate to such departments, and recommending procedures to ensure the consistency and quality of all the services to be provided by Centers.

(Budimir ¶ 25 Exh. 1a-1d; O'Leary Aff. ¶ 36).

599. Thus, the management and consulting services that Skilled Staffing purported to provide were duplicative of the services that the Nursing Homes were already paying Centers to provide. Either Skilled Staffing did not actually deliver the services for which the Nursing Homes paid or Skilled Staffing provided unnecessary services. Either way, Skilled Staffing is another

way through which Rozenberg covertly channels government healthcare funds from the Nursing Homes to his relatives.

600. Also, like BIS Funding, no contracts exist between the Nursing Homes and Skilled Staffing, despite that it was allegedly providing staffing, consulting, and/or management services (*see* Pettigrew Aff. ¶ 115, Exh. 109).

601. Despite the total lack of documentation, from December 28, 2018, through February 29, 2022, Respondents transferred approximately $1.8 million from Buffalo Center to Skilled Staffing. This sum mainly consisted of two large payments of $980,000 in December 2018 and $700,000 in December 2019, which were categorized in Skilled Staffing's general ledger as "management income." Buffalo Center also paid Skilled Staffing $37,033 in 2020 and $64,256 in 2021, which Skilled Staffing's invoices described only as for "Quarterly Management/Consulting." However, there are no written invoices documenting the services provided in exchange for these payments (Giacoia Aff. ¶ 38).

602. From January 2020 through October 2021, Skilled Staffing invoiced Holliswood Center $170,477.90 for "Quarterly Management/Consulting" services, which Holliswood paid. Demonstrating the false and fraudulent nature of these invoices, during this 20-month period, Holliswood paid Skilled Staffing on three occasions before Skilled Staffing had even issued an invoice to Holliswood. In addition, Holliswood *never* hired staff through Skilled Staffing, so it is unclear exactly for what "quarterly management/consulting" Holliswood would have paid (*see* Rhody Aff. ¶¶ 93-94).

603. Likewise, Martine Center paid Skilled Staffing $107,303 in "management fees" from January 2020 through October 2021, yet during that time, it provided no staff to the facility

(*see* Winslow Aff. ¶¶ 133-35). For that reason, it is questionable whether Skilled Staffing provided any service in exchange for those payments during those years.

604. Beth Abraham also paid Skilled Staffing $247,725 in "management fees" between January 2020 and October 2021 (Waldropt Aff. ¶ 65).

605. Skilled Staffing's general ledger demonstrates that Respondents used Skilled Staffing to siphon funds from Centers-affiliated nursing homes to themselves. Although Skilled Staffing is owned by Rozenberg's daughter on paper, the true beneficiaries of the entity are Rozenberg, his wife, Beth Rozenberg, and other Centers executives. For instance, from March 2019 through January 2021, Skilled Staffing recorded $5,071,000 in checks written to "Mrs. Rozenberg." These funds were deposited into two bank accounts jointly held by Rozenberg and Beth Rozenberg (Giacoia Aff. ¶ 35).

606. On December 28, 2018, Buffalo Center and another Centers-affiliated nursing home, Schenectady Center, deposited a total of $1.98 million into Skilled Staffing's bank account. Skilled Staffing's general ledger records these payments as "management income." Less than three months later, on March 19, 2019, Skilled Staffing wrote a $1.98 million check to Beth Rozenberg, which Skilled Staffing's general ledger recorded as a "draw" to "KR." Plainly, "KR" is Kenneth Rozenberg (Giacoia Aff. ¶ 36).

607. The next year, on December 31, 2019, Skilled Staffing received a total of $2.34 million from various Centers-affiliated nursing homes, including Buffalo Center. Three weeks later, on January 21, 2020, Skilled Staffing wrote a $2.34 million check to Beth Rozenberg, which Skilled Staffing once again recorded in the general ledger as a "draw" to "KR" (Giacoia Aff. ¶ 36).

608. Characterizing transfers to Beth Rozenberg as a "KR draw" is highly suspicious because the word "draw" ordinarily refers to money withdrawn by the owner of an entity, yet on

paper, neither Beth Rozenberg nor Kenneth Rozenberg has an ownership interest in Skilled Staffing. In addition, Skilled Staffing's general ledger states that "S. Rozenberg" has never taken a "draw" (Giacoia Aff. ¶ 35). These facts show that while Shoshana Areman is the owner on paper, Kenneth Rozenberg is the true owner of Skilled Staffing, in that he controls it, as he does his Nursing Homes, to serve his own personal interests.

609. Rozenberg was not the only Centers executive to profit from payments by Centers-affiliated facilities to Skilled Staffing. From December 2018 through March 2021, Skilled Staffing transferred almost $3 million to several other executives at Centers and/or other Centers-related entities, including Abramchik, Sicklick, and Wolff. Skilled Staffing's 2020 general ledger categorized the payments made that year to these individuals as "consultant" fees (Giacoia Aff. ¶¶ 34, 36). However, there are no written agreements setting forth any such consulting arrangement between these executives and Skilled Staffing (*see* Pettigrew Aff. ¶ 116, Exh. 110). At least one Centers executive who received payment from Skilled Staffing, Centers Division President Aharon Lantzitsky, admitted that he is neither an owner nor an employee of Skilled Staffing, and could only guess that the 2020 funds could have been a bonus payment from Centers (Lantzitsky Tr. at 165-76).[101]

610. The payments from the Nursing Homes to Skilled Staffing are just another way that Respondents extracted up-front profit from the Nursing Homes to pad their own bank accounts, taking for themselves money that should have been used for resident care.

[101] On May 4, 2022, Centers Division President Aharon Lantzitsky testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of his testimony is hereto annexed.

iii. Respondents Caused Martine Center and Buffalo Center to Pay $1.3 Million to Related Party CFSC Downstate in Sham Management Fees that Respondents Pocketed

611. Respondents used CFSC Downstate as yet another conduit to siphon funds from the Nursing Homes under the guise of sham "management fees."

612. CFSC Downstate is owned by Rozenberg (1%), Shoshana Areman (42%), Hagler (33%), Jonathan Hagler (10%), Amir Abramchik (13%), and Deborah Abramchik (1%). However, prior to 2021, Rozenberg identified himself as the 100% owner of, and the only authorized signatory on, its bank account (Winslow Aff. ¶¶ 113-14).

613. Hagler oversees CFSC Downstate's finances, and Amir Abramchik runs its day-to-day operations (Hagler Tr. at 39-40).

614. CFSC Downstate's business purpose is unclear because Respondents have made conflicting statements about the entity. CFSC Downstate's tax filings identify the company as a "payroll" service; its bank records show that it received most of its revenue from other entities owned and/or controlled by Rozenberg, including Centers-affiliated nursing homes (Winslow Aff. ¶¶ 113, 116). Yet Hagler and Centers Director of Accounting, Avi Garritano, describe it as a "staffing agency" that provides a specialized health plan for Centers employees who have high-risk health needs (Hagler Tr. at 38; Garritano Tr. at 37-38). Nonetheless, what is clear is that Respondents used CFSC Downstate to take Medicaid dollars paid to the Nursing Homes for themselves, to the detriment of the Nursing Homes' residents.

615. The Nursing Homes and other Centers-affiliated entities repeatedly and persistently transferred to CFSC Downstate large, whole-dollar amounts that ranged from hundreds of thousands of dollars to millions of dollars, which were then transferred to the personal bank accounts of Rozenberg, Hagler, and Abramchik.

616. For example, Centers-affiliated entities, including Martine Center and Buffalo Center, transferred a net total of $7,038,000 to CFSC Downstate on three dates between December 2018 and December 2019. Each time, within weeks of the transfers into CFSC Downstate, Respondents transferred the funds to Rozenberg, Hagler, and Abramchik's personal accounts, as follows:

a. On December 24, 2018, Centers Business Office transferred $3 million to CFSC Downstate. On January 10, 2019, CFSC Downstate issued two checks signed by Rozenberg: one for $1,965,000, which was deposited into his personal account, and one for $1,035,000, which was deposited into Hagler's personal account.

b. By check dated December 27, 2018, Ontario Center, which is owned by Abramchik and managed by Centers, transferred $450,000 to CFSC Downstate. On December 31, 2018, CFSC Downstate issued a check signed by Rozenberg for $450,000, which was then deposited into Abramchik's personal bank account.

c. By check dated December 31, 2019, nine Centers-affiliated nursing homes transferred a net total of $3,588,000 to CFSC Downstate, including $750,000 from Martine Center and $495,000 from Buffalo Center. Within the next three weeks, CFSC Downstate issued three checks signed by Rozenberg, which were deposited as follows: $1,635,000 to Abramchik's personal account, $976,500 to Rozenberg's personal account, and $976,500 to Hagler's personal account.

(Winslow Aff. ¶¶ 120-23).

617. A December 31, 2019, invoice from CFSC Downstate to Martine Center describes the above-referenced $750,000 payment by Martine Center as being paid for "management fees." However, consistent with the other sham transactions described above, CFSC Downstate does not have any contracts with Martine Center. The sole documentation of any services that CFSC Downstate provided to Martine Center are invoices that show only *one* Martine Center employee was ever paid through CFSC Downstate, for her work from November 2019 through March 2020. During that time, Martine Center paid CFSC Downstate $46,155 for the employee's payroll, taxes, workers' compensation insurance, and health insurance. Yet CFSC Downstate charged Martine

Center more than 16 times the amount of the employee costs in management fees (Winslow Aff. ¶¶ 117-18).

618. In addition, Martine Center's Administrator from 2018 to 2021 testified that he had never heard of CFSC Downstate (Weisz Tr. at 118).

619. Buffalo Center, as mentioned above, paid $550,000 to CFSC Downstate in December 2019. This payment was broken into two parts in Buffalo Center's records: an amount posted as $495,000 for "management fees" and $55,000 posted as "loans & exchanges." CFSC Downstate returned the $55,000 to Buffalo Center the following month (Giacoia Aff. ¶ 30).

620. As at Martine Center, there are no contracts or invoices between Buffalo Center and CFSC Downstate, and CFSC Downstate did not produce any evidence that it paid payroll or other benefits for any Buffalo Center employees. Yet Respondents caused Buffalo Center to pay CFSC Downstate $495,000 in management fees.

621. On December 31, 2020, three Centers-affiliated nursing homes transferred $2,035,486 to CFSC Downstate (in three payments: $1,500,000, $500,000, and $35,486). On January 6, 2021, CFSC Downstate wired the exact same amount, $2,035,486, to Abramchik's personal account (Winslow Aff. ¶ 123).

622. These transfers to and from CFSC Downstate demonstrate that Respondents used this entity as a pass-through to enrich Centers executives and their family members through nursing home funds, at the expense of resident care. The millions of dollars transferred from Centers-affiliated nursing homes to CFSC Downstate failed to provide any benefit to those facilities or their residents. These transfers simply lined the pockets of Rozenberg, Hagler, and Abramchik, while hiding from DOH how much profit Respondents removed from the Nursing

Homes. These transfers also constituted repeated and persistent fraud, and conversion of government healthcare funds.

* * *

623. Through the schemes described in this section, Respondents caused the Nursing Homes to pay many millions of dollars to Related Parties owned by Rozenberg, Hagler, Abramchik, and their family members, even though those Related Parties did not provide goods, services, and/or benefits to the Nursing Homes. These schemes shared a single purpose: they enabled Respondents to convert funds from the Nursing Homes to enrich themselves at the expense of the Nursing Homes' residents.

C. Respondents Repeatedly and Persistently Committed Fraud and Violated the Law By Paying Themselves Over $2.1 Million in "Salaries" for No-Show Positions

624. Nursing home owners and operators are entitled to "reasonable compensation" for "services actually performed and required to be performed" (*see* 10 NYCRR § 86-2.25).

625. Schedule 14 of DOH Medicaid Cost Reports requires nursing homes to "[r]eport any salary (paid or imputed), fringe benefits, or other payments made to or on behalf of, which are included in the statement of expenses (Part VI, Exhibit H) ***for services rendered*** by the following: operators, relatives of operators, executive directors, administrators, assistant administrator[s] and receiver[s]" (*see* Budimir Aff. ¶ 115) (emphasis added). The Cost Reports also require nursing homes to "detail any imputed amounts for these services" (*id.*).

626. In its 2016 and 2017 Cost Reports, which were certified as true and accurate by Rozenberg, Holliswood disclosed the payment of salaries to its owners. However, as set forth below in § VIII(D)(2), despite being characterized as salaries, these appear to be sham payments wholly unconnected to the performance of any services.

627. In addition to sham "salaries" reported on its Cost Reports, Holliswood also made supplementary payments to its owners that were characterized as salaries on Holliswood's internal financial documents but were not disclosed at all on Holliswood's Cost Reports. Holliswood also paid its owners an equity withdrawal that was not disclosed on the facility's Cost Report or federal tax forms.

628. Similarly, Sicklick, an owner of Buffalo Center, received payments from Buffalo Center that were characterized as salary on Buffalo Center's internal financial documents but were not disclosed on the facility's Cost Reports or federal tax filings.

629. By failing to disclose payments and withdrawals on their facilities' Cost Reports, Holliswood's and Buffalo's owners deceived DOH. And whether disclosed or not, Holliswood's and Buffalo's owners taking of salaries was fraudulent, as they did not perform work for the facilities to justify such salaries. Moreover, these "salaries" were paid in addition to any equity withdrawals that Rozenberg, Sicklick, Kaufman, and Lerner took from Holliswood and Buffalo Center (Budimir Aff. ¶¶ 128-35, 139-40).

1. In 2016 and 2017, Respondents Paid $461,158 in "Salaries" to Owners for No-Show Administrative Jobs

630. In 2016, Respondents caused certain Centers-affiliated nursing homes to pay Rozenberg, Beth Rozenberg, and Sicklick for their purported work. In 2017, Respondents caused certain Centers-affiliated nursing homes to pay Rozenberg, Beth Rozenberg, Sicklick, Reuven Kaufman, and Leo Lerner salaries for their purported work in administrative roles for those facilities, according to Schedule 14 of the facilities' Cost Reports, as prepared by Centers, certified by Rozenberg, and filed with DOH (Budimir Aff. ¶¶ 114-23). Centers-affiliated nursing homes made similar payments to Rozenberg, Beth Rozenberg, Sicklick, Reuven Kaufman, and Leo Lerner in 2017 (*id*. ¶¶ 116-23). However, based on the number of hours purportedly worked, the

amounts of the salaries paid, and the particular job titles listed with those salaries, it is plain that these individuals did not render services to the facilities justifying such salaries.

631. In 2017, Respondents caused certain Centers-affiliated nursing homes to pay Rozenberg, Beth Rozenberg, Sicklick, Reuven Kaufman, and Leo Lerner salaries for their purported work in administrative roles for those facilities, according to Schedule 14 of the facilities' Cost Reports, as prepared by Centers, certified by Rozenberg, and filed with DOH (Budimir Aff. ¶¶ 116-23). Centers-affiliated nursing homes made similar payments to Rozenberg, Beth Rozenberg, and Sicklick in 2016 (Budimir Aff. ¶¶ 114-23). However, based on the number of hours purportedly worked, the amounts of the salaries paid, and the particular job titles listed with those salaries, it is plain that these individuals did not render services to the facilities justifying such salaries.

632. As depicted in the chart below, in 2016, six Centers-affiliated facilities, including Holliswood, paid Kenneth Rozenberg nearly $1.2 million in purported salaries for allegedly working 130 hours per week at those facilities:

Kenneth Rozenberg's 2016 Salaries from Centers-Affiliated Facilities			
Provider Name	**Salary**	**Title**	**Hours Worked Per Week**
Boro Park Center For Rehabilitation And Healthcare	$246,500	Operator	35
Bushwick Center For Rehabilitation And Healthcare	$196,040	Assistant Administrator	5
Holliswood Center For Rehabilitation And Healthcare	$192,375	Operator	35
Brooklyn Center For Rehabilitation And Residential Healthcare	$189,000	Assistant Administrator	10
Bronx Center For Rehabilitation And Healthcare	$180,500	Operator	35
Hope Center For HIV And Nursing Care	$180,500	Operator	10
Totals	**$1,184,915**		**130**

(Budimir Aff. ¶ 116).

633. As depicted in the chart below, in 2017, 9 Centers-affiliated facilities, including Holliswood, paid Rozenberg nearly $2 million in purported salaries for allegedly working 113 hours per week at those facilities:

Kenneth Rozenberg's 2017 Salaries from Centers-Affiliated Facilities			
Provider Name[102]	**Salary**	**Title**	**Hours Worked Per Week**
Boro Park Center For Rehabilitation And Healthcare	$250,000	Operator	5
Holliswood Center For Rehabilitation And Healthcare	$225,000	Operator	35
Ellicott Center For Rehabilitation And Nursing	$199,000	Assistant Administrator	10
Bushwick Center For Rehabilitation And Healthcare	$198,400	Assistant Administrator	5
Brooklyn Center For Rehabilitation And Residential Healthcare	$195,000	Assistant Administrator	10
Bronx Center For Rehabilitation And Healthcare	$190,000	Operator	35
Hope Center For HIV And Nursing Care	$190,000	Operator	10
Williamsbridge Center For Rehabilitation And Nursing	$190,000	Operator	2
Triboro Center For Rehabilitation And Nursing	$175,000	Operator	1
Totals	**$1,812,400**		**113**

(Budimir Aff. ¶ 116). The hours Rozenberg allegedly worked per week in 2016 and 2017 are patently unbelievable.

634. If Rozenberg, in fact, worked 113 hours per week for 9 different facilities in 2017, it would mean that he worked for those facilities over 16 hours per day, seven days per week. Had Rozenberg, in fact, worked 130 hours per week for 6 different facilities in 2016, he would have worked for those facilities over 18.5 hours per day, seven days per week. Under either scenario, Rozenberg would have little time to eat or sleep, let alone attend to the rest of his business empire, including, at the time, the duties and responsibilities of being the CEO of Centers, as well as the owner and/or operator of 30 Centers-affiliated facilities, and the owner of several other companies

[102] All of the nursing homes in this chart will be described below with a shortened name (*e.g.*, Boro Park Center For Rehabilitation and Healthcare will be called "Boro Park Center").

in the healthcare industry including Centers Plan for Healthy Living, the largest managed long-term care plan in New York State, and SeniorCare, one of New York State's largest privately owned ambulance companies (*see* Budimir Aff. ¶ 24, Exhs. 57-59).

635. Moreover, the amounts of each of Rozenberg's "salaries" appear to be disconnected from the hours Rozenberg allegedly worked. For example, as listed in the above chart, in 2017, Holliswood paid Rozenberg $225,000 for purportedly working 35 hours a week as an "operator," while Boro Park Center paid him even more money ($250,000) for working a fraction of those hours (5 hours per week) for the same role. Similarly, in 2016, Bronx Center paid Rozenberg $180,500 for purportedly working 35 hours per week as the "operator," while Hope Center paid him the same amount for working 10 hours per week in the same role. The same held true in 2017, when Bronx Center paid Rozenberg $190,000 for purportedly working 35 hours a week as an "operator," while Williamsbridge Center also paid him $190,000 for only 2 hours of purported work per week for the same role (Budimir Aff. ¶ 116, Exh. 54a-54i). In addition, Rozenberg was paid nearly $630,000 more in 2017 than 2016, even though he worked 17 fewer hours in 2017 (Budimir Aff. ¶ 116, Exh. 60a-54f). The wide disparity between the amounts Rozenberg received from the different homes for ostensibly performing the same role and rendering the same services strongly suggests that those "salaries" do not reflect compensation based on hours actually worked or upon the performance of any actual services.

