

12-083

HFPB



### Long-Term Care Facility - Approved Licensure Actions

Current Licensure Information:

Facility ID # 6016794

Licensee ID# 0052209

Facility Name: Bridge Care Suites, The

Address: 3089 Old Jacksonville Road

City: Springfield

County: Sangamon

ZIP Code: 62704

The Division of Long-Term Care Quality Assurance has approved the facility listed above for the following licensure actions(s):

New Facility  CHOW  Name Change  Licensee Change  Address Change  Bed Change  Closure

1. New Facility - Effective Date of Initial Licensure: 03 - 19 - 13

<b>Bed Capacity:</b>	Skilled	75
	Under Age 22	
	Intermediate	
	ICF/DD	
	ICF/DD > 16 Beds	
	Sheltered Care	
	Community Living	
	<b>TOTAL</b>	75

**RECEIVED**

APR 05 2013

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

Facility will operate an ASCU:  Yes  No

2. Change of Ownership - Effective Date of Ownership: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Effective Date of Licensure: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

New Facility Name: \_\_\_\_\_

New Licensee ID#: \_\_\_\_\_

<b>Bed Capacity:</b>	Skilled	_____
	Under Age 22	_____
	Intermediate	_____
	ICF/DD	_____
	ICF/DD > 16 Beds	_____
	Sheltered Care	_____
	Community Living	_____
	<b>TOTAL</b>	_____

Facility will operate an ASCU:  Yes  No



## Long-Term Care Facility - Approved Licensure Actions

3. Change of Facility Name - Effective Date of Change: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

New Facility Name: \_\_\_\_\_

4. Change of Licensee Name - Effective Date of Change: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

New Licensee Name: \_\_\_\_\_

5. Change of Address - Effective Date of Change: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

New Address: \_\_\_\_\_

6. Capacity and/or Level of Care - Effective Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

<b>From:</b>			<b>To:</b>		
Skilled	_____		Skilled	_____	
Under Age 22	_____		Under Age 22	_____	
Intermediate	_____		Intermediate	_____	
ICF/DD	_____		ICF/DD	_____	
ICF/DD > 16 Beds	_____		ICF/DD > 16 Beds	_____	
Sheltered Care	_____		Sheltered Care	_____	
Community Living	_____		Community Living	_____	
TOTAL	_____		TOTAL	_____	

7. Closure of Facility - Effective Date of Closure: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Reason for Closure: \_\_\_\_\_

Additional Notes: \_\_\_\_\_

*Joni Colón*<sub>16</sub>

Licensure Program Administrator

03/19/13

Date