Casse1.883800433 CDalaim6552 FFFibelc00.12281.99 DiesscMalainDioociumeent Pagee11.06281

Fill in this in	nformation to identify the case:
Debtor 1	Belvidere Associates LLC
Debtor 2 (Spouse, if filing)
United States	Bankruptcy Court for the: Northern District of Illinois
Case number	18-30043

Official Form 410

Proof of Claim AMENDED

04/16

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

Part 1: **Identify the Claim** Who is the current Cynthia Levandoski creditor? Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor Has this claim been **☑** No acquired from ☐ Yes. From whom? someone else? Where should notices Where should notices to the creditor be sent? Where should payments to the creditor be sent? (if and payments to the different) creditor be sent? Cynthia Levandoski c/o Fonfrias Law Federal Rule of Name Bankruptcy Procedure 125 S Wacker Dr. #300 (FRBP) 2002(g) Street Number Number Street 60606 Chicago Ш State ZIP Code State ZIP Code 312-969-0730 Contact phone Contact email rfonfrias2025@gmail.com Contact email Uniform claim identifier for electronic payments in chapter 13 (if you use one): **☑** No Does this claim amend one already filed? ☐ Yes. Claim number on court claims registry (if known) ___ MM / DD / YYYY **☑** No 5. Do you know if anyone else has filed a proof ☐ Yes. Who made the earlier filing? of claim for this claim?

Official Form 410 Proof of Claim page 1

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No Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A). Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information. Work Injury as employee of Debtor Work Injury as employee of Debtor
No Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A). Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information. Work Injury as employee of Debtor Work Injury as employee of Debtor Work Injury as employee. The claim is secured by a lien on property. Real estate. If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim. Motor vehicle Other. Describe: Basis for perfection:
charges required by Bankruptcy Rule 3001(c)(2)(A). 8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information. Work Injury as employee of Debtor 9. Is all or part of the claim secured? Nature of property: Real estate. If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim. Other. Describe: Basis for perfection: Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.) Value of property: Amount of the claim that is secured: \$ Amount of the claim that is secured: \$
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information. Work Injury as employee of Debtor 9. Is all or part of the claim secured? No Yes. The claim is secured by a lien on property. Nature of property: Real estate. If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim. Other. Describe: Basis for perfection: Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.) Value of property: \$ Amount of the claim that is secured: \$
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Attachment (Official Form 410-A) with this Proof of Claim. Motor vehicle Other. Describe: Basis for perfection: Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.) Value of property: \$ Amount of the claim that is secured: \$
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Value of property: \$ Amount of the claim that is secured: \$
Amount of the claim that is secured: \$
· · · · · · · · · · · · · · · · · · ·
Amount of the claim that is unaccount (* //The cure of the account and unaccount
Amount of the claim that is unsecured: \$(The sum of the secured and unsecured amounts should match the amount in line 7
Amount necessary to cure any default as of the date of the petition: \$
Annual Interest Rate (when case was filed)% □ Fixed □ Variable
10. Is this claim based on a ☑ No lease?
Yes. Amount necessary to cure any default as of the date of the petition. \$
11. Is this claim subject to a ☑ No
right of setoff? Yes. Identify the property:

Official Form 410 Proof of Claim page 2

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12. Is all or part of the claim entitled to priority under	☑ No					
11 U.S.C. § 507(a)?	Yes. Check	one:				Amount entitled to priority
A claim may be partly priority and partly		ic support obligations (includin C. § 507(a)(1)(A) or (a)(1)(B).	g alimony and child supp	ort) under		\$
nonpriority. For example, in some categories, the law limits the amount entitled to priority.		2,850* of deposits toward purc al, family, or household use. 11		roperty or	services for	\$
	bankrup	salaries, or commissions (up to otcy petition is filed or the debto C. § 507(a)(4).	o \$12,850*) earned within or's business ends, which	n 180 days ever is ea	before the lier.	\$
	☐ Taxes o	or penalties owed to governmen	ntal units. 11 U.S.C. § 50	7(a)(8).		\$
	☐ Contribu	utions to an employee benefit p	olan. 11 U.S.C. § 507(a)(5).		\$
	Other. S	Specify subsection of 11 U.S.C	. § 507(a)() that applie	s.		\$
		are subject to adjustment on 4/01/1			pegun on or afte	er the date of adjustment.
				211100000000000000000000000000000000000		
Part 3: Sign Below						
The person completing this proof of claim must	Check the appro	ppriate box:				
sign and date it.	I am the cre					
FRBP 9011(b).		editor's attorney or authorized				
If you file this claim		istee, or the debtor, or their au			04.	
electronically, FRBP 5005(a)(2) authorizes courts	I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.					
to establish local rules specifying what a signature	Leaders to the translational signature on this Proof of Claim convey on an eal-newledgment that when calculating the					
is.	I understand that an authorized signature on this <i>Proof of Claim</i> serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.					
A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5						
years, or both. 18 U.S.C. §§ 152, 157, and	I declare under	penalty of perjury that the fore	going is true and correct.			
3571.	Executed on da	te 01/24/2019				
	Signature					
	Print the name	of the person who is comple	eting and signing this c	laim:		
	Name	Heath S. Isaacs	Middle name		Last name	
	Title	Paralegal				
	Company	Fonfrias Law Group				
		Identify the corporate servicer a	as the company if the authori	zed agent is	a servicer.	
		405.0 \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	00			
	Address	125 S Wacker Dr., #3	00			· · · · · · · · · · · · · · · · · · ·
		Number Street Chicago		IL	60606	
		City		State	ZIP Code	
		(3.000) - 1				iver com
	Contact phone	801-726-7704		Email ⊓ea	th@casedr	IVEL.COIII

