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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Brian Gregory, County Administrator

City Sycamore State Illinois Zip 60178

Contact Phone Number

815-895-1638

Contact E-Mail Address

bgregory@dekalbcounty.org

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)

Representing DeKalb County

III. POSITION (*Circle appropriate position*)

Proponent (circled) Opponent Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

Please note that anyone who does not pre-register in accordance with the HFSRB Public Participation Guidelines will not have an opportunity to speak at a Board meeting.

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Dawn Graves

City Sycamore State IL Zip 60178

Contact Phone Number

815-751-8212

Contact E-Mail Address

Penguin1980@Comcast.net

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 ~~citizne~~ citizen of the residents that reside there as well as a family member of a resident

III. POSITION (*Circle appropriate position)*

Proponent (Opponent) Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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Pass

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Tom MarsH

City Sycamore State IL Zip 60178

Contact Phone Number

815-901-1031

Contact E-Mail Address

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 Relative of Resident

III. POSITION (*Circle appropriate position)*

Proponent Opponent (circled) Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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Pass

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Nickie Marsh

City Sycamore State IL Zip 60178

Contact Phone Number

630-335-0119

Contact E-Mail Address

nickie.marsh@ipmg.com

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 Relative of a Resident

III. POSITION (*Circle appropriate position)*

Proponent   **(Opponent)** [circled]   Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov** or **217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Ken Ostrom

City Millington State IL. Zip 60537

Contact Phone Number

Contact E-Mail Address

N/A

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 relative of a resident

III. POSITION (*Circle appropriate position)*

Proponent — **Opponent** (circled) — Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Madelyn Nelson

City DeKalb State Illinois Zip 60115

Contact Phone Number

815-756-3274

Contact E-Mail Address

mjnelson@niu.edu

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) Self

III. POSITION (*Circle appropriate position*)

Proponent — **Opponent** (circled) — Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Melody Benjamin

City Yorkville State IL Zip 60560

Contact Phone Number

815-378-8444

Contact E-Mail Address

mb60178@hotmail.com

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 !!

my mom (margaret Ostrom) is a Resident

III. POSITION (*Circle appropriate position*)

Proponent | **Opponent** (circled) | Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Mike Ostrom

City Somonauk State IL Zip 60552

Contact Phone Number

815-378-2427

Contact E-Mail Address

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)

Relative of Resident !!!

III. POSITION (*Circle appropriate position*)

Proponent — **Opponent** (circled) — Neutral

This form must be returned to John Kniery at john.kniery@illinois.gov **or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Starr Peterson

City Kingston State IL Zip 60145

Contact Phone Number

815-751-0280

Contact E-Mail Address

Starrpeterson1@gmail.com

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 Family member of resident

III. POSITION (*Circle appropriate position*)

Proponent   (Opponent) [circled]   Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Sharon Miller

City Maple Park State IL Zip 60151

Contact Phone Number

815-762-8534

Contact E-Mail Address

hearn 94@yahoo.com

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)

Family member of Resident

III. POSITION (*Circle appropriate position*)

Proponent   Opponent (circled)   Neutral

This form must be returned to John Kniery **at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Cindy Lofthouse

City Sycamore State IL Zip 60178

Contact Phone Number

815-757-5627

Contact E-Mail Address

~~lofthouse@dcta~~ lofthouse.dcta@gmail.com

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 (*Circle appropriate position)*

Proponent Opponent Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Ferald Bryan

City DeKalb State IL Zip 60115

Contact Phone Number

815-501-3760

Contact E-Mail Address

Fbryan@niu.edu

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)

Former member of the DeKalb County Nursing Home Board for Five years.

III. POSITION (*Circle appropriate position)*

Proponent Opponent Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) William H Lofthouse

City Sycamore State IL Zip 60178

Contact Phone Number

815 757-0922

Contact E-Mail Address

Loftyfit 1 @ comcast.net

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 (*Circle appropriate position*)

Proponent Opponent Neutral (circled)

This form must be returned to John Kniery at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761 at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) CHARLES A Simpson

City Rochelle State IL Zip 61068

Contact Phone Number

815 793-0262

Contact E-Mail Address

Chuck34769@AOL.com

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 (*Circle appropriate position*)

~~Proponent~~ Opponent (circled) Neutral

This form must be returned to John Kniery at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761 at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Carolyn Simpson

City Dekalb State IL Zip 60115

Contact Phone Number

815-793-6645

Contact E-Mail Address carolmom1949@Aol.com.

