

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital – Orland Park

| 1.   | Name (Please Print) Derrence Moisan, MD   |
|------|---|
|      | City Polos Hughes State IL zip/104/67   |
|      | Signature Musico  |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any graup, organization or other entity.) |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|      | Polos Commenty Hospital   |
|      |   |
|      |   |
| III. | POSITION (please circle appropriate position)   |
|      | Support Oppose Neutral  |
| IV.  | Testimony (please circle )  |
|      | Oral Written  |



## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## Public Hearing Testimony Registration Form

| Project N | Number: 16-001  |
|-----------|---|
| l.        | Name (Please Print) Thomas A. Pratt   |
|           | city Orland Park State IL zip 60469   |
|           | Signature Thomas A. Piul  |
| 11.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|           | Save PHFC   |
|           |   |
|           |   |
| III.      | POSITION (please circle appropriate position)   |
|           | Support Oppose Neutral  |
| IV.       | Testimony (please circle )  |
|           | Oral Written  |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001 ١. Zip 60462 II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) 111. POSITION (please circle appropriate position) Support Oppose Neutral IV. Testimony (please circle) Written





| Project | t Number: 16-001                          |                                    |                          |                      |                     |
|---------|---|------------------------------------|--------------------------|----------------------|---------------------|
| 1.      | IDENTIFICATION Name (Please Print)        | DANIEL 7                           | 2057                     |                      |                     |
|         | City MAYWOO                               | <u>වර</u> State ු                  | IL                       | Zip                  | 60153               |
|         | Signature                                 | mio Par                            | <u></u>                  |                      |                     |
| II.     | REPRESENTATION (This so                   | ection is to be filled if the witr | ess is appearing on beha | lf of any group, org | ganization or other |
|         | Entity, Organization, etc<br>Health Care) | ersity Health                      |                          | ABC Concerne         | d Citizens for      |
|         |   |                                    |                          |                      |                     |
|         |   |                                    |                          |                      |                     |
|         |   |                                    |                          |                      |                     |
| III.    | POSITION (please circle                   | appropriate position               | )                        |                      |                     |
|         | Support                                   | Oppose                             | Neutral                  |                      |                     |
| IV.     | Testimony (please circle                  | ,)                                 |                          |                      |                     |
|         | Oral                                      | Written                            |                          |                      |                     |





**Project Number: 16-001** 

## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## Public Hearing Testimony Registration Form

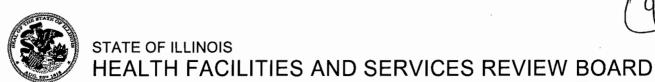
| •    |  |
|------|--|
| 1.   | Name (Please Print) Lon Mazika Mise  |
|      | city Palos Heights State II zip 60467  |
|      | Signature Lala K. Mazula Myse  |
| 11.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
|      | entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for                   |
|      | Health Care)   |
|      | Reading a letter from Mayor  |
|      | Mchaughlin   |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      | Support Oppose Neutral   |
| IV.  | Testimony (please circle )   |
|      | Orgal Written  |





| Pro | ject | Num | ber: | 16-001 |
|-----|------|-----|------|--------|
|     |      |     |      |        |

| l.   | IDENTIFICATION Name (Please Print) | AROL WEST                             | -SAELE                       |                             |
|------|------------------------------------|---------------------------------------|------------------------------|-----------------------------|
|      | City ORLAND PA                     | IKKState                              | TZ                           | zip 60462                   |
|      | Signature (W) (                    | WET-Face                              | e                            |                             |
| И.   | REPRESENTATION (This sec           | tian is to be filled if the witness i | appearing on behalf of any g | roup, organization or other |
|      | Entity, Organization, etc.         | represented in this app               | earance (i.e., ABC Cor       | ncerned Citizens for        |
|      | Health Care) PALOS                 | HEALTH 11                             | - MUSS COM                   | Uter_                       |
|      |                                    |                                       |                              |                             |
|      |                                    |                                       |                              |                             |
|      |                                    |                                       |                              |                             |
| 111. | POSITION (please circle o          | appropriate position)                 |                              |                             |
|      | Support                            | Oppose                                | Neutral                      |                             |
| IV.  | Testimony (please circle )         |                                       |                              |                             |
|      | Oral                               | Written                               |                              |                             |





Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001 Name (Please Print) BARDING HARPER

City Hope GKN State IC Zip GO FT IDENTIFICATION ١. II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) Concerned PW III. POSITION (please circle appropriate position) Neutral Testimony (please circle) IV. Written





Facility Name: Palos Community Hospital - Orland Park

| 1.   | Name (Please Print) ale = = wingle  |
|------|---|
|      | City Orland Park State IL zip 60462   |
|      | Signature Signature   |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any graup, organization or other entity.) |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|      | - PSIOS PERCENCE OF STY   |
|      |   |
|      |   |
| III. | POSITION (please circle appropriate position)   |
| (    | Support Oppose Neutral  |
| IV.  | Testimony (please circle )  Oral  Written   |