Official Form 410 Proof of Claim page 3

Casse1883800433 CDainm6552 FilibelCO11228199 DesscMain Document Fragge4406f281 ILLINOIS WORKERS' COMPENSATION COMMISSION

APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

Workers' Compensation Act X. Occupational Diseases Act OCT 19 2017 Cynthia Levandoski	ATTENTION.	Please type or print. Answer all quantity	uestions. File three copies	s of this form.	
Cynthia Levandoski Employee/Petitioner Case # (Office use only) Waukegan IL Employer/Respondent City, State Cynthia Levandoski Injured employee's name 1 Street address Delvidere Road Street address Delvidere Road Delvidere Associates, LLC 2650 Belvidere Road Waukegan IL 60084 Maukegan IL 60085 Maukegan IL 600	Workers' Compensation Act X Occupa	tional Diseases ActFat	al case? No X Yes	Date of death	
Home Owners Bargain Outlet Belvidere Associates, LLC Employer/Respondent Cynthia Levandoski Injured employee's name 1 Street address City, State, Zip code Home Owners Bargain Outlet Belvidere Associates, LLC 2650 Belvidere Road Belvidere Associates, LLC 2650 Belvidere Road Employer's name Street address City, State, Zip code Waukegan L 60085 Employer's name Street address City, State, Zip code Waukegan L 60085 Employer's name Street address City, State, Zip code City, State, Zip code Waukegan L 60085 Employer information: State Employee? Yes No X Male Female X Married Single X # Dependents under age 18 0 Birthdate 05/03/1963 Average weekly wage \$ 630.00 Date of accident 2 05/22/2017 The employer was notified of the accident orally X in writing How did the accident occur? Pulling out a bedding set. What part of the body was affected? Left hand/wrist. What is the nature of the injury? To be determined. Return-to-work date 3 Is a Petition for an Immediate Hearing attached? Yes No X Is the injured employee currently receiving temporary total disability benefits? Yes No X Is the injured employee currently receiving temporary total disability benefits? Yes No X If a prior application was ever filed for this employee, list the case number and its status ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before a sign this. Refer to the Commission's Handbook on Workers' Compensation and Occupational Diseases 4 for more information.				17#c031	7770
Home Owners Bargain Outlet Belvidere Associates, LLC Employer/Respondent Cynthia Levandoski Injured employee's name 1 Street address City, State, Zip code Home Owners Bargain Outlet Belvidere Associates, LLC 2650 Belvidere Road Belvidere Associates, LLC 2650 Belvidere Road Belvidere Associates, LLC 2650 Belvidere Road Belvidere Associates, LLC Maukegan Belvidere Associates, LLC Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Whate Employee's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Belvidere Associates, LLC Bemployer's name Bemployer's name Street address City, State, Zip code Waukegan Belvidere Associates, LLC Bemployer's name Belvidere Associates, LLC Bemployer's name Belvidere Associates, LLC Belvidere Associates, LC Belvidere Associates, LLC Belvidere Associates, LLC Belvidere A			(Office use only)		
Home Owners Bargain Utlet Employer/Respondent Cynthia Levandoski Injured employee's name 1 Street address City, State Cynthia Levandoski Injured employee's name 1 Street address City, State, Zip code Home Owners Bargain Outlet Belvidere Associates, LLC 2650 Belvidere Road Belvidere Associates, LLC 2650 Belvidere Road Waukegan IL 60085 Employer's name Street address City, State, Zip code Waukegan IL 60085 Employer's name Street address City, State, Zip code Waukegan IL 60085 Employer's name Street address City, State, Zip code Waukegan IL 60085 Employer's name Street address City, State, Zip code Waukegan IL 60085 Employer's name Street address City, State, Zip code Waukegan IL 60085 Employer's name Street address City, State, Zip code Waukegan IL 60085 Employer information: State Employee? Yes No _X Male Female _X Married Single _X # Dependents under age 18 Birthdate 05/03/1963 Average weekly wage \$ 630.00 Date of accident 2 05/22/2017	v.				
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Date of accident 2 05/22/2017 The employer was notified of the accident orally X in writing How did the accident occur? Pulling out a bedding set. What part of the body was affected? Left hand/wrist. What is the nature of the injury? To be determined. Is a Petition for an Immediate Hearing attached? Yes No X Is the injured employee currently receiving temporary total disability benefits? Yes No X If a prior application was ever filed for this employee, list the case number and its status ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's Handbook on Workers' Compensation and Occupational Diseases 4 for more information.					
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ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's Handbook on Workers' Compensation and Occupational Diseases 4 for more information.	Is the injured employee currently receiving	g temporary total disability ber	nefits? Yes	NO VETT	•
you sign this. Refer to the Commission's Handbook on Workers' Compensation and Occupational Diseases for more information.	If a prior application was ever filed for th	is employee, list the case numb	er and its status		
N H' Anador	ATTENTION, PETITIONER. This is a loyou sign this. Refer to the Commission's	egal document. Be sure all blan Handbook on Workers' Compe	ks are completed corrections are completed correction and Occupation	ctly and you understand Diseases for my	nd the statements before ore information.
Signature of petitioner Date	the state of the s	loski	%\2% 1 Date		
APPEARANCE OF PETITIONER'S ATTORNEY Please attach a copy of the Attorney Representation Agreement.		APPEARANCE OF PETI [*] Please attach a copy of the <i>Attorn</i>	TIONER'S ATTORNI ey Representation Agreen	EY nent.	
Signature of attorney 3416 W. Elm Street Street address	Signature of attorney			et a same	
Mark J. Vogg 1919 McHenry IL 60050 Attorney's name and IC code #5 (please print) City, State, Zip code	Mark J. Vogg Attorney's name and IC code #5 (please print)				60050
Law Offices of Thomas J. Popovich Firm name 815-344-3797 Telephone number E-mail address			process and the second	E-mail	address

