IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

Health Facilities Division

License Application

Please answer all questions completely and accurately to avoid unnecessary delays in processing. Return the completed application with the required fee to the address below 30 days prior to the expiration of your current license. Note: This application is an open record and available to the public upon request.

Iowa Department of Inspections and Appeals
Health Facilities Division
Lucas State Office Building – Third Floor
321 East 12th Street
Des Moines, IA 50319-0083

FOR OFFICE USE ONLY	
License Number:	490974
License Fee:	60.00
License Type:	NF/SNF
Effective Date:	11/16/2022
Expiration Date:	11/16/2023

Type of Application

☐ New ☐ Renewal ☐ Amendment * ☒ Change of Ownership, or Conversion

*** Please specify reason for amendment:**

I. GENERAL INFORMATION

Facility Name (Doing Business As):
Timber City Wellness and Rehabilitation

Previous Name (if applicable)
Crestridge Care Center

Street Address (physical location)
1015 Wesley Dr

City	County	State	Zip Code
Maquoketa	Jackson	IA	52060

Mailing Address (if different from physical address)

City	County	State	Zip Code

Telephone Number	FAX Number	Email Address
(563) 652-4967		david@stellarhcm.com

- Intermediate, Residential, and Nursing Facility License Type and Fee Structure -

☒ Nursing Facility
- ☒ CCDI Unit 37 beds

☐ Intermediate Care Facility for the Intellectually Disabled
☐ Intermediate Care Facility for the Mentally Ill
☐ Residential Care Facility
- ☐ ID Unit __ Beds
- ☐ Memory Care Unit _____ Beds

☐ Residential Care Facility for the Mentally Ill
☐ Specialized 3-5 Bed Facility

Intermediate, Residential, and Nursing Facilities:

☐ 10 or fewer beds - $20.00
☐ 11 to 25 beds - $40.00
☒ 26 to 75 beds - $60.00
☐ 76 to 150 beds - $80.00
☐ 151 or more beds - $100.00
☐ 25% late fee

- Subacute Mental Health Care Facility License and Fee Structure -

☐ Freestanding Subacute Mental Health Care Facility _____ beds
☐ Distinct Part Subacute Mental Health Care Facility _____ beds

☐ $25

Total Licensed Bed Capacity:	**Total** License Fee(s) Enclosed:
75	$60

Licensee is the ☐ owner(s)/lessor(s), or ☒ lessee
The Licensee is the person(s) or business entity with the authority to direct the management or policies of the facility.

Type of Certification	
☐ Medicare (Title XVIII)	☒ Medicare and Medicaid (Dual Certification)
☐ Medicaid (Title XIX)	☐ State Licensed Only (no certification)

II. ADMINISTRATION

A. Administrator

Name – Administrator	License Number
Amanda Carr	99167

Indicate whether the administrator is also the **designee** (person authorized to accept personal service and receive registered and certified mail). If "No," complete the Designee section.

☐ Yes ☒ No

B. Designee

Name – Designee	Title
Sam Haikins	President

C. Director of Nursing

Name – Director of Nursing	Status
Christine Dusanek, RN	☐ Permanent ☒ Temporary

D. Medical Director

Name – Medical Director: Dr. Jerald Bybee

III. OWNERSHIP INFORMATION

A. Owner(s)/Lessor(s)

Name – Owner(s)/Lessor(s): Blue Care PropCo Maquoketa, LLC

Street Address (physical location): 1015 Wesley Drive

City	State	Zip Code	County
Maquoketa	IA	52060	Jackson

Mailing Address (if different from street address): 36 Airport Rd, Ste 206

City	State	Zip Code	County
Lakewood	NJ	08701	Ocean

Telephone Number	FAX Number	E-mail Address
563-652-4968	563-652-3150	sam@bdequities.com

Contact Person	Telephone Number
Sam Haikins	732-637-9191

B. Type of Organization (check type of organization)

Governmental	Proprietary	Voluntary Non-Profit
☐ City	☐ Sole Proprietary	☐ Corporation
☐ County	☐ Partnership	☐ Church
☐ State	☐ Corporation	☐ Association
☐ Federal	☒ Limited Liability Company	☐ Church/Corporation
☐ City/County	☐ Limited Liability Partnership	☐ Private Non-Profit
☐ Tribal	☐ Trust	☐ Limited Liability Company
		☐ Limited Liability Partnership
		☐ Trust

C. Interested Parties

List all names, principal business addresses, and the percentage of ownership interest of all officers, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal address of all officers, directors, and board members. Attach additional pages if necessary.