636. The difference between Rozenberg's purported salaries for work as an assistant administrator in three different homes and the salaries of administrators in those same facilities also indicates that Rozenberg was not paid based on hours worked or services provided. By way of example, in 2016, Bushwick Center paid its administrator $150,100 for working 40 hours per

week, while it paid Rozenberg even more ($196,040) for purportedly working a fraction of the time (5 hours per week) in a less senior role (assistant administrator).

637. Similarly, in 2016, Hope Center paid its administrator $200,111 for working 37.5 hours per week, while it paid Rozenberg $180,500 for purportedly working 10 hours per week as an "operator" (Budimir Aff. ¶ 120, Exh. 60a-60f).

638. Indeed, it is unlikely that Rozenberg rendered any services commensurate with his job titles as listed on the Cost Reports. In 2016, Rozenberg received "salaries" for purportedly working as an "Operator" at four facilities and an "Assistant Administrator" at two facilities. In 2017, he received a "salary" from 6 facilities for which his title was "Operator" and from 3 facilities for which his title was "Assistant Administrator." Given that these facilities pay Centers to perform the staffing, procurement, admissions, marketing, billing, and finance functions, among others, at these facilities (*see* Budimir Aff. ¶ 25), and these facilities each employ their own administrators (*see* Budimir Aff. ¶ 116, 120. Exh. 54a-54i), it is unclear exactly what additional services Rozenberg personally rendered to these facilities as either the operator or an assistant administrator. Indeed, Rozenberg's role as "Assistant Administrator" is particularly dubious.

639. Assistant administrators' have undefined or amorphous responsibilities, which basically amount to doing whatever the administrator instructs, including overseeing technology, assisting with compliance, and monitoring morale (*see* Gestetner Tr. at 20-21, 29-30, 47-60). Given Rozenberg's role as the CEO at Centers, it is highly unlikely that he spent 15 hours per week in 2016 or 25 hours per week in 2017 taking direction from, or otherwise "assisting," different facilities' administrators.

640. Additionally, the notion that Rozenberg actually worked as an assistant administrator is further belied by his outsized compensation. In 2016, Bushwick Center paid

Rozenberg $196,040 for purportedly working 5 hours per week as an "assistant administrator"—which was more than Bushwick Center paid its administrator—while Bronx Center paid Rozenberg less ($180,500) for working significantly more hours per week (35) as the "operator" (Budimir Exh. 60b, 60d). For the three Centers-affiliated facilities where Rozenberg purportedly served as the assistant administrator in 2017, he was paid as much or more than these facilities' own administrators for working fewer hours: Ellicott Center paid Rozenberg $199,000 for 10 hours of work per week and its administrator $105,500 for working 35 hours per week; Bushwick Center paid Rozenberg $198,400 for 5 hours of work per week and its administrators a combined $143,924 for working 40 hours per week; and Brooklyn Center paid Rozenberg $195,000 for 10 hours of work per week and its administrator $195,000 for working 35 hours per week (Budimir Aff. ¶ 116, 120, Exh. 54a, 54f-g).

641. Purported "salaries" paid to Beth Rozenberg in 2016 and 2017 are similarly dubious. In 2016, Beth Rozenberg received a total of $13,000 for purportedly working 40 hours a week as an operator for two different facilities (Budimir Aff. ¶ 117, Exh. 60a, 60d). In 2017, Beth Rozenberg received a total of $33,571 for purportedly working 39 hours a week as an operator for four different facilities (Budimir Aff. ¶ 117, Exh. 54b-54d, 55h). It is unlikely Beth Rozenberg rendered any services to these facilities. Based upon CON documents, she retired over 25 years ago as a teacher and appears to have no experience in the healthcare area (*see* Pettigrew Aff. ¶ 129, Exh. 123 at 8). Beth Rozenberg's "salaries" also appear to have no connection to the hours she purportedly worked. In 2017, Bronx Center paid Beth Rozenberg $10,000 for purportedly working 35 hours per week, while Hope Center paid her $10,000 for purportedly working 1 hour a week (Budimir Aff. ¶ 117, Exh. 60b, 60f). As with Kenneth Rozenberg, Beth Rozenberg was paid more money in 2017 than 2016 for working fewer hours per week (Budimir Aff. ¶ 117).

642. The sham nature of these salaries is further demonstrated by the fact that Bronx Center paid Rozenberg and Beth Rozenberg wildly different amounts for ostensibly working the same number of hours in identical roles at the same facility. As per Bronx Center's 2017 Cost Report, Rozenberg and Beth Rozenberg each purportedly worked 35 hours per week as an "operator." However, despite having the same title and working the same number of hours, Bronx Center paid Rozenberg $190,000, while Beth Rozenberg was paid only $10,000.

643. At first blush, these disparities seem arbitrary. However, an analysis of the "salaries" paid to Holliswood's owners in 2016 and 2017, as disclosed on Schedule 14 of Holliswood's Cost Reports, reveals that these payments were, in fact, thinly veiled equity withdrawals bearing no apparent relationship to the number of hours purportedly worked or to any actual services rendered by the owners to the facility:

Holliswood "Salaries" Paid To Its Owners in 2016				
Name	**Ownership Interest**	**Title**	**Salary**	**Hours Per Week**
Kenneth Rozenberg	85.5%	Operator	$192,375	35
Jeffrey Sicklick	2.5%	Operator	$5,625	1
Total			**$198,000**	**36**

Holliswood "Salaries" Paid To Its Owners in 2017				
Name	**Ownership Interest**	**Title**	**Salary**	**Hours Per Week**
Kenneth Rozenberg	85.5%	Operator	$225,000	35
Reuven Kaufman	10%	Operator	$26,316	1
Jeffrey Sicklick	2.5%	Operator	$6,579	1
Leo Lerner	2%	Operator	$5,263	1
Total			$263,158	38

(Budimir Aff. ¶ 121, Exh. 54i, 60e).

644. Indeed, as set forth in the above charts, the "salaries" paid to Holliswood's owners were paid in exact proportion to their respective ownership interests. In 2017, the total "salary" pool paid to Holliswood's owners was $263,158, of which Rozenberg was paid 85.5%; Kaufman was paid 10%; Sicklick was paid 2.5%; and Lerner was paid 2% (Budimir Aff. ¶ 121). The same is true for the "salaries" paid in 2016 (*id.*). Basing "salaries" on ownership percentages also explains how Kaufman was paid so much more than Sicklick or Lerner in 2017 for purportedly working the same hours in the same role. Further evidence that these "salaries" are no more than camouflaged equity distributions can be found in the manner in which they were paid; in 2017, Holliswood paid these "salaries" to its owners in lump sums, unlike employees who are generally paid biweekly (*see id.*).

645. That Holliswood's owners worked 36 hours per week for the facility in 2016 or 38 hours for the facility in 2017 in exchange for salary, as set forth in the above charts, is unbelievable on its face. As noted above, it is unlikely Rozenberg worked 35 hours a week for Holliswood in 2016 or 2017, considering his other professional commitments.

646. Moreover, according to Holliswood employees, Rozenberg did not render any specific services to Holliswood. Holliswood's administrator testified that he had no dealings with Rozenberg and that Rozenberg had no relationship with Holliswood other than as the CEO of Centers (Liff Tr. at 25-26, 100).

647. It is similarly unlikely that Sicklick rendered any services specifically for Holliswood separate from his full-time role as the Director of Operations at Centers. In 2016, in addition to his jobs at Centers, Sicklick allegedly worked 35 hours per week as the CEO of Bronx Center (for which he was paid $268,456), and 5 hours per week as the assistant administrator at Bushwick Center (for which he was paid $2,360) (Budimir Aff. ¶ 118, Exh. 60b, 60d). Similarly,

in 2017, in addition to his jobs at Centers and Holliswood, Sicklick allegedly worked 35 hours per week as the CEO at Bronx Center (for which he was paid $268,831), 5 hours per week as an assistant administrator at Bushwick Center (for which he was paid $23,951), 5 hours per week as "Fiscal" at Ellicott Center (for which he was paid $31,250), and 1 hour per week as an operator at Triboro Center (for which he was paid $3,571) (Budimir Aff. ¶ 118, Exh. 54a, 54c, 54e, 54f). If these numbers are taken at face value, Sicklick worked 40 hours per week in 2016 and 46 hours per week in 2017 at Centers facilities *in addition* to his full-time role as Centers Director of Operations and his purported role at Holliswood. This is simply incredible.

648. It is also unlikely Reuven Kaufman rendered any services to Holliswood, since he is heavily involved in the diamond industry, including as the President and CEO of Reuven Kaufman, Inc., a diamond exporter and wholesaler, and as the President of the Diamond Dealers Club of New York (Pettigrew Aff. ¶¶ 144-45, Exhs. 137-38; ¶¶ 147-48, Exhs. 140-41).

649. Leo Lerner also likely failed to render any services to Holliswood in 2017. That year, Lerner allegedly worked 37.5 hours per week at Williamsbridge Center as the facility's administrator for which he was paid $174,808 (Budimir Aff. ¶ 123, Exh. 54b). He may have also been employed as a controller at Centers (*see* Pettigrew Aff. ¶ 146, Exh. 139 at 5).

650. That these purported salaries are no more than disguised equity payments is further evidenced by the glaring disparities in the salaries Sicklick, Kaufman, and Lerner are paid, each purportedly for a single hour of work per week. For example, in 2017, Lerner, a purported "Operator" of Holliswood, received an annual salary of $5,263, for one hour of work per week. Sicklick, also a purported "Operator" of Holliswood, received an annual salary of $6,579, also for one hour of work per week. In contrast, Kaufman, also a purported "Operator" of Holliswood, received an annual salary of $26,3162, also for one hour of work per week. Tellingly, in 2017,

Lerner held a 2% ownership interest and Sicklick held a 2.5% ownership interest, while Kaufman was a 10% Owner of Holliswood. It cannot possibly have been coincidental that these salaries are perfectly proportionate to Lerner, Sicklick, and Kaufman's ownership interests.

651. Thus, in 2016 and 2017, Holliswood's owners paid themselves $461,158 in "salaries" for which they did not render any services to facility. Instead of using those funds to support patient care, the owners used these funds to line their own pockets. As such, Respondents' representation in Holliswood's Cost Report that the owners did render services to the facility was false and these payments should be properly categorized as equity withdrawals subject to DOH's restrictions (*see* § VIII[E]).

652. That Respondents characterized these payments as "salaries," as opposed to equity withdrawals, on Holliswood's 2016 and 2017 Cost Reports is unsurprising given that nursing home owners and operators are subject to limits on equity withdrawals and may not withdraw equity above those limits without prior approval from DOH. Owners and operators may characterize salaries of up to $199,000 per year as an expense without counting those salaries against the equity withdrawal limitations, if the nursing home owner or operator "***is in fact rendering services to the facility***," (*see* Pettigrew Aff. ¶ 118, Exh. 112 at 7; *see also* § VIII[E]) (emphasis added). However, any salary paid above $199,000 per year is considered an equity withdrawal and is subject to DOH's scrutiny and equity withdrawal restrictions (*id.*), which explains why many of the "salaries" Rozenberg received are right at or just below that amount (*see* ¶¶ 635-37, 40).

2. Respondents Repeatedly Made Undisclosed Cash Payments to Owners of Holliswood and Buffalo Center

653. Not only did Holliswood's Owners receive "salaries" for work they never performed, but according to Holliswood's 2017 Cost Report, they also paid themselves additional amounts that were not disclosed to DOH or reported on federal tax documents.

654. These additional funds were identified by comparing the owners' equity withdrawals and salaries as listed on Cost Reports, and the Internal Revenue Service's Schedule K-1 tax forms[103] from each facility to payments from the facility's operating account to their owners (Budimir Aff. ¶ 128).

i. Respondents Caused Holliswood to Make $831,148 in Payments to Its Owners That Were Not Disclosed on Holliswood's Cost Reports and/or Federal Tax Forms

655. From 2017 through 2020, Respondents caused Holliswood to make $831,148 in payments to its owners that were not disclosed on Schedule 14 of Holliswood's Cost Reports (Budimir Aff. ¶ 128). Of that amount, $243,750 was also not disclosed on the owners' Schedule K-1 forms (Budimir Aff. ¶ 129).[104]

656. In 2017, Holliswood paid Rozenberg, Kaufman, and Lerner $243,750 more than was listed on Holliswood's 2017 Cost Report or Holliswood's Schedule K-1 forms:

2017 Undisclosed Equity Withdrawals by Holliswood's Owners			
Source	**Kenneth Rozenberg**	**Reuven Kaufman**	**Leo Lerner**
Total Payments from Holliswood's Bank Account	$1,080,000	$126,316	$25,263
Equity Withdrawals Reported on Schedule K-1	$641,250	$75,000	$15,000
Salary Reported on Cost Report Schedule 14	$225,000	$26,316	$5,263
Unreported Equity Withdrawal	$213,750	$25,000	$5,000
Total Unreported	**$243,750**		

(Budimir Aff. ¶ 129).

[103] Partnerships use Schedule K-1 to report partners' share of the partnership's income, among other things (*see* Internal Revenue Service, *Partner's Instructions for Schedule K-1 (Form 1065)*, 2021, available at https://www.irs.gov/pub/irs-pdf/i1065sk1.pdf).

[104] Holliswood Owner Jeffery Sicklick's reported equity withdrawals and salary slightly exceeded the amounts shown in Holliswood's bank statement. This discrepancy was $329, which decreased the total difference between bank payments and reported payments to $243,421 (Budimir ¶ 130).

657. These unreported equity withdrawals by Rozenberg, Kaufman, and Lerner are equal to a quarter of each individual's annual equity withdrawal (Budimir Aff. ¶¶ 129-30). Thus, in 2017, Holliswood's internal financial records, Cost Report, and Schedule K-1 forms all failed to report one quarterly equity withdrawal to Rozenberg, Kaufman, and Lerner (Budimir Aff. ¶¶ 129-30, Exh. 52a, 53a, 54i).

658. In 2018, Holliswood's internal financial records identified $373,977 in "salaries" paid to Kaufman, Sicklick, and Lerner that were not included in Holliswood's Cost Report:

2018 Undisclosed "Salaries" to Holliswood's Owners			
Source	**Reuven Kaufman**	**Jeffrey Sicklick**	**Leo Lerner**
Total Payments from Holliswood's Bank Account	$367,398	$98,099	$78,480
Equity Withdrawals Reported on Schedule K-1	$125,000	$25,000	$20,000
Salary Reported on Cost Report Schedule 14	$0	$0	$0
Unreported Salary	$242,398	$73,099	$58,480
Total Unreported	**$373,977**		

(Budimir Aff. ¶ 131).

659. The 2018 payments to Kaufman,[105] Sicklick, and Lerner are all characterized as "Operator Salary" expenses in Holliswood's internal financial records and are paid in amounts proportionate to Kaufman, Sicklick, and Lerner's respective ownership interests (Budimir Aff. ¶ 132). While these "salaries" were declared on Holliswood's 2018 Schedule K-1 forms,[106] they

[105] For Kaufman's undisclosed 2018 "salary," Holliswood's internal financial records and Schedule K-1 indicate that Kaufman received $50,000 more than can be identified through Holliswood's bank accounts (Budimir Aff. ¶ 132). It is unclear if this was an accounting error or if this additional $50,000 to Kaufman was paid from another account (Budimir Aff. ¶ 132).

[106] These "salaries" were declared as "guaranteed payments," which are those "made by a partnership to a partner that are determined without regard to the partnership's income." Internal

were not disclosed on Holliswood's 2018 Cost Report (Budimir Aff. ¶ 131-32, Exh. 7a pg. 54, 52b, 53b).

660. In 2019, Holliswood's internal financial records identified $168,750 in "salaries" paid to Sicklick and Lerner that were not included in Holliswood's 2019 Cost Report:

2019 Undisclosed "Salaries" to Holliswood's Owners		
Source	**Jeffrey Sicklick**	**Leo Lerner**
Total Payments from Holliswood's Bank Account	$118,750	$95,000
Equity Withdrawals Reported on Schedule K-1	$25,000	$20,000
Salary Reported on Cost Report Schedule 14	$0	$0
Unreported Salary	$93,750	$75,000
Total Unreported	**$168,750**	

(Budimir Aff. ¶ 133, Exh. 8a pg. 53, 52c, 53c).

661. The payments to Sicklick and Lerner in 2019 are characterized as "Operator Salary" expenses in Holliswood's internal financial records and are paid in proportion to Sicklick and Lerner's respective ownership interests (Budimir Aff. ¶ 133). These "salaries" were declared as guaranteed payments on Holliswood's 2019 Schedule K-1 forms, yet were not disclosed on Holliswood's 2019 Cost Report (Budimir Aff. ¶ 133).

662. In 2020, Sicklick and Lerner were paid $45,000 in "salaries" that were not included in Holliswood's Cost Report and Rozenberg was paid Kaufman's share of the declared equity withdrawal:

Revenue Service, *Publication 541 (03/2022), Partnerships*, March 2022, Publication 541 (03/2022), Partnerships | Internal Revenue Service (irs.gov).

2020 Undisclosed Payments to Holliswood's Owners				
Source	**Kenneth Rozenberg**	**Reuven Kaufman**	**Jeffrey Sicklick**	**Leo Lerner**
Total Payments from Holliswood's Bank Account	$473,720	$0	$37,401	$29,921
Equity Withdrawals Reported on Schedule K-1	$424,116	$49,604	$12,401	$9,921
Salary Reported on Cost Report Schedule 14	$0	$0	$0	$0
Unreported Equity Withdrawal or Salary	$49,604	($49,604)	$25,000	$20,000
Total Unreported	**$45,000**			

(Budimir Aff. ¶ 134, Exh. 9a pg. 53, 52d, 53d).

663. The payments to Sicklick and Lerner are characterized as "Operator Salary" expenses in Holliswood's internal financial records and are paid in proportion to Sicklick and Lerner's respective ownership interests (Budimir Aff. ¶ 134). These salaries were declared as guaranteed payments on Holliswood's 2020 Schedule K-1 forms, yet they were not disclosed on Holliswood's 2020 Cost Report (Budimir Aff. ¶ 134).

664. Further, Holliswood's bank records show that Holliswood paid Rozenberg an additional payment of $49,604 that was not listed on his Schedule K-1 form (Budimir Aff. ¶ 134). It matches the exact amount that Kaufman was supposed to receive as an equity withdrawal on Kaufman's Schedule K-1 (Budimir Aff. ¶ 134).