Case 1883800433 CD anim 6552 Filiber 17748199 Spass Alphanin Document Page 5506281

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized. If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, Mark J. Vogg	, affirm that I delivered	mailed with proper postage X
in the city of McHenry, IL	a copy of this	form
at 5:00 AM/PM on 10-10-	to the respondent list	ed on this application and to each
additional party, if any, at the address liste	ed below.	
	W_	
	Signature of	person completing Proof of Service
Signed and sworn to before me on		
Notary Public		
	A Company	

IC1 page 2

¹ In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

² This may be the date of the accident, last exposure, disability, or death.

³ If the employee has not returned to work, leave this space blank.

⁴ The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.

⁵ The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.



EMPLOYEE?	NAME:	Garlie bern decki	00000000000000000000000000000000000000			
EMPLOYER:	j in jarra	Date: 7/ [1/ / Admit Time: 1 7 5			
		WORK STATUS				
🗇 Regular Work as of: 🌊	· · · · · · · · · · · · · · · · · · ·	□ Work Status to be determ	nined by Specialist			
🛘 Off Work Rest of Toda	ay Only	ည့် Can Work with the Restr	ictions Specified Below:			
□ Off Work Until:		· · ·				
LIFTING/BEN	DING	ARMS/SHOULDERS	WALK/SIT/STAND			
CINo lifting, pushing or pu	illing over	□No work using RIGHT/LEFT arm	☐ Sitting job, minimum of walking			
lbs		□ Limited use of RIGITI/LEFT arm	□ Uses crutches			
☐ No repetitive lifting		□No reaching while lifting	C) Get up from sitting position every half hour			
DNo lifting above the sho	ulder ievel	□No working with RIGHT/LEFT arm	Alternate standing/sitting positions every			
Gradually increase liftin		above chest level	□ half hour □ as needed			
lbs over the next		□ Wear sling for days				
(DLimit bending, stooping	and twisting					
HANDS/WRI:	NO TRANSPORTED CONTRACTOR OF THE CONTRACTOR OF T	SQUAT/CLIMB	SKIN			
ो्रेश्वर्व use of RIGHT/LEF		☐ No squatting or kneeling	Keep wound clean and dry			
Limit use of RIGHT/LA	EFT hand	🗅 No climbing	☐ Keep covered at work			
CINo tight gripping with		Ground level work only				
RIGHT/LEFT hand		NECK	MACHINE/VEHICLE			
☐ No repeat twisting/bending of RIGHT/LEFT wrist		Avoid repeated acok motions	☐ No hezardous or fast moving machinery			
Wear splint on RIGHT/LEFT		,	□ No driving			
WRIST/FINGER						
		PATIENT INSTRUCTIONS				
ri Start PT/OT	e		stches as instructed			
h Ibuprofen: [6] mg; e	very 🔣 hrs;		wound twice daily			
O Cyclobenzaprine: mg; every hrs; take at bedtime ONLY; DO NOT drive within 8 hrs of each dose - may make drowsy						
		ADDITIONAL INSTRUCTIONS	3			
, , , , , , , , , , , , , , , , , , ,						
DIAGNOSIS:		,·				
Chidotal	1 67 53.551)	Recivite				
		MD/PA Signat	ore:			
Next Appointment:	Date:	Time:	u DISCHARGED			
Physical/Occupational			41,000			
Therapy	Date:					
**************************************	Doctor:	LLII Date:	Time:			
Referral to Specialist		Bridger of	Atola Todiera			
	Location:		Time: Phone: City			
Drug Screen	u YES o N	O DN/A DAfter care instructions given and discussed	Discharge Time:			
	C	all Corporate Health at 847.360.2860 or	847.356.4746			
Vista West 2	615Washing	ton St., Waukegan Vista Lindenbu	rst 1050 Red Oak Lane, Lindenhurst			
STON ATTEMPS	PATIENT *	RN	/тесн <u>(2.43)</u>			
CONTRACT Y VARABLES	THE RESERVE THE PROPERTY OF THE PARTY OF THE	Approximate the second	**************************************			