Name	Title		Ownership %
See Attached Exhibit A			
Street	**City**	**State**	**Zip Code**
Name	**Title**		**Ownership %**
Street	**City**	**State**	**Zip Code**
Name	**Title**		**Ownership %**
Street	**City**	**State**	**Zip Code**
Name	**Title**		**Ownership %**
Street	**City**	**State**	**Zip Code**
Name	**Title**		**Ownership %**
Street	**City**	**State**	**Zip Code**
Name	**Title**		**Ownership %**
Street	**City**	**State**	**Zip Code**
Name	**Title**		**Ownership %**
Street	**City**	**State**	**Zip Code**

D. Lessee Information (If the lease includes sub-leases, complete for all parties)

Is the facility leased? ☒ **Yes** ☐ **No**
If "Yes," continue. If "No," skip to Section E.

Name of Lessee			
Blue Care Opco Maquoketa, LLC			
Street Address (physical location)			
1015 Wesley Drive			
City	**State**	**Zip Code**	**County**
Maquoketa	IA	52060	Jackson
Mailing Address (if different from physical location)			
City	**State**	**Zip Code**	**County**
Telephone Number	**FAX Number**	**E-Mail Address**	
563-652-4968	563-652-3150	sam@bdequities.com	
Contact Person		**Telephone Number**	
Sam Haikins		732-637-9191	

E. Type of Organization (check type of organization)

Governmental	Proprietary	Voluntary Non-Profit
☐ City ☐ County ☐ State ☐ Federal ☐ City/County ☐ Tribal	☐ Sole Proprietary ☐ Partnership ☐ Corporation ☒ Limited Liability Company ☐ Limited Liability Partnership ☐ Trust	☐ Corporation ☐ Church ☐ Association ☐ Church/Corporation ☐ Private Non-Profit ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Trust

Interested Parties

List all names, principal business addresses, and the percentage of ownership interest of all officers, stockholders owning 5% or more of stock, members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal address of all officers, directors, and board members. Attach additional pages if necessary.

Name	Title		Ownership %
See Attached Exhibit B			
Street	**City**	**State**	**Zip Code**
Name	**Title**		**Ownership %**
Street	**City**	**State**	**Zip Code**

F. Subsidiary/Parent Information

Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

☒ Yes ☐ No

If "Yes," please provide the following information:

Legal Business Name – Parent Corporation Blue Care OpCo Holdings, LLC			
DBA (Doing Business As)			
Type of Ownership Sole member of limited liability company			
Address 36 Airport Rd, Ste 206	**City** Lakewood	**State** NJ	**Zip Code** 08701
Contact Person Sam Haikins		**Telephone Number** 732-637-9191	

G. Chain Organization

Is the applicant under the control of a chain organization?

☐ Yes ☒ No

Chain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other device, controlled by a single business entity (defined as chain home office). Each entity in the chain may have a different owner but the "home office" maintains uniform procedures in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, providers/suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporation parent.

Name – Chain Organization:

If the applicant/licensee is a Limited Liability Company (LLC) or Limited Liability Partnership (LLP):

- Provide the names and addresses of all LLCs, LLPs or any other type of entity that any of the member(s) of the applicant are also members, officers, directors and/or board members.
- Provide an organizational chart exhibiting the legal business names of any and all subsidiaries, LLCs, LLPs involved with the applicant and its members.

IV. Adverse Action – To be completed by new applicants only

Has any adverse action(s) initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

☐ Yes ☒ No

If "Yes," complete the following table. Use abbreviations to describe the type of adverse action.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

Has any adverse action initiated by any state or federal agency based on non-compliance resulted in civil money penalties (CMPs), termination of provider agreement (TPA), denial of payments (DOP), or the appointment of temporary management of the facility (TMF)?

☐ Yes ☒ No

If "Yes," complete the following table. Use abbreviations to describe the type of adverse action.

Facility Name and Address	State	Federal or State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Actions

V. Other Providers

Identify the other types of providers owned by the applicant/licensee.
If more than two, check here ☐ and attach additional pages.

Name – Provider		
N/A		
City	State	Zip Code
Relationship Type (nursing facility, home health agency, community-based residential care facility, hospital, etc.)		
Name – Provider		
City	State	Zip Code
Relationship Type (nursing facility, home health agency, community-based residential care facility, hospital, etc.)		

VI. Applicant/Licensee

If the applicant/licensee has never been licensed to operate a health care facility in the State of Iowa, we request that you respond to the following:

1. Provide resumes for each officer (if the applicant is a corporation) or each partner (if partnership) or member (if limited liability company), etc. to assist the Department in determining the applicant's ability to operate a health care facility.
2. Is your licensed Nursing Home Administrator (NHA) in good standing with the State of Iowa? What facilities has this individual directed and what time periods and bed sizes? Yes. Administrator is currently this facility's Administrator.