665. For the reasons stated above, the evidence suggests that none of Holliswood's owners rendered services to the facility in exchange for these undisclosed "salaries" and these undisclosed "salaries" should be properly categorized as equity withdrawals subject to DOH's restrictions. Respondents' failure to disclose these payments as either salaries or equity

withdrawals also represents a violation of Holliswood's Cost Report disclosure requirements (*see* § VIII[E][2]).

ii. Respondents Caused Buffalo Center to Pay Sicklick $840,000 In "Salary" That Was Not Disclosed on Buffalo Center's Cost Reports or Federal Tax Forms

666. From 2018 through 2020, Buffalo Center paid Sicklick, a 10% owner of Buffalo Center, $840,000 in "salary" that was not disclosed on Schedule 14 of Buffalo Center's Cost Reports:

Undisclosed "Salary" from Buffalo Center to Sicklick			
Source	**2018**	**2019**	**2020**
Total Payments from Buffalo Center's Purchase Journals	$240,000	$375,777	$316,930
Equity Withdrawals Reported on Schedule K-1	$20,000	$25,777	$46,930
Salary Reported on Cost Report Schedule 14	$0	$0	$0
Unreported Salary	$220,000	$350,000	$270,000
Total Unreported	**$840,000**		

(Budimir Aff. ¶ 139, Exh. 50a-50c, 51a-51c; O'Leary Exh. 33 pg. 54, 34 pg. 53, 35 pg. 53). In addition, Buffalo Center also failed to report these payments on its 2019 and 2020 Schedule K-1 forms (Budimir Aff. ¶ 139, Exh. 50b-50c).

667. The payments to Sicklick are characterized as "Assistant Administrator" expenses in Buffalo Center's internal financial records (Budimir Aff. ¶ 139). Moreover, Sicklick's work as an assistant administrator at Buffalo Center would seemingly interfere with Sicklick's roles as the Director of Operations at Centers and the "CEO" and/or administrator at Bronx Center (Budimir Aff. ¶ 33).

D. Respondents Rozenberg, Hagler, Centers, and the Nursing Homes' Owners and Operators Repeatedly and Persistently Committed Fraud and Illegality by Filing, or Causing to be Filed, False and Misleading Cost Reports to Conceal Their Self-Dealing Transactions and Payment of "Salaries" for No-Show Jobs

668. Nursing home operators are required to file annual Cost Reports to report financial information and statistics to DOH pursuant to 10 NYCRR Part 86-2. The data is used by DOH to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends.

669. When a nursing home files its Cost Report, the nursing home's operator must certify that the Cost Report is "true and complete" and must execute the following certifications:

> 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 hereby certify that I am the Operator and have read the above statement and I have examined and compared the information contained in the RHCF-4 report file ["Cost Report"] with the information provided in my electronically transmitted Department of Health file . . . and that to the best of my knowledge and belief, they are true and complete and that these files are identical.
>
> I also certify that Parts I and II were completed in accordance with the [Cost Report] instructions and that Part IV was completed in accordance with the residential Health Care Facility Accounting and Reporting Manual (RHCFARM). I also certify, the Part(s) III, if required to be filed as part of this report, was (were) completed in accordance with RHCFARM 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.

(Budimir Aff. ¶ 10).

670. As the majority member of each of the Nursing Homes' Operators, Rozenberg signed, certified, and caused the Nursing Homes' Cost Reports to be filed (*see* Budimir Aff. ¶¶ 31, 106; Winslow Aff. ¶ 59; O'Leary Aff. ¶ 100; Waldropt Aff. ¶ 35).

671. Centers prepares the Cost Reports for all the Centers-affiliated nursing homes (Hagler Tr. at 86). As CFO of Centers, Hagler oversees the preparation of the Cost Reports, including for the Nursing Homes (Hagler Tr. at 240-50). Accordingly, Hagler also causes the Nursing Homes' Cost Reports to be filed.

672. To conceal their conversion of millions of dollars from the Nursing Homes, Respondents repeatedly and persistently filed and/or caused the Nursing Homes to file fraudulent Cost Reports. In addition to misrepresenting and concealing purported salary payments to Holliswood's and Buffalo's owners in the facilities' respective Cost Reports (*see* VIII[C]), Respondents routinely failed to disclose the existence of and transactions with Related Party vendors in the Nursing Homes' annual Cost Reports in violation of 10 NYCRR Part 86-2, which sets forth regulations regarding cost reporting and rate certifications for nursing homes. In doing so, Respondents were able to conceal from DOH their business model—direct the Nursing Homes to transact business with Related Parties to siphon off government funds from the Nursing Homes for their personal benefit.

1. Respondents Repeatedly and Persistently Filed, or Caused to be Filed, False and Misleading Cost Reports that Failed to Disclose Transactions with Related Parties

673. The Cost Report and the instructions thereto require, at several points, that nursing homes disclose instances in which they transact business with Related Parties (*see* Budimir Aff. ¶ 11).

674. Cost Report Schedule 16, Section A, requires nursing homes to disclose whether they had "any Interest Expense incurred to a lender related through control ownership, affiliation, or personal relationship to the borrower" (*see* Budimir Aff. ¶ 13).

675. Schedule 16 and the instructions thereto require that every nursing home identify and list each company with which it has a "Non-Arm's Length Arrangement," for which the following definition is provided:

> An arrangement between the operator of a facility and an organization related to the 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.

(Budimir Aff. ¶ 12).

676. Schedule 16 further requires the facility to submit an audited financial statement for each Related Party identified by the nursing home (*see* Budimir Aff. ¶ 13).

677. In addition to Schedule 16, the Cost Report also requires disclosure of related parties in the sections entitled "Pre-fatory-5) Ownership Information-Related Companies" and "Part IV, Schedule of Fees and Purchased or Contracted Services – Schedule 1." In Part IV, the Cost Report requires nursing homes to designate the vendors they have paid, and to note the operator's relationship to said vendor, if one exists (whether through family, marriage, or other non-arm's-length business relationship), and to disclose how much money the nursing home paid to such vendor that year. Part IV also has a Notepad attached to the Cost Report that requires a continuation of the listing of vendors in Part IV (*see* Budimir Aff. ¶ 14).

678. As previously discussed, many of the entities with which the Nursing Homes had commercial relationships are Related Parties because the entities are owned in whole or part by Rozenberg, Hagler, and/or their family members. The following entities are Related Parties with which one or more of the Nursing Homes has done business:

ENTITY	MEMBERS
Abraham Operations Associates LLC d/b/a Beth Abraham Center for Rehabilitation and Nursing	Light Operational Holdings Associates LLC 98% (Kenneth Rozenberg 95%, Rivka Rozenberg 5%) and Rivka Rozenberg 2%
Airtac LLC	Isaac Laniado 59%, Daryl Hagler 40% and Jonathan Hagler 1%
BIS Funding Capital LLC	Daryl Hagler 99% and Jonathan Hagler 1%
CBO Funding LLC	Daryl Hagler and Kenneth Rozenberg
Centers Agency LLC d/b/a Centers Laboratory	Kenneth Rozenberg 95% and Beth Rozenberg 5%
Centers Business Office LLC (NJ)	Kenneth Rozenberg
Centers FC Realty LLC	Daryl Hagler, 50% and Kenneth Rozenberg, 50%
Centers for Care LLC d/b/a Centers Health Care; d/b/a Centers Business Office	Kenneth Rozenberg 50% and Daryl Hagler 50%
Centers Lab NJ, LLC d/b/a. MedLabs Diagnostics	Centers Lab NJ, LLC is a wholly owned subsidiary of Centers Agency LLC, which is owned by Kenneth Rozenberg 95% and Beth Rozenberg 5%
CFSC Downstate LLC	Shoshana Areman 42%, Daryl Hagler 33%, Amir Abramchik 13%, Jonathan Hagler 10%, Deborah Abramchik 1%, and Kenneth Rozenberg 1%
CFSC Maintenance LLC d/b/a ONE70 Group	Daryl Hagler 40% and Yitzy ("Isaac") Laniado 60%[107]
CFSC Syracuse LLC	Kenneth Rozenberg 100%
CFSC Upstate, LLC	Kenneth Rozenberg 100%

[107] This is the ownership structure of CFSC Maintenance LLC d/b/a ONE70 Group to which Hagler testified (Hagler Tr. at 55). A Paycheck Protection Program loan application for CFSC Maintenance LLC d/b/a ONE70 Group dated April 6, 2020, lists Hagler as its 100% owner (*see* Budimir Aff. ¶ 29, Exh. 49v). Bank records for CFSC Maintenance LLC d/b/a ONE70 Group, dated May 6, 2016, list Kenneth Rozenberg as its sole owner (*see* Budimir Aff ¶ 29, Exh. 49w).

Delaware Operations Associates LLC d/b/a Buffalo Center for Rehabilitation and Healthcare	Kenneth Rozenberg 90% and Jeffrey Sicklick 10%
Delaware Real Property Associates LLC	Daryl Hagler 99% and Jonathan Hagler 1% (Landlord of Buffalo Center)
Hollis Operating Co LLC d/b/a Holliswood Center for Rehabilitation and Healthcare	Kenneth Rozenberg 95.5%, Jeffrey Sicklick 2.5%, and Leo Lerner 2%
Hollis Real Estate Co. LLC	Daryl Hagler 90% and Moti Hellman 10%[108] (Landlord of Holliswood)
LI Script LLC	Michael Shamalov 13.68%, Daryl Hagler 26.6%, Alex Solovey 18.24%, Joseph Carillo II 18.24%, Pasquale DeBenedictis 18.24%; and Lola Tanzer 5%
Light Operational Holdings Associates LLC	Kenneth Rozenberg 95% and Rivka Rozenberg 5%
Light Property Holdings Associates LLC	Daryl Hagler 99% and Jonathan Hagler 1% (Landlord of Beth Abraham)
Light Property Holdings II Associates LLC	Daryl Hagler 99% and Jonathan Hagler 1% (Landlord of Martine)
ONE70 Services LLC	Daryl Hagler 40% and Isaac Laniado 60%[109]
Schnur Operations Associates LLC d/b/a Martine Center for Rehabilitation and Nursing	Light Operational Holdings Associates LLC 65% (Kenneth Rozenberg 95%, Rivka Rozenberg 5%), Amir Abramchik 10%, David Greenberg 10%, Elliot Kahan 10%, Kenneth Rozenberg 4%, and Sol Blumenfeld 1%
SeniorCare EMS	Michael Vatch 10%, Kenneth Rozenberg 48.85%, Jeremy Strauss 29.90%, Uri Lerner 11.25%
Skilled Staffing LLC d/b/a Kansas Staffing; Upside Dietary Services	Shoshana Areman 82% and Elisabeth Farkas 18%

[108] *See* Hagler Tr. at 19-20, 181-82; *see also* Footnote 80.
[109] This is the ownership structure of ONE70 Services LLC to which Hagler testified (Hagler Tr. at 62-64). However, bank records for ONE70 Services LLC, dated July 9, 2016, show Daryl Hagler as the sole owner (*see* Budimir Aff. ¶ 29, Exh. 49x pg. 2).

Upside Services LLC d/b/a Upside Cleaning	Kenneth Rozenberg 100%

See Budimir Aff. ¶ 29, Exh. 491-49y; Petition Exh. 28; O'Leary Aff. ¶ 107.

679. By causing the Nursing Homes to do business with Related Parties, Rozenberg and Hagler created a business model that maximizes their profits, without regard to the best interests of the Nursing Homes' residents or the Nursing Homes' financial health. The Nursing Homes receive millions of Medicaid and Medicare dollars each year, and by hiring Related-Party companies as their vendors, Respondents ensure that those funds do not leave their control. Rozenberg even signs both sides of contracts between the Nursing Homes and Centers, a Related Party (*see* Budimir Aff. ¶ 25).

680. However, Rozenberg caused the Nursing Homes to file Cost Reports that almost entirely fail to disclose transactions with these Related Parties and/or to identify these parties as Related. For example, in 2020, not one of the Nursing Homes declared any Related Parties on their Cost Reports. In fact, only one out of Rozenberg's 32 nursing homes in New York declared any Related Parties on its Cost Report (*see* Budimir Aff. ¶ 113).

681. By repeatedly failing to disclose their connections to these companies in the Nursing Homes' Cost Reports—and frequently failing to provide the Related Parties' audited financial statements—Respondents violated the law and committed fraud.

i. Holliswood Center's Failure to Identify Related Parties and Disclose Payments to Same

682. From 2014 through 2020, Respondents filed, or caused to be filed, Cost Reports for Holliswood Center that failed to identify interest expenses paid to, and "Non-Arm's Length Arrangements" with, numerous Related Parties. Respondents also filed, or caused to be filed, Cost Reports for Holliswood Center that did not attach audited financial statements for each such Related Party, as required by Schedule 16 of the Cost Reports.

683. From 2014 through 2020, Schedule 16, Section A of Holliswood Center's Cost Reports answered "no" to the question of whether there was any interest expense incurred to a lender that was related to the borrower. However, during this time, Holliswood Center paid at least $780,000 per year in interest to Hollis Real Estate Co. for the Holliswood Unsecured Loan (*see* § VIII[A][1] above). Hagler owns Hollis Real Estate Co. and is, thus, plainly "related to" the borrower. In fact, on the CON application that Rozenberg submitted to DOH to become the operator of Holliswood, he disclosed that Holliswood had a non-arm's-length lease with Hollis Real Estate Co. Nevertheless, Respondents never once identified Hollis Real Estate Co. as a Related Party in Holliswood's Cost Reports.

684. In 2015, Holliswood disclosed two Related Parties on the Prefatory section, Schedule 16, and Part IV: Centers and CFSC Agency LLC. However, Holliswood inexplicably included financial statements in Part III for Centers and CFSC Downstate (rather than CFSC Agency). Holliswood disclosed $7,870,448 in expenses to Hollis Real Estate Co. ($7,850,000); and One70 Group, LLC ($20,448), but failed to disclose that those entities are Related Parties (Budimir Aff. ¶ 110, Exh. 4a-4c).

685. In 2016, Holliswood disclosed only Centers as a Related Party in the Prefatory section, Schedule 16 and Part III of its Cost Report, thereby omitting several Related Parties with which Holliswood did business, including Hollis Real Estate Co. and CFSC Downstate, which together received a total of $7,849,970 from Holliswood (Budimir Aff. ¶ 110, Exh. 5a-5c).

686. In 2017, Holliswood disclosed only Centers as a Related Party in the Prefatory section, Schedule 16, and Part III of its Cost Report, thereby omitting payments totaling $13,584,032 to the following Related Parties: CFSC Downstate, LLC ($252,847); Centers FC Realty, LLC ($78,034); Hollis Real Estate Co. ($6,026,112); LI Script, LLC ($510,881); One70

Group, LLC ($279,001); and other Centers-affiliated nursing homes ($6,437,157). Finally, although Rozenberg disclosed payments to CFSC Downstate in Part IV, he failed to identify that it was a Related Party (Budimir Aff. ¶ 111).

687. In 2018, Holliswood's disclosed only Centers as a Related Party in the Prefatory section and Schedule 16. However, unlike in previous years, Holliswood failed to attach an audited financial statement for Centers to Part III of its Cost Report. Holliswood also failed to disclose that it paid $5,791,073 to the following Related Parties: CFSC Downstate ($270,889); Hollis Real Estate Co. ($5,028,288); LI Script ($343,721); One70 Group ($97,976); One70 Services ($1,200); Centers FC Realty ($38,377); Fulton Center ($50); and SeniorCare EMS ($10,572). Finally, although Holliswood disclosed payments to CFSC Downstate and SeniorCare EMS in Part IV, it failed to disclose that these entities were Related Parties (Budimir Aff. ¶ 111).

688. In 2019, Holliswood Center did not list *any* Related Parties in *any* section of the Cost Report. The Cost Report failed to disclose that Holliswood paid $10,278.213 to the following Related Parties: Centers ($2,366,378); BIS Funding ($146,228); CFSC Downstate ($182,015); Centers Business Office ($1,426,701); Centers FC Realty, LLC ($35,283); Centers Lab ($20,150); Hollis Real Estate Co. ($5,220,636); LI Script, LLC ($297,196); One70 Group, LLC ($71,718); other Centers-affiliated nursing homes ($508,917); and SeniorCare Ambulance ($2,991). Finally, although the Cost Report discloses payments in Part IV to Centers, CFSC Downstate, Centers Business Office, Centers Lab, and SeniorCare Ambulance, it does not disclose that these entities are Related Parties (Budimir Aff. ¶ 111).

689. In 2020, Holliswood Center again did not list *any* Related Parties in *any* section of the Cost Report. The Cost Report failed to disclose that Holliswood paid $11,036,672 to the following Related Parties: Centers ($2,310,889); BIS Funding ($437,922); CFSC Downstate

($51,328); Centers Business Office ($664,062); Centers Business Office, LLC (NJ) ($1,095,323); Centers FC Realty, LLC ($32,705); Centers Lab ($43,490); Hollis Real Estate Co. ($2, 571,282); LI Script, LLC ($425,365); Centers Lab NJ, LLC[110] ($162,900); One70 Group, LLC ($95,381); other Centers-affiliated nursing homes ($3,055,485); SeniorCare Ambulance ($7,455); and Skilled Staffing ($83,085). Finally, although Rozenberg disclosed, in Part IV, payments to Centers, CFSC Downstate, Centers Lab, Centers Lab, Centers Lab NJ, and SeniorCare Ambulance, he failed to disclose these entities as Related Parties (Budimir Aff. ¶ 111).

690. In 2021, Holliswood Center's Cost Report listed three Related Parties on the Prefatory section: Centers, Centers Business Office NJ, and Centers Lab. However, Holliswood Center did not disclose these parties or any other Related Parties on Schedule 16 or submit financials for Part III. Moreover, the Cost Report failed to disclose that Holliswood paid $3,723,139 to additional Related Parties: Hollis Real Estate Co. ($2,437,759); CFSC Downstate ($95,941); Skilled Staffing ($87,393); Centers FC Realty LLC ($29,732); BIS Funding ($376,450); LI Script LLC ($279,689); One70 Group ($369,206); other Centers-affiliated nursing homes ($32,901) and Centers Lab NJ ($14,068) (Budimir Aff. ¶ 111).

ii. Beth Abraham's Failure to Disclose Related Parties

691. From 2018 through 2021, Rozenberg, Hagler, Centers, and Beth Abraham's Operator and Owners repeatedly and persistently committed fraud by filing, or causing to be filed, false and misleading Cost Reports on behalf of Beth Abraham. Beth Abraham's Cost Reports for these years are false because they (1) omitted Related Parties in certain sections and, (2) in other sections, acknowledged having made payments to certain entities, but failed to disclose that those entities were Related Parties, and (3) understated the amounts of money paid to such vendors.

[110] Centers Lab NJ, LLC d/b/a MedLabs Diagnostics.

692. In Beth Abraham Center's 2018 Cost Report, the only Related Party disclosed was Centers, in the Prefatory section and in Part IV, and in certain entries in the General Notepad. In 2019, Beth Abraham's Cost Report was blank in the Prefatory section but disclosed Centers, Centers Business Office NJ LLC, and Centers Lab in Part IV, and in the General Notepad. In 2020, Beth Abraham's Cost Report did not disclose any Related Parties in the Prefatory section or Part IV. In 2021, Beth Abraham's Cost Report disclosed Centers, Centers Business Office NJ LLC, and Centers Lab in the Prefatory section and Part IV, and inconsistently disclosed Centers in the General Notepad (*see* Waldropt Aff. ¶¶ 95-98).

693. Beth Abraham Center's 2018, 2019, 2020, and 2021 Cost Reports did not disclose Beth Abraham's landlord, Light Property, as a Related Party in either the Prefatory section or Schedule 16, despite the fact that Hagler owns Light Property (*see* Waldropt Aff. ¶ 98, 100). In fact, on the CON Rozenberg submitted to DOH when he applied to become the licensed owner of Beth Abraham, Rozenberg disclosed that Beth Abraham Center had a non-arm's length lease with Light Property. Nevertheless, Respondents never once identified Light Property as a Related Party in the Beth Abraham Cost Reports.