Project Number: 16-001

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## Public Hearing Testimony Registration Form

| IDENTIFICATION Name (Please Print)   | MARY            | -204             | CARRO              | 1                                |
|--------------------------------------|-----------------|------------------|--------------------|----------------------------------|
| City Homer                           |                 | State            | II-                | zip_60491                        |
| Signature Man                        | 5°°5            | State            |                    |                                  |
|                                      |                 |                  |                    | any group, organizotion or other |
| entity.)                             |                 |                  |                    |                                  |
| Entity, Organization<br>Health Care) | , etc. represer | ited in this app | earance (i.e., ABC | Concerned Citizens for           |
|                                      |                 |                  |                    |                                  |
|                                      |                 |                  |                    |                                  |
|                                      |                 |                  |                    |                                  |
|                                      |                 |                  |                    |                                  |
|                                      |                 |                  |                    |                                  |
| POSITION (please c                   | ircle appropria | ite position)    |                    |                                  |
| Support                              | Орро            | se               | Neutral            |                                  |
| Testimony (please o                  | ircle )         |                  |                    |                                  |
| Oral                                 | Writte          | en               |                    |                                  |





## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| Project N | Number: 16-001   |          |
|-----------|--|----------|
| l.        | Name (Please Print) MARION LOSOLE  |          |
|           | City HOMER GLEN State IL. zip 604  | 19/      |
|           | Signature (Marcon Desale   | _        |
| II.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization entity.) | or other |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citize Health Care)                     | ns for   |
|           | PALOS HEALTH AND FITNESS CEN   | TER      |
|           |  |          |
|           |  |          |
| 111.      | POSITION (please circle appropriate position)  |          |
|           | Support Oppose Neutral   |          |
| IV.       | Testimony (please circle )   |          |
|           | (Oral) Written   |          |

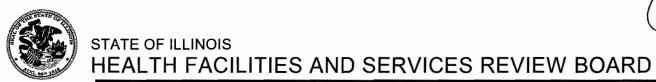




## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| Project N | Number: 16-001  |
|-----------|---|
| I.        | Name (Please Print) AT All Coplan   |
|           | city <u>Partys Heights</u> State 1L zip 60463   |
|           | Signature M 3 4 4   |
| II.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)   |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)  Palos Chammity Hospital |
|           |   |
|           |   |
|           |   |
| 111.      | POSITION (please circle appropriate position)   |
|           | Support Oppose Neutral  |
| IV.       | Testimony (please circle )  |
|           | (Oral ) Written   |





Facility Name: Palos Community Hospital – Orland Park

| I.   | Name (Please Print) JAMES Prendergast   |
|------|---|
|      | City PALOS 41/5. State IL zip 60463   |
|      | Signature Jame Inchit   |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|      |   |
|      |   |
|      |   |
| III. | POSITION (please circle appropriate position)   |
|      | Support Oppose Neutral  |
| IV.  | Testimony (please circle )  |
|      | Oral Written  |





## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## Public Hearing Testimony Registration Form

| Project N | Number: 16-001                               |                    |                           |                         |                              |
|-----------|--|--------------------|---------------------------|-------------------------|------------------------------|
| I.        | IDENTIFICATION Name (Please Print)           | 1012               | Klabi                     | ende                    |                              |
|           | City Palos Here                              | phb_               | _State                    |                         | zip <u>60463</u>             |
|           | Signature <u>Alluw</u>                       | Klabi              | inde                      |                         |                              |
| II.       | REPRESENTATION (This section entity.)        | on is to be filled | if the witness is app     | earing on behalf of any | group, organization or other |
|           | Entity, Organization, etc. r<br>Health Care) |                    | in this appeara<br>Munity |                         | oncerned Citizens for        |
|           |  | Cond               | minung                    | THOSPACE                |                              |
|           |  |                    | 5                         |                         |                              |
|           |  |                    |                           |                         |                              |
| III.      | POSITION (please circle ap                   | ppropriate μ       | oosition)                 |                         |                              |
|           | Support                                      | Oppose             |                           | Neutral                 |                              |
| IV.       | Testimony (please circle )                   |                    |                           |                         |                              |
|           | Oral   | Written            |                           |                         |                              |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001 ł. **IDENTIFICATION** Flora Movtell Name (Please Print) Burbaul II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for III. POSITION (please circle appropriate position) Oppose Neutral Testimony (please circle ) IV. Oral Written





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

I. IDENTIFICATION
Name (Please Print)

City Palos Lills State IL Zip 60 46 5

Signature

II. REPRESENTATION (This section is to be filled if the witness is appearing on beholf of any group, organization or other entity.)
Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

III. POSHTION (please circle appropriate position)

Support Oppose Neutral

IV. Testimony (please circle )

Oral

Written





| Project I | Number: 16-001  |
|-----------|---|
| l.        | Name (Please Print) Martha Kraus 7  |
|           | City Pals Plc State Dl. Zip Co 46   |
|           | Signature h wth M. Kuus   |
| 11.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for                                     |
|           | Health Care) SAVE PHFC  |
|           |   |
|           |   |
|           |   |
| III.      | POSITION (please circle appropriate position)   |
|           | Support Oppose Neutral  |
| IV.       | Testimony (please circle )  |
|           | Oral Written  |





## Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital – Orland Park

| I.   | Name (Please Print) Doreen Dan W  |
|------|---|
|      | City Tipley Park State Il zip 60487   |
|      | Signature Dorun Dam   |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for |
|      | Health Care)  |
|      | <del></del>   |
|      |   |
|      |   |
| III. | POSITION (please circle appropriate position)   |
|      | Support Oppose Neutral  |
| IV.  | Testimony (please circle )  |
|      | Oral Written  |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

| l.   | Name (Please Print) MARY BULDW STOULWSKI   |
|------|--|
|      | City MOKENA State TU Zip God 48 Signature Plan Ille Inle X   |
| 11.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
|      | entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)      |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      | Support Oppose Neutral   |
| IV.  | Testimony (please circle )   |
|      | Oral Written   |





## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## Public Hearing Testimony Registration Form

| Project N | Number: 16-001   |
|-----------|--|
| 1.        | Name (Please Print) JOS LPT SMOUNSIE Zip 60448   |
|           |  |
|           | Signature / Signat |
| 11.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)  |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for  |
|           | Health Care)   |
|           |  |
|           | ,  |
|           |  |
| III.      | POSITION (please circle appropriate position)  |
|           | Support Oppose Neutral   |
| IV.       | Testimony (please circle )   |
|           | Oral Written   |





### HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

| i.   | Name (Please Print) Pana Bardrey   |
|------|--|
|      | city Wiand Ph State 11 zip60462  |
|      | Signature Millimedewer   |
| 11.  | REPRESENTATION (This section is ta be filled if the witness is appearing on behalf of any group, arganization or other |
|      | entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)      |
|      |  |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      | Support Oppose Neutral   |
| V.   | Testimony (please circle )   |
|      | Oral Written   |





## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital - Orland Park

| l.   | IDENTIFICATION  Name (Please Print) | Sort.             | Stra7             | <u>-</u>                  |                                  |
|------|-------------------------------------|-------------------|-------------------|---------------------------|----------------------------------|
|      | city Palas Heis                     | ; h /-            | State             |                           | Zip                              |
|      | Signature                           | <u> </u>          |                   |                           |                                  |
| II.  | REPRESENTATION (This section        | on is to be fille | ed if the witness | is appearing on behalf of | any group, organization or other |
|      | Entity, Organization, etc. re       | epresente         | d in this app     | oearance (i.e., ABC       | Concerned Citizens for           |
|      | Health Care)                        |                   |                   | Hegys                     |                                  |
|      |                                     |                   |                   | ,<br>                     |                                  |
|      |                                     | _                 |                   |                           |                                  |
|      |                                     |                   |                   |                           |                                  |
| 111. | POSITION (please circle ap          | propriate         | position)         |                           |                                  |
|      | Support                             | Oppose            | •                 | Neutral                   |                                  |
| IV.  | Testimony (please circle )  Oral    | Written           |                   |                           |                                  |
|      |                                     |                   |                   |                           | •                                |





## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| Project N | lumber: 16-001  |
|-----------|---|
| I.        | IDENTIFICATION Name (Please Print) City State Zip Signature   |
| II.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)  Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |
| III.      | POSITION (please circle appropriate position)   |
|           | Support Oppose Neutral  |
| IV.       | Testimony (please circle )  Oral  Written   |





Facility Name: Palos Community Hospital – Orland Park

| f.   | Name (Please Print) AARICIA Kellin  |
|------|---|
|      | City Mos Hs State In Zip 609/03 Signature Co Miles Line   |
|      |   |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|      | Palax Comming Hopi V  |
|      |   |
| III. | POSITION (please circle appropriate position)   |
|      | Support Oppose Neutral  |
| IV.  | Testimony (please circle )  |
|      | Oral Written  |





Project Number: 16-001

## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| l.   | Name (Please Print) 1 1 1 The Ever S  |   |
|------|---|---|
|      | City 0, P State I 1 Zip 60462   | · |
|      | Signature andy Euro K =   |   |
| 11.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |   |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |   |
|      |   |   |
|      |   |   |
|      |   |   |
| III. | POSITION (please circle appropriate position)   |   |
|      | Support Oppose Neutral  |   |
| IV.  | Testimony (please circle )  |   |
|      | Oral Written  |   |



## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| l.   | Name (Please Print) Branda Guerdini   |
|------|---|
|      | City Malana State IL zip 60448  |
|      | Signature San Signature   |
| II.  | REPRESENTATION (This section is to be filled if the witness is oppearing on behalf of any group, organization or other entity.) |
|      |   |
|      | Health Care) Community M. Frings (e.g., ABC Concerned Citizens for  |
|      |   |
|      |   |
|      |   |
| III. | POSITION (please circle appropriate position)   |
|      | Support Oppose Neutral  |
| IV.  | Testimony (please circle )  |
|      | Oral Written  |





## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital – Orland Park

| l.   | IDENTIFICATION   |
|------|--|
|      | Name (Please Print) VILON FOX  |
|      | City Orland Park State 16 zip  |
|      | Signature / n/   |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
|      | entity.)   |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)               |
|      | Life Time Citness  |
|      |  |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      |  |
|      | Support Oppose Neutral   |
| (    |  |
| IV.  | Testimony (please circle )   |
|      | Oral Written   |





