



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) Brian Gregory, County Administrator City Sycamore State Illinois zip 60178 |
|------|--|
| | Contact Phone Number |
| | 815-895-1638 |
| | Contact E-Mail Address |
| | bgregory c dekalb county. org |
| 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) |
| | Representing De Kalb County |
| | |
| III. | POSITION (Circle appropriate position) The Market succession prosition) |
| | Proponent Opponent Neutral |

This form must be returned to John Kniery at <u>iohn.kniery@illinois.gov</u> 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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| Project Nu | mber: | #23-024 |
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| l. | IDENTIFICATION Name (Please Print) | <u>lawn</u> | Graves | | |
| | city <u>Sycamore</u> | 2 | State IL | zip_60 | 178 |
| | Contact Phone Number | | | | |
| | 815-751-8 | 212 | | | - |
| | Contact E-Mail Address | | | | |
| | Penguin 19 | 1800 a | Comcost. | net | |
| 11. | REPRESENTATION | | | | |
| | (This section is to be filled if the | | | - | |
| | Entity, Organization, et Health Care) | c. represente | ed in this appearant | ce (i.e., ABC Concerned Ci | tizens for |
| | | | | | |
| | Concerned | Citiz | ine citi | zen of H | ne |
| | residents | that | reside - | there as i | well |
| | as a fam | ilv me | ember of | a residen | + |
| | | | | | |
| III. | POSITION (Circle approprie | te position) | | | |
| | Proponent | | Opponent | Neutral | |

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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.

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project N | umber: | #23-024 |
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| I. | Name (Please Print) Tom Mars H |
|------|---|
| | City Sycamore State 16 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 |
| 111. | POSITION (Circle appropriate position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| -, | |
|------|--|
| 1. | IDENTIFICATION Name (Please Print) NICKIE MARSL |
| | Octy Sycamore State 72 Zip 60/78 |
| | 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 Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| .t Number: #25-024 | | | |
|---------------------------------------|--|--|--|
| Name (Please Print) | Ken Ostro | m H | zip 20537 |
| City - 1771NA | Jiate | | Zip Good |
| Contact Phone Numbe | • | | |
| P_MIR. | | 1000 | |
| Contact E-Mail Addres | | | |
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| Health Care) | | | 1 |
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| POSITION (Circle appropri | ite position) | | Intolles to |
| Proponent | Opponent | | leutral |
| | City Milling City Contact Phone Number Contact E-Mail Address Contact E-Mail Address A REPRESENTATION (This section is to be filled if the Entity, Organization, et Health Care) CONCERNES POSITION (Circle approprie | IDENTIFICATION Name (Please Print) City Millington State Contact Phone Number Contact E-Mail Address A REPRESENTATION (This section is to be filled if the witness is appearing on behalf of Entity, Organization, etc. represented in this aphealth Care) LONCERNED RELATIVE OF | IDENTIFICATION Name (Please Print) City Millington State TI. Contact Phone Number Contact E-Mail Address A. REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or oth Entity, Organization, etc. represented in this appearance (i.e., ABC Con Health Care) Concerned Relative of A Recibent |

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PASS

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) Madelyn Welson |
|------|--|
| | Name (Please Print) Madelyn Nelson City DeKalb State DI//no/s zip 60/15 |
| | Contact Phone Number |
| | 815-756-3274 |
| | Contact E-Mail Address |
| | minelson@niu.edu |
| П. | 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 (Circle appropriate position) |
| 111. | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project | Number: | #23-024 |
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IDENTIFICATION

| l. | Name (Please Print) Me on Ben amin |
|-------|--|
| | City Yorkville State IL Zip 605760 |
| | Contact Phone Number |
| | 815-378-8444 |
| | Contact E-Mail Address |
| | mb 60178 @ 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) |
| | my mom (margaret Ostrom) is a Resident |
| | |
| | |
| III. | POSITION (Circle appropriate position) |
| | Proponent Opponent Neutral |
| s for | rm must be returned to John Kniery at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West |

This Jefferson Street, 2nd Floor; Springfield, Illinois 62761 at least 24 hours prior to the HFSRB meeting.