694. Likewise, Beth Abraham Center's Cost Reports from 2018 through 2021 disclosed payments to the following vendors in Part IV but failed to disclose Beth Abraham's Related-Party relationship to them: Airtac; MedLabs; One70 Group; One70 Services LLC; SeniorCare; SeniorCare Emergency Medical Services; and Skilled Staffing (*see* Waldropt Aff. ¶ 99).

695. In all four years, Beth Abraham left Schedule 16 entirely blank, failing to disclose any of the Related Parties listed above in ¶¶ 692-93. Beth Abraham also failed to attach the audited financial statements for any Related Party to its Cost Reports.

696. From 2018 through 2021, on Schedule 16, Section A of the Cost Reports, Beth Abraham always answered "no" to the question of whether there was any interest expense incurred to a lender that was related to the borrower. However, during this time, Beth Abraham paid at least $3,294,775 in interest to Light Property on the Light Property-Abraham Operations Note.

697. In Beth Abraham's 2019 and 2021 Cost Reports, even where Beth Abraham disclosed its relationship to certain vendors, it understated the money Beth Abraham paid to Related Parties by $2.9 million in 2019 and over $774,000 in 2021. In 2020, Rozenberg failed to identify those same parties as related *and* understated the money Beth Abraham Center paid to them by over $3.3 million (*see* Waldropt Aff. ¶ 102).

iii. Martine Center's Failure to Disclose Related Parties

698. From 2018 through 2021, Rozenberg, Hagler, Centers, and Martine Center's Operator and Owners repeatedly and persistently committed fraud by filing, or causing to be filed, false and misleading Cost Reports on behalf of Martine Center. Martine Center's Cost Reports for these years are false and misleading because they omit disclosure of several entities with which Martine Center conducted business that were Related Parties due to common ownership, family relationships, or other business relationships.

699. From 2018 through 2021, Schedule 16 of Martine Center's Cost Reports listed no response to the question of whether there was any interest expense incurred to a lender that was related to the borrower. However, during this time, Martine Center paid interest to Light Property II under the Light Property II-Schnur Note (*see* p. 182). Hagler owns Light Property II and is, thus, plainly "related to" the borrower. In fact, on the CON that Rozenberg submitted to DOH when he applied to become the licensed owner of Martine Center, Rozenberg disclosed that Martine Center had a non-arm's length lease with Light Property II (*see* Winslow Aff. ¶¶ 103, 136-37).

700. In Martine Center's 2018 Cost Report, the only Related Party disclosed was Centers, in the Prefatory section. Even then, Martine Center failed to attach to the 2018 Cost Report an audited financial statement for Centers, as required by Part III. In addition, the Cost Report failed to disclose Light Property II, Skilled Staffing, and SeniorCare Transportation as Related Parties (*see* Winslow Aff. ¶ 137).

701. Martine Center's 2019 Cost Report disclosed Centers and Centers Lab as Related Parties in Part IV, but once again, failed to attach those companies' audited financial statements. The 2019 Cost Report again failed to disclose that Light Property II, CFSC Downstate, Skilled Staffing, and SeniorCare Transportation are Related Parties (*see id.*).

702. Martine Center's 2020 Cost Report failed to disclose any Related Parties, and thus failed to attach audited financial statements to Part III, despite disclosing payments to following entities in Part IV, all of which are undisclosed Related Parties: Centers, Light Property II, MedLabs, CFSC Downstate, One70 Group, Skilled Staffing, Centers Lab, Centers Business Office NJ, and SeniorCare Transportation (*see id.*).

703. Martine Center's 2021 Cost Report disclosed Centers, Centers Lab, and Centers Business Office NJ as Related Parties, but failed to attach audited financial statements for them. However, the Cost Report failed to disclose Light Property II, MedLabs, and Skilled Staffing as Related Parties (*see id.*).

iv. Buffalo Center's Failure to Disclose Related Parties

704. From 2016 through 2021, Rozenberg, Hagler, Centers, and Buffalo Center's Operator and Owners repeatedly and persistently committed fraud by filing, or causing to be filed, false and misleading Cost Reports on behalf of Buffalo Center. Buffalo Center's Cost Reports for these years are false and misleading because they omit disclosure of several entities with which

Buffalo Center conducted business that were Related Parties due to common ownership, family relationships, or other business relationships.

705. Buffalo Center's Cost Reports from 2016 to 2021 failed to disclose Buffalo Center's Landlord, Delaware Real Property, as a Related Party in Schedule 16 (*see* O'Leary Aff. ¶ 110).

706. Moreover, Delaware Real Property provided staffing agency services to Buffalo Center from 2018 through 2021 (Hagler Tr. at 157-58). While Buffalo Center did disclose the payments to Delaware Real Property for such services in Part IV in those years, it failed to identify Delaware Real Property as a Related Party (*see* O'Leary Aff. ¶ 113).

707. In Buffalo Center's 2018 through 2021 Cost Reports, Part IV disclosed large expenditures for Skilled Staffing totaling $1,711,289 but failed to disclose Skilled Staffing as a Related Party (*see* O'Leary Aff. ¶¶ 113-15).

708. Similarly, Buffalo Center's 2019 Cost Report disclosed in Part IV payments to CFSC Syracuse and CFSC Downstate totaling $720,000 but again failed to disclose these entities as Related Parties (*see* O'Leary Aff. ¶¶ 114-15).

709. Buffalo Center's 2020 and 2021 Cost Reports disclosed that payments were made to CFSC Upstate totaling $55,230 for both years, but again both Cost Reports failed to disclose it as a Related Party (*see* O'Leary Aff. ¶ 116; Giacoia Aff. ¶ 29).

710. Buffalo Center's Cost Reports from 2016 through 2020 disclosed payments to Centers in Part IV. However, in 2019 and 2020, the Cost Reports failed to disclose Centers as a Related Party in Part IV or Schedule 16 (*see* O'Leary Aff. ¶ 109).

711. Similarly, Buffalo Center's 2018 and 2021 Cost Reports listed the payments made by Buffalo Center to Upside Services LLC but failed to disclose it as a Related Party (*see* O'Leary Aff. ¶¶ 113-15).

712. Finally, Buffalo Center's 2020 Cost Report failed to list MedLabs and Centers Business Office NJ in Schedule 16 and failed to list as Related Parties the other Centers-affiliated facilities to which Buffalo Center transferred money (*see* O'Leary Aff. ¶¶ 111, 113-15).

* * *

713. In the instances described above, Respondents Rozenberg, Hagler, Centers, and the Nursing Homes' Owners and Operators directed the Nursing Homes to contract with companies that were related to, or had non-arm's-length relationships with, Rozenberg and Hagler, and yet Respondents repeatedly failed to disclose those companies as Related Parties in the Nursing Homes' Cost Reports.

714. In so doing, Respondents misrepresented their financial gains from the Nursing Homes – and in the many instances where Respondents failed to file audited financial statements for Related Parties, they hid those companies' financial gains as well. Respondents also hid from DOH and the public their profits and income generated through self-dealing. Accordingly, the Nursing Homes have, for years, paid millions of government healthcare dollars to vendors seemingly chosen based on nothing more their relationship to Rozenberg and Hagler – not on their competitive price or top-quality service – without any scrutiny or oversight and to the detriment of residents.

2. Respondents Repeatedly and Persistently Filed, or Caused to be Filed, False and Misleading Cost Reports That Mischaracterized or Failed to Disclose Owner "Salaries" for No-Show Jobs

715. As noted above, Schedule 14 of DOH Cost Reports require nursing homes to report any salaries or other payments made to operators, relatives of operators, executive directors, administrators, and assistant administrators for services rendered to the facility.

716. In 2016, Rozenberg, Hagler, Centers, and Holliswood Center's Operator and Owners claimed, on Schedule 14 of Holliswood's annual Cost Report, that Rozenberg and Sicklick worked 36 hours per week for the facility and were each paid $198,000 in salaries. As previously discussed, these payments do not appear to be legitimate salaries for services rendered, but rather, sham payments for no-show jobs (*see* above § VIII[C]). This is further evidence that, in 2016, Respondents filed, or caused to be filed, a false and misleading Cost Report for Holliswood.

717. In 2017, Rozenberg, Hagler, Centers, and Holliswood Center's Operator and Owners claimed on Schedule 14 of Holliswood's annual Cost Report that its owners collectively worked 38 hours per week for the facility and were paid $263,158 in salaries). As detailed above, these payments do not appear to be legitimate salaries for services rendered, but rather, sham payments for no-show jobs (*see* above § VIII[C]). In addition, Respondents failed to disclose an equity withdrawal from the facility paid to Rozenberg, Kaufman, and Lerner in Holliswood's 2017 Cost Report (*see* below § VIII[E]). This is further evidence that, in 2017, Respondents filed, or caused to be filed, a false and misleading Cost Report for Holliswood.

718. From 2018 to 2020, Holliswood made payments to Kaufman, Sicklick, and Lerner that were not disclosed on Holliswood's Cost Reports as either salaries or equity withdrawals (*see* above § VIII[C]). Similarly, from 2018 to 2020, Buffalo Center made payments to Sicklick that were not disclosed on Buffalo Center's Cost Reports as either salaries or equity withdrawals (*see*

above § VIII[C]). This is further evidence that, from 2018 through 2020, Respondents filed, or caused to be filed, a false and misleading Cost Report for Holliswood.

3. Respondents Filed, or Caused the Nursing Homes to File, Cost Reports that Falsely Certified that Expenses that Were Incurred to Provide Patient Care in the Facility

719. As previously discussed, when a facility operator files a Cost Report with DOH, the facility operator must sign the Operator's Certification. In addition to the attestation in the Operator's Certification that all information contained in the Cost Report is "true and complete," the operator must attest that all salary and non-salary expenses presented in the Cost Report, with limited exceptions, were "incurred to provide patient care in the facility." This certification reads as follows:

> 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 Ship, 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*.

(Budimir Aff. ¶ 10, emphasis added).

720. Rozenberg signed the above certification on each of the Nursing Homes' relevant Cost Reports (*see* Budimir Aff. ¶ 106; O'Leary Aff. ¶ 100; Waldropt Aff. ¶¶ 5, 35; Winslow Aff. ¶ 59). As detailed below, Rozenberg's certifications were false because many of the costs presented in the Cost Report were not incurred to provide patient care in the facility.

i. Holliswood Center's False Certifications

721. On Holliswood Center's Cost Reports from 2014 through 2020, Rozenberg falsely certified that the costs disclosed were incurred to provide patient care at Holliswood Center. Yet, Holliswood's Cost Reports for those years disclose costs that were not used for patient care, such as the excessive "rent" payments to Hollis Real Estate Co., the payments to Hollis Real Estate Co.

under the Holliswood Unsecured Loan, the payments to BIS Funding and Skilled Staffing, and the 2016 and 2017 "salaries" paid to Holliswood's owners for no-show jobs.

ii. Beth Abraham's False Certifications

722. On Beth Abraham Center's 2018-2021 Cost Reports, Rozenberg falsely certified that the costs disclosed were incurred to provide patient care at Beth Abraham. Yet, Beth Abraham's Cost Reports for those years include certain expenses that were not incurred to provide patient care in the facility, including inflated "rent" and loan payments to Light Property, and the payments to BIS Funding.

iii. Martine Center's False Certifications

723. On Martine Center's Cost Reports from 2018 through 2020, Rozenberg falsely certified that the costs disclosed were incurred to provide patient care at Martine Center. Yet, Martine Center's Cost Reports for those years include certain expenses that were not incurred to provide patient care in the facility, including inflated "rent" and loan payments to Light Property II, the payments of sham management fees to CFSC Downstate and Skilled Staffing, and the payments to BIS Funding.

iv. Buffalo Center's False Certifications

724. On Buffalo Center's Cost Reports from 2016 through 2021, Rozenberg falsely certified that the costs disclosed were incurred to provide patient care at Buffalo Center. Yet, Buffalo Center's Cost Reports for those years include certain expenses that were not incurred to provide patient care in the facility, including inflated "rent" and loan payments to Delaware Real Property, the payments to of sham management fees to CFSC Downstate and Skilled Staffing, and the payments to BIS Funding.

* * *

725. As detailed above, Respondents repeatedly and persistently committed fraud by filing, and/or causing the Nursing Homes to file, Cost Reports with false certifications signed by Rozenberg.

E. Respondents Repeatedly and Persistently Violated Equity Withdrawal Limits and Disclosure Obligations

726. To conceal their conversion of millions of dollars in profit, the Nursing Homes' Operators repeatedly and persistently violated state law limiting equity withdrawals by nursing home owners and in so doing, deceived DOH. *See* Pub. Health Law § 2808(5)(c); 10 NYCRR § 400.19; *Brightonian*, 21 NY3d 570 (2013). Respondents did so while they failed to provide legally required care to the Nursing Homes' residents.

727. New York Public Health Law prohibits nursing homes from "withdraw[ing] equity or transfer[ring] assets which in the aggregate exceed three percent of such facility's total reported annual revenue for patient care services" for the previous year without prior written approval from the Commissioner of DOH. *See* PHL § 2808(5)(c). Total reported annual revenue for patient care services is listed in the previous year's Cost Report for the facility (*see* Pettigrew Aff. ¶ 118, Exh 112).

728. DOH regulations define "withdrawal" broadly to "include, ***but not be limited to***, the following examples:

> (i) any transfer of a facility's cash or other assets directly or indirectly to or for the benefit of its operator;
>
> (ii) expenditures of the facility's assets or equity for personal items not recognized as reimbursable under the state's medical assistance program;
>
> (iii) any liability incurred within any period of time required for financial reporting in accordance with Part 86 of this Title by a facility or its operator by reason of a mortgage, lease, borrowing or other transaction relating to such a facility that exceeds, in the aggregate, $50,000;

> (iv) any non-arm's length or related party loans made by the facility or its operator, including loans to any individual, corporation, partnership, or other organization related to the facility within the meaning of 'related organization,' as that term is defined in [10 NYCRR §] 451.229[111] . . . ; [and]
>
> (v) payment to the operator or owner of a salary in excess of the maximum amount allowed for reimbursement purposes by the Department of Health."

10 NYCRR § 400.19(a)(3) (emphasis added).

729. To receive DOH approval for an equity withdrawal greater than 3% of the prior year's revenue, the operator must submit, 60 days prior to the anticipated withdrawal, a cover letter to DOH indicating a request for approval of the equity withdrawal and attach a signed Equity Withdrawal/Transfer of Asset Request Form. This form explicitly states that equity withdrawals also include "[e]quity [d]istributions or consulting fees paid to other affiliated companies/individuals that do not have a substantial business purpose" (Pettigrew Aff. ¶ 118, Exh. 112 at 2-3).

730. DOH has clarified that "[s]ubstantial business purpose means that the majority of the related party expense . . . *directly translates into goods and/or services rendered that directly benefit the nursing home*. Related party expenses are those provided by any company in which the operator(s) of the nursing home have ownership and/or a direct financial interest" (Pettigrew Aff. ¶ 118, Exh. 112 at 7; emphasis added). Only those related-party expenses with no substantial business purpose need be disclosed as equity withdrawals (*see id.*).

731. DOH's equity withdrawal process focuses on ensuring resident care by preventing excessive profit taking. For example, a nursing home owner's application for DOH approval of withdrawals beyond the 3% threshold "shall specify the necessity, purpose, and impact on patient care of the withdrawal." 10 NYCRR § 400.19(c)(1).

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[111] *See* f.n. 72.

732. Recognizing the potential for nursing home owners to profit through the use of Related-Party loans, DOH also requires nursing home owners to provide specific "details concerning . . . withdrawal[s] including, but not limited to, the principal amount, interest rate, repayment terms, conditions of default, remedies upon default and obligee of any transactions to be consummated in a proposed withdrawal." *Id.*

733. These equity withdrawal requests are key because DOH must review the requests and consider the "necessity" of a requested withdrawal, "whether such withdrawal would impair the facility's ability to render quality care," the "expense which such requested withdrawal would generate," and the "financial condition of the facility in general." 10 NYCRR § 400.19(c)(3).

734. As set forth below, by failing to request and receive approval for equity withdrawals, both direct or indirect, from the Nursing Homes, Rozenberg repeatedly and persistently violated the equity withdrawal limits on nursing home operators. Respondents Rozenberg, Centers, the Nursing Homes' Owners and Operators, and Hagler converted over $69.3 million, money they took in excess of the equity withdrawal limit. Further, by failing to seek permission for such withdrawals (and failing to disclose the nature of their relationship with Related Parties through which they siphoned the Nursing Homes' funds), they fraudulently hid from DOH the true scope of their illegal profits.

1. Rozenberg and Holliswood's Other Owners Fraudulently and Illegally Withdrew over $36.6 Million from Holliswood Beyond the 3% Threshold

735. Between 2014 and 2021, Respondents repeatedly and persistently caused Holliswood to engage in transactions that qualify as equity withdrawals or asset transfers in excess of the 3% threshold. Yet, Holliswood's owners never once sought or received DOH approval for these transactions. As a result, Respondents violated the equity-withdrawal limits every single year from 2014 through 2021.

736. As detailed in the Budimir Affidavit, Holliswood's owners' equity withdrawals ranged between 1.21% and 7.33% of Holliswood's total reported annual revenue from 2014 through 2021, as shown in the following table:

Year	Previous Year Revenue (Sch. 7)	Current Year Capital Withdrawal (Exhibit B)	Owner Salaries over $199,000 (Schedule 14)	Capital Withdrawal % Per Cost Reports
2014	$34,421,452	$2,522,144		**7.33%**
2015	$39,614,813	$2,300,000		**5.81%**
2016	$39,958,119	$1,725,000		**4.32%**
2017	$40,141,639	$750,000	$26,000	1.93%
2018	$37,733,000	$1,025,000		2.72%
2019	$38,673,175	$1,000,000		2.59%
2020	$41,097,854	$496,042		1.21%
2021	$40,004,117	$1,103,069		2.76%
Totals	**$311,644,169**	**$10,921,255**	**$26,000**	**3.51%**

(Budimir Aff. ¶ 127).

737. Thus, taking the Cost Reports at face value, Holliswood's owners violated the 3% equity-withdrawal limits in 2014, 2015, and 2016, because Rozenberg and Holliswood's other owners failed to seek or obtain the legally required DOH approvals in those three years for withdrawing equity in excess of 3% of the previous year's annual revenue for patient care services.

738. However, Holliswood's Cost Reports for 2014 through 2021 are not accurate reflections of Respondents' equity withdrawals and asset transfers because Holliswood's owners failed to properly account for payments to Related Parties that had no substantial business purpose and other transactions that qualify as withdrawals under 10 NYCRR § 400.19. In reality, for the years 2014-2021, Respondents withdrew $36,607,336 in equity from Holliswood above the 3% threshold without prior approval from DOH.

739. Holliswood's payments to Skilled Staffing, totaling $170,477.90, are transfers of Holliswood's funds for Rozenberg's direct or indirect benefit because his daughter and daughter-

in-law own Skilled Staffing and he regularly received equity distributions from Skilled Staffing. *See* 10 NYCRR § 400.19(a)(3)(i). The transfers to Skilled Staffing are also payments with no substantial business purpose to an individual affiliated with the operator (*see* § VIII[B]). However, neither Rozenberg nor Holliswood's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the 3% threshold (*see* DOH Certification annexed hereto; Budimir Aff. ¶ 138).

