E-FILED 2023 JAN 25 3:53 PM WEBSTER - CLERK OF DISTRICT COURT 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. Litense Number: License Number: State Office Building - Third Floor 321 East 12 th Street Des Moines, IA 50319-0083 License Number: State Number: State Number: License Number: State Numb					Steele state of a state of the second state of the second state.	
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 321 East 12 th Street Des Moines, IA 50319-0083 Type of Application New Renewal Amendment * Change of Ownership, or Conversion Please specify reason for amendment: I GENERAL INFORMATION Facility Name (Doing Business As): Webster Post Acute Renabiliation Previous Name (if applicable) Or Dodge Villa, LLC Street Address (hyskal location) 2721 Tonth Avenue North City County State Zip Code Telephone Number (515) 576-7525 (515) 955-7528 david@stellarhorm.com - Intermediate, Residential, and Nursing Facility License Type and Fee Structure - Nursing Facility Intermediate Care Facility for the Intellectually Disabled Intermediate Care Facility for the Intellectually Disabled Intermediate Care Facility for the Mentally III Beds Handling III Care Facility Icense and Fee Structure - Subcurke Mental Health Care Facility License Earlier Structure - Subcurke Mental Health Care Facility License Earlier Structure - Subcurke Mental Health Care Facility License Earlier Structure - Structure Mental Health Care Facility Earlier Structure - Structure Mental Health Care Facility Beds Structure Mental Health		FOR OFFICE USE ONLY				
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 12 th Street Des Moines, IA 50319-0083 Type of Application New Renewal Amendment * Change of Ownership, or Conversion *Please specify reason for amendment: . GENERAL INFORMATION Facility Name (Doing Business As): Webster Fort Acute Rehabilitation Previous Name (If applicable) GHC Fort Dodgo Villa, LLC Street Address (physical location) 2721 Torth Avonue North City Fort Dodgo Gity County State City County City City City City City City City Ci	below 30 days prior to the expiration of your current license. Note: This application is				License Number:	
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85 \$80.00		Facility b				
				se Fee(s) End	ciosed:	
the state of a second data and the second data	85		\$80.00			
The Licensee is the person(s) or business entity with the authority to direct the management or policies of the facility.	Licensee is the 🗌 owner(s)/lessor(s), or 🔀 le The Licensee is the person(s) or business entity		to direct the m	ianagement or	policies of the facility.	

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Type of Certification

Medicare (Title XVIII) Medicaid (Title XIX)

X Medicare and Medicaid (Dual Certification)
State Licensed Only (no certification)

	II. ADMIN	ISTRATION			
A. Administrator					
Name – Administrator Jessica Bellinger			License Number 111523		
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.					
B. Designee					
Name – Designee Sam Haikins			Title President		
C. Director of Nursing					
Name – Director of Nursing Kim Mack, RN			Status Permanent	✓ Temporary	
D. Medical Director					
Dr. Josep	oh Larson				
	III. Ownership	PINFORMATION		-	
A. Owner(s)/Lessor(s)					
Name – Owner(s)/Lessor(s) Blue C	are PropCo	Fort Dodge	- North, LLC	,	
Street Address (physical location) 272	21 Tenth Ave	nue North			
City Fort Dodge		State Iowa	Zip Code 50501	^{County} Webster	
Mailing Address (if different from street 36 Airport Rd, Ste 206	t address)			-	
City Lakewood		State NJ	Zip Code 08701	^{County} Ocean	
Telephone Number (515) 576-7525	FAX Number (515) 955-752	8	E-mail Address sam@bdequiti	es.com	
Contact Person Sam Haikins			Telephone Number 732-637-9191		
B. Type of Organization (check type	e of organization)				
Governmental Proprietary Voluntary Non-Profit					
 City County State Federal City/County Tribal 	Sole Proprietary Partnership Corporation Limited Liability Limited Liability Trust	v Company	Corporation Church Association Church/Corpor Private Non-Pro Limited Liability Limited Liability Trust	ofit / Company	

C. Interested Parties					
List all names, principal business addr	esses, and the perce	entage of owners	ship interest of	all officers	s, stockholders
owning 5% or more of stock, members	s, partners, and all c	other persons ha	ving authority o	r respons	ibility for the
operation of the organization. For no	n-profit organizatio	ns or governmen	tal organization	is, list the	names and
principal address of all officers, direct	ors, and board mem		ditional pages if	necessar	
Name		Title			Ownership %
See Attached Exhibit A					
Street		City		State	Zip Code
					Ownership %
Name		Title			Ownership 70
				State	Zip Code
Street		City		State	zip code
N		Title		<u> </u>	Ownership %
Name		Inte			Ownership 70
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Wante		1110			
Street		City		State	Zip Code
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Street		City		State	Zip Code
Name		Title			Ownership %
Street		City		State	Zip Code
Name		Title			Ownership %
				I 	
Street		City		State	Zip Code
D. Lessee Information (If the lease incl	udes sub-leases, co	mplete for all pa	rties)		
Is the facility leased? 🛛 🛛 Yes	⊡No				
If "Yes," continue. If "No," skip to Sec	tion E.				
Name of Lessee					
Blue Care OpCo Fort Dodge - North Ll	_C				
Street Address (physical location)					
2721 Tenth Avenue North					
City		State	Zip Code		County
Fort Dodge		lowa	5050	1	Webster
Mailing Address (if different from phy	sical location)				
City		State	Zip Code	!	County
	1				
Telephone Number	FAX Number		E-Mail A	ddress lequities.c	om
(515) 576-7525	(515) 955-7528				
Contact Person			732-637-	ne Numbe 9191	ſ
Sam Haikins			102-007-	0101	

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E. Type of Organization (check type of	organization)				
Governmental Proprietary				Voluntary Non-Profit	
Governmental	Propi			voluntary Non-Front	
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	"I		.		
List all names, principal business addresses more of stock, members, partners, and all For non-profit organizations or governmen members. Attach additional pages if neces	other persons having a Ital organizations, list t	uthority or responsibil	ity for the o	peration o	f the organization.
Name See attached Exhibit B		Title			Ownership %
Street		City		State	Zip Code
Name		Title		<u> </u>	Ownership %
Street		City		State	Zip Code
F. Subsidiary/Parent Information		I			I
Is the applicant a subsidiary company, eith	er wholly or partially o XYes	whed by another organ	nization or i	ousinessr	
If "Yes," please provide the following infor 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		J	Telephon 732-637-	e Number 9191	
G. Chain Organization					
Is the applicant under the control of a chai	n 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. 					