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024 I. IDENTIFICATION Name (Please Print **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 Neutral

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) Starr Peterson |
|------|--|
| | City Kingston State 12 Zip 100145 |
| | Contact Phone Number |
| | 815-751-0280 |
| | Contact E-Mail Address |
| | Storpeterson 1@gmail, com |
| 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 |
| | Concerned Family member of resident |
| | |
| | |
| | |
| III. | POSITION (Circle appropriate position) HOUR Chebe appropriate position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| | Name (Please Print) | m | Miller | |
|-----------|---|----------|----------------------------|--|
| | city Maple Park | | State | zip 60151 |
| | Contact Phone Number | | | |
| | 815-762-85 | 34 | | |
| | Contact E-Mail Address | | | |
| | hearn 940 | yah | ico cm | |
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| ١. | REPRESENTATION | | | 120 |
| ۱. | (This section is to be filled if the witnes | | | ization or other entity.) ., ABC Concerned Citizens for |
| 1. | (This section is to be filled if the witnes Entity, Organization, etc. rep | present | ed in this appearance (i.e | * * |
| i. | (This section is to be filled if the witnes Entity, Organization, etc. rep Health Care) | present | ed in this appearance (i.e | * * |
| i. II. | (This section is to be filled if the witnes Entity, Organization, etc. rep Health Care) | oresent. | Resident | ., ABC Concerned Citizens for |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) CINDY LOTHOUSE |
|------|--|
| | City Sycamore State 72 Zip 60178 |
| | Contact Phone Number |
| | 815-757-5627 |
| | Contact E-Mail Address |
| | Tofthouse etcta. lofthouse deta e 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) |
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| III. | POSITION (Circle appropriate position) TON (Circle appropriate position) |
| | Proponent Opponent Neutral Neutral |

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| Project Num | ber: #23 | 3-024 |
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| I. | Name (Please Print) Feral Bryay |
|------|--|
| | city DeKalh State IL zip 6017 |
| | Contact Phone Number |
| | 815-501-3760 |
| | Contact E-Mail Address |
| | Floryan ENIV-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) Tormer Member of HA DeKalh Covery Uvraing Home |
| | Board for Five years. |
| | |
| 111. | POSITION (Circle appropriate position) 130% Carcle appropriate position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project | Number: | #23-024 |
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| l. | Name (Please Print) William H Lotthouse |
|------|--|
| | City Sycamore State 1L zip 60178 |
| | Contact Phone Number |
| | 815 757-0922 |
| | Contact E-Mail Address Loft of 12 concast, net |
| Ħ. | 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) WGM (Cardio appropriate position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| 1. | Name (Please Print) CHARLES A SIMPSON |
|------|--|
| | City Ratlelle State IL Zip 6/068 |
| | 815 793-0262 |
| | Contact E-Mail Address CHUCK 34769 CAOL-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) [110]. (Circle appropriate position) |
| | Profipment Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| Name (Please Print) State State Zip 68 115 |
|--|
| Contact Phone Number |
| 815-793-6645 |
| Contact E-Mail Address Care mom 1949 & Aol. Com. |
| 90 W Chestnot Ave COKTIAND |
| 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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| POSITION (Circle appropriate position) TION (Circle appropriate position) |
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Facility or Project Name: DeKalb Nursing and Rehabilitation

