FIRST

(44)

STATE OF ILLINOIS
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*) Terrence Moisan, MD

City Palos Heights State IL Zip 60463

Signature [illegible]

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

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

Palos Community Hospital

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

1

STATE OF ILLINOIS
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*) Thomas A. Pratt

City Orland Park State IL Zip 60462

Signature Thomas A. Pratt

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, orgonization 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

9/17/15

(2)

STATE OF ILLINOIS
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*) MELANIE NIOBECK
City Orland Park State IL Zip 60462
Signature Melanie L Niobeck

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

9/17/15

3

STATE OF ILLINOIS
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*) DANIEL POST

City MAYWOOD State IL Zip 60153

Signature Daniel Post

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)

Loyola University Health System

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(4)

STATE OF ILLINOIS
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*) Lori Mazeika Myre

City Palos Heights State IL Zip 60467

Signature Lori K. Mazeika Myre

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

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

Reading a letter from Mayor McLaughlin

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(5)

STATE OF ILLINOIS
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*) CAROL WEST-SAELE

City ORLAND PARK State IL Zip 60462

Signature Carol J West-Saele

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 HEALTH & FITNESS CENTER

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(9)

STATE OF ILLINOIS
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*) BARBARA HARPER

City Homer Glen State IL Zip 60491

Signature [illegible]

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 Patient

III. POSITION (*please circle appropriate position)*

[redacted] Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

7

STATE OF ILLINOIS
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*) Dale Swingle

City Orland Park State IL Zip 60462

Signature Dale Swingle

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)

Palos Medical Group

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(6)

STATE OF ILLINOIS
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*) MARY JOY CARROLL

City Homer Glen State IL Zip 60491

Signature Mary Joy Carroll

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

9/17/15

(8)

STATE OF ILLINOIS
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*) MARION LOSOLE

City HOMER GLEN State IL. Zip 60491

Signature Marion Losole

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 HEALTH AND FITNESS CENTER

III. POSITION (*please circle appropriate position)*

Support (Oppose) Neutral

IV. Testimony (*please circle)*

(Oral) Written

9/17/15

(10)

STATE OF ILLINOIS
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*) Margie Zeglen

City Palos Heights State IL Zip 60463

Signature M Zeglen

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 Community Hospital

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

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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

Project Number: 16-001

I. IDENTIFICATION
Name (*Please Print*) JAMES Prendergast

City Palos Hts. State IL Zip 60463

Signature James Prendergast

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

9/17/15

(12)

STATE OF ILLINOIS
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*) Alicia Klabunde

City Palos Heights State IL Zip 60463

Signature Alicia Klabunde

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 Community Hospital

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(13)

STATE OF ILLINOIS
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*) Flora Mortell

City Burbank State Il Zip 60459

Signature Flora a Mortell

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) ABC Concerned Citizens for Palos Health Care

III. POSITION (*please circle appropriate position*)

Support Oppose Neutral

IV. Testimony (*please circle*)

Oral Written

9/17/15

14

STATE OF ILLINOIS
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*) Mike Schneider

City Palos Hills State IL Zip 60465

Signature Mike S

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

9/17/15

15

STATE OF ILLINOIS
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*) Martha Krausz

City Palos Pk State Il. Zip 60464

Signature Martha M. Krausz

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)

SAVE PHFC

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

16

STATE OF ILLINOIS
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*) Doreen Damm

City Tinley Park State IL Zip 60487

Signature Doreen Damm

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

9/17/15

17

STATE OF ILLINOIS
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*) MARY ELLEN SMOLINSKI

City MOKENA State IL Zip 60448

Signature Mary Ellen Smolinski

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 (*please circle appropriate position*)

Support Oppose Neutral

IV. Testimony (*please circle*)

Oral Written

9/17/15

(18)

STATE OF ILLINOIS
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*) JOSEPH SMOLINSKI

City MOKENA State IL Zip 60448

Signature [illegible]

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

9/17/15

19

STATE OF ILLINOIS
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*) Paula Gardner

City Orland Pk State IL Zip 60462

Signature [illegible]

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

9/17/15

(20)

STATE OF ILLINOIS
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*) Robert Stratz

City Palos Heights 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) City of Palos Heights

III. POSITION (*please circle appropriate position*)

Support Oppose Neutral

IV. Testimony (*please circle*)

Oral Written

9/17/15

21

STATE OF ILLINOIS
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*) Colleen Voith