740. Rozenberg also benefitted directly or indirectly from Holliswood's payments to BIS Funding totaling $960,598.94. Hagler, Rozenberg's longtime friend and business partner, is the owner of BIS Funding. BIS Funding transferred funds to Hagler's personal bank account; the same account that Hagler repeatedly used to transfer funds to Rozenberg's personal account; thus, Holliswood's payments to BIS Funding are for Rozenberg's direct or indirect benefit (*see* 10 NYCRR § 400.19(a)(3)(i)) and are payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Holliswood's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the 3% threshold (*see* DOH Certification; Budimir Aff. ¶ 138).

741. Hagler and Hellman's equity withdrawals from Hollis Real Estate Co. totaling $17,077,512 are qualifying liabilities incurred by Holliswood or its operator as a result of the leases between Hollis Operating Co. and Hollis Real Estate Co., and qualifying liabilities incurred by Holliswood or its operator by reason of a borrowing or other transaction under the Holliswood Unsecured Loan. *See* 10 NYCRR § 400.19(a)(3)(iii). Hagler's equity withdrawals are also payments that directly or indirectly benefited Rozenberg because Hollis Real Estate Co. transferred funds to the same personal bank account that Hagler used to transfer funds to Rozenberg (*see also* 10 NYCRR § 400.19(a)(3)(i)). Hagler's equity withdrawals from Hollis Real Estate Co. are also

payments with no substantial business purpose to individuals affiliated with the operator. However, neither Rozenberg nor Holliswood's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (*see* DOH Certification; Budimir Aff. ¶ 138).

742. Holliswood's transfers to other Centers-affiliated nursing homes, totaling $10,034,510, some of which were characterized as "loans and exchanges" in Holliswood's general ledger, qualify as Related Party loans made by the facility or its operator. *See* 10 NYCRR § 400.19(a)(3)(iv); 10 NYCRR § 451.229. These transfers were also made without a substantial business purpose. However, neither Rozenberg nor Holliswood's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (*see* DOH Certification; Budimir Aff. ¶ 138).

743. Hollis Real Estate Co.'s repayment of Rozenberg's $5.5 million Holliswood Option Loan qualifies as a Related Party loan made by the facility or its operator. *See* 10 NYCRR § 400.19(a)(3)(iv); 10 NYCRR § 451.229. Holliswood repaid the Holliswood Option Loan by adding principal debt to the HUD Loan, which is serviced by payments from Holliswood (*see* § VIII[A][1][i]). These transfers were also made without a substantial business purpose. However, neither Rozenberg nor Holliswood's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (*see* DOH Certification; Budimir Aff. ¶ 138).

744. In 2016 and 2017, Holliswood paid its owners a total of $461,158 in purported "salaries." However, Holliswood's owners failed to render any services to the facility that would justify those salaries (*see* § VIII(C)(1). As such, said "salaries" are more properly recognized as transfers of the facility's cash directly for the benefit of its owners. *See* 10 NYCRR §

400.19(a)(3)(i). Even assuming Rozenberg properly earned his $225,000 salary in 2017, any owner salaries above $199,000 per year count toward the operator's 3% equity-withdrawal limit. *See* 10 NYCRR § 400.19(a)(3)(v). In addition, during 2017, Holliswood paid its owners $243,421 in equity distributions that Holliswood failed to disclose on that year's Cost Report. These undisclosed equity distributions are transfers of the facility's cash directly to its owners. *See* 10 NYCRR § 400.19(a)(3)(i). Neither Rozenberg nor Holliswood's other owners ever sought DOH approval for any of these withdrawals that, when combined with other withdrawals, exceeded the 3% threshold (*see* DOH Certification; Budimir Aff. ¶¶ 126-27).

745. From 2018 to 2020, Holliswood made payments totaling $587,727 to Kaufman, Sicklick, and Lerner that were not disclosed on Holliswood's Cost Reports for those years as either salaries or equity withdrawals. These payments were transfers of the facility's cash directly to its owners. *See* 10 NYCRR 400.19(a)(3)(i). However, neither Rozenberg nor Holliswood's other owners ever sought DOH approval for any of these withdrawals that, when combined with other withdrawals, exceeded the 3% threshold (*see* DOH Certification; Budimir Aff. ¶¶ 138).

746. Properly accounting for the foregoing transactions as equity withdrawals under 10 NYCRR § 400.19, in addition to the capital withdrawals disclosed on the Cost Reports' Statement in Changes of Equity, demonstrates the massive scale of Respondents' fraud and illegalities, through which Rozenberg and Holliswood's other owners steered Holliswood's funds to benefit themselves and Related Parties, both directly and indirectly. As depicted in the following table, from 2014 through 2021, Holliswood's owners illegally withdrew from Holliswood $36,607,336 above the 3% threshold without prior approval from DOH:

Year	Prior Year Total Operating Revenue	Reported Withdrawals from Cost Reports	Transfers that Benefitted the Operators	Qualifying Leases and Borrowing	Non-Arm's Length Loans	Total Withdrawals	Total Withdrawals as Percentage of Revenue	Unauthorized Withdrawals
2014	$34,421,452	$2,522,144	$0	$250,012	$5,500,000	$8,272,156	24.03%	$7,239,512
2015	$39,614,813	$2,300,000	$0	$1,950,000	$0	$4,250,000	10.73%	$3,061,556
2016	$39,958,119	$1,725,000	$198,000	$3,000,000	$0	$4,923,000	12.32%	$3,724,256
2017	$40,141,639	$750,000	$506,579	$4,000,000	$6,437,157	$11,693,736	29.13%	$10,489,487
2018	$37,733,000	$1,025,000	$373,977	$3,000,000	$50	$4,399,027	11.66%	$3,267,037
2019	$38,673,175	$1,000,000	$314,978	$2,490,000	$508,917	$4,313,895	11.15%	$3,153,699
2020	$41,097,854	$496,042	$566,007	$2,387,500	$3,055,485	$6,505,034	15.83%	$5,272,098
2021	$40,004,117	$1,103,069	$463,843	$0	$32,901	$1,599,813	4.00%	$399,689
Total	**$311,644,169**	**$10,921,255**	**$2,423,384**	**$17,077,512**	**$15,534,510**	**$45,956,661**	**14.75%**	**$36,607,336**

See Budimir Aff. at ¶ 138; *see also* DOH Certification.

747. Respondents withdrew an average of 14.75% of Holliswood's prior year revenue between 2014 and 2021, despite never requesting or obtaining DOH approval, thereby fraudulently and illegally depriving Holliswood of funds that it should have used on resident care and/or staffing.

748. Respondents' pattern of fraud and illegality at Holliswood continues to this day. Holliswood's lease and the Holliswood Unsecured Loan that Rozenberg incurred on behalf of Holliswood are still in place. Rozenberg still causes Holliswood to pay Related Parties that provide little to no goods or services. Respondents must be stopped from this continuing pattern of fraudulently and illegally withdrawing equity from Holliswood at the expense of Holliswood's residents.

2. Rozenberg and Martine Center's Other Owners Fraudulently and Illegally Withdrew over $9 Million from Martine Center Beyond the 3% Threshold

749. Between 2019 and 2021, Respondents repeatedly and persistently caused Martine Center to engage in transactions that qualify as equity withdrawals or asset transfers in excess of the 3% threshold. Yet, Martine Center's owners never once sought nor received DOH approval for these transactions and, as a result, violated the equity-withdrawal limits every year from 2019

through 2021, thereby evidencing yet another pattern of repeated and persistent fraud and illegality.

750. Based on the Statement of Changes in Equity portion of Martine Center's 2019 through 2021 Cost Reports, Martine Center's owners purportedly took no equity withdrawal in 2019; an equity withdrawal in 2020 of 1.04% of the facility's prior year revenue; and an equity withdrawal in 2021 of 2.98% of the facility's prior year revenue. Thus, assuming Martine Center's Cost Reports are truthful and accurate, Martine Center's owners did not violate the 3% equity withdrawal limits from 2019 through 2021 (Winslow Aff. ¶ 141).

751. However, Martine Center's Cost Reports for 2019 through 2021 do not accurately disclose Respondents' total equity withdrawals and asset transfers in those years, because Rozenberg and Martine Center's other owners failed to properly account for equity distributions or consulting fees paid to other affiliated companies that do not have a substantial business purpose and qualifying liabilities. In reality, Respondents took $9,076,908 above the 3% threshold from Martine Center without prior approval from DOH (*see* DOH Certification; Winslow Aff. ¶¶ 142-56).

752. Martine Center's 2019 payment to CFSC Downstate for purported management fees totaling $750,000 was a transfer of Martine Center's funds for Rozenberg's direct or indirect benefit, because he owns CFSC Downstate and transferred funds from CFSC Downstate directly into his personal bank account. *See* 10 NYCRR § 400.19(a)(3)(i). The transfers to CFSC Downstate also had no substantial business purpose. However, neither Rozenberg nor Martine Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Winslow Aff. ¶¶ 143-44).

753. Martine Center's payments to Skilled Staffing for purported management fees totaling $107,302.56 are transfers of Martine Center's funds for Rozenberg's direct or indirect benefit, because his daughter owns Skilled Staffing and Rozenberg regularly received equity distributions from Skilled Staffing. *See* 10 NYCRR § 400.19(a)(3)(i). The transfers to Skilled Staffing are also payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Martine Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Winslow Aff. ¶¶ 143, 145).

754. Rozenberg also benefitted directly or indirectly from Martine Center's payments to BIS Funding totaling $348,095 (*see* Winslow Aff. ¶ 125). BIS Funding transferred funds to Hagler's personal bank account—the same account that Hagler repeatedly used to transfer funds to Rozenberg's personal account—thus, Martine Center's payments to BIS Funding are for Rozenberg's direct or indirect benefit (*see* 10 NYCRR § 400.19(a)(3)(i)) and are payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Martine Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification).

755. Hagler's equity withdrawals from Light Property II totaling $3,235,000 are qualifying liabilities incurred by Martine Center or its operator as a result of a lease. *See* 10 NYCRR § 400.19(a)(3)(iii). Hagler's equity withdrawals are also payments that directly or indirectly benefited Rozenberg because Light Property II transferred funds to the same personal bank account that Hagler used to transfer funds to Rozenberg (*see also* 10 NYCRR § 400.19(a)(3)(i)). Hagler's equity withdrawals from Light Property II are also payments with no substantial business purpose to an individual affiliated with the operator. However, neither

Rozenberg nor Martine Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Winslow Aff. ¶ 152).

756. The Rozenberg-Light Property II Loan qualifies as a non-arm's length or Related Party loan made by the facility or its operator. *See* 10 NYCRR § 400.19(a)(3)(iv); 10 NYCRR § 451.229. Rozenberg loaned $4.3 million to Light Property II, whose sole source of income is the rent and interest income it derives from Martine Center. This loan was repaid at Martine Center's 2017 closing, and again with interest, at the 2022 HUD refinancing of the mortgage. Thus, Martine Center's funds continue to be used to repay this loan by its operator because its mortgage principal increased to cover the second repayment of the Rozenberg-Light Property II loan. This loan was also made without a substantial business purpose. However, neither Rozenberg nor Martine Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Winslow Aff. ¶ 154).

757. Properly accounting for the foregoing transactions as equity withdrawals under 10 NYCRR § 400.19, in addition to the withdrawals disclosed on the Cost Reports' Statement in Changes of Equity, demonstrates the massive scale of Respondents' fraud and illegalities, through which Rozenberg steered Martine Center's funds to benefit himself and Related Parties, both directly and indirectly. From 2019 through 2021, Rozenberg illegally withdrew from Martine Center $9,076,908 above the 3% threshold without prior approval from DOH, as shown in the following table:

Year	Prior Year Total Operating Revenue	Reported Withdrawals from Cost Reports	Transfers that Benefitted the Operators	Qualifying Leases and Borrowing	Non-Arm's Length Loans	Total Withdrawals	Total Withdrawals as Percentage of Revenue	Unauthorized Withdrawals
2019	$21,885,079	$0	$918,809	$500,000	$0	$1,418,809	6.48%	$762,257
2020	$24,794,374	$258,122	$215,085	$500,000	$0	$973,207	3.93%	$229,376
2021	$24,668,598	$736,028	$68,409	$2,235,000	$0	$3,039,437	12.32%	$2,299,379
2022	$26,473,724	Not Available	Not Available	Not Available	$6,580,108	$6,580,108	24.86%	$5,785,896
Total	**$97,821,775**	**$994,150**	**$1,202,303**	**$3,235,000**	**$6,580,108**	**$12,011,561**	**11.90%**	**$9,076,908**

See Winslow Aff. ¶ 156; *see* DOH Certification.

758. From 2019 to 2022, Rozenberg withdrew an average of 11.90% of Martine Center's prior year revenue without the requisite DOH approval, depriving the facility of funds that should have been used on resident care and staffing (DOH Certification; Winslow Aff. ¶ 156).

759. Respondents' pattern of fraud and illegality at Martine Center continues to this day. Martine Center's lease and loan are still in place. Rozenberg still causes Martine Center to pay Related Parties who provide little to no goods or services. Respondents must be stopped from this continuing pattern of fraudulently and illegally withdrawing equity from Martine Center at the expense of its residents.

3. Rozenberg and Beth Abraham's Other Owners Fraudulently and Illegally Withdrew over $8 Million from Beth Abraham Beyond the 3% Threshold

760. Between 2019 and 2021, Respondents repeatedly and persistently caused Beth Abraham to engage in transactions that qualify as equity withdrawals or asset transfers in excess of the 3% threshold. Yet, Beth Abraham's owners never once sought or received DOH approval for these transactions. As a result, Respondents violated the equity-withdrawal limit every year from 2019 through 2021, in another pattern of repeated and persistent fraud and illegality.

761. Based on Beth Abraham's Cost Reports' Statement in Changes of Equity, from 2019 through 2021, Beth Abraham's owners purportedly only took a single equity withdrawal of $1,698,344 in 2020, which was 2.66% of Beth Abraham's prior year revenue. Thus, assuming Beth Abraham Center's Cost Reports are truthful and accurate, Beth Abraham Center did not violate the 3% equity-withdrawal limit from 2019 through 2021.

762. However, Beth Abraham's Cost Reports for 2019 through 2021 do not accurately disclose equity withdrawals and asset transfers from the facility because Rozenberg and Beth Abraham's other owners failed to properly account for equity distributions or asset transfers paid to other affiliated companies that do not have a substantial business purpose and qualifying liabilities, such as its lease and loan with Beth Abraham's Landlord. In reality, Respondents took $8,012,309 from Beth Abraham above the 3% threshold without prior approval from DOH (*see* Waldropt Aff. ¶ 106; DOH Certification).

763. Beth Abraham's payments to Skilled Staffing for purported management fees totaling $247,725 amount to transfers of Beth Abraham's funds for Rozenberg's direct or indirect benefit because his daughter owns Skilled Staffing, from which he regularly received equity distributions. *See* 10 NYCRR § 400.19(a)(3)(i). The transfers to Skilled Staffing are also payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Martine Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Waldropt Aff. ¶¶ 104-08).

764. Rozenberg also benefited directly or indirectly from Beth Abraham's payments to BIS Funding between 2019 and 2021, totaling $1,131,456. BIS Funding transferred funds to Hagler's personal bank account; the same account that Hagler repeatedly used to transfer funds to

Rozenberg's personal account; thus, Beth Abraham's payments to BIS Funding are for Rozenberg's direct or indirect benefit (*see* 10 NYCRR § 400.19(a)(3)(i)) and are payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Beth Abraham's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Waldropt Aff. ¶¶ 104-08).

765. Hagler's equity withdrawals from Light Property totaling $9,960,000 are qualifying liabilities incurred by Beth Abraham or its operator as a result of the leases between Light Property and Abraham Operations, and a qualifying liability incurred by Beth Abraham or its operator by reason of a borrowing or other transaction under the Light Property-Abraham Operations Note. *See* 10 NYCRR § 400.19(a)(3)(iii). Hagler's equity withdrawals are also payments that directly or indirectly benefited Rozenberg because Light Property transferred funds to the same personal bank account that Hagler used to transfer funds to Rozenberg (*see also* 10 NYCRR § 400.19(a)(3)(i)). Hagler's equity withdrawals from Light Property are also payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Beth Abraham's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Waldropt Aff. ¶¶ 104-08).

766. Properly accounting for the foregoing transactions as qualifying withdrawals under 10 NYCRR § 400.19, in addition to the capital withdrawals disclosed on Beth Abraham's Cost Reports' Statement of Changes of Equity, demonstrates the massive scale of Respondents' fraud and illegalities, through which Rozenberg steered Beth Abraham's funds to benefit himself and Related Parties, both directly and indirectly. From 2020 through 2021, Rozenberg illegally

withdrew $8,012,309 above the 3% threshold from Beth Abraham without prior approval from DOH:

Year	Prior Year Total Operating Revenue	Reported Withdrawals from Cost Reports	Transfers that Benefitted the Operators	Qualifying Leases and Borrowing	Total Withdrawals	Total Withdrawals as Percentage of Revenue	Unauthorized Withdrawals
2020	$63,665,173	$0	$592,511	$2,500,000	$3,092,511	4.86%	$1,182,556
2021	$63,849,927	$1,698,344	$586,907	$6,460,000	$8,745,251	13.70%	$6,829,753
Total	**$183,124,964**	**$1,698,344**	**$1,379,181**	**$9,960,000**	**$13,037,525**	7.12%	**$8,012,309**

See Waldropt Aff. ¶¶ 107-08.

767. For 2020 and 2021, Rozenberg withdrew an average of 9.28% of Beth Abraham's prior year revenue without the requisite DOH approval, depriving the facility of funds that should have been used on resident care and staff.

768. Respondents' pattern of fraud and illegality at Beth Abraham continues to this day. Beth Abraham's lease and loan are still in place. Rozenberg still causes Beth Abraham to do business with Related Parties that provide little to no goods or services. Respondents must be stopped from this continuing pattern of fraudulently and illegally withdrawing equity from Beth Abraham at the expense of its residents.

4. Rozenberg and Buffalo Center's Other Owners Illegally Withdrew Over $15.6 Million From Buffalo Center Beyond the 3% Threshold

769. Between 2018 and 2021, Respondents repeatedly and persistently caused Buffalo Center to engage in transactions that qualify as equity withdrawals or asset transfers in excess of the 3% threshold. Yet, Buffalo Center's owners never once sought or received DOH approval for these transactions. As a result, Respondents violated the equity-withdrawal limit every year from 2018 through 2021, in another pattern of repeated and persistent fraud and illegality.

770. Based solely on the Statement in Changes of Equity portion of Buffalo Center's Cost Reports, from 2018 through 2021, Buffalo Center's owners declared equity withdrawals ranging from 1.08% and 2.68% of Buffalo Center's prior year revenue. Assuming Buffalo Center's Cost Reports are truthful and accurate, Buffalo Center's owners did not violate the 3% equity withdrawal limits from 2018 through 2021 (Giacoia Aff. ¶¶ 45-46).