Project Number: 16-001

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| I.   | IDENTIFICATION Name (Please Print)  | SASON FO                             | X                              |                                |
|------|---|--------------------------------------|--------------------------------|--------------------------------|
|      | City Do Jamo  | State_                               | 16                             | Zip                            |
|      | Signature   | an Joy                               | <u> </u>                       |                                |
| II.  |   | ection is to be filled if the witnes | s is appearing on behalf of an | y group, arganization or other |
|      | entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) |                                      |                                |                                |
|      | Life Time Fitness   |                                      |                                |                                |
|      |   |                                      |                                | ·                              |
|      |   |                                      |                                |                                |
| III. | II. POSITION (please circle appropriate position)   |                                      |                                |                                |
|      | Support   | Oppose                               | Neutral                        |                                |
| IV.  | Testimony (please circle  | ? )                                  |                                |                                |
|      | Oral  | Written                              |                                |                                |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001 I. **IDENTIFICATION** Name (Please Print) Karw Evers REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other II. entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) III. POSITION (please circle appropriate position) Neutral Support Oppose IV. Testimony (please circle) Oral Written





## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| Facility Name: Palos Community Hospital – Orland Park |  |  |  |
|---|--|--|--|
| Project N   | Number: 16-001   |  |  |
| i.  | IDENTIFICATION Name (Please Print) Sharon Hoffman  City Palos Heightstate  |  |  |
| И.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |  |  |
|   | Current Cancer patient   |  |  |
| III.<br>·   | POSITION (please circle appropriate position)  Support Oppose Neutral  Testimony (please circle )  |  |  |
| (   | Oral Written   |  |  |





## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| Project N | lumber: 16-001  |  |  |  |
|-----------|---|--|--|--|
| l.        | IDENTIFICATION Name (Please Print)  AG1  MOSTE IKA  |  |  |  |
| II.       | City State Zip 467  Signature A Mossell State Zip 66 467  REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |  |  |  |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)  |  |  |  |
|           | MEMBER OF PHG   |  |  |  |
|           |   |  |  |  |
| III.      | POSITION (please circle appropriate position)   |  |  |  |
|           | Support Oppose Neutral  |  |  |  |
| IV.       | Testimony (please circle )  Oral Written  |  |  |  |
|           |   |  |  |  |





**Project Number: 16-001** 

## HEALTH FACILITIES AND SERVICES REVIEW BOARD

### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

| l.  | IDENTIFICATION Name (Please Print) Condy Copen haves  |
|-----|---|
|     | city Thornton State II zip 6047   |
|     | Signature Course Con  |
|     |   |
| 11. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|     | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for                                     |
|     | Health Care) ARTHRITIS Foundation   |

III. POSITION (please circle appropriate position)

Support



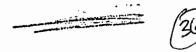
Neutral

IV. Testimony (please circle )









Facility Name: Palos Community Hospital - Orland Park

| l.   | Name (Please Print) DICAU DUOL  |
|------|---|
|      | City Gen wood State Di Zip 60411  |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)  Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)  M. A. H. M. M. A. L. M. L. |
|      |   |
| III. | POSITION (please circle appropriate position)  Support Oppose Neutral   |
| IV.  | Testimony (please circle )  Oral  Written   |





## HEALTH FACILITIES AND SERVICES REVIEW BOARD

## Public Hearing Testimony Registration Form

| roject l   | Number: 16-001  |  |  |
|--|---|--|--|
| t.   | Name (Please Print) Michelle S. Martin  |  |  |
|  | City Evergreen PK State III Zip 60805   |  |  |
|  | Signature   |  |  |
| II.  | REPRESENTATION (This section is to be filled if the witness is oppearing on behalf of any group, organization or other entity.) |  |  |
| Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citiz Health Care)  Concerned Citizen |   |  |  |
|  |   |  |  |
|  | <del></del>   |  |  |
|  | · · · · · · · · · · · · · · · · · · ·   |  |  |
| III.   | POSITION (please circle appropriate position)   |  |  |
|  | Oppose Neutral  |  |  |
| IV.  | Testimony (please circle)   |  |  |
|  | Oral Written  |  |  |





Project Number: 16-001

#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

I. IDENTIFICATION

Name (Please Print) Helen Hermansen

City Orland PK State III Zip 60642

Signature Helen Hermansen

II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

Concern

Neutral

III. POSITION (please circle appropriate position)

Support Oppose

IV. Testimony (please circle )

Oral Written





# HEALTH FACILITIES AND SERVICES REVIEW BOARD Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital - Orland Park

| i.   | Name (Please Print) IERRY STOEF #   |
|------|---|
|      | City MOKENA State 1L zip 60448  |
| (    | Signature Kerry Hell  |
| И.   | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for                                     |
|      | Health Care) SAVE PHFC  |
|      |   |
|      |   |
|      |   |
| 111. | POSITION (please circle appropriate position)   |
|      | Support Oppose Oppose   |
| IV.  | Testimony (please circle )  |
|      | Qral Written  |





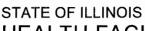
## STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

## **Public Hearing Testimony Registration Form**

| <b>Project Number: 16</b> | 5-001 |
|---------------------------|-------|
|---------------------------|-------|

| l.   | Name (Please Print) Nich A THORF   |                |          |             |  |
|------|--|----------------|----------|-------------|--|
|      | Name (Please Print)  | INCA MEDICE    | -        |             |  |
|      | City PALOS PARK  | State( <u></u> | <u> </u> | Zip & # 464 |  |
|      | Signature <u>hima</u>  | Korp.          |          |             |  |
| 11.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |                |          |             |  |
|      | Entity, Organization, etc. r<br>Health Care)   | •              |          |             |  |
|      | SAVE PFHC  |                |          |             |  |
|      |  |                |          |             |  |
|      |  |                |          |             |  |
|      |  |                |          |             |  |
| III. | POSITION (please circle appropriate position)  |                |          |             |  |
|      | Support  | Opposè         | Neutral  |             |  |
| IV.  | Testimony (please circle )   |                |          |             |  |
|      | Oral   | Written        |          |             |  |





Testimony (please circle )

IV.

