IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
HEALTH FACILITIES DIVISION
APPLICATION FOR CERTIFICATE

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 opening of the program or the expiration of your current certificate. Note: This application is an open record and available to the public.

Iowa Department of Inspections & Appeals
Health Facilities Division – Adult Services Bureau
Lucas State Office Building – Third Floor
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-6325
Fax: (515) 242-5022

FOR OFFICE USE ONLY
Certificate Number:
Certificate Fee:
Certificate Type
Effective Date:
Expiration Date:

Type of Application

☐ Initial ☐ Recertification ☐ Amendment* ☒ Change of Ownership

* Please specify the reason for the amendment (i.e., Program name change, % ownership change of an interested party):
APPOINTMENT OF A RECEIVER EFFECTIVE AUGUST 9, 2022

GENERAL INFORMATION

Program Name (doing business as): Madison Square Assisted Living			
Previous Name (if applicable): QHC Madison Square, LLC			
Street Address (physical location): 209 W. Jefferson			
City: Winterset	County: Madison	State: IA	Zip Code: 50273
Mailing Address (if different from physical address)			
City	County	State	Zip Code
Program Telephone Number: 5154625087	Program FAX Number: 5154629058	E-mail Address: sam@bdequities.com	

CERTIFICATE TYPE (CHOOSE ONE) AND FEE STRUCTURE

☒ Assisted Living Program Type of ☒ General and/or ☒ Dementia-Specific ☐ Population: Elder ☐ Group Home Adult Day Service	☐ Initial certificate - $750 ☐ Recertification - $1,000 ☐ Accreditation via a national body of accreditation (ALP and ADS only) - $125 **N/A**
Total Number of Dwelling Units: 80 If an Assisted Living Program, Number of Dwelling Units: General Population _____ Dementia-Specific 80 Maximum Occupancy: 80	Fee Enclosed: $

Certificate Holder is the ☒ owner(s)/lessor(s), ☐ lessee, or ☐ management company.
The Certificate Holder is the person(s) or business entity ultimately responsible for the operation of the program and with the authority to direct the management and policies of the program.

ADMINISTRATION			
A. Program Manager			
Name – Program Manager Barbara Painter			
Indicate whether the Program Manager is also the **designee** (person authorized to accept personal service and receive registered and certified mail). If "No," complete the Designee section. ☒ **Yes** ☐ **No**			
Note: Any changes to the Program Manager should be reported to the Department in writing within ten (10) business days of the change.			
B. Designee			
Name – Designee Sam Haikins		Title President	E-Mail Address: sam@bdequities.com

OWNERSHIP INFORMATION			
A. Owner(s)/Lessor(s)			
Name – Owner(s)/Lessor(s) Blue Care PropCo Winterset - West, LLC			
Street Address (physical location) 209 W. Jefferson			
City Winterset	State IA	Zip Code 50273	County Madison
Mailing Address (if different from street address) 36 Airport Road, Ste 206			
City Lakewood	State NJ	Zip Code 08701	County Ocean
Telephone Number (515)462-5087	FAX Number	sam@bdequities.com	
Contact Person Sam Haikins		Telephone Number (515)462-5087	

B. 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

C. Interested Parties

List all the names, addresses, and percentages of stock, shares, and partnerships or other equity interest of all officers, members of the board of directors, and trustees, as well as stockholders, partners, or any individuals who have greater than a 10% equity interest in the program. The program shall notify DIA of any changes in the list no later than 10 working days after the effective date of the changes.

Name See Attached Exhibit A	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
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 program leased? ☒ Yes ☐ No
If "**Yes**," continue. If "**No**," skip to Section E.

Name of Lessee Blue Care OpCo Winterset - West LLC			
Street Address (physical location) 209 W. Jefferson			
City Winterset	State IA	Zip Code 50273	County Madison
Mailing Address (if different from physical location)			
City	State	Zip Code	County
Telephone Number (515)462-5087	FAX Number (515) 462-9058	E-Mail Address sam@bdequities.com	
Contact Person Sam Haikins		Telephone Number 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

F. Interested Parties

List all the names, addresses, and percentages of stock, shares, and partnerships or other equity interest of all officers, members of the board of directors, and trustees, as well as stockholders, partners, or any individuals who have greater than a 10% equity interest in the program. The program shall notify DIA of any changes in the list no later than 10 working days after the effective date of the changes.

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

G. 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	

H. 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 program for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, providers/suppliers cost reports, etc.