90 W Chestnut Ave Cortland

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 (*Circle appropriate position*)

Proponent (circled) Opponent Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Diane Tolhurst

City DeKalb State IL Zip 60115

Contact Phone Number

815-756-3827

Contact E-Mail Address

ddtolhurst@hotmail.com

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 Citizen

III. POSITION (*Circle appropriate position*)

Proponent — **Opponent** (circled) — Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Mary Lee Cozad

City DeKalb State IL Zip 60115

Contact Phone Number

815-756-9908

Contact E-Mail Address

marycozad@gmail.com

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) DeKalb County Board

III. POSITION (*Circle appropriate position*)

Proponent (circled) Opponent Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Don Gates

City Sandwich State IL Zip 60548

Contact Phone Number

815 593-0427

Contact E-Mail Address

gates4269@hotmail.com

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 citizens
mother lives there

III. POSITION (*Circle appropriate position*)

Proponent　　Opponent (circled)　　Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) CHARLES Simpson

City DEKALB State ILL Zip 60112

Contact Phone Number

815/793/2643

Contact E-Mail Address

Southern prince 43 @ aol.com

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)

____

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____

____

III. POSITION (*Circle appropriate position*)

~~Proponent~~ (Opponent) Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Christine Ewald

City Sycamore State IL Zip 60178

Contact Phone Number

779 400 6252

Contact E-Mail Address

cewald @ niu. edu

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 (*Circle appropriate position*)

Proponent Opponent (circled) Neutral

This form must be returned to John Kniery at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761 at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Gayle Hawkins

City Genoa State IL Zip 60135

Contact Phone Number

847-363-4987

Contact E-Mail Address

gaylehawkins53@gmail.com

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)

Relative to Dekalb County Nursing home resident

III. POSITION (*Circle appropriate position)*

Proponent Opponent (circled) Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Gary Hawkins

City Genoa State IL. Zip 60135

Contact Phone Number

847-363-4986

Contact E-Mail Address

ghawkins12156@g.mail.com

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)

relative of Resident Helen Hawkins

III. POSITION (*Circle appropriate position*)

Proponent | **Opponent** (circled) | Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Carol Deemer

City DeKalb State IL Zip 60115

Contact Phone Number

815-762-9213

Contact E-Mail Address

cadeemer@aol.com

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 (*Circle appropriate position*)

Proponent   Opponent (circled)   Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Kathy Burright

City DeKalb State Il. Zip 60115

Contact Phone Number

815-501-7765

Contact E-Mail Address

memakb91@comcast.net

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 (*Circle appropriate position)*

Proponent   **(Opponent)** [circled]   Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Montez Soliz

City Dekalb State Illinois Zip 60115

Contact Phone Number

815-566-6403

Contact E-Mail Address

Montez Soliz.staterepyednock@gmail.com

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) With Dekalb District office of State Representative Lance Yednock

III. POSITION (*Circle appropriate position*)

Proponent Opponent **Neutral** (circled)

This form must be returned to John Kniery at **john.kniery@illinois.gov** or **217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Cheryl LaRosa

City DeKalb State Illinois Zip 60115

Contact Phone Number

815 2220244

Contact E-Mail Address

slm17818@yahoo.com

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) family member in this health care facility

III. POSITION (*Circle appropriate position*)

Proponent | **(Opponent)** | Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Mark LaRosa

City DeKalb State Illinois Zip 60115

Contact Phone Number

815 670 2204

Contact E-Mail Address

slml7818@yahoo.com

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) family member in this health care facility

III. POSITION (*Circle appropriate position*)

Proponent　　Opponent (circled)　　Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) KATHLEEN PERILONGO

City DEKALB State ILL Zip 60115

Contact Phone Number

815-761-0712

Contact E-Mail Address

____

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 (*Circle appropriate position*)

Proponent Opponent (circled) Neutral

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Donna deOliveira

City DeKalb State IL Zip 60115

Contact Phone Number

832 721 1473

Contact E-Mail Address

deoliwko@gmail.com

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 (*Circle appropriate position*)

Proponent (Opponent) Neutral

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Ashley Rockstead

City DeKalb State IL Zip 60115

Contact Phone Number

815-793-4447

Contact E-Mail Address

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 (*Circle appropriate position*)

Proponent   Opponent (circled)   Neutral

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Amy Larson

City ______ State ______ Zip ______

Contact Phone Number

______

Contact E-Mail Address

______

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 (*Circle appropriate position*)

Proponent | **Opponent** (circled) | Neutral

This form must be returned to John Kniery at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761 at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) RHONDA HENKE

City CLARE State IL Zip 60111

Contact Phone Number

815-761-2163

Contact E-Mail Address

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 (*Circle appropriate position)*

Proponent Opponent Neutral X

This form must be returned to John Kniery **at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Scott Campbell