WHITE - CHS YELLOW - COMPANY PINK - PATIENT



P 847.336.3335 F 847.336,3249

Gurnee | Lake Forest | Lindenhurst | Ibji.com

Date: 5/24/2017	Physician:
JIL TILL TILL THE TIL	Serafin Del.eon,MD
Name: Levandoski, Cynthia	Diagnosis: Left distal radius fracture
Employer: Home Owner's Bargain Outlet	
Date of Injury: 05/22/17	
☐ Employee can return to work as of	without restrictions.
☑ Employee can return to work as of 5-29-17 to last through 5-30-17 . If modified duty that me considered to be off work.	with the restrictions identified below which are expected ets these restrictions is not available, the patient should be
 Employee is <u>unable to return to work</u> as of 5-24-17 5-28-17 (date) ☐ until next appoin until surgery. (awaiting W/C approval). ☐ until diagnost 	tment (listed below) and will be assessed then.
Posture/Motion Restrictions (if any): Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day No Work Involving: Hand/Wrist/Arm R L Not to exceed lbs	
Leg R L No lifting/carrying Foot/Ankle R L No pushing/pulling Neck No pinching Back No grasping/squeezing Climbing Restrictions No ladder No stairs No ramp	□ R □ L □ Sitting only □ R □ L □ Must use crutches □ R □ L □ Walking/Standing as tolerated □ R □ L □ No driving □ No operating heavy equipment/moving machine □ R □ L □ No overhead work □ R □ L □ R □ L
Other Restrictions (if any):	
Expected Follow-up Services Include:	
Next Appointment Date: <u>5-30-17</u> Time: <u>7:40am</u>	at Gurnee Office
Diagnostic Studies Requested:	
Surgery Recommended:	
	forweeks starting
Referral to:	
NONE. This is the last scheduled visit for this problem. At	this time no further medical care is anticipated. eted By: Krystal Perez



P 847.336.3335 F 847.336.3249

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Date: 5/30/2017	Physician:	<u>S</u> .	Dester
Jake. Sisorzuli	r irysiolasi.	Serafin Del	Leon,MD
Name: Levandoski, Cynthia	Diagnosis:	left distal rad	lius fracture
Employer: Home Owner's Bargain Outlet		***************************************	· · · · · · · · · · · · · · · · · · ·
Date of Injury: 05/22/17			
☐ Employee can return to work as of	without res	trictions.	
Employee can return to work as of 5-30-17 to last through pending surgery . If modified duty that me considered to be off work.			ntified below which are expected tavailable, the patient should be
Employee is unable to return to work as of (date) until next appoin until surgery. (awaiting W/C approval). until diagnosti		pelow) and wil	ited to be off of work through: If be assessed then. omplete, (awaiting W/C approval)
Posture/Motion Restrictions (if any): Standing Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day Nos/day No Work Involving: Hand/Wrist/Arm R L Not to exceed lbs Leg R L No lifting/carrying Foot/Ankle R L No pushing/pulling Nock No pinching No grasping/squeezing Climbing Restrictions No ladder No stairs No ramp	☐ Clir ☐ Gra ☐ Sqr ☐ Re ☐ Ov ☐ Ke	mbing I asping I ueezing I aching I erhead I yboarding I Misc. Restr Sitting o Sitting o Must use Walking No drivir	lint/brace/sling/cast at work nly e crutches /Standing as tolerated .
Other Restrictions (if any): Patient may not work at the regi	ster	70.00 TO THE RESERVE	
Expected Follow-up Services Include:			
Next Appointment Date: pending surgery Time:	at Sele	ect Office	
Diagnostic Studies Requested:			
Surgery Recommended: left distal radius open reduction a			
Rehab (PT/OT) Recommended:x per week	for	weeks st	tarting
Referral to:			
NONE. This is the last scheduled visit for this problem. At	this time no fu eted By: Kryst		I care is anticipated.