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| l. | Name (Please Print) Diane Tolhurst |
|------|--|
| | City DeKalb State I2 Zip 60115 |
| | Contact Phone Number |
| | 815-756-3827 |
| | Contact E-Mail Address |
| | ddtolhurst@hotmail.com |
| li. | 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) On cerned Citizens |
| IĮI. | POSITION (Circle appropriate position) HON (Circle appropriate position) |
| | Proponent Opponent Neutral |
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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| • | Name (Please Print) Mary Lee Cozad |
|----|--|
| | City Dekalb State Th Zip GOIS |
| | 815 - 756 - 9908 |
| | Contact E-Mail Address |
| | mary cozad@gmail.com |
| | |
| l. | REPRESENTATION |
| l. | REPRESENTATION (This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.) |
| I. | (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 f |
| l. | (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 f |
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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) DOW Control |
|------|--|
| | city Sundwich State Ib zip 60548 |
| | Contact Phone Number |
| | 815 593 - 0427 |
| | Contact E-Mail Address |
| | gates 9269 @ Notmail-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) |
| | Converted citizens |
| | mother Lives there |
| | 8 |
| | POSITION (Single appropriate position) (1992) |
| III. | POSITION (Circle appropriate position) 101 (and a particular position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) HARLES SIMPSON |
|------|--|
| | City DEAALB State 166 Zip 60112 |
| | Contact Phone Number |
| | 815/793/2643 |
| | Contact E-Mail Address |
| | Southern prince 43 @ Hol, 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) Western Cardio appropriate positions |
| | Proportent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| I. | Name (Please Print) Christine EWALD |
|------|---|
| | city Syc4 more state IL zip60178 |
| | Contact Phone Number |
| | 779 400 6252 |
| | Contact E-Mail Address |
| | _ CeWALQ C Will. eda |
| 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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| | |
| 101. | POSITION (Circle appropriate position) With (Circle appropriate position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| Name (Please Print) Cayle Halkins |
|--|
| City Genoa State IL zip 60135 |
| Contact Phone Number |
| 847-363-4987 |
| Contact E-Mail Address |
| gaylehawkins 53@gmoul.com |
| 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 Dekath County Mursig home resident |
| |
| |
| POSITION (Circle appropriate position) ITION (Circle appropriate position) |
| Proponent Opponent Neutral |
| |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project I | Number: | #23-024 |
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| Zip <i>60135</i> |
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Project Number: #23-024

| l. ID | ENTIFICATION Name (Please Print) | cool Deemer | |
|--------|-----------------------------------|---|-----------|
| | City DeKalb | State TL | zip 60115 |
| | Contact Phone Number | | |
| | 815-762- | 9213 | |
| | Contact E-Mail Address | | |
| | acdeemer a | a a a l. Come | |
| II. RE | | itness is appearing on behalf of any group, organization represented in this appearance (i.e., Al | • |
| | | | |
| III. P | OSITION (Circle appropriate | e position) I HAN (2 m le nijerope que pos | |
| | Proponent | Opponent | Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project | Number: | #23-024 |
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| l. | Name (Please Print) Kathy Burrisht |
|--------|---|
| | City DeKalb State I/ Zip 60115 |
| | Contact Phone Number |
| | 815-501-7765 |
| | Contact E-Mail Address |
| | memakb91 @ comcast. net |
| H. | 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) (IIC) (Circle appropriate position) |
| ia fa- | Proponent Opponent Neutral m must be returned to John Kniery at John kniery (illinois roy or 217, 785, 4111 (fax) or 525 West |

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| l. | Name (Please Print) MONter Soliz |
|------|---|
| | city Dekalb State Flinois Zip Gulls |
| | Contact Phone Number |
| | 815-566-6403 |
| | Contact E-Mail Address |
| | Montez Soliz. State repyednock Egmail. con |
| 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) TOON (Circle appropriate position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project N | lumber: | #23-024 |
|-----------|---------|---------|
|-----------|---------|---------|

| 1. | Name (Please Print) Chery La Rosa |
|------|--|
| | • |
| | City Dokalb State IIIIA015 Zip 60115 |
| | Contact Phone Number |
| | 815 2220244 |
| | Contact E-Mail Address |
| | s/m/7818 @ 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) |
| | tanily member in this |
| | health care facility |
| | |
| | |
| | |
| III. | POSITION (Circle appropriate position) 1903-100-100-100-100-100-100-100-100-100-1 |
| | |
| | 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.

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.