771. However, as is true for the other Nursing Homes, Buffalo Center's Cost Reports for 2018 through 2021 do not accurately disclose the total equity withdrawals and asset transfers from Buffalo Center because Buffalo Center's owners failed to properly account for transactions that qualify as withdrawals under 10 NYCRR § 400.19. In reality, Respondents withdrew $15,606,546 above the 3% threshold from Buffalo Center without prior approval from DOH (Giacoia Aff. ¶¶ 45, 47; *see* DOH Certification).

772. Buffalo Center's 2019 payment to CFSC Downstate for purported management fees totaling $495,000 is a transfer of Buffalo Center's funds for Rozenberg's direct or indirect benefit because he owns CFSC Downstate and transferred funds from CFSC Downstate directly into his personal bank account (Giacoia Aff. ¶ 48; Budimir Aff. ¶ 29). *See* 10 NYCRR § 400.19(a)(3)(i). As set forth above, the transfers to CFSC Downstate also had no substantial business purpose. However, neither Rozenberg nor Buffalo Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH certification; Giacoia Aff. ¶¶ 45-47).

773. Buffalo Center's payments to Skilled Staffing for purported management fees totaling $1,781,289 are transfers of Buffalo Center's funds for Rozenberg's direct or indirect benefit because his daughter owns Skilled Staffing, from which he regularly received equity distributions (Giacoia Aff. ¶ 48). *See* 10 NYCRR § 400.19(a)(3)(i). The transfers to Skilled

Staffing are also payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Buffalo Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Giacoia Aff. ¶¶ 45-47).

774. Rozenberg also benefitted directly or indirectly from Buffalo Center's payments to BIS Funding totaling $663,777 (Giacoia Aff. ¶ 48). BIS Funding transferred funds to Hagler's personal bank account; the same account that Hagler repeatedly used to transfer funds to Rozenberg's personal account; thus, Buffalo Center's payments to BIS Funding are for Rozenberg's direct or indirect benefit (*see* 10 NYCRR § 400.19(a)(3)(i)) and are payments with no substantial business purpose to an individual affiliated with the operator. However, Rozenberg did not count any of these transactions toward the 3% equity-withdrawal limit, nor did he or Buffalo Center's Operator seek DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Giacoia Aff. ¶¶ 45-47).

775. Hagler's equity withdrawals from Delaware Real Property totaling $8 million are qualifying liabilities incurred by Buffalo Center or its operator as a result of the leases between Delaware Real Property and Delaware Operations (*see* Giacoia Aff. ¶ 50; 10 NYCRR § 400.19(a)(3)(iii)). Hagler's equity withdrawals are also payments that directly or indirectly benefited Rozenberg because Delaware Real Property transferred funds to the same personal bank account that Hagler used to transfer funds to Rozenberg (*see* 10 NYCRR § 400.19(a)(3)(i)). Hagler's equity withdrawals from Delaware Real Property are also payments with no substantial business purpose to an individual affiliated with the operator. However, neither Rozenberg nor Buffalo Center's other owners ever sought DOH approval for these withdrawals that, when

combined with other withdrawals, exceeded the threshold (DOH Certification; Giacoia Aff. ¶¶ 45-47).

776. The transfers from Buffalo Center to other Centers-affiliated nursing homes totaling $4,840,000 qualify as Related Party loans made by the facility or its operator (*see* Giacoia Aff. ¶ 51; *see also* 10 NYCRR § 400.19(a)(3)(iv); 10 NYCRR § 451.229). These transfers were also made without a substantial business purpose. However, neither Rozenberg nor Buffalo Center's other owners ever sought DOH approval for these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Giacoia Aff. ¶¶ 45-47).

777. From 2018 to 2020, Buffalo Center paid Sicklick, one of Buffalo Center's owners, a total of $840,000 in purported "salary" that was not disclosed on Buffalo Center's Cost Reports as either salary or an equity withdrawal (Giacoia Aff. ¶ 49). These payments were transfers of the facility's funds directly to one of its owners. *See* 10 NYCRR § 400.19(a)(3)(i). However, neither Rozenberg nor Buffalo Center's other owners ever sought DOH approval for any of these withdrawals that, when combined with other withdrawals, exceeded the threshold (DOH Certification; Giacoia Aff. ¶¶ 45-47).

778. Properly accounting for the foregoing transactions as qualifying withdrawals under 10 NYCRR § 400.19, in addition to the capital withdrawals disclosed on Buffalo Center's Cost Reports' Statement of Change in Equity, demonstrates the massive scale of Respondents' fraud and illegalities, through which Rozenberg and Buffalo Center's other owners steered Buffalo Center's funds to benefit themselves and Related Parties, both directly and indirectly. From 2018 through 2021, Buffalo Center's owners illegally withdrew from Buffalo Center $15,606,546 above the 3% threshold without prior approval from DOH, as shown in the following table:

Year	Prior Year Total Operating Revenue	Reported Withdrawals from Cost Reports	Transfers that Benefitted the Operators	Qualifying Leases and Borrowing	Non-Arm's Length Loans	Total Withdrawals	Total Withdrawals as Percentage of Revenue	Unauthorized Withdrawals
2018	$18,553,616	$200,000	$1,200,000	$0	$750,000	$2,150,000	11.59%	$1,593,392
2019	$21,390,865	$257,772	$1,602,779	$1,000,000	$4,090,000	$6,950,551	32.49%	$6,308,825
2020	$22,265,400	$469,299	$636,816	$3,200,000	$0	$4,306,115	19.34%	$3,638,153
2021	$22,872,450	$611,879	$340,471	$3,800,000	$0	$4,752,350	20.78%	$4,066,176
Total	**$85,082,331**	**$1,538,950**	**$3,780,066**	**$8,000,000**	**$4,840,000**	**$18,159,016**	**21.05%**	**$15,606,546**

See Giacoia Aff. ¶¶ 45-47; *see* DOH Certification.

779. During these years, Respondents withdrew an average of 21.05% of Buffalo Center's prior year revenue, despite having never requested or obtained DOH approval, thereby fraudulently and illegally depriving Buffalo Center of funds that should have been used on resident care and staff (DOH Certification; Giacoia Aff. ¶ 47).

780. Respondents' pattern of fraud and illegality at Buffalo Center continues to this day. Buffalo Center's lease is still in place. Rozenberg still causes Buffalo Center to do business with Related Parties that provide little to no goods or services. Respondents must be stopped from this continuing pattern of fraudulently and illegally withdrawing equity from Buffalo Center at the expense of its residents.

* * *

781. Rozenberg and Hagler's unconscionable looting drained the Nursing Homes at the expense of resident care.

782. The following chart demonstrates the measure of Respondents' conversion of funds:

Facility	Realty Withdrawals	Realty Loans	BIS Funding, Skilled Staffing and CFSC Downstate	Interfacility Loans (L&E)	Salaries & Undisclosed Withdrawals	Total
Holliswood	$17,077,512	$5,500,000	$1,131,077	$10,034,510	$1,292,306	$35,035,405
Martine	$3,235,000	$6,580,108	$1,202,303	$0	$0	$11,017,411
Beth Abe	$9,960,000	$0	$1,555,941	$0	$0	$11,515,941
Buffalo	$17,595,000	$0	$2,966,787	$4,840,000	$840,000	$26,241,787
Total	**$47,867,512**	**$12,080,108**	**$6,856,108**	**$14,874,510**	**$2,132,306**	**$83,810,544**

783. Taking millions of dollars for themselves also allowed Rozenberg and Hagler to continue expanding their empire by buying nursing homes around the country. Given Rozenberg and Hagler's longstanding practice of providing woefully deficient care, this puts many more vulnerable nursing home residents at risk of neglect and mistreatment.

784. The close relationship between Rozenberg and Hagler enabled them to fraudulently and illegally obtain profits they used to expand far beyond nursing homes. Since 2020, Rozenberg has invested in El Al Airlines – an investment that was largely funded by his decades-long business partner, friend, and next-door neighbor, Hagler (Hagler Tr. at 171-73).

785. From January 2017 through July 2021, nearly $275 million was deposited into Hagler's personal bank account at Popular Bank (*see* Waldropt Aff. ¶¶ 87-88).

786. Of that amount, from January 2020 through July 2021 – in just 18 months – $175 million dollars came from entities that do business with Centers or business with nursing homes owned by Rozenberg and/or managed by Centers (*see* Waldropt Aff. ¶ 89).

787. Of this nearly $175 million, Hagler's largest revenue source, almost $70 million, was from his ownership of real estate entities that lease nursing homes to Rozenberg (*see* Waldropt Aff. ¶ 90).

788. Notably, from March 2019 through March 2021, Hagler transferred over $103 million from his personal account at Popular Bank to Rozenberg's personal account at Popular Bank (*see* Waldropt Aff. ¶ 91).

789. According to Hagler's sworn testimony, the approximately $103 million that he transferred to Rozenberg's personal account was a loan to help Rozenberg invest in El Al (Hagler Tr. at 170-72). Hagler is not charging Rozenberg any interest on the loan, the loan does not have a term, and the loan is not documented in any way (*id.*). Thus, this $103 million loan came, at least in part, from Hagler's fraudulently and illegally obtained profits from Medicaid-funded nursing homes.

790. On September 16, 2020, a company controlled by Rozenberg's son, Eli, purchased a controlling stake in El Al for $107 million (*see* Pettigrew Aff. ¶ 194, Exh. 187) . Rozenberg financed his son's acquisition of El Al by loaning $109 million to his son's company (*see* Pettigrew Aff. ¶ 195, Exh. 188). At the time, Rozenberg could not own El Al in his own name because he was not an Israeli citizen. *Id.*

791. However, on May 19, 2021, after becoming an Israeli citizen, Rozenberg took control of El Al and was named to the company's Board of Directors; six days later, Hagler also became a director of El Al (*see* Pettigrew Aff. ¶ 196-197, Exh. 189-90).

792. Therefore, Rozenberg's investment in El-Al, which ultimately allowed him to become the controlling shareholder of the airline, was made possible by his and Hagler's longstanding pattern of fraud and illegality.

IX. RESPONDENTS CENTERS, ROZENBERG, HAGLER, AND OTHER CENTERS EXECUTIVES HAD KNOWLEDGE OF, AND CONTROL OVER, THE POOR RESIDENT CARE AND CONDITIONS AT THE NURSING HOMES

793. Centers controls the Nursing Homes by setting their staffing levels, choosing and paying vendors including laboratories that process resident testing, and hiring and firing key personnel. As such, the Nursing Homes' administrators lack authority to make significant decisions relating to resident care.

794. Centers's control over the Nursing Homes violates New York State regulations that vest the nursing home administrator—the individual who is actually on the ground in the facility, with the residents and staff—with the responsibility of managing the Nursing Home and making decisions in the best interests of the nursing home's residents. *See, e.g.*, 10 NYCRR § 415.26(a)(1).

795. Although Centers purports to be a mere consulting company consulting with the Nursing Homes, Respondents Rozenberg and Centers had knowledge of and control over the Nursing Homes' operations. Their knowledge extended to, among other issues, staffing crises, violations of infection control protocols, and resident neglect and harm. That knowledge stemmed from multiple sources, including communication from the Nursing Homes' administrators and DONs, DOH survey deficiency citations, poor scores on federal nursing home quality measures and metrics, and the findings of the Nursing Homes' quality assurance committees. Further, through Centers, Rozenberg and Hagler, the CFO of Centers, controlled the Nursing Homes' finances. Rozenberg and Centers failed to direct and/or approve expenditures that would have improved conditions and care at the Nursing Homes.

A. Respondents Knew About Failures at the Nursing Homes Because the Nursing Homes' Staff Regularly Reported Such Problems to Centers Executives

796. The Nursing Homes' administrators and DONs regularly communicated with Centers about "day-to-day operations" at the facilities (Liff Tr. at 24), including about budget, staffing numbers, hiring, admissions, CMS Star Ratings, DOH surveys and deficiencies, and CNA documentation rates (Weisz [3/31/22] Tr. at 46-50, 56-57, 97-98, 103, 206-13, 259, 279; Weisz [4/27/22] Tr. at 108-09; Liff Tr. at 20-22, 67-68, 94, 221-22; Serebrowski Tr. at 37-41, 43, 55; Smith Tr. at 40-41; Blackstein Tr. at 209-13, 278-81, 474-79; Pettigrew Aff. ¶¶ 119-121, Exhs. 113-115). Indeed, Centers's website confirms that ". . . on any given day [Rozenberg] is in contact with nursing home administrators, directors of nursing, rehab directors, and others at the forefront of delivering the care and customer service that make every Centers Health Care facility something special."[112]

797. The Nursing Homes' administrators and DONs also provided COVID-19-related information to Centers, including the number of residents who had tested positive for COVID-19, shortages of supplies (including PPE), staffing challenges, and problems at the Nursing Homes, such as having inaccurate thermometers (Pettigrew Aff. ¶¶ 72-77, Exhs. 67-71; Hendrix Tr. at 108-12). Martine Center's administrator could not even refuse a new admission without checking first with Centers COO Abramchik (Weisz [3/31/22] Tr. at 131) and Abramchik even overruled the administrator's recommendation against accepting new admissions (Weisz [4/27/22] Tr. at 109).

798. The DONs at the Nursing Homes reported clinical information to Heidi Hendrix, the Chief Nursing Officer for Centers, who then reported that information to Abramchik daily (Hendrix Tr. at 145) and to other Centers executives regularly (Hendrix Tr. at 97-98). Hendrix gathered information from the Nursing Homes and reported back to Centers executives about,

[112] *See* https://centershealthcare.com/leadership/kenny-rozenberg/ (last accessed 1/8/2023).

among other topics, regulatory compliance, DOH surveys, and concerns about staffing and resident care (Hendrix Tr. at 108-11; Pettigrew Aff. ¶ 122, Exh. 116).

799. Abramchik reports directly to Rozenberg (Hagler Tr. at 72). Hendrix, and other Centers executives report, directly or indirectly, to Rozenberg (Hagler Tr. at 72; Hendrix Tr. at 51, 73, 78-79, 148).

800. Respondents Rozenberg and Centers knew that the Nursing Homes faced staffing crises because the Nursing Homes regularly informed Centers executives that they had insufficient staffing. For instance, on February 27, 2020, during the Pre-Pandemic Period, the Martine Administrator emailed the Centers Director of Finance and Centers Workforce Management, who then alerted the Talent Acquisition supervisor, that:

> We really need assistance with LPN's [*sic*]. Its [*sic*] not looking good. Our acuities are a lot higher as we are suffering terribly with staffing shortages. We need to do something quick

(Pettigrew Aff. ¶ 28, Exh. 22).

801. Similarly, during the Peak-Pandemic Period, the Martine DON informed Centers Director of Clinical Operations Gemma Moore that "we are having very challenging staffing issues with nurses again" (Pettigrew Aff. ¶ 29, Exh. 23).

802. During the same period, Holliswood's administrator pleaded to Abramchik and Sicklick for additional compensation for RN supervisors and cited the dire staffing conditions at the facility. At first, another Centers executive rebuffed the request, but eventually, Abramchik relented, but only to increase profit: Centers expressly conditioned the additional pay on having an RN stay late "to help with admissions" (Pettigrew Aff. ¶ 30, Exh. 24), which would, of course, increase the nursing home's revenue.

803. Also, during this period, Martine Center's DON informed Moore that "Martine Center is in official state of staffing emergency" (Pettigrew Aff. ¶ 40, Exh. 34).

804. Finally, throughout the COVID-19 pandemic, the Nursing Homes also kept Rozenberg and Centers informed about COVID-19 cases that developed in the Nursing Homes (*see, e.g.*, Pettigrew Aff. ¶ 10, Exh. 4; ¶ 31, Exh. 25; ¶ 73, Exh. 67; ¶¶ 122-123, Exhs. 116-117; Hendrix Tr. at 109-12).

B. Respondents Knew About Failures at the Nursing Homes Because Centers Compiled and Distributed that Information in Quarterly Score Cards

805. Further demonstrating that Rozenberg and Centers had knowledge of the care and conditions at the Nursing Homes is the fact that Centers created and distributed "Score Cards" to the Nursing Homes on a quarterly basis, from the fourth quarter of 2019 through the third quarter 2020 (Pettigrew Aff. ¶¶ 14-18, Exhs. 8-12).

806. Indeed, in March 2020, the Director of Financial Analysis at Centers Business Office explained that the Score Card contained "definable metrics for each facility that Kenny [Rozenberg], Jeff [Sicklick], Izzy [Wolff], and Amir [Abramchik] like to review regularly." He explained that the Score Cards highlight certain areas of importance and would be sent out quarterly (*see* Pettigrew Aff. ¶ 14, Exh. 8).

807. The Score Cards included such metrics as the CMS star rating for survey and quality measures, payroll hours versus budgeted hours, census, average length of stay, and rehospitalization rates (Pettigrew Aff. ¶ 14, Exh. 8).

C. Respondents Knew About Failures at the Nursing Homes Because Centers Compiled and Distributed that Information in Quality Measures Reports

808. Rozenberg and Centers also knew that the Nursing Homes were performing poorly, compared to nursing homes around the country and New York State, because of Centers's dissemination of quality measures reports with data from CMS.

809. Centers distributed quality measures reports that show that the Nursing Homes had poor scores in certain categories of care contained in CMS CASPER reports,[113] which are useful in evaluating nursing home performance (Budimir Aff. ¶¶ 146-56). The CASPER reports show nursing home quality measure data, compare nursing homes' metrics to state and national averages, and determine if nursing homes are performing significantly worse than other nursing homes.

810. Respondents were aware of the data in the Nursing Homes' CASPER reports. Indeed, at least in 2020, Centers advised that facility MDS coordinators received the Casper Reports weekly and that Centers required MDS coordinators and DONs to "meet[] weekly . . . to review the Quality Measures/Casper Report" (Pettigrew Aff. ¶¶ 124-127, Exhs. 118-121).

811. These reports reveal that the Nursing Homes were outliers for providing poor resident care on several quality measures from 2018 through 2021. (As used in this Petition, a nursing home is an outlier for a given measure if it is worse than 80% of the nursing homes across the state or nation for that particular measure.)

812. For the entire four-year period, using the yearly average scores, all of the Nursing Homes were above the 90th percentile, both statewide and nationally, for "long-stay residents who have depressive symptoms" (Budimir Aff. ¶ 153). In other words, at least 90% of nursing homes statewide and nationwide had fewer long-stay residents who had depressive symptoms.

813. Buffalo Center, Holliswood Center, and Martine Center were also, at times, outliers in the categories of "long-stay residents who received an anti-psychotic medication" (Buffalo) and

[113] CASPER stands for Certification and Survey Provider Enhanced Reports. *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Public-Reporting (last visited Nov. 22, 2022).

"short-stay residents who newly received an anti-psychotic medication" (Holliswood, Martine). High rates of anti-psychotic medication prescriptions can indicate that a nursing home is failing to provide adequate care, especially to residents suffering from dementia. Some nursing homes improperly use anti-psychotic drugs to make residents with dementia more "manageable," especially where staffing is low (*see* Budimir Aff. ¶ 154).

814. Buffalo Center was an outlier for "long-stay residents who received an anti-psychotic medication" in New York State in 2020 and 2021 (80th and 84th percentile, respectively). Martine Center was an outlier for "short-stay residents who newly received an anti-psychotic medication" statewide and nationwide in 2020 (81st percentile statewide and 86th percentile nationally), during the pandemic. Holliswood Center was also an outlier for "short-stay residents who newly received an anti-psychotic medication" in New York State in 2018 (85th percentile) and in New York State and nationwide in 2019 (95th and 91st percentile, respectively) (Budimir Aff. ¶ 154).