Hawthorn Surgery Center

Patient Centered, Extraordinary Care.

		,	•	•		V		
	e Patient or Guardian:			. ,		•		
	physician may dispense an ort products include but are not l		bracing d	evice as part	of your treatm	ent at Haw t ho	m Surgical Cen	iter.
<u> </u>	_ Arm Sling		1	Sho	oulder Abduction	on Sling		
······	CAM Walker Boot		,	Crı	utches		•	
	Knee Immobilizer			Po	st-Op Shoe/AF	> B		
	_TED Compression Hose		^	4-F	rong Walker			
charge not Ha	products are very common co is for a soft good or bracing de withom Surgical Center. Paym s. For example, you may be c	evice will be billed dir sent for the soft good	rectly to yo for bracing	our insurance g device will b	company by S e made accor	Specialty Media ding to your m	cal Services, IN Iembers plan	IC.
Service	nave any questions regarding es, Inc., at the number below. es, Inc. and Hawthorn Surgery	There is no financial	ctaim, ple- interest or	ase contact y r other busine	ou insurance c ess association	carrier directly between Spe	or Specialty Me cialty Medical	adica
	read the assignment of insur- gn below.	ance benefits for the	soft good	or bracing de	vice that you r	nay receive fr	om you physicia	an,
	ilty Medical Services, Inc. h		y practice	that are in o	ompliance w	ith the Health	Insurance	,
procesi produc it is a b	ies in our office are intended to s your claim for benefits and p t and pertinent information ne rusiness associate, Specialty l bing your orthotic, soft good o	payment. This include cessary to process y Medical Services, Inc	e: demogra our claim v c. complies	aphic informa with your insu	tion, the nature trance carrier/r	e of treatment responsible pa	requiring our rty for payment	t. As
PA	TIENT AUTHORIZATION TO	USE OR DISCLOSI MATION, AND BEN	E PROTEC	CTED HEALT	H INFORMAT SCLOSURE F	TON, RELEAS	SE OF MEDICA	λL
at this provide	ALTY MEDICAL SERVICES, facility, I authorize the release ed to me. Additionally, I author e responsible for any co-pa	of my medical inforrize assignment of m	nation nec y insuranc	essary to pro e benefit to S	cess the resultipecialty Medic	ting claim for to al Service, Inc	he product(s) c. I understand	
Patient	l/ Guardian Signature:	Lilmost	كالمحت				• .	
Physic	ian Signature: V.O. PCL	Dr. Dele	<u>'00</u>		Date: 6	<u> </u>		
SPEC	ALTY MEDICAL SERVICES.	INC		•				
·	usiness Center Dr.	4						
	Prospect, IL 60056			J.				
	720-4310 – Billing Departmen	t						
-								

Specialty Medical keep the original- one copy to patient, one copy remains in patient's chart



7

Move better. Live better.

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Date: 6/19/2017	Physician:			
	Serafin DeLeon,MD			
Name: Levandoski, Cynthia	Diagnosis: Status Post Left ORIF of 3-Part Intra-Articular			
Employer: Home Owner's Bargain Outlet	Distal Radius Fracture			
Date of Injury: 5/22/17 DOS: 6/8/17				
☐ Employee can return to work as of	without restrictions.			
Employee can return to work as of 6/26/17 with the restrictions identified below which are expected to last through NEXT APPT. If modified duty that meets these restrictions is not available, the patient should be considered to be off work.				
 Employee is unable to return to work as of 6/19/17 6/25/17 (date) until next appoint until surgery, (awaiting W/C approval). □ until diagnostic 	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)			
Neck No pinching Back No grasping/squeezing Climbing Restrictions	R L Wear splint/brace/sling/cast at work			
Other Restrictions (if any): No use of arm sling				
Expected Follow-up Services Include: Next Appointment Date: 7/17/17 Time: 12:15PM Diagnostic Studies Requested:				
Surgery Recommended:				
⊠ Rehab (PT/OT) Recommended: 2 x per week	for 4 weeks starting pending WC approval			
Referral to:				
NONE. This is the last scheduled visit for this problem. At				
Note Compl	eted By: Ofelia Diaz, CCMA			