City Chgo State IL Zip 60655

Signature Colleen Voith

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.S. Group

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(23)

STATE OF ILLINOIS
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*) Patricia Heerlen

City Palos Hts State Il Zip 60463

Signature Pat Heerlen

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 Community Hospital

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

22

STATE OF ILLINOIS
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*) ANDY Evers

City O.P State IL Zip 60462

Signature Andy Evers KS

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

9/17/15

(24)

STATE OF ILLINOIS
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*) Brenda Guendling

City Mokena State IL Zip 60448

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 Citizens for Health Care) Community Fitness Center

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

25

STATE OF ILLINOIS
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*) Jason Fox

City Orland Park State IL 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)

Life Time fitness

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(26)

STATE OF ILLINOIS
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*) JASON FOX

City Orland Park State IL 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)

Life Time Fitness

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(30)

STATE OF ILLINOIS
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*) Karin Evers

City O.P. State IL Zip 60462

Signature Karin Evers

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

9/17/15

(32)

STATE OF ILLINOIS
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*) Sharon Hoffman
City Palos Heights State Ill Zip 60463
Signature Sharon L. Hoffman

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)

Current cancer patient

III. POSITION (*please circle appropriate position*)

Support Oppose Neutral

IV. Testimony (*please circle*)

Oral Written ✓
and

9/17/15

(34)

STATE OF ILLINOIS
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*) PAUL MOSTEIKA

City ORLAND PK State ILL Zip 60467

Signature Paul Mosteika

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, orgonization 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

9/17/15

35

STATE OF ILLINOIS
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*) Cindy Copenhaver

City Thornton State IL Zip 60476

Signature Cindy Copenhaver

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)

Arthritis Foundation

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(36)

STATE OF ILLINOIS
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*) Diana Duda

City Glenwood State IL Zip 60425

Signature Diana Duda

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

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

37

STATE OF ILLINOIS
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*) Michelle S. Martin

City Evergreen PK State Ill Zip 60805

Signature Michelle S. Martin

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 Citizens for Health Care) Concerned Citizen

III. POSITION (*please circle appropriate position)*

~~Support~~ Oppose Neutral

Oppose

IV. Testimony (*please circle)*

Oral Written

9/17/15

(39)

STATE OF ILLINOIS
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*) Helen Hermansen

City Orland PK State Ill Zip 60642

Signature Helen Hermansen

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

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

Concern

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(38)

STATE OF ILLINOIS
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*) TERRY STOEFF

City MOKENA State IL Zip 60448

Signature Terry Stoeff

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) SAVE PHFC

III. POSITION (*please circle appropriate position*)

Support Oppose ~~Neutral~~

IV. Testimony (*please circle*)

Oral Written

9/17/15

(40)

STATE OF ILLINOIS
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*) NINA THORP

City PALOS PARK State IL Zip 60464

Signature Nina Thorp

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)

SAVE PFHC

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

41

STATE OF ILLINOIS
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*) Lynn Corriveau

City Palos Park State IL Zip 60464

Signature Lynn Corriveau

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) PHFC

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

42

STATE OF ILLINOIS
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*) ISABELL CAPUTO

City HOMER GLEN State IL. Zip 60491

Signature Isabell T. Caputo

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)

SAVE PH&F PLEASE!!!

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

45

STATE OF ILLINOIS
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*) Robert E. Sullivan

City Orland Park State IL Zip 60462

Signature Robert E. Sullivan

II. 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)

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(43)

STATE OF ILLINOIS
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*) Monica White.

City Palos Heights State IL Zip 60463.

Signature Monica White

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

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

Member of Palos Fitness Center

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

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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

Project Number: 16-001

I. IDENTIFICATION

Name (*Please Print*) Michael Swain

City Orland Park State IL Zip 60462

Signature Michael Swain

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) American Parkinson's Disease Assoc.