815. Martine Center and Beth Abraham were outliers for "high-risk long-stay residents with pressure ulcers." Pressure ulcers are frequently caused when a nursing home fails to turn and position residents on a timely basis. Martine Center was an outlier nationally in 2020 (82nd percentile) and Beth Abraham Center was an outlier in New York State in 2018 (88th percentile), and nationally in 2018 and 2019 (91st and 82nd percentile, respectively) (Budimir Aff. ¶ 155).

816. Further, in 2019, based on the average score for the year, 94 percent of nursing homes nationwide performed better than Holliswood Center for "short-stay residents who made improvements in function." Even more striking is the fact that, based on scores for the period October 1, 2017 through September 30, 2019, 96 percent of nursing homes statewide and 98

percent of nursing homes nationwide scored better than Holliswood for "Rate of Successful Return to Home and Community from an SNF" (Budimir Aff. ¶ 149).

Similarly, Buffalo Center was an outlier in "long-stay residents whose ability to move independently worsened." In 2018 through 2020, 80 to 90 percent of nursing homes in New York State scored better than Buffalo Center (Budimir Aff. ¶ 156). This means that a greater proportion of Buffalo Center's long-stay residents suffered a decline in mobility (ability to move from one location to another) than long-stay residents of most other nursing homes in New York State.

D. Respondents Knew About Failures at the Nursing Homes Because DOH Repeatedly Cited the Nursing Homes for Poor Care

817. Rozenberg, Centers and the Nursing Homes also had knowledge about the poor care and conditions at the Nursing Homes because DOH repeatedly cited the Nursing Homes for violating DOH rules regarding resident care.

1. DOH Cited Holliswood Center for Rehabilitation & Nursing for Resident Neglect and Mistreatment

818. Respondents were put on notice of poor care at Holliswood Center because DOH repeatedly issued it deficiency citations between May 2019 and December 2021.

819. DOH found the following deficiencies at Holliswood during that time:

- In a May 23, 2019 survey: lack of medical documentation justifying the use of a physical restraint on multiple occasions for a resident in a wheelchair; failure to protect three residents from resident-on-resident physical abuse (*see* Pettigrew Aff. ¶ 137, Exh. 131 at 1-8);
- In a June 1, 2021 survey: failure to provide treatment and care (*see* Pettigrew Aff. ¶ 138, Exh. 132);
- In a June 8, 2021 survey: failure to provide pain management (*see* Pettigrew Aff. ¶ 139, Exh. 133); and
- In a December 6, 2021 survey: failure to ensure resident was free from sexual abuse by another resident (*see* Pettigrew Aff. ¶ 140, Exh. 134).

820. On March 3, 2022, DOH conducted a survey during which it determined that Holliswood's residents were in immediate jeopardy due to Holliswood's use of medically unnecessary physical restraints. DOH observed that Holliswood subjected 11 residents—all of whom were cognitively impaired and required extensive assistance for bed mobility and transfers—to physical restrains that were not required to treat their medical conditions. 10 of the 11 residents could not independently release the siderails placed on their beds. In other words, Holliswood locked these 10 residents into their beds, leading to at least one resident injury: on February 19, 2022, a resident was found kneeling on the floor mat and the resident's head was between the siderail and the bed (Pettigrew Aff. ¶ 96, Exh. 90 at 16-31).

821. As a result of the IJ, Holliswood removed siderails from the beds of 49 of 51 the residents who had them (Pettigrew Aff. ¶ 96, Exh. 90 at 30).

822. The IJ finding is even worse in the context of Holliswood's prior deficiencies, because DOH had cited Holliswood twice in the last five years for inappropriate use of restraints. DOH cited Holliswood in 2017 for improperly using siderails as a restraint (Pettigrew Aff. ¶ 37, Exh. 31) and, as noted above, in 2019 for the unjustified use of a seatbelt in a wheelchair as a restraint. Because of Holliswood's repeated and persistent failure to correct these problems, in the March 3, 2022 survey, DOH also cited Holliswood for failing to ensure that its Quality Assurance Performance Improvement ("QAPI") program made a good faith attempt to identify and correct previously identified deficiencies related to improperly using physical restraints (Pettigrew Aff. ¶ 96, Exh. 90 at 59-61).

823. The March 3, 2022 survey further cited Holliswood for a plethora of issues directly relating to resident welfare, many of which echo the resident complaints discussed above. Holliswood could have avoided these problems if Respondents had allowed it to hire sufficient

staff to monitor and care for residents (Pettigrew Aff. ¶ 96, Exh. 90). Specifically, in the March 3, 2022 survey, DOH cited Holliswood for failing to ensure:

- a clean, comfortable and homelike environment for the residents; that allegations involving abuse or serious bodily injury were reported within two hours; that a resident's comprehensive care plan was developed and implemented to address care needs for a resident's tracheostomy/respiratory care; that a second resident's comprehensive care plan included interventions to address the use of a Bilevel Positive Airway Pressure machine; that the comprehensive care plan was reviewed and/or revised after each assessment and as needed; that a resident was free from the unnecessary use of antipsychotic medications for a resident who had no documented evidence that the resident had a history of Schizophrenia (*see id*. at 8-16, 31-56);

- that multiple residents washed their hands before lunch and dinner (*see id*. at 62-67);

- that residents receiving oxygen therapy did not have tubing that was touching the floor and that tubing that was stored had a plastic cover wrapped around the top of the oxygen concentrator (*see* Id. at 62-67); and,

- that a resident's designated representative was notified of a change in the resident's antipsychotic medication (*see* Id. at 2-8).

2. DOH and CMS Cited Buffalo Center for Rehabilitation & Nursing for Providing Poor Care

824. Respondents were put on notice of poor care at Buffalo Center by DOH placing the facility in IJ status—which can result in denial of payment by CMS (42 CFR § 488.406)—in April 2020 and May 2021, and because CMS added Buffalo Center to its Special Focus Facilities list in May 2022.

825. On April 30, 2020, during the initial wave of the COVID-19 pandemic, DOH placed Buffalo Center in IJ status because Buffalo Center was violating infection control protocols and putting the health and safety of its residents at risk. CMS fined Buffalo Center $11,180 per day until Buffalo Center corrected the deficiency. Ultimately, Buffalo Center ended up paying a civil monetary penalty of over $50,000 due to this IJ (Pettigrew Aff. ¶ 50, Exh. 44; Giacoia Aff. ¶

52). DOH also required Buffalo Center to pay a penalty of $22,000 for violations found during the same survey (*see* Pettigrew Aff. ¶ 71, Exh. 65).

826. Just one year later, on May 2, 2021, DOH again placed Buffalo Center in IJ status because it had such low staffing that it could not provide adequate resident care. As a result of the May 2021 IJ, Buffalo Center paid a fine of $20,423 to CMS (Giacoia Aff. ¶ 52; See Pettigrew Aff. ¶ 13, Exh. 7) and DOH required Buffalo Center to pay a civil penalty of $6,000 (*see* Pettigrew Aff. ¶ 54, Exh. 48).

827. Approximately one year later, in April 2022, CMS designated Buffalo Center a Special Focus Facility because of its "history of serious quality issues" (*see* § V[A] above). CMS's list of Special Focus Facilities is a list of nursing homes that fail to provide the standard of care to which residents are legally entitled. At any given time, CMS limits this list to the three worst nursing homes in New York State.

3. DOH Cited Martine Center for Rehabilitation & Nursing for Resident Neglect and Mistreatment

828. Between May 2018 and April 2022, Martine Center received notice of 36 citations by DOH, significantly higher than the statewide average of 23 citations (see Pettigrew Aff. ¶ 101, Exh. 95).

829. These citations stemmed from surveys on June 27, 2018, May 22, 2019, and September 22, 2020, and included failures by Martine Center to ensure that:

- staff followed proper hygiene techniques to prevent the spread of infection and cross-contamination of wounds and wound supplies (*see* Pettigrew Aff. 104, Exh. 98 at 13-16);
- staff/administration completed a thorough investigation after a reportable incident (*see id*. at 7-9);
- a comprehensive resident assessment was completed following a significant change (*see id*. at 1-3);

- each resident was provided with supervision to prevent accidents (*see* Pettigrew Aff. ¶ 136, Exh. 130);
- the facility employed a full-time social worker (*see* Pettigrew Aff. ¶ 143, Exh. 136 at 8-10); and
- an unwitnessed fall was reported to DOH (*see* Pettigrew Aff. ¶ 143, Exh. 136 at 12-14).

E. Respondents Rozenberg, the Nursing Homes' Owners, and the Nursing Homes' Operators Recklessly and Deliberately Failed to Learn About Additional Problems at the Nursing Homes Because They Illegally Failed to Participate in Quality Assurance Meetings

830. Finally, Respondents Rozenberg, the Nursing Homes' Operators, and the Nursing Homes' Owners deliberately and recklessly failed to participate in quality assessment and assurance committee meetings that are required by law. By not participating, Respondents deliberately ignored further evidence of poor conditions at the Nursing Homes that were discussed at these meetings.

831. New York State regulations require facilities "to establish and maintain a coordinated quality assessment and assurance program, which integrates the review activities of all nursing home programs and services to enhance the quality of life and resident care and treatment." 10 NYCRR § 415.27.

832. The quality assessment and assurance committee must include "at least one member of the governing body who is not otherwise affiliated with the nursing home in an employment or contractual capacity." 10 NYCRR § 415.27(b).

833. The governing bodies of the Nursing Homes are the "proprietors" of the Nursing Homes, or in other words, Rozenberg, the Nursing Homes' Owners, and the Nursing Homes' Operators. *See* 10 NYCRR § 415.2(g).

834. At least at Martine Center and Beth Abraham Center, not one member of the Nursing Homes' governing body ever attended a quality assessment and assurance committee meeting (Winslow Aff. ¶ 47; Blackstein Tr. at 106-08).

835. By violating their regulatory obligation to attend quality assessment and assurance committee meetings, the Nursing Homes' governing body ignored the opportunity to learn even more about quality care issues at the facility, which it was responsible for addressing.

* * *

836. As demonstrated above, Respondents knew about the poor care, including resident neglect and mistreatment, at the Nursing Homes, because they received such information directly from the Nursing Homes' staff, through quality measure reports, and through DOH deficiency citations. In addition, Respondents deliberately chose to ignore evidence of further problems at the Nursing Homes by illegally failing to attend quality assessment and assurance committee meetings.

X. RESPONDENTS ILLEGALLY DELEGATED AUTHORITY OVER THE NURSING HOMES TO CENTERS

837. Not only do Respondents know about the Nursing Homes' poor conditions, they have also illegally delegated control over the operations at the Nursing Homes to Centers from the date Rozenberg took over each Nursing Home through the present. Respondents' decision to do so leaves the employees in the Nursing Homes powerless to improve patient care.

838. Centers controls, among other things, staffing budgets, admissions, and purchasing decisions (Clark Tr. at 81-82; Liff Tr. at 67-68, 94, 221-222; Weisz [3/31/22] Tr. at 46-50, 56-57, 97-98, 103; Serebrowski Tr. at 36-38, 43; Flanagan Tr. at 300-01, 313; Kasperek Tr. at 33;

Blackstein Tr. at 26-30, 152-153, 464-466; Pettigrew Aff. ¶ 26, Exh. 20; ¶ 128, Exh. 122).[114] Centers has exercised that control over the Nursing Homes from the time that Rozenberg purchased them through the present. Centers's control over these aspects of the Nursing Homes violates state law.

839. The Nursing Homes' Owners and Operators repeatedly and persistently delegated, and continue to delegate, complete control over the Nursing Homes to Centers in violation of 10 NYCRR § 600.9(d)(2). This regulation is designed to limit control by an unregulated and unaccountable entity over a licensed nursing home, and ultimately, to protect the residents from a company that has not been approved by DOH to operate the Nursing Homes. Yet, Centers controls virtually every element of the Nursing Homes' operations.

840. Respondents repeatedly and persistently delegated, and continue to delegate, authority from the Nursing Homes to Centers to hire and fire key management employees, in violation of law. For instance, Beth Abraham's administrator lacks the independent authority to fire a new medical director. Recently, Centers controlled the search and interview process for that position (Blackstein [5/5/22] Tr. at 190-193). At Holliswood Center, the Administrator and DON could not hire the Assistant DON without Centers's approval of her salary (Liff Tr. at 42). At Buffalo Center, Centers made the decision to change Medical Directors (Serebrowski Tr. at 138-139). Respondents' delegation of this authority to Centers violates 10 NYCRR § 600.9(d)(2)(i).

841. Respondents repeatedly and persistently delegated, and continue to delegate, control over the Nursing Homes' books and records to Centers, in violation of law. The

[114] On Nov. 24, 2020, former Buffalo Center DON Kelly Kasperek testified pursuant to an Executive Law §63(12) investigatory subpoena. The transcript of her testimony is hereto annexed. On May 13, 2021, Buffalo Center Assistant DON Jeannine Clark testified pursuant to an Executive Law § 63(12) investigatory subpoena. The transcript of her testimony is hereto annexed.

administrators at the Nursing Homes do not have control over the home's books and records; Centers handles that exclusively (Liff Tr. at 22). For instance, Centers prepares the Nursing Homes' Cost Reports and quarterly and annual financial statements (Hagler Tr. at 86). Hagler even reviews the Nursing Homes' financial statements to ensure the facilities are financially sound (Hagler Tr. at 87). Respondents' repeated and persistent delegation of this authority violates 10 NYCRR § 600.9(d)(2)(ii).

842. Furthermore, Respondents repeatedly and persistently delegated, and continue to delegate, control over the disposition of assets and the incurring of liabilities on behalf of the Nursing Homes to Centers, in violation of law. Administrators are directly supervised by, and answer to, Centers executives (Blackstein Tr. at 328), who control the Nursing Homes' funds (Weisz [3/31/22] Tr. at 50, 89; Hagler Tr. at 94-95; Liff Tr. at 22, 27-29; Serebrowski Tr. at 53; Lantzitsky Tr. at 129-30). When a Centers-affiliated nursing home receives an invoice, the facility is supposed to submit it to the accounts payable group at Centers, where a Centers employee reviews it, determines whether to approve it, and, if it is approved, pays it (Hagler Tr. at 94-95). As set forth above, executives at Centers set a detailed budget for the Nursing Homes' staffing and instructed facilities to further reduce staffing to comply with the budgeted plan, including during the Peak and Post-Peak Pandemic Periods (Blackstein Tr. at 523; Pettigrew Aff. ¶ 130, Exh. 124; Flanagan Tr. at 300-301; Liff Tr. at 221-222; Serebrowski Tr. at 43; Kasperek Tr. at 33; Pettigrew Aff. ¶ 19, Exh. 13; ¶¶ 22-23, Exhs. 16-17).

843. In fact, Centers exercises such complete control over the finances that the Nursing Homes' administrators do not even understand their facility's expenses. For instance, the Holliswood administrator does not know if Holliswood pays rent for the building but indicated that Centers would know (Liff Tr. at 22, 33). Centers selects the vendors the Nursing Homes must

use and pays those vendors on the Nursing Homes' behalf (Liff Tr. at 29, Blackstein [5/5/22] Tr. at 290; Weisz [3/31/22] Tr. at 114). When a Centers-affiliated facility needs to purchase items or pay for staffing, Centers has a Director of Purchasing and a Director of Workforce Management to handle those financial decisions (Lantzitsky Tr. at 51). And, at least at Holliswood, a request for an expenditure "goes through" Centers (Liff Tr. at 27-28). When Hagler, as Chief Financial Officer of Centers, reviews facilities' financial statements, he tracks large changes in expenses over time and questions them, demanding an explanation (Hagler Tr. at 89-90). Executives at Centers even go so far as to question clinical decisions made by Beth Abraham staff, in an attempt by Centers to cut Beth Abraham's costs (Blackstein Tr. at 474-479; Pettigrew Aff. ¶¶ 120-21, Exhs. 114-15). And Martine's administrator has so little purchasing discretion on behalf of his facility that his authority is limited to decisions about ordering food for his staff (Weisz [3/31//22] Tr. at 114-15; 97-98). Respondents' repeated and persistent delegation of control over its Nursing Homes' finances violates 10 NYCRR § 600.9(d)(2)(iii).

844. Respondents also repeatedly and persistently delegated, and continue to delegate, control over the adoption and enforcement of policies regarding the operation of the facility to Centers, in violation of law. Centers, rather than the Nursing Homes' Operators or administrators, promulgates policies that the Nursing Homes must follow (Hendrix Tr. at 60, 77; Liff Tr. at 44-45). For instance, during the pandemic, the infection control policies that the Nursing Homes had in place were established by Centers (Hendrix Tr. at 123-24). Centers issued the guidance, rules, policies, and procedures the facilities followed and made all major facility decisions (Serebrowski Tr. at 139; Smith Tr. at 69-71). Buffalo Center did not even have discretion about how policies were implemented (Smith Tr. at 21; Serebrowski Tr. at 41-42). Respondents' repeated and

persistent delegation of control over the Nursing Homes' adoption and enforcement of policies violates 10 NYCRR § 600.9(d)(2)(iv).

845. By establishing a business model whereby Centers, the ostensible management company, took control of all of these aspects of running the Nursing Homes, in violation of the law, Respondents engaged in repeated and persistent illegality. Furthermore, this business model enabled Rozenberg—the owner of Centers and the Nursing Homes—to force the facilities to pay millions of dollars in "consulting" fees to Centers each year, in exchange for which Centers directed the Nursing Homes to make decisions (*e.g.*, continuing to take admissions when insufficiently staffed) that ultimately inured to Rozenberg's benefit.

XI. RESPONDENTS REPEATEDLY AND PERSISTENTLY VIOLATED THEIR MEDICAID PROVIDER AGREEMENTS AND NEW YORK MEDICAID REGULATIONS IN THEIR OPERATION OF THE NURSING HOMES

846. Respondents repeatedly and persistently violated 18 NYCRR § 515.2(a) through their conduct in operating the Nursing Homes, which defines as an "unacceptable practice" conduct by a provider that is contrary to Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State. *See also* 18 NYCRR §§ 515.5(a) and (b).

847. Respondents repeatedly and persistently committed multiple violations of 18 NYCRR § 515.2(b) through their conduct in operating the Nursing Homes, which prohibits the following as "unacceptable practice[s] . . . which constitute[] fraud or abuse":

> (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 and benefit intended by the medical assistance program. . .
> (12) Failure to meet recognized standards. Furnishing medical care, services or supplies that fail to meet professionally recognized standards for health care.

848. In addition, each year, the Nursing Homes were required to file with DOH an annual Certification Statement for Provider Billing Medicaid (the "Medicaid Electronic Certification"). These certifications read:

> 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 and the Office of the Medicaid Inspector General 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 eMedNY Provider Manuals and other official bulletins of the Department.

(Emphasis added).

849. Centers signs these certifications on behalf of the Nursing Homes. From August 2016 through July 2022, the Centers Controller signed these certifications on behalf of Holliswood. For Martine Center, in 2017, Rozenberg signed this certification form, and from 2018 through 2022, the Centers Controller signed it. From 2018 through 2022, the Centers Controller signed these certifications on behalf of Beth Abraham. From 2017 through 2022, the Centers Controller signed these certifications on behalf of Buffalo Center (*see* Pettigrew Aff. ¶¶ 156-91, Exhs. 149-84).