PAS



Facility or Project Name: DeKalb Nursing and Rehabilitation

| 1. | Name (Please Print) Mark La Rosa | | |
|------|--|--|--|
| | City De Kalb State Iculois Zip 60115 | | |
| | Contact Phone Number | | |
| | 815 670 2204 | | |
| | Contact E-Mail Address | | |
| | 5/m/7818 @ 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 | | |
| | heath care facility | | |
| | | | |
| | | | |
| | | | |
| III. | POSITION (Circle appropriate position) | | |
| | Proponent Opponent Neutral | | |

This form must be returned to John Kniery at <u>john.kniery@illinois.gov</u> 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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RR59



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| I. | Name (Please Print) KANLEON PERILONGO | |
|------|--|--|
| | City DCKA213 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) | |
| | | |
| | | |
| | ti- | |
| III. | POSITION (Circle appropriate position) ENDIN (Circle appropriate position) | |
| | Proponent Opponent Neutral Neutral | |

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



Facility or Project Name: DeKalb Nursing and Rehabilitation

| l. | Name (Please Print) Donna de Oliveira | | |
|--------|--|--|--|
| | City DeKalb State IL Zip 60115 | | |
| | Contact Phone Number | | |
| | 832 721 1473 | | |
| | Contact E-Mail Address | | |
| | deoliwho @ 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) | | |
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| | | | |
| 111. | POSITION (Circle appropriate position) The Micche appropriate position | | |
| | Proponent Opponent Neutral | | |
| is for | rm must be returned to John Kniery at john.kniery@illinois.gov or 217-785-4111 (fax) or 525 West | | |

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



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

Proponent

| I. | Name (Please Print) ANA RUKSER OF |
|------|--|
| | City DeKall State 12 zip 1001/5 |
| | 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) ITON (Cardle and regardle position) |

This form must be returned to John Kniery at <u>john.kniery@illinois.gov</u> 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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Opponent

PRST

Neutral



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) A M M M M M M M M M M M M |
|------|--|
| | Name (Freuse Frint) |
| | CityZip |
| | Contact Phone Number |
| | Contact E-Mail Address |
| | |
| IL. | 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.



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| | Name (Please Print) RUONDA HENKE | | |
|------|--|--|--|
| | City CLARE State 12 Zip GO11) | | |
| | 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) | | |
| | Health Care) | | |
| | Health Care) | | |
| | Health Care) | | |
| | Health Care) | | |
| III. | | | |

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.



Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project Nu | mber: | #23-024 |
|------------|-------|---------|
|------------|-------|---------|

| I. | 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) THE METANGE appropriate position | | |
| | Proponent Opponent Neutral | | |

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



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| I. | Name (Please Print) Nancy Dashner | | |
|------|--|--|--|
| | City bo Kalb State 1L Zip 60/15 | | |
| | Contact Phone Number | | |
| | 815-756-6832 | | |
| | Contact E-Mail Address | | |
| | _ dehalbdash cofrontier.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) IFON Grede appropriate position) | | |
| | Proponent Opponent Neutral | | |

This form must be returned to John Kniery at john.knierv@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.



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024 I. IDENTIFICATION Name (Please Print) Rukishe (Fawford City De Kalb State IL Zip 66115 **Contact Phone Number** 690-6810 Contact E-Mail Address eKalb 2 uc hahoo.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) TVON (Grede 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.



Facility or Project Name: DeKalb Nursing and Rehabilitation

| Project I | Number: | #23-024 |
|-----------|---------|---------|
|-----------|---------|---------|

| l. | IDENTIFICATION Name (Please Print) STEVEN | KAPITAN | |
|------|---|---------------------------------|-----------|
| | City DE KALB | State IL | zip 60/15 |
| | Contact Phone Number | | |
| | 812-18208-095 | | |
| | Contact E-Mail Address | | |
| | steve kapitan & yaho | 00,00M | |
| II. | REPRESENTATION | | |
| | (This section is to be filled if the witness is appear Entity, Organization, etc. represente Health Care) | | |
| | .5 | | |
| | | G-ANDRE DA | |
| | | | |
| III. | POSITION (Circle appropriate position) | Tičih lävele appressivete pusis | m) |
| | 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.