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

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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

Project Number: 16-001

I. IDENTIFICATION

Name (*Please Print*) Anne Matty

City Orland Park State IL Zip 60467

Signature Anne M. Matty

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)

MS Aquatics

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(48)

STATE OF ILLINOIS
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*) JANIS GRADY

City 19446 Newport Ave State IL Zip 60448

Signature Janis Grady

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, orgonization 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

9/17/15

52

STATE OF ILLINOIS
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*) ANTHONY HOGAN

City ORLAND PARK State IL. Zip 60462

Signature Anthony Hogan

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

9/17/15

51

STATE OF ILLINOIS
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*) Wynell Whitmore
City Orland Park State IL Zip 60462
Signature Wynell Whitmore

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

9/17/15

53

STATE OF ILLINOIS
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*) Terri Sheppard

City Palos Pk State IL Zip 60464

Signature Terri Sheppard

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

9/17/15

54

STATE OF ILLINOIS
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*) Karen Jones

City Crestwood State IL Zip 60445

Signature Karen 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

IV. Testimony (*please circle)*

Oral Written

9/17/15

56

STATE OF ILLINOIS
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*) Alyce Christensen
City Palos Hills State IL Zip 60465
Signature Alyce Christensen

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)

PHFC

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

59

STATE OF ILLINOIS
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*) Roberta Rudolph

City Orland Park State IL Zip 60467

Signature [illegible]

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 South Campus Expansion

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

(60)

STATE OF ILLINOIS
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*) Mary Ann Krueger
City Palos Hills State Illinois Zip 60465
Signature Mary Ann Krueger

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)
Expansion of Palos South Fitness Center

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

65

STATE OF ILLINOIS
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*) JOAN DONOVAN

City PALOS HEIGHTS State ILLINOIS Zip 60463

Signature Joan Donovan

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

9/17/15

(67)

STATE OF ILLINOIS
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*) JAMES GIERACH

City Palos Park State IL Zip 60464

Signature James E. Gierach

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

"Issue Conditional Certificate of Need"
Preserve Palos Health Center.

9/17/15

(62)

STATE OF ILLINOIS
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*) Stathia Xanos

City Orland Park State IL Zip 60467

Signature Stathia Xanos

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

9/17/15

63

STATE OF ILLINOIS
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*) Charlene Sandberg

City Orland Park State IL Zip 60462

Signature Charlene D. Sandberg

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

9/17/15

(61)

STATE OF ILLINOIS
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*) Mary Kopec

City Tinley Pk. State IL. Zip 60487

Signature Mary M Kopec

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

9/17/15

(64)

STATE OF ILLINOIS
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*) Gerhild Waggert

City Orland Park State IL Zip 60467

Signature Gerhild Waggert

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

9/17/15

(66)

STATE OF ILLINOIS
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*) Kathy Sullivan
City Orland Park State IL Zip 60462
Signature Kathy Sullivan

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

9/17/15

Last Speaker for Hospital ~~29~~

STATE OF ILLINOIS
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*) TIMOTHY BROSNAN

City PALOS Heights State IL Zip 60463

Signature Timothy J Brosnan

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 Community Hospital

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

Did not come up

50

STATE OF ILLINOIS
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*) RONALD FUHRMAN

City ORLAND PARK State ILLINOIS Zip 60462

Signature Ronald Fuhrman

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

9/17/15

Submitted written testimony

(57)

STATE OF ILLINOIS
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*) WILLIAM J. KANE

City ORLAND PARK State IL Zip 60462

Signature William J. Kane

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

9/17/15

Changed her mind

58

STATE OF ILLINOIS
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*) Denise L. Smith

City Orland Park State IL Zip 60462

Signature Denise L. Smith

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

9/17/15

~~Needs to leave by 11 am~~
Didn't come up
47

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Testimony Registration Form

Facility Name: Palos Community Hospital – Orland Park

Project Number: 16-001

O Connor

I. IDENTIFICATION
Name (*Please Print*) John K O'Connor

City ORLAND PARK State IL Zip 60462

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

9/17/15

Already Spoke
DIDN'T COUNT IN TOTAL
B/C A DUPLICATE (31)

STATE OF ILLINOIS
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*) PATRICIA Heerlein
City Palos Hts State IL Zip 60462
Signature Patricia Heerlein

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 Community Hospital

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

Already spoke
DIDN'T COUNT
B/C A DUPLICATE (28)

STATE OF ILLINOIS
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*) Lori K. Mazeika-Myre

City Orland Park State IL Zip 60467

Signature Lori K. Mazeika Myre

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 Citizens for Health Care)
Palos Community Hospital

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15

already spoke

DIDN'T COUNT (33) B/C DUPLICATE

STATE OF ILLINOIS
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*) Alicia Klabunde

City Palos Heights State IL Zip 60463

Signature Alicia Klabunde

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 Community

III. POSITION (*please circle appropriate position)*

Support Oppose Neutral

IV. Testimony (*please circle)*

Oral Written

9/17/15