850. Given Respondents' conduct in operating the Nursing Homes as described herein, Respondents repeatedly and persistently falsely certified and submitted to DOH these Medicaid Electronic Certifications.

CLAIMS FOR RELIEF

AS AND FOR THE FIRST CAUSE OF ACTION PURSUANT TO EXECUTIVE LAW § 63(12): REPEATED AND PERSISTENT FRAUD

As against All Respondents

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. 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.

3. 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, to wit:

a. Converting $83,810,544 in Government Healthcare reimbursement funds through deception, misrepresentation, and concealment.

4. 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 OF ACTION PURSUANT TO EXECUTIVE LAW § 63(12): REPEATED AND PERSISTENT FRAUD

As against Kenneth Rozenberg, Centers for Care LLC d/b/a Centers Health Care, the Nursing Homes' Operators, and the Nursing Homes' Owners

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. 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.

3. 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, to wit:

a. Falsely certifying that the Nursing Homes complied with the rules and regulations of the Medicaid program on their Medicaid Electronic Certifications.

4. 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 Kenneth Rozenberg, Centers for Care LLC d/b/a Centers Health Care, the Nursing Homes' Operators, the Nursing Homes' Owners, the Landlords, Daryl Hagler, Jonathan Hagler, and Mordechai "Moti" Hellman

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. 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.

3. 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, to wit:

a. Entering into collusive and/or self-dealing real estate transactions, including but not limited to: lease agreements obligating the Nursing Homes to pay unreasonably high rent; loans between the Nursing Homes and Related Parties that require the Nursing Homes to pay unreasonably high interest; and loans with no business purpose.

4. 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 FRAUD

As Against Kenneth Rozenberg, Centers for Care LLC d/b/a Centers Health Care, the Nursing Homes' Operators, the Nursing Homes' Owners, and Daryl Hagler

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. 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.

3. 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, to wit:

a. Failing to disclose to and seek and obtain approval from DOH for withdrawals and transfers from the Nursing Homes for Respondents' benefit, in violation of the disclosure requirements of Public Health Law § 2808(5)(c) and 10 NYCRR § 400.19.

b. Filing and/or causing to be filed with DOH false cost reports, on behalf of the Nursing Homes, that failed to accurately and completely disclose required information, including but not limited to: Related Party transactions; Related Party financial statements; the amounts of money transferred to Related Parties; and/or the amounts of money transferred to the Nursing Homes' Owners.

4. 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 FIFTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
VIOLATIONS OF NURSING HOME REGULATIONS
REPEATED AND PERSISTENT ILLEGALITY

As against Kenneth Rozenberg, Centers for Care LLC d/b/a Centers Health Care, the Nursing Homes' Operators, and the Nursing Homes' Owners

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. Respondents have also engaged in repeated and persistent illegal acts and/or illegality in the carrying on, conducting or transaction of business in violation of New York Executive Law 63(12). Respondents, through their agents and employees, repeatedly and

persistently committed illegalities by violating their legal obligations to provide required care to the Nursing Homes' residents, to wit, by failing to:

a. Maintain sufficient numbers of nursing staff "to assure . . . [the] well-being of each resident," in violation of 42 CFR § 483.35;

b. Maintain sufficient personnel on a 24-hour basis to provide nursing care to all residents in accordance with each resident's needs, as set forth in the Care Plan, in violation of 10 NYCRR § 415.13(a);

c. Maintain sufficient staff to ensure that each resident is offered sufficient fluid intake to maintain proper hydration and health, in violation of 42 CFR § 483.25(g)(2);

d. Limit resident admissions, and "accept and retain only those nursing home residents for whom [they] can provide adequate care," in violation of 10 NYCRR § 415.26(i)(1)(ii);

e. Provide timely, consistent, safe, adequate, and appropriate services, treatment, and care, including nutrition, therapies, sanitary clothing and surroundings, and activities of daily living, in violation of Public Health Law § 2803-d and 10 NYCRR § 81.1(c);

f. Provide appropriate treatment and services to assist with urinary incontinence to prevent urinary tract infections, in violation of 10 NYCRR § 415.12(d)(1);

g. Ensure that each resident receives adequate supervision to prevent accidents, in violation of 10 NYCRR § 415.12(h)(2);

h. Provide residents with "good nutrition, grooming, and personal and oral hygiene," in violation of 10 NYCRR § 415.12(a)(3);

i. Timely administer treatments, medications, diets, and other health services, in violation of 10 NYCRR § 415.13(a);

j. Ensure that residents are free of any significant medication errors, in violation of 10 NYCRR § 415.12(m);

k. Provide proper treatment for special services such as colostomy care and podiatric care, in violation of 10 NYCRR § 415.12(k),

l. Promote the safekeeping, maintenance and use of vision or hearing assistive devices that the residents need, in violation of 10 NYCRR § 415.12(b)(3);

m. Fulfill each resident's right to "adequate and appropriate medical care" in violation of 10 NYCRR § 415.3(f)(1)(i);

n. Maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment, in violation of 10 NYCRR § 415.19;

o. Ensure that residents remain without pressure ulcers unless they were "unavoidable despite every reasonable effort to prevent them," in violation of 10 NYCRR § 415.12(c)(1);

p. Provide necessary treatment and services to residents coming into the nursing home with pressure ulcers to promote healing, prevent infection and prevent new pressure ulcers from developing, in violation of 10 NYCRR § 415.12(c)(3);

q. Ensure that residents do "not experience reduction in range of motion" unless unavoidable and ensure that residents who are limited in their range of motion receive appropriate treatment and services to increase range of motion, in violation of 10 NYCRR § 415.12(e)(1) and (2);

r. maintain acceptable parameters of nutritional status, such as body weight and protein levels, and sufficient fluid intake to maintain proper hydration and health, in violation of 10 NYCRR §§ 415.12(i), (j) and 42 CFR § 483.25(g)(2);

s. Ensure that the residents' abilities in activities of daily living "do not diminish" and that they are given appropriate services to improve such abilities, including their ability to bathe, dress and groom, ambulate, toilet, eat, and use speech or other communication systems, in violation of 10 NYCRR §§ 415.12(a)(1) and (2);

t. Ensure that laboratory services meet the needs of the nursing home residents, in violation of 10 NYCRR § 415.20(a);

u. Ensure that staff maintained clinical records for each resident that were complete and accurately documented care, in violation of 10 NYCRR §415.22(a);

v. Ensure that at least one member of the governing body who is not otherwise affiliated with the Nursing Homes in an employment or contractual capacity participates in the quality assessment and assurance committee, as required by 10 NYCRR § 415.27(b);

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

x. Comply with the prohibitions of 10 NYCRR § 600.9 by impermissibly delegating to Centers: the authority to hire and fire key management employees; maintenance and control of the Nursing Homes' books and records; authority over the disposition of the Nursing Homes' assets and incurring of liabilities on behalf of the Nursing Homes; and control over the adoption and enforcement of policies regarding the operation of the Nursing Homes; and

y. 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"; provide appropriate treatment and services to assist with urinary incontinence; provide appropriate treatment and services to maintain or improve residents' abilities; maintain "good nutrition, grooming, and personal and oral hygiene"; ensure that residents remain without pressure sores unless they were "unavoidable despite every reasonable effort to prevent them"; provide necessary treatment and services to promote the healing, prevent infection, and prevent new pressure sores from developing; maintain acceptable parameters of nutrition and hydration; ensure that residents are free of any significant medication errors; and ensure that each resident receives adequate supervision to prevent accidents, as required by 10 NYCRR § 415.12; *see also* 42 CFR § 483.10(a)(1);

3. Respondents engaged in repeated and persistent 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(12):
VIOLATIONS OF PHL § 2808(5)(c) & 10 NYCRR § 400.19(b)(1)
REPEATED AND PERSISTENT ILLEGALITY

As Against Kenneth Rozenberg, Centers For Care LLC d/b/a Centers Health Care, the Nursing Homes' Operators, the Nursing Homes' Owners and Daryl Hagler

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. Respondents have also engaged in repeated and persistent illegal acts and/or illegality in the carrying on, conducting or transaction of business in violation of New York Executive Law 63(12) by:

a. Failing to seek and obtain approval from DOH for withdrawals and transfers from the Nursing Homes for Respondents' benefit, in violation of the disclosure requirements of Public Health Law § 2808(5)(c) and 10 NYCRR § 400.19.

3. Respondents engaged in repeated and persistent illegality in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE SEVENTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
VIOLATIONS OF 10 NYCRR § 86-2
REPEATED AND PERSISTENT ILLEGALITY

As Against Kenneth Rozenberg, Centers For Care LLC d/b/a Centers Health Care, the Nursing Homes' Operators, the Nursing Homes' Owners and Daryl Hagler

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. Respondents have also engaged in repeated and persistent illegal acts and/or illegality in the carrying on, conducting or transaction of business in violation of New York Executive Law § 63(12) by:

a. filing and/or causing to be filed with DOH false cost reports, on behalf of the Nursing Homes, that failed to accurately and completely disclose required information, including but not limited to: Related Party transactions; Related Party financial statements; the amounts of money transferred to Related Parties; and/or the amounts of money transferred to Nursing Homes' Owners, in violation 10 NYCRR part 86-2.

3. Respondents engaged in repeated and persistent illegality in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE EIGTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
VIOLATIONS OF 18 NYCRR § 515.2
REPEATED AND PERSISTENT ILLEGALITY

As against All Respondents

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. Respondents have also engaged in repeated and persistent illegal acts and/or illegality in the carrying on, conducting, or transaction of business in violation of New York Executive Law § 63(12) by:

a. Filing and/or causing to be filed claims to Medicaid for unfurnished medical care and services; converting Medicaid payments to a use or benefit other than for the intended use and benefit; and making or causing to be made false statements and/or misrepresentations of material fact in claiming Medicaid payments; all in violation 18 NYCRR § 515.2.

3. Respondents engaged in repeated and persistent illegality in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE NINTH CAUSE OF ACTION:
OVERPAYMENT OF PUBLIC FUNDS
PURSUANT TO EXECUTIVE LAW § 63-c

As Against All Respondents

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. Respondents directly and/or indirectly obtained, received, converted, or disposed of Medicaid funds to which they were not entitled, as alleged in the foregoing paragraphs of this Verified Petition.

3. 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.

AS AND FOR THE TENTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
VIOLATIONS OF EXECUTIVE LAW § 63-c
REPEATED AND PERSISTENT ILLEGALITY

As Against All Respondents

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. Respondents have also engaged in repeated and persistent illegal acts and/or illegality in the carrying on, conducting, or transaction of business, in violation of New York Executive Law § 63(12) by:

a. Repeatedly and persistently obtaining, receiving, converting, or disposing of Medicaid funds, directly and/or indirectly, to which they were not entitled, in violation of the Tweed Law, Executive Law § 63-c, as alleged in the foregoing paragraphs of this Verified Petition.

AS AND FOR THE ELEVENTH CAUSE OF ACTION
UNJUST ENRICHMENT

As Against All Respondents

1. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

2. Respondents have been unjustly enriched to the detriment of Medicaid by diverting Medicaid payments intended for resident care to themselves and Related Parties, and it is against equity and good conscience to permit them to retain those payments.

PRAYER FOR RELIEF

WHEREFORE, as a result of the conduct described herein, Petitioner respectfully requests that this Court grant the relief set forth below against Respondents, pursuant to Public Health Law § 2801-c, Executive Law § 63(12), and Executive Law § 63-c, and the theory of common law Unjust Enrichment, by issuing an order and judgment:

1. Declaring that:

   a. Respondents have engaged in repeated and persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law §63(12); and

   b. Respondents have repeatedly and persistently engaged in illegal acts in the carrying on, conducting, and transaction of business, in violation of Executive Law §63(12), by engaging in the financial fraud alleged herein, and in the operation of the Nursing Homes by illegally failing to deliver required care;

   c. Respondents have obtained, received, converted, and/or disposed of Medicaid funds, directly or indirectly, to which they were not entitled.

2. Permanently enjoining Respondents from:

   a. Further violating healthcare regulations relating to nursing home services in New York State;

   b. Further engaging in the illegal and fraudulent practices alleged herein;

   c. Engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program and federal Medicare Program;

d. Admitting or allowing to be admitted to the Nursing Homes new residents until the Nursing Homes' Operators provide signed certifications to the Attorney General certifying that that an identified clinician has determined that the Operators have met their obligations to ensure: sufficient care and staffing for all existing residents and for any new residents, and that each Nursing Home's minimum staffing level meets, at a minimum of 4.1 HPRD and 0.75 HPRD from RN staff; and that the Nursing Homes are otherwise fully complying with all New York State laws regarding minimum staffing levels and spending on direct care staff; and

e. Filing false, incomplete, or misleading Cost Reports with DOH.

3. Directing Respondents to correct the Nursing Homes' false and misleading cost reports for 2018, 2019, 2020, and 2021 by October 25, 2023, and to submit to MFCU such revisions;

4. Appointing a financial monitor to oversee the Nursing Homes' financial operations, prevent the Nursing Homes from making collusive and self-dealing payments to Respondents, and cause the Nursing Homes to terminate loans with Related Parties; and granting the financial monitor specific authority to withhold any payments to any Respondent and any other Related Parties;

5. Appointing an independent healthcare monitor with the specific authority to visit and inspect the Nursing Homes at any time, to review all documents maintained by Respondents regarding the Nursing Homes, to oversee healthcare operations at the Nursing Homes, to make recommendations to improve the Nursing Homes compliance with their legal duties under state and federal law, and to enable the Nursing Homes to provide required care to all residents, and to ensure that the Nursing Homes take all necessary steps to avoid preventable neglect and improve healthcare outcomes for their residents;

6. Directing all Respondents except the Nursing Homes to pay for the expenses of the monitors appointed hereunder, and to pay for the Nursing Homes' implementation of the monitors' recommendations;

7. Directing Respondents to provide to MFCU a complete accounting of all monies wrongfully received;

8. Directing that each Respondent disgorge to MFCU, for return to Medicaid, all monies wrongfully received, as a result of Respondents' conversion of Medicaid funds, and/or unjust enrichment, within 30 days;

9. Directing all Respondents, except the Nursing Homes, pay restitution and/or damages to New York State;

10. Directing all Respondents, except the Nursing Homes, to reimburse the State for the costs of this investigation;

11. Directing each Respondent, except the Nursing Homes, to pay statutory costs in the amount of $2,000 pursuant to CPLR § 8303(a)(6); and

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

13. During the pendency of this proceeding:

    a. Granting a preliminary injunction pursuant to Executive Law § 63(12), (i) enjoining all Respondents from engaging in any fraudulent, deceptive, or illegal acts in violation of Executive Law § 63(12), including but not limited to violations of the Public Health Law and those regulations promulgated to promote and ensure the wellbeing of nursing home residents; (ii) enjoining all Respondents from obtaining, receiving, converting, and/or disposing of Medicaid funds, directly or indirectly, to

which they are not entitled; (iii) enjoining Respondents Kenneth Rozenberg, Daryl Hagler, Centers for Care LLC d/b/a Centers Health Care, Abraham Operations Associates LLC d/b/a Beth Abraham Center For Rehabilitation And Nursing ("Beth Abraham"), Delaware Operations Associates LLC d/b/a Buffalo Center For Rehabilitation And Nursing ("Buffalo Center"), Hollis Operating Co., LLC d/b/a Holliswood Center For Rehabilitation And Healthcare ("Holliswood"), Schnur Operations Associates LLC d/b/a Martine Center For Rehabilitation And Nursing ("Martine Center"), Jeffrey Sicklick, Amir Abramchik, and Aron Gittleson from filing false and/or misleading Cost Reports; and (iv) enjoining Respondents Kenneth Rozenberg, Daryl Hagler, Centers for Care LLC d/b/a Centers Health Care, Abraham Operations Associates LLC d/b/a Beth Abraham Center For Rehabilitation And Nursing ("Beth Abraham"), Delaware Operations Associates LLC d/b/a Buffalo Center For Rehabilitation And Nursing ("Buffalo Center"), Hollis Operating Co., LLC d/b/a Holliswood Center For Rehabilitation And Healthcare ("Holliswood"), Schnur Operations Associates LLC d/b/a Martine Center For Rehabilitation And Nursing ("Martine Center"), Jeffrey Sicklick, Amir Abramchik, and Aron Gittleson from transferring any assets to the following entities: BIS Funding LLC, Skilled Staffing LLC, and CFSC Downstate, LLC.

b. Appointing an independent healthcare monitor for the pendency of this action to oversee compliance with the preliminary injunction, including oversight of the healthcare functions at the Nursing Homes.

c. Appointing an independent financial monitor for the pendency of this action to ensure compliance with this injunction, including review of the financial condition

of the Nursing Homes, and BIS Funding LLC, Skilled Staffing LLC, and CFSC Downstate LLC ("Related Party Vendors"), to ensure that the Nursing Homes maintain sufficient funds to: a) fund the operations of the Nursing Homes, in accordance with all applicable laws, rules, and regulations, b) implement the recommendations of the independent healthcare monitor and c) ensure compliance with this Order, including but not limited to, the prohibitions against the Nursing Homes transferring assets, directly or indirectly, to the Related Party Vendors; and

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

Dated: New York, New York
June 28, 2023

LETITIA JAMES

Attorney General of the State of New York

BY: Amy Held
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AMY HELD
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212 417 5250

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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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. _____/23

VERIFICATION

ABRAHAM OPERATIONS ASSOCIATES
LLC d/b/a BETH ABRAHAM CENTER
FOR REHABILITATION AND NURSING,
DELAWARE OPERATIONS ASSOCIATES LLC
d/b/a BUFFALO CENTER FOR REHABILITATION
AND NURSING, HOLLIS OPERATING CO., LLC
d/b/a HOLLISWOOD CENTER FOR REHABILITATION
AND HEALTHCARE, SCHNUR OPERATIONS
ASSOCIATES LLC d/b/a MARTINE
CENTER FOR REHABILITATION AND NURSING,
LIGHT PROPERTY HOLDINGS ASSOCIATES LLC,
DELAWARE REAL PROPERTY ASSOCIATES LLC,
HOLLIS REAL ESTATE CO., LLC,
LIGHT OPERATIONAL HOLDINGS ASSOCIATES LLC,
LIGHT PROPERTY HOLDINGS II ASSOCIATES LLC,
CENTERS FOR CARE LLC d/b/a CENTERS HEALTH CARE,
CFSC DOWNSTATE, LLC, BIS FUNDING CAPITAL LLC,
SKILLED STAFFING, LLC, KENNETH ROZENBERG,
DARYL HAGLER, BETH ROZENBERG, JEFFREY SICKLICK,
LEO LERNER, REUVEN KAUFMAN, AMIR ABRAMCHIK,
DAVID GREENBERG, ELLIOT KAHAN, SOL BLUMENFELD,
ARON GITTLESON, AHARON LANTZITSKY,
JONATHAN HAGLER, and MORDECHAI “MOTI” HELLMAN,

Respondents.

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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 the 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 Petitioner 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, auditors, detectives, and medical analysts 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
June 28, 2023

LETITIA JAMES
Attorney General of the State of New York

Amy Held
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Office of the Attorney General of the
State of New York
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