		Yes	X No			
If "Yes," complete the following tabl	le. Use abbreviat	ions to desc	ribe the ty	pe of adverse a	action.	
Facility Name and Address	City a	nd State	1 · ·	of Health Provider	Type of Adverse Action	Effective Date Adverse Action
Has any adverse action initiated by a termination of provider agreement (any state or feder (TPA), denial of pa	al agency ba ayments (DC	ased on no OP), or the	n-compliance r appointment c	esulted in civil mone of temporary manag	ey penalties (CMP ement of the facil
(TMF)?		Yes	X No			
If "Yes," complete the following tabl	le. Use abbreviat	ions to desc	ribe the ty	pe of adverse a	action.	
Facility Name and Address	State	Federal	or State	Type of Heal Care Provide		se Effective Da of Advers Actions
-						
Identify the other types of providers		V. OTHER		RS		
If more than two, check here and		-	nsee.			
Name – Provider N/A						
			State		Zip Code	
City				residential care	facility, hospital, et	c.)
City	ome health agen	cv. commun	itv-based			•
City Relationship Type (nursing facility, h	ome health agen	cy, commun	ity-based			
City	ome health agen	cy, commun	iity-based i			
City Relationship Type (nursing facility, h	ome health agen	cy, commun	ity-based		Zip Code	
City Relationship Type (nursing facility, h Name – Provider			State			
City Relationship Type (nursing facility, h Name – Provider City	ome health agen	cy, commun	State ity-based	residential care		
City Relationship Type (nursing facility, h Name – Provider City Relationship Type (nursing facility, h	ome health agen	cy, commun /I. APPLIC	State ity-based i	residential care	e facility, hospital, et	c.)
City Relationship Type (nursing facility, h Name – Provider City	ome health agen	cy, commun /I. APPLIC	State ity-based i	residential care	e facility, hospital, et	c.)
City Relationship Type (nursing facility, h Name – Provider City Relationship Type (nursing facility, h If the applicant/licensee has new you respond to the following: 1. Provide resumes for eac (if limited liability comp	ome health agen Ner been licensed	cy, commun /I. APPLIC/ d to operat applicant i	State ity-based i ANT/LICEN is a corpor	residential care ISEE n care facility ration) or eac	facility, hospital, et in the State of Iow h partner (if partne	c.) va, we request th ership) or memb
City Relationship Type (nursing facility, h Name – Provider City Relationship Type (nursing facility, h If the applicant/licensee has neve you respond to the following: 1. Provide resumes for eac	ome health agen er been licensed h officer (if the any), etc. to ass Home Administ	cy, commun /I. APPLIC/ d to operat applicant i ist the Dep trator (NH/	State ity-based i ANT/LICEN e a health s a corpor partment i A) in good	residential care ISEE In care facility ration) or eac in determinin standing wit	facility, hospital, et in the State of Iow h partner (if partn g the applicant's a h the State of Iowa	c.) va, we request th ership) or memb bility to operate a? What facilitie

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	VII. MANAGE	MENT COMPANY			
Is the operation of the facility under a					
	Yes	XNo		and the facility of	
If "Yes," provide the following information regarding any management company retained to operate this facility or program.					
Type of Management Company:	Corporation	Partnership			
If "Other," please specify:	,•	1			
Name – Management Company					
Name – Contact Person	Telephone Number				
Address		City	State	Zip Code	
Please identify officers, directors, trus necessary.	tees or supervisors o	f the management o	ompany. Attacl	n additional pages if	
Name	<u></u>		Title		
Address		City	State	Zip Code	
Name Title					
Address		City	State	Zip Code	
		ACT PERSON			
Identify the person responsible for cor	npleting this applica	tion and who can be		have questions.	
Name Catherine C. Cownie			Title Attorney		
Telephone Number 515-699-3261	FAX Number		E-Mail Addres cownie.katie@		
	IX. CHILD OR	ADULT ABUSE			
Does any owner, officer, director, trus child or dependent adult abuse, or hav	ve they ever been co Ves	nvicted of a crime in \overline{X} No	inistrator have a the State of Iow	record of founded va or any other state?	
If "Yes," please identify those individu Name	ais. Attach additiona	ai page ir necessary.	Title		
Address		City	State	Zip code	
Name	Name Title				
Address		City	State	Zip code	
Name			Title		
Address		City	State	Zip code	

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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 lowa 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) wApplicant/Licensee	Name – Applicant/Licensee (print or type)		
Alaber	Blue Care OpCo Fort Dodge - North LLC d/b/a Webster 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

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Exhibit B Lessee Interested Parties

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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

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POST IN CONSPICUOUS PLACE

NONTRANSFERABLE

STATE OF IOWA

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

DES MOINES

WEBSTER POST ACUTE REHABILITATION 2721 TENTH AVENUE NORTH FORT DODGE,IA 50501 License Number: 940690 Beds/Capacity: 85

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

DATE OF ISSUE: NOVEMBER 16,2022

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