

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 12 th Street Des Moines, IA 50319-0083	FOR OFFICE USE ONLY
	License Number: 4160216
	License Fee: 60.00
	License Type: NF15NF
	Effective Date: 11/16/2022
Expiration Date: 11/16/2022	

Type of Application

New
 Renewal
 Amendment *
 Change of Ownership, or Conversion

* Please specify reason for amendment:

I. GENERAL INFORMATION

Facility Name (Doing Business As):
Humboldt Wellness and Rehabilitation

Previous Name (if applicable)
QHC Humboldt North, LLC

Street Address (physical location)
1111 11th Avenue North

City Humboldt	County Humboldt	State Iowa	Zip Code 50548
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Mailing Address (if different from physical address)

City	County	State	Zip Code
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Telephone Number (515) 332-2623
FAX Number (515) 462-1572
Email Address david@stellarhcm.com

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

<input checked="" type="checkbox"/> Nursing Facility <input checked="" type="checkbox"/> CCDI Unit <u>24</u> beds <input type="checkbox"/> Intermediate Care Facility for the Intellectually Disabled <input type="checkbox"/> Intermediate Care Facility for the Mentally Ill <input type="checkbox"/> Residential Care Facility <input type="checkbox"/> ID Unit <u> </u> Beds <input type="checkbox"/> Memory Care Unit <u> </u> Beds <input type="checkbox"/> Residential Care Facility for the Mentally Ill <input type="checkbox"/> Specialized 3-5 Bed Facility	Intermediate, Residential, and Nursing Facilities: <input type="checkbox"/> 10 or fewer beds - \$20.00 <input type="checkbox"/> 11 to 25 beds - \$40.00 <input checked="" type="checkbox"/> 26 to 75 beds - \$60.00 <input type="checkbox"/> 76 to 150 beds - \$80.00 <input type="checkbox"/> 151 or more beds - \$100.00 <input type="checkbox"/> 25% late fee
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- Subacute Mental Health Care Facility License and Fee Structure -

<input type="checkbox"/> Freestanding Subacute Mental Health Care Facility <u> </u> beds <input type="checkbox"/> Distinct Part Subacute Mental Health Care Facility <u> </u> beds	<input type="checkbox"/> \$25
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Total Licensed Bed Capacity: 75	Total License Fee(s) Enclosed: \$60.00
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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	
<input type="checkbox"/> Medicare (Title XVIII) <input type="checkbox"/> Medicaid (Title XIX)	<input checked="" type="checkbox"/> Medicare and Medicaid (Dual Certification) <input type="checkbox"/> State Licensed Only (no certification)

II. ADMINISTRATION	
A. Administrator	
Name – Administrator Stacy Benna	License Number 2137
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. <div style="text-align: center;"> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </div>	
B. Designee	
Name – Designee Sam Haikins	Title President
C. Director of Nursing	
Name – Director of Nursing Lanett Powers, RN	Status <input type="checkbox"/> Permanent <input checked="" type="checkbox"/> Temporary
D. Medical Director	
Name – Medical Director Dr. Sharmini Suriar	

III. OWNERSHIP INFORMATION			
A. Owner(s)/Lessor(s)			
Name – Owner(s)/Lessor(s) Blue Care PropCo Humboldt - North, LLC			
Street Address (physical location) 1111 11th Avenue North			
City Humboldt	State Iowa	Zip Code 50548	County Humboldt
Mailing Address (if different from street address) 36 Airport Rd, Ste. 206			
City Lakewood	State NJ	Zip Code 08701	County Ocean
Telephone Number (515) 332-2623	FAX Number (515) 332-2653	E-mail Address sam@bdequities.com	
Contact Person Sam Haikins		Telephone Number 732-637-9191	
B. Type of Organization (check type of organization)			
Governmental	Proprietary	Voluntary Non-Profit	
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City/County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church/Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> 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
D. Lessee Information (If the lease includes sub-leases, complete for all parties)			
Is the facility leased? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," continue. If "No," skip to Section E.			
Name of Lessee			
Blue Care OpCo Humboldt - North LLC			
Street Address (physical location)			
1111 11th Avenue North			
City	State	Zip Code	County
Humboldt	Iowa	50548	Humboldt
Mailing Address (if different from physical location)			
City	State	Zip Code	County
Telephone Number	FAX Number	E-Mail Address	
(515) 332-2623	(515) 332-2653	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	
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City/County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church/Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> 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 See attached Exhibit B	Title		Ownership %
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? <div style="text-align: center;"> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No </div>			
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 Halkins		Telephone Number 732-637-9191	
G. Chain Organization			
Is the applicant under the control of a chain organization? <div style="text-align: center;"> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </div>			
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):			
<ul style="list-style-type: none"> ● 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? <div style="text-align: center;"> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </div> If "Yes," provide the following information regarding any management company retained to operate this facility or program.			
Type of Management Company:		<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership
		<input type="checkbox"/> LLC	<input type="checkbox"/> 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	
Officer			
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? <div style="text-align: center;"> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </div> 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) of Applicant/Licensee  <small>3E192EE2E1A04E9</small>	Name – Applicant/Licensee (print or type) Blue Care OpCo Humboldt - North LLC d/b/a Humboldt Wellness and Rehabilitation
Title – Applicant/Licensee Sam Haikins, President	Date Signed 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

STATE OF IOWA

NONTRANSFERABLE

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

DES MOINES

HUMBOLDT WELLNESS AND REHABILITATION

1111 11TH AVENUE NORTH

HUMBOLDT, IA 50548

License Number: 460216

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

James Rumbold Jr

Director



POST IN CONSPICUOUS PLACE

STATE OF IOWA

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

DES MOINES

NONTRANSFERABLE

HUMBOLDT WELLNESS AND REHABILITATION
1111 11TH AVENUE NORTH
HUMBOLDT, IA 50548
License Number: 460216
Beds/Capacity: 24

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