VII. MANAGEMENT COMPANY

Is the operation of the facility under a management contract?

☐ Yes ☐ No

If "Yes," provide the following information regarding any management company retained to operate this facility or program.

Type of Management Company:	☐ Corporation	☐ Partnership	☐ LLC	☐ LLC
If "Other," please specify:				
Name – Management Company				
Name – Contact Person			Telephone Number	
Address	City		State	Zip Code

Please identify officers, directors, trustees or supervisors of the management company. Attach additional pages if necessary.

Name		Title	
Address	City	State	Zip Code
Name		Title	
Address	City	State	Zip Code

VIII. CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

Name Catherine C. Cownie		Title Attorney
Telephone Number 515-699-3261	FAX Number	E-Mail Address cownie.katie@dorsey.com

IX. CHILD OR ADULT ABUSE

Does any owner, officer, director, trustee, supervisor, lessor, manager, or administrator have a record of founded child or dependent adult abuse, or have they ever been convicted of a crime in the State of Iowa or any other state?

☐ Yes ☒ No

If "Yes," please identify those individuals. Attach additional page if necessary.

Name		Title	
Address	City	State	Zip code
Name		Title	
Address	City	State	Zip code
Name		Title	
Address	City	State	Zip code

X. ATTESTATION

The Department issues health care facility licenses pursuant to Iowa Code chapter 135C. A license is issued to the person(s) or entity that has responsibility for the operation of the facility or program and authority to comply with all applicable statutes, rules, and regulations. The person(s) or entity must be the owner of the facility or, if the facility is leased, the lessee.

The applicant/licensee is responsible for compliance with the Iowa Code and all rules promulgated pursuant to it.

The information contained in this application is complete and accurate to the best of my knowledge.

Signature (Full) – Applicant/Licensee	**Name – Applicant/Licensee (print or type)**
DocuSigned by: 3F182FE2F1A04F9...	Blue Care OpCo Maquoketa, LLC dba Jackson Post Acute Rehabilitation
Title – Applicant/Licensee	**Date Signed**
Sam Haikins, President	10/26/2022

Exhibit A
Lessor Interested Parties

Name	Title	Ownership %	Address
Blue Care OpCo Holdings, LLC	Member	100%	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Blue Care Homes, LLC	Indirect Owner	100% (indirect)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Blue Care Investments, LLC	Indirect Owner	100% (indirect through Blue Care Homes, LLC)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Sam Haikins	President and Indirect Owner	50% (indirect through Blue Care Investments, LLC)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Joseph Rubin	Indirect Owner	50% (indirect through Blue Care Investments, LLC)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701

Exhibit B
Lessee Interested Parties

Name	Title	Ownership %	Address
Blue Care OpCo Holdings, LLC	Member	100%	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Blue Care Homes, LLC	Indirect Owner	100% (indirect)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Blue Care Investments, LLC	Indirect Owner	100% (indirect through Blue Care Homes, LLC)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Sam Haikins	President and Indirect Owner	50% (indirect through Blue Care Investments, LLC)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701
Joseph Rubin	Indirect Owner	50% (indirect through Blue Care Investments, LLC)	36 Airport Rd, Ste. 206 Lakewood, NJ 08701

POST IN CONSPICUOUS PLACE

NONTRANSFERABLE

STATE OF IOWA

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

DES MOINES

TIMBER CITY WELLNESS AND REHABILITATION
1015 WESLEY DRIVE
MAQUOKETA,IA 52060
License Number: 490974
Beds/Capacity: 75

This is to certify that a license is hereby granted to the above-named facility to operate a Nursing Facility in accordance with Iowa Code chapter 135C and the rules and regulations promulgated thereunder. This license shall not be transferable or assignable, except with the written approval of the Health Facilities Division of the Iowa Department of Inspections and Appeals, and shall be subject to suspension or revocation for failure to comply with Iowa Code chapter 135C or the rules or minimum standards adopted pursuant to chapter 135C.

DATE OF ISSUE: NOVEMBER 16,2022

Director

POST IN CONSPICUOUS PLACE

NONTRANSFERABLE

STATE OF IOWA

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

DES MOINES

TIMBER CITY WELLNESS AND REHABILITATION
1015 WESLEY DRIVE
MAQUOKETA,IA 52060
License Number: 490974
Beds/Capacity: 37

This is to certify that a license is hereby granted to the above-named facility to operate a Chronic Confusion or Dementing Illness Unit in accordance with Iowa Code chapter 135C and the rules and regulations promulgated thereunder. This license shall not be transferable or assignable, except with the written approval of the Health Facilities Division of the Iowa Department of Inspections and Appeals, and shall be subject to suspension or revocation for failure to

DATE OF ISSUE: NOVEMBER 16,2022

Director