In addition, a chain program would not necessarily be a subsidiary of the parent corporation but the chain program or programs 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.

MANAGEMENT COMPANY

Is the operation of the program under a management contract?

☐ Yes ☒ No

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

Type of Management Company:	☐ Corporation	☐ Partnership	☐ LLC	☐ Other
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

FUNDING – FOR ASSISTED LIVING PROGRAMS ONLY

Is the Program considered an Affordable Assisted Living Program, which is built with low-income housing tax credits?

☐ Yes ☒ No

Will the Program participate in the Medicaid Home and Community-Based Services (HCBS) Waiver program?

☒ Yes ☐ No

Will the Program participate in the HCBS Rent Subsidy Waiver or HUD Section 8 Rental Vouchers program?

☐ Yes ☒ No

STRUCTURE (FILL IN STRUCTURAL INFORMATION SHEET REGARDING DWELLING UNITS)

A. Is the Program attached to one of the following: ☐ RCF ☐ NF ☐ Hospital ☒ Freestanding

B. Is the Program part of a licensed Continuing Care Retirement Community (CCRC)? ☐ Yes ☒ No

C. What is the targeted opening date of the new program? CHOW effective date

D. For Recertification only:

Have there been any structural modifications to the building since the most recent state certification?

☐ Yes ☒ No

If you answered "Yes," please provide the month and year of completion of the modification(s):

Month/Year: _____

OTHER BUSINESS/ACTIVITY

Please list all other business(es) or activity(ies) located in the program, such as respite care, physical therapy, occupational therapy, etc.: _____

_____

_____

TARGET CLIENTELE

Please describe the clientele to be served (i.e. Intellectually Disabled, Brain Injury, Dementia, Elderly, etc.):
Elderly, Dementia

EMERGENCY RESPONSE SYSTEM

Will the program have staff on-site on a 24-hour/day basis to respond to emergency situations?

☒ Yes ☐ No

If you checked "No," please annotate the staff's emergency response time in minutes: _____

FOOD SERVICE

The Program will serve 3 meals each day in a common dining room.

Meals will be prepared:
☒ On-site, a copy of the food service establishment or nursing facility license is attached
☐ Off-site, a copy of the provider's food service establishment or nursing facility license is attached

ADVERSE ACTION – TO BE COMPLETED BY NEW APPLICANTS ONLY

Within the last 10 years, has any adverse action(s) initiated by another state license agency (other than Iowa) resulted in the denial (D), suspension (S), or revocation (R) of a license or certificate held by the owner/lessor, lessee, interested parties, parent corporation, "home office" of a chain organization and/or any of the members of a LLC/LLP?

☐ 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

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		
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.)		

APPLICANT/LICENSEE - TO BE COMPLETED BY NEW APPLICANTS ONLY

If the applicant/licensee has never been licensed to operate a program in the State of Iowa, we request that you 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 program.

CONTACT PERSON

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

Name		Title
Sam Haikins		President
Telephone Number 732-637-9191	FAX Number	E-Mail Address sam@bdequities.com

Disclosures

1. In accordance with 481 IAC 69.4(3), 68.4(3) or 70.4(3), do any of the individuals referred to in the "Interested Parties" sections of this application have, or have they had, any ownership interest in an adult day service program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code chapter 135C, or a licensed hospital as defined in Iowa Code chapter 135B, which has been closed in any state due to removal of program, agency, or facility licensure or certification, due to involuntary termination from participation in either the Medicare or Medicaid Program, or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants, or participants.

2. In accordance with 481 IAC rules 68.4(2), 69.4(2), or 70.4(2), have any of the individuals referred to in the "Interested Parties" section of this application been convicted of a felony, aggravated or serious misdemeanor or found in violation of the child abuse or dependent adult abuse laws of any state.

☐ Yes ☒ No

If *"Yes,"* please provide an explanation on a separate sheet of paper.

AFFIRMATION STATEMENT

I hereby affirm to the best of my knowledge that the information in this application is complete and accurate. I assure the owner(s) of the program named herein will work with the Department of Inspections and Appeals, Department of Public Safety, and others as deemed necessary, to bring the program into full compliance with the requirements of Iowa Code chapters 231B, 231C, or 231D; 481 Iowa Administrative code chapters 67, 68, 69 or 70; and other applicable local, state, and federal regulations.

DocuSigned by:
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Authorized Signature and Title

10/26/2022
Date

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