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| 1. | Name (Please Print) Lori Ireton |
|------|--|
| | city Sycamore State II zip 60178 |
| | Contact Phone Number |
| | 815-761-1654 |
| | Contact E-Mail Address |
| | lori. ireton 1 a 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 facilit down + under |
| III. | POSITION (Circle appropriate position) |
| | Proponent Opponent Neutral Meutral |

This form must be returned to John Kniery at iohn.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.



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| I. | Name (Please Print) DOTIANNE BUG |
|------|--|
| | City Dokah State IL Zip 6015 |
| | 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) |
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| III. | POSITION (Circle appropriate position) ITM (Circle appropriate position) |
| | |

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.

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| 1. | Name (Please Print) Stave Duchrow |
|------|--|
| | City De Kal6 State IL Zip 60115 |
| | Contact Phone Number |
| | 815-761-1417 |
| | Contact E-Mail Address |
| | sduchrow e 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) |
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| | |
| III. | POSITION (Circle appropriate position) TION (Circle appropriate position) |
| | Proponent Opponent Neutral |

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I wish to address their body + neeting

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024 I. IDENTIFICATION Name (Please Print) Mary Soman Contact Phone Number 217-0592 317-0596 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 - DE Kalb County Kehab and Mursing Doms III. POSITION (Circle appropriate position) all the listenes appropriate position. Neutral Proponent Opponent

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



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) Brother El-Jamal |
|-----|--|
| | City Dekalb State IL zip 60115 |
| | Contact Phone Number |
| | 886217-766-5390 |
| | 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) |
| | |
| | |
| Ш. | POSITION (Circle appropriate position) |
| | m must be returned to John Kniery at john.kniery@illinois.gov or 217-785-411 (fax) or 525 West |



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| I. IDENTIFICATION | |
|--|-----------|
| Name (Please Print) Tille M MACKEY | |
| Name (Please Print) TILLE M MACKEY City DEKALB State TT. Zip 60 | 115 |
| Contact Phone Number | |
| -\$18-212 518-918-532 | 3 |
| Contact E-Mail Address | |
| 2608 | _ |
| 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 Cit | izens for |
| Health Care) | |
| RESIDENT | |
| | |
| | |
| | |
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| | |
| | <u>V</u> |
| III. POSITION (Circle appropriate position) | |
| | |
| Proponent Opponent Neutral | |
| | |

This form must be returned to John Kniery at iohn.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.

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| l. | Name (Please Print) Magdalen Nichi |
|-------|--|
| | City Rochelle State Zip 61068 |
| | 215 - 607 - 6600 |
| | Contact E-Mail Address |
| | nurscmagdalen@gwail.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 |
| | Concerned citizen for healthcore |
| | |
| | |
| | |
| HI. | POSITION (Circle appropriate position) (Circle appropriate position) |
| | Proponent Opponent Neutral |
| is fo | rm must be returned to John Kniery at iohn.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.



Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| I. | Name (Please Print) Cindy Kozumplik |
|------|---|
| | City Sycamore State 1L zip 60178 |
| | Contact Phone Number |
| | Contact E-Mail Address |
| | Cindy Koz 98 Egmail.com |
| H. | 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 |
| | |
| | |
| | ea |
| III. | POSITION (Circle appropriate position) MCMA Circle appropriate position) |
| | Proponent Opponent Neutral Neutral |

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

Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| I. | IDENTIFICATION Name (Please Print) MARY Subserve |
|------|--|
| | City DEED State 11 Zip Cools |
| | Contact Phone Number |
| | 319 319 4952 |
| | Contact E-Mail Address |
| | MSILBERMAN & BENESCH LAW. 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) TIUN (Circle appropriate position) |
| | Proponent Opponent Neutral |

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Facility or Project Name: DeKalb Nursing and Rehabilitation

Project Number: #23-024

| Name (Please Print) Amanda C. Walter |
|--|
| City (2002 State 12 zip 60135 |
| Contact Phone Number |
| 847 - 409 - 4685 |
| Contact E-Mail Address |
| sveacarlson@yahoo.com |
| 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 |
| 51911 METHOER |
| POSITION (Circle appropriate position) |
| Proponent Opponent Neutral (1991) |
| |

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