#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital – Orland Park

II. POSITION (please circle appropriate position)

Support

Open Carrier State

II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

FOSITION (please circle appropriate position)

Neutral

Written





### Public Hearing Testimony Registration Form

| 1.   | Name (Please Print) / SABELL CAPUTO  |
|------|--|
|      | City HOMER GLEW State 1L. Zip 60491  |
|      | Signature & abell T. Caput   |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)  Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for |
|      | Health Care)   |
|      | SAUE PHOF PLEASE!!!  |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      | Support Oppose Neutral   |
| IV.  | Testimony (please circle )   |
|      | Oral Written   |





# STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

# **Public Hearing Testimony Registration Form**

| Project | Number: | 16-001 |
|---------|---------|--------|
|---------|---------|--------|

| l.   | Name (Please Print) Robert E. Sullivan  |   |
|------|---|---|
|      | city Orland Park State 1L zip 60462   | - |
|      | Signature Polit C. Sullwy   | _ |
| 11.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of ony group, organization or other entity.) |   |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |   |
|      |   | _ |
|      |   |   |
|      |   |   |
| 111. | POSITION (please circle appropriate position)   |   |
|      | Support Oppose Neutral  |   |
| IV.  | Testimony (please circle )  |   |
| ,    | Oral Written  |   |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

### **Public Hearing Testimony Registration Form**

| <b>Project</b> | Number: | 16-001 |
|----------------|---------|--------|
|----------------|---------|--------|

|   | DENTIFICATION  Name (Please Print)  |
|---|---|
| С | City Paws Herones State In Zip bout 3.  |
| S | ignature House London   |
|   | EPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other ntity.) |
| Ε | ntity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for lealth Care)                       |
| _ |   |
| _ |   |
| _ |   |
| P | POSITION (please circle appropriate position)   |
|   | Support Oppose Neutral  |
| T | estimony ( <i>please circle</i> )   |
|   | Qral Written  |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park Project Number: 16-001 **IDENTIFICATION** ١. Name (Please Print) zip 60462 Signature REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other 11. entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) POSITION (please circle appropriate position) III. Support Neutral Testimony (please circle ) IV. Written



#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

### Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital - Orland Park

| i.   | IDENTIFICATION Name (Please Print)    | mellia the                              |                            |                              |
|------|---------------------------------------|---|----------------------------|------------------------------|
|      | city Do Jana Pa                       | XX State                                | 11                         | zip 60467                    |
|      | Signature MAS                         | n. Watter                               |                            | ·<br>                        |
|      |                                       | 0                                       |                            |                              |
| 11.  | REPRESENTATION (This section entity.) | on is to be filled if the witness is ap | pearing on behalf of any g | group, organizotion or other |
|      | Entity, Organization, etc. r          | epresented in this appea                | rance (i.e., ABC Coi       | ncerned Citizens for         |
|      | Health Care)                          |   | • •                        |                              |
|      | - MS                                  | Roughes_                                |                            |                              |
|      |                                       | P                                       |                            |                              |
|      |                                       |   | <del></del>                |                              |
|      |                                       |   |                            |                              |
|      |                                       |   |                            |                              |
|      |                                       |   |                            |                              |
| III. | POSITION (please circle a             | opropriate position)                    |                            |                              |
|      | Support                               | Oppose                                  | Neutral                    |                              |
| IV.  | Testimony (please circle )            |   |                            |                              |
|      | Oral                                  | Written                                 |                            |                              |





# STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

# Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital – Orland Park

| IDENTIFICATION Name (Please Print)         | 17N/5                | GRA                 | 1dy             |                    |                      | _ |
|--|----------------------|---------------------|-----------------|--------------------|----------------------|---|
| City 19446 N                               | suporta              | Státe               | TL'_            | Zip_               | 40448                |   |
| Signature and                              | ) Fra                | of                  |                 |                    |                      | - |
| REPRESENTATION (This sec                   | tion is to be filled | f the witness is ap | pearing on beha | lf of any group, o | rgonization or other |   |
| Entity, Organization, etc.<br>Health Care) | represented          | in this appea       | rance (i.e., A  | ABC Concern        | ed Citizens for      |   |
|  |                      |                     |                 |                    |                      | _ |
|  |                      |                     |                 |                    |                      |   |
|  |                      |                     |                 |                    | _                    | _ |
| POSITION (please circle o                  | appropriate p        | osition)            |                 |                    |                      |   |
| Support                                    | Oppose               |                     | Neutral         |                    |                      |   |
| Testimony (please circle                   | )                    |                     |                 |                    |                      |   |
| Oral                                       | Written              |                     |                 |                    |                      |   |