P 847.336.3335 🔍 ₹ 847.336.3249

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	S. We Jun
Date: 7/17/2017	Physician:
	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: Left three-part intraarticular distal radius
Employer: Home Owner's Bargain Outlet	Fracture S/P Open Reduction Internal Fixation
Date of Injury: 5/22/17 DOS: 6/8/17	
Employee can return to work as of	without restrictions.
Employee can return to work as of 7/17/17 to last through 8/15/17 if modified duty that me considered to be off work.	
Catch light (data) [until next appoin	and is expected to be off of work through: ntment (listed below) and will be assessed then. lic testing (listed below) is complete. (awaiting W/C approval)
Standing	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Not to exceed hrs/day Keyboarding Not to exceed hrs/day Stions Misc. Restrictions R U Wear splint/brace/sling/cast at work R U Sitting only R U Must use crutches R U No driving No operating heavy equipment/moving machine R U No overhead work
Other Restrictions (if any):	hand 12 hand 24
Expected Follow-up Services Include:	
Next Appointment Date: 8/15/17 Time: 8:15AN	A at Gurnee Office
Comments Studies Requested	
Diagnostic Studies Requested.	
Surgery Recommended:	k forweeks starting
T Deferred to:	
NONE. This is the last scheduled visit for this problem. A	t this time no further medical care is anticipated.
	pleted By: Clairie Chicas, CCMA



Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
07/17/2017	12:15 pm	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-	Deleon MD, Serafin M
<u> </u>		336-3335	

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

01/14/19 19:59:22 0472441419 Cassei 8:350043 Chamilo 552 Filibelo 01/12/8199 Described 12/12/8199 Described 12/12/8199

Create Date:

6/19/2017

Due Date: 7/19/2017

Procedure:

OT

Facility:

IBJI Rehab Gurnee

Ordering Provider: Serafin DeLeon - NPI # 1326091414



ILLINOIS BONE AND JOINT INSTITUTE, LLC OCCUPATIONAL THERAPY ORDER

☐ Right ☑ Left	
Patient Name: Levandoski, Cynthia Patient ID: 1520501 Diagnosis: Treatment Frequency: □ x1 ⊠ x2 □ x3 per week Treatment Duration: □ 1 □ 2 □ 3 図 4 □ 5 □ 6 図 weeks	□ mentha
Treatment Frequency: ☐ x1 x2 ☐ x3 per week Treatment Duration: ☐ 1 ☐ 2 ☐ 3	. L. monas
☐ Right ☑ Left SPLINT FABRICATION	Notes:
Hand based	
☐ Right	
□ Range of Motion □ Soft Tissue Care □ Strengthening □ Unlimited Mobilization □ Cryotherapy □ Digital Flexion/Extension □ T □ □ □ □ □ □ Specific Goals □ Desensitization □ Wrist □ Active □ Electrical Stim □ Elbow Flexion / Extension □ Passive □ Electrical Stim □ Elbow Flexion / Extension □ Flexion □ Friction Massage □ Shoulder Abduction / Flexion □ Pronation □ Internal / External Rotation □ Computerized Measurement □ Internal / External Rotation □ TENS □ Detailed ROM □ Abduction / Forward Flexion □ Wound Care □ Return to Work Evaluation □ Limited □ C ☑ Semmes-Weinstein Monofilament Exam □ Semmes-Weinstein Monofilament Exam	R 「S
□ Protocols □ CMC Resection Arthroplasty □ Extensor Tenolysis Zone □ Rheumatoid Arthritical Control Contro	itis ity
NOTES	- V-Aller seri reserv
Letter of Medical Necessity: I certify that the above prescribed equipment, its setup and related patient education are medically indicated and necessary to the accepted stan medicine of this patient's condition.	dards of
S. W. Jun	
Signed Date 6/19/2017 Serafin DeLeon,MD	

For your information, the Physical Therapists, Occupational Therapists and Athletic Trainers at IBJI are financially integrated. If you are referred to a clinician in IBJI for any related services, you may request and receive a referral for these services outside or independent of IBJI