City DeKalb State IL Zip 60115

Contact Phone Number

708 305 4441

Contact E-Mail Address

scampbell@dekalbcounty.org

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)

Dekalb County Board

III. POSITION (*Circle appropriate position*)

Proponent Opponent Neutral

This form must be returned to John Kniery at john.kniery@illinois.gov **or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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PASS

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Nancy Dashner

City DeKalb State IL Zip 60115

Contact Phone Number

815-756-6832

Contact E-Mail Address

dekalbdash@frontier.com

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 (*Circle appropriate position*)

Proponent Opponent (circled) Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) RuKisha Crawford

City DeKalb State IL Zip 60115

Contact Phone Number

(815) 690-6810

Contact E-Mail Address

dekalb2u@yahoo.com

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) Community Concerned Citizens

III. POSITION (*Circle appropriate position*)

Proponent Opponent (circled) Neutral

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) STEVEN KAPITAN

City DEKALB State IL Zip 60115

Contact Phone Number

815-508-0955

Contact E-Mail Address

stevekapitan@yahoo.com

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)

CITIZEN

III. POSITION (*Circle appropriate position*)

Proponent Opponent (circled) Neutral

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Lori Ireton

City Sycamore State IL Zip 60178

Contact Phone Number

815-761-1654

Contact E-Mail Address

lori.ireton1@gmail.com

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)

Retired Social Worker 28 yrs service
2017 - May 9 2017 - letter to Gary Hansen
& County Board RT St. Louis Company was
taking this facility down & under.

III. POSITION (*Circle appropriate position*)

Proponent   **(Opponent — circled)**   Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Dorianne Burg

City DeKalb State IL Zip 60115

Contact Phone Number

815-508-9296

Contact E-Mail Address

None

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 (*Circle appropriate position*)

Proponent — **Opponent** (circled) — Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Steve Duchrow

City DeKalb State IL Zip 60115

Contact Phone Number

815-761-1417

Contact E-Mail Address

sduchrow@yahoo.com

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 (*Circle appropriate position*)

Proponent — **Opponent** (circled) — Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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I wish to address this body & meeting

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Mary Roman

City DeKalb State Illinois Zip 60115

Contact Phone Number

(815) 217-0592 \ 217-0596

Contact E-Mail Address

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)

resident - DeKalb County Rehab and Nursing Home

III. POSITION (*Circle appropriate position*)

(Proponent) [circled] Opponent Neutral

This form must be returned to John Kniery at **john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Brother El-Jamal

City DeKalb State IL Zip 60115

Contact Phone Number

217-766-5390

Contact E-Mail Address

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 (*Circle appropriate position)*

Proponent Opponent (circled) Neutral

Brother Abdul El-Jamal

This form must be returned to John Kniery **at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West Jefferson Street, 2nd Floor; Springfield, Illinois 62761** at least 24 hours prior to the HFSRB meeting.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) TILLIE M MACKEY

City DEKALB State IL Zip 60115

Contact Phone Number

~~815 217~~ 518-918-5323

Contact E-Mail Address

2600

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)

RESIDENT

III. POSITION (*Circle appropriate position*)

Proponent **Opponent** (circled) Neutral

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Magdalen Niemi

City Rochelle State IL Zip 61068

Contact Phone Number

815-677-6600

Contact E-Mail Address

nursemagdalen@gmail.com

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 citizen for healthcare

III. POSITION (*Circle appropriate position*)

Proponent   **(Opponent)** [circled]   Neutral

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Lori Ireton
Maggie Niemi } wish to speak today

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Cindy Kozumplik

City Sycamore State IL Zip 60178

Contact Phone Number

Contact E-Mail Address

Cindy Koz98@gmail.com

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) family member of resident

III. POSITION (*Circle appropriate position*)

Proponent   (Opponent — circled) of sale   Neutral

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) MARK J SILBERMAN

City DEERFIELD State IL Zip 60015

Contact Phone Number

312 212 4952

Contact E-Mail Address

MSILBERMAN @ BENESCHLAW.COM

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) APPLICANT

III. POSITION (*Circle appropriate position*)

Proponent (circled) Opponent Neutral

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STATE OF ILLINOIS

HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Participation Form

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

I. IDENTIFICATION

Name (*Please Print*) Amanda C. Walter

City Genoa State IL Zip 60135

Contact Phone Number

847-409-4685

Contact E-Mail Address

sveacarlson@yahoo.com

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)

DeKalb County Rehab and Nursing Center staff member

III. POSITION (*Circle appropriate position*)

Proponent Opponent (circled) Neutral

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