# **Public Hearing Testimony Registration Form**

| Project N | Number: 16-001                            |                                    |                               |                                  |
|-----------|---|------------------------------------|-------------------------------|----------------------------------|
| 1.        | IDENTIFICATION Name (Please Print)        | NTHONY HO                          | GAN                           |                                  |
|           | City ORLAND PAR                           | ,                                  | IL.                           | zip 60462                        |
|           | Signature_Untilion                        | y Dogn                             |                               |                                  |
| II.       | REPRESENTATION (This so                   | ection is to be filled if the with | ess is appearing on behalf of | any group, organization or other |
|           | Entity, Organization, etc<br>Health Care) | c. represented in this a           | appearance (i.e., ABC         | Concerned Citizens for           |
|           |   |                                    |                               |                                  |
|           |   |                                    |                               |                                  |
|           |   |                                    |                               |                                  |
| III.      | POSITION (please circle                   | appropriate position)              |                               |                                  |
|           | Support                                   | Oppose                             | Neutral                       |                                  |
| IV.       | Testimony (please circle                  | •)                                 |                               | •                                |
|           | Oral                                      | Written                            |                               |                                  |





# Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital - Orland Park

| ,,   |  |
|------|--|
| l.   | Name (Please Print) Wynell Whitmore  |
|      | city Orland Park State IL zip 60462  |
|      | Signature Wynell Whitmore  |
| И.   | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
|      | entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)      |
|      |  |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      | Oppose Neutral   |
| IV.  | Testimony (please circle )   |
|      | Oral Written   |
|      |  |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

I. IDENTIFICATION
Name (Please Print)

City PAOS PK State IL Zip 60404

Signature Signature State State II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

III. POSITION (please circle appropriate position)

Support Oppose

Neutral

IV. Testimony (please circle )

Oral

Written





IV.

Testimony (please circle )

Project Number: 16-001

# STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital – Orland Park

| l.   | Name (Please Print) Karen Jones  |
|------|--|
|      | City Corestwood State 16 zip 60445   |
|      | Signature Kaun Jones   |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |
|      |  |
|      |  |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      | Support Oppose Neutral   |

Written





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park Project Number: 16-001 I. **IDENTIFICATION** Name (Please Print) II. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) POSITION (please circle appropriate position) III. Support Oppose Neutral IV. Testimony (please circle) Oral Written





### HEALTH FACILITIES AND SERVICES REVIEW BOARD

# **Public Hearing Testimony Registration Form**

| Project N | lumber: 16-001   |
|-----------|--|
| l.        | Name (Please Print) Roberta Rudolph  |
|           | City Orland Park State IL zip 60467  |
|           | Signature to but the second se |
| II.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)  |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)   |
|           | Palsa South Compus Expansion   |
|           | , – , ,  |
|           |  |
| III.      | POSITION (please circle appropriate position)  |
|           | Support Oppose Neutral   |
| IV.       | Testimony (please circle )   |
|           | Oral Written   |





# STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

# **Public Hearing Testimony Registration Form**

| acility N | lame: Palos Community Hospital – Orland Park  |
|-----------|---|
| Project N | Number: 16-001  |
| i.        | IDENTIFICATION Mary ANN Krueger  City Palos Hills State IlliNois zip 60465  |
|           | City Palos Hills State IlliNois Zip 60465   |
|           | Signature Mary an Frueger   |
| 11.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|           | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
| zpa       | NSI Palos South Fitness Center  |
| 1         |   |
|           |   |
| III.      | POSITION (please circle appropriate position)   |
|           | Support Oppose Neutral  |
| IV.       | Testimony (please circle )  |
|           | Oral Written  |





#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

Project Number: 16-001 1. **IDENTIFICATION** Name (Please Print) JOAN DONOUAN PALOS HEIGHTS IlliNois zip 60463 Signature\_ 11.  ${\sf REPRESENTATION} \ (\textit{This section is to be filled if the witness is appearing on behalf of any group, organization or other) \\$ entity.) Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) III. POSITION (please circle appropriate position) Support Opposé Neutral IV. Testimony (please circle) Oral Written





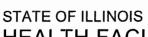
#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

# Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital – Orland Park

| l.   | Name (Please Print) TAMES GURREN   |
|------|--|
|      | City Folog Port State In Zip 60066   |
|      | Signature Laur En Veule  |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other |
|      | entity.)   |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)               |
|      |  |
|      |  |
|      |  |
|      |  |
| III. | POSITION (please circle appropriate position)  |
|      | Support Oppose Neutral   |
| IV.  | Testimony (please circle )   |
|      | Oral Written   |
| (    |  |
| _    | 11   |
| _    | Present Pales Hat Center.  |
|      | Que Pol Shat 1 19/17/15  |
|      | gresse and that add  |