Date	Time	Appt Status	Clinician	Location	Copay Date Created	Last Changed Date	Last Changed UserID
Jul 06, 2017	08:30 AM	Rescheduled	Almanza, PT , Stacy	40720-NVC Gurnee IL	\$.00 Jun 27, 2017	Jul 06, 2017	SELECT\escobedc
Jul 10, 2017	12:30 PM	Arrived	Leipold, PT , Tracy	40720-NVC Gurnee IL	\$.00 Jul 06, 2017	Jul 11, 2017	SELECTlepoidt
Jul 12, 2017	09:30 AM	Void	Bastable, PTA, Todd	40720-NVC Gumee IL	\$.00 Jul 10, 2017	Jul 11, 2017	SELECTMeipoidt
Jul 14, 2017	11:30 AM	Arrived	Bastable, PTA, Todd	40720-NVC Gurnee IL	\$.00 Jul 10, 2017	Jul 14, 2017	SELECT.JorRivera
Jul 18, 2017	03:00 PM	Arrived	Leipold, PT, Tracy	40720-NVC Gumee IL	\$.00 Jul 17, 2017	Jul 18, 2017	SELECTVeipoidt
Jul 20, 2017	04:30 PM	Void	Leipold, PT , Tracy	40720-NVC Gurnee II.	\$.00 Jul 17, 2017	Jul 19, 2017	SELECTiescobedo
Jul 21, 2017	02:00 PM	Arrived	Bastable, PTA , Todd	40720-NVC Gumee IL	\$.00 Jul 19, 2017	Jul 21, 2017	SELECT JorRivera
Jul 25, 2017	03:30 PM	Scheduled	Leipold, PT, Tracy	40720-NVC Gumee IL	\$.00 Jul 21, 2017	Jul 21, 2017	SELECT.JorRivera
Jul 27, 2017	04:30 PM	Scheduled	Leipold, PT, Tracy	40720-NVC Gumee IL	\$.00 Jul 21, 2017	Jul 21, 2017	SELECTubrRivera

JUES -3HES U JULY 25% 1 HR CATE 4 PER NIKE

01/14/19 11:10:15002437244141116552 Filibelo 01228199 Description Description

NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee, IL 60031 Phone: (847) 336-7468 Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Additional Instructions:

TUESDAY JULY 184K - 300 PM

14025024 JULY 20th - 430 pm

Thank you.

NovaCare Rehabilitation

NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee, IL 60031 Phone: (847) 336-7468

Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Сорау
Wed, Jul 12, 2017	09-80 AM	Workers Comp	Bastable, PTA , Todd	0.00
Fn, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00

Additional Instructions:

-TUESPZM

Thank you, NovaCare Rehabilitation

NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee, IL 60031 Phone: (847) 336-7468

Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Aug 23, 2017	12:00 PM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 29, 2017		Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 30, 2017		Workers Comp	Bastable, PTA , Todd	0.00
	12:00 PM	Workers Comp	Leipold, PT , Tracy	O. <u>O</u> O

Additional Instructions:

Thank you, NovaCare Rehabilitation

NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee , IL 60031 Phone: (847) 336-7468

Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

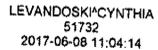
Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date Tim	e Appoin	ment Type Cli	nician	Copay
Tue, Aug 01, 2017 12:0	00 PM Workers	Comp Lei	pold, PT , Tracy	0.00
Wed, Aug 02, 2017-04:3	30-PM Workers	Comp Bar	stable, PTA, Todd	0.00
Mon, Aug 07, 2017 09:3	30 AM Workers	Comp Ba	stable, PTA , Todd	0.00
Wed, Aug 09, 2017 11:3	30 AM Workers	Comp Ba	stable, PTA , Todd	0.00
Tue, Aug 15, 2017 12:0	00 PM Workers	Comp Lei	ipold, PT , Tracy	0.00
Wed, Aug 16, 2017 04:0	00 PM Workers	Comp Lei	ipold, PT , Tracy	0.00
Tue, Aug 22, 2017 04:0	00 PM Workers	Comp Lei	ipold, PT . Tracy	0.00
Wed, Aug 23, 2017 12:0	00 PM Workers	Comp Bas	stable, PTA, Todd	0.00
Tue, Aug 29, 2017 04:0	00 PM Workers	Comp Lei	ipold, PT , Tracy	0.00
Wed, Aug 30, 2017 12:0	00 PM Workers	Comp Bas	stable, PTA , Todd	0.00

Additional Instructions:

Thank you, NovaCare Rehabilitation

LEVANDOSKI^CYNTHIA 51732 2017-06-08 11:04:40







LEVANDOSKI^CYNTHIA 51732 2017-06-08 11:04:14





Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone		Provider	
08/15/2017	08:15 am	350 S. Greenleaf Ave. Suite 4	05, Gurnee, IL / 847-	Deleon MD,	Serafin M
		336-3335			

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.