#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

### Public Hearing Testimony Registration Form

| I.   | IDENTIFICATION Name (Please Print) 5+           | athi                        | a Xar                        | 05                             |
|------|---|-----------------------------|------------------------------|--------------------------------|
|      | City Distance                                   | L Parstote_                 | 14                           | Zip 6046                       |
|      | Signature                                       | this,                       | Kanos                        | 2                              |
| 11.  | REPRESENTATION (This section is entity.)        | to be filled if the witness | is appearing on behalf of ar | y group, organization or other |
|      | Entity, Organization, etc. repr<br>Health Care) | resented in this ap         | pearance (i.e., ABC (        | oncerned Citizens for          |
|      |   |                             |                              |                                |
|      |   |                             |                              |                                |
|      |   |                             |                              |                                |
| III. | POSITION (please circle appro                   | opriate position)           |                              |                                |
|      | Support   | ppose                       | Neutral                      |                                |
| IV.  | Testimony (please circle )                      |                             |                              |                                |
|      | Oral  | 11-111                      |                              |                                |





# HEALTH FACILITIES AND SERVICES REVIEW BOARD

# Public Hearing Testimony Registration Form

| Project | Number:    | 16-001  |
|---------|------------|---------|
| ı.      | IDENTIFICA | ATION . |

| Name (Please Print) harlone Sandberg  |
|---|
| City Drland Park State IL Zip 6046  |
| Signature Charlene D. Sandberg  |
| REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
| Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|   |
|   |
|   |
|   |
| POSITION (please circle appropriate position)   |
| Support Oppose Neutral  |
| Testimony (please circle )  |
|   |





Oral

# HEALTH FACILITIES AND SERVICES REVIEW BOARD

### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital – Orland Park

| Name (Please Print) Mary Copec  |
|---|
| City Tinley PK. State IL. zip 68487   |
| Signature Mary M Hpc  |
| REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
| Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|   |
|   |
|   |
| POSITION (please circle appropriate position)   |
| Support Oppose Neutral  |
|   |
| Testimony (please circle )  |

Written





# STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

### **Public Hearing Testimony Registration Form**

| I.   | Name (Please Print) Gerhild Waggert   |
|------|---|
|      | city Orland Park State TL zip 60467   |
|      | Signature Gerhald Wagget  |
| II.  | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|      |   |
|      |   |
|      |   |
| III. | POSITION (please circle appropriate position)   |
|      | Support Oppose Neutral  |
| IV.  | Testimony (please circle )  |
|      | (Oral) Written  |





# STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

# **Public Hearing Testimony Registration Form**

| Facility Name: | Palos Community Hospital – Orland Park |
|----------------|--|
|----------------|--|

| l <b>.</b> | Name (Please Print) Kathy Sullivan  |
|------------|---|
|            | city OR and Park State IL zip 60467   |
|            | Signature Kuthy Sullwan   |
| 11.        | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
|            | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                        |
|            |   |
|            |   |
|            |   |
| II.        | POSITION (please circle appropriate position)   |
|            | Support Oppose Neutral  |
| V.         | Testimony (please circle )  |
|            | Oral Written  |



#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

| I.   | Name (Please Print) TMOTHY BROWAN  |
|------|--|
|      | City PALOS Heights State IL zip 60462  |
|      | Signature Amally & Brasnau   |
| 11.  | REPRESENTATION (This section is to be fived if the witness is appearing on behalf of any group, organization or other entity.) |
|      | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)                       |
|      | Polos Community Hospits  |
|      |  |
|      |  |
| 111. | POSITION (please circle appropriate position)  |
|      | Support Oppose Neutral   |
| IV.  | Testimony (please circle )   |
|      | Oral Written   |







### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

| I.   | IDENTIFICATION  Name (Please Print) RONF                     | ALD FUHRMAN  |
|------|--|--|
|      | City ORLAND PARK Sta   | tate <u>TLLINOIS</u> zip 60/62                                       |
|      |  | ed Tuema   |
| II.  | REPRESENTATION (This section is to be filled if the entity.) | e witness is appearing on behalf of any group, organization or other |
|      | Entity, Organization, etc. represented in the Health Care)   | this appearance (i.e., ABC Concerned Citizens for                    |
|      |  |  |
|      |  |  |
|      |  |  |
| III. | POSITION (please circle appropriate positi                   | ition)   |
|      | Support Oppose   | Neutral  |
| IV.  | Testimony (please circle )                                   |  |
|      | Oral Written   |  |

Submitted written totiming



#### STATE OF ILLINOIS

### HEALTH FACILITIES AND SERVICES REVIEW BOARD

### **Public Hearing Testimony Registration Form**

| <b>Project</b> | Number: | 16-001 |
|----------------|---------|--------|
|----------------|---------|--------|

| l.   | IDENTIFICATION Name (Please Print) | WILLIAM Fil                          | YANE                           |                |                   |
|--|------------------------------------|--------------------------------------|--------------------------------|----------------|-------------------|
|  | City DR MAND Signature Will        | PARN State                           | Ih<br>10                       | Zip            | 60462             |
| II.  | REPRESENTATION (This s             | ection is to be filled if the witnes | is is appearing on behalf of a | ny group, orga | nization or other |
| Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care) |                                    |                                      |                                | Citizens for   |                   |
|  |                                    |                                      |                                |                |                   |
|  |                                    |                                      |                                |                |                   |
|  |                                    |                                      |                                |                |                   |
| III.   | POSITION (please circle            | e appropriate position)              |                                |                |                   |
|  | Support                            | Oppose                               | Neutral                        |                |                   |
| IV.  | Testimony ( <i>please circle</i>   | e)                                   |                                |                |                   |
|  | Oral                               | Written                              |                                |                |                   |

Changed her mind



# STATE OF ILLINOIS

# HEALTH FACILITIES AND SERVICES REVIEW BOARD

# **Public Hearing Testimony Registration Form**

| Project | Number: 16-001                     | 1                                    | $\stackrel{\sim}{\sim}$ | ΛΛ                                     |     |
|---------|------------------------------------|--------------------------------------|-------------------------|--|-----|
| I.      | IDENTIFICATION Name (Please Print) | Denise                               | 21                      | Smith                                  |     |
|         | city Julyn                         | L Buck State                         |                         | Zip 504                                | £6. |
|         | Signature                          | is of                                | mill                    | <b>&gt;</b>                            |     |
| II.     | REPRESENTATION (Th                 | is section is to be filled if the wi | ness is appearing on be | ehalf of any group, organization or ot | her |
|         |                                    | etc. represented in this             | appearance (i.e.        | ., ABC Concerned Citizens fo           | or  |
|         | <i>j</i>                           |                                      |                         |  |     |
|         |                                    |                                      |                         |  |     |
|         |                                    |                                      |                         |  |     |
| III.    | POSITION (please cir               | cle appropriate position             | 1)                      |  |     |
|         | Support                            | Opposel                              | Neutral                 |  |     |
| IV.     | Testimony (please cir              | cle )                                |                         |  |     |
|         | Oral                               | Written                              |                         |  |     |
|         |                                    |                                      |                         |  |     |

Didn't ome Cy



#### STATE OF ILLINOIS

#### HEALTH FACILITIES AND SERVICES REVIEW BOARD

# **Public Hearing Testimony Registration Form**

| ·Project N | Number: 16-001 0 CONN OT   |
|------------|--|
| I.         | Name (Please Print) John K Common  |
|            | City of CAND PARK State 16 Zip 604 G   |
|            | Signature De La Company Compan |
| II.        | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)  |
|            | Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)   |
|            |  |
|            |  |
|            |  |
| III.       | POSITION (please circle appropriate position)  |
|            | Support Oppose Neutral   |
| IV.        | Testimony (please circle )   |
|            | Oral Written   |

DIDN'T COUNT IN TOTAL
THE A DUPLICATE 31



#### STATE OF ILLINOIS

### HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### Public Hearing Testimony Registration Form

| Project N | Number: 16-001  |
|-----------|---|
| I.        | IDENTIFICATION Name (Please Print)  City Aus Hts  State IC zip 60492  |
|           | Signature Carl Harrie   |
| II.       | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.)  Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) |
|           | Polos Commun Hopika   |
|           |   |
| III.      | POSITION (please circle appropriate position)   |
|           | Support Oppose Neutral  |
| IV.       | Testimony (please circle )  |
|           | Oral Written  |

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### STATE OF ILLINOIS

# HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

|   | •                                  |  |  |                              |
|---|------------------------------------|--|--|------------------------------|
| Ι.  | IDENTIFICATION Name (Please Print) | K. Maz                                 | eika-Myr                                     | ٠                            |
|   | city Orland Pork                   | State                                  | <u>.                                    </u> | zip 60467                    |
|   | Signature Lout.                    | Muzika                                 | Myre   |                              |
| II.   | REPRESENTATION (This section       | on is to be filled if the witness is o | opearing on behalf of any g                  | group, organization or other |
| Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens Health Care)  Palos Carry, 'ty Hospital |                                    |  |  | ncerned Citizens for         |
|   |                                    |  |  |                              |
|   |                                    |  |  |                              |
|   | ·                                  |  |  |                              |
|   |                                    |  |  |                              |
| 111.  | POSITION (please circle ap         | ppropriate position)                   |  |                              |
|   | Support                            | Oppose                                 | Neutral                                      |                              |
| IV.   | Testimony (please circle )         |  |  |                              |
|   | Oral                               | Written                                |  |                              |

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#### STATE OF ILLINOIS

# HEALTH FACILITIES AND SERVICES REVIEW BOARD

#### **Public Hearing Testimony Registration Form**

Facility Name: Palos Community Hospital - Orland Park

| 1.   | IDENTIFICATION Name (Please Print)                 | icia Klai                              | bunde                     |                              |
|------|--|--|---------------------------|------------------------------|
|      | ()   | 11.5 State II                          |                           | zip 65463                    |
|      | Signature <u>Aldres</u>                            | Kinnund                                | 1                         |                              |
| И.   | REPRESENTATION (This section entity.)              | on is to be filled if the witness is a | ppearing on behalf of any | group, organization or other |
|      | Entity, Organization, etc. r<br>Health Care)       | epresented in this appe                | arance (i.e., ABC Co      | ncerned Citizens for         |
|      | Palos Commi  | inse Co                                |                           |                              |
|      |  |  |                           |                              |
|      |  |  |                           |                              |
| III. | III. POSITION (please circle appropriate position) |  |                           |                              |
|      | Support  | Oppose                                 | Neutral                   |                              |
| IV.  | Testimony (please circle )                         |  |                           |                              |
|      | Oral   | Written                                |                           |                              |