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F 847.336.3249

Date: 9/21/2017	Physician:	De Ja
Name I avandanki Ovetki	Serafin De	
Name: Levandoski, Cynthia		dius retained hardware as well as
Employer: Home Owner's Bargain Outlet	possible triangular fibroca	ілнаде complex tear.
Date of Injury: 05/22/17	ALIAMINIANAN MARKAMAN ANALYS A	
☐ Employee can return to work as of	without restrictions.	
Employee can return to work as of to last through If modified duty that n considered to be off work.		ntified below which are expected t available, the patient should be
 Employee is <u>unable to return to work</u> as of <u>09/28/17</u> (date) until next appo until surgery. (awaiting W/C approval). 	tment (listed below) and wi	
Standing Not to exceed hrs/day Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day No Work Involving: Lift/Carry/Push/Pull Restrictions Leg R L No lifting/carrying Foot/Ankle R L No pushing/pulling Neck No pinching No grasping/squeezing Climbing Restrictions No ladder No stairs	Climbing Grasping Squeezing Reaching Overhead Keyboarding tions R L Wear sp R L Sitting o R L Must use R L Walking R L No driving R L No opere	olint/brace/sling/cast at work nly e crutches /Standing as tolerated
Other Restrictions (if any):		
Expected Follow-up Services Include:		
Next Appointment Date: 10/06/17 Time: 8:45 A	at Gurnee Office	
		·
Surgery Recommended; left distal radius removal of har	ware as well as an arthrosc	
Rehab (PT/OT) Recommended: x per wee	forweeks s	tarting
Referral to:	**************************************	— постоят постоять выполнения на постоя на выполнения на постоят на постоят на постоят на постоят на постоят н
NONE. This is the last scheduled visit for this problem. A		



Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
10/06/2017	08:45 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-	Deleon MD, Serafin M
		336-3335	

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.



Workers' Compensation Work Status Report

P 847.336.3335
F 847.336.3249
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Date: 11/3/2017	Physician: Serafin Del.eon,MD
Name: Levandoski, Cynthia	Diagnosis: Left distal radius retained hardware as well as
Employer: Home Owner's Bargain Outlet	possible triangular fibrocartilage complex tear.
Date of Injury: 05/22/17 DOS 9/28/17	s/p removal of hardware, arthroscopy & synovectomy
Employee can return to work as of	without restrictions.
	with the restrictions identified below which are expected ets these restrictions is not available, the patient should be
Employee is unable to return to work as of (date) until next appoin until surgery. (awaiting W/C approval). until diagnosti	and is expected to be off of work through: tment (listed below) and will be assessed then c testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any): Standing	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Overhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Misc. Restrictions R L Sitting only R L Must use crutches R L Walking/Standing as tolerated R L No driving No operating heavy equipment/moving machine R L No overhead work R L R L No overhead work
Other Restrictions (if any): ****NO REGISTER***	
Expected Follow-up Services Include:	
Next Appointment Date: 11/3/17 Time: 8:15 AM	at Gurnee Office
☐ Diagnostic Studies Requested:	
Surgery Recommended:	
Rehab (PT/OT) Recommended:x per week	forweeks starting
Referral to:	
NONE. This is the last scheduled visit for this problem. At	this time no further medical care is anticipated.



Workers' Compensation Work Status Report

P 847.336.3335 F 847.336.3249 Gurnee | Lake Bluff | Linden

Gurnee | Lake Bluff | Lindenhurst ibjl.com

Date: 11/7/2017 *Updated*	Physician:
	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: Left distal radius retained hardware and
Employer: Home Owner's Bargain Outlet	possible triangular fibrocartilage complex tear.
Date of Injury: 05/22/17 DOS 9/28/17	s/p removal of hardware, arthroscopy & synovectomy
Employee can return to work as of	without restrictions.
Employee can return to work as of 11/3/17 to last through next appt If modified duty that me considered to be off work.	with the restrictions identified below which are expected ets these restrictions is not available, the patient should be
☐ Employee is <u>unable to return to work</u> as of ☐ (date) ☐ until next appoint ☐ until surgery. (awaiting W/C approval). ☐ until diagnosti	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any): Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Overhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day
No Work Involving: Hand/Wrist/Arm	Misc. Restrictions R
Other Restrictions (if any): ***NO REGISTER***	
Expected Follow-up Services Include:	
Next Appointment Date: 12/01/17	at Gumee Office
☐ Diagnostic Studies Requested:	
Surgery Recommended:	
	forweeks starting
Referral to:	
☐ NONE. This is the last scheduled visit for this problem. At	
Note Comple	eted By: Isabel Villarreal,CCMA



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Date: 12/1/2017	Physician:	Serafin DeLe	L.J.
Name: Levandoski, Cynthia	Diagnosis:)	is retained hardware and
Employer: Home Owner's Bargain Outlet	possible tria	ngular fibrocarti	age complex tear.
Date of Injury: 05/22/17 DOS 9/28/17	s/p removal	of hardware, år	hroscopy & synovectomy
Employee can return to work as of 12/1/17	without res	trictions.	f^*
VIII VIII VIII VIII VIII VIII VIII VII	with the res eets these res	trictions identil trictions is not a	ied below which are expected vailable, the patient should be
Employee is <u>unable to return to work</u> as of		celow) and will t	
Standing	Clii Gri Sq Re Ov Ke	mbing No asping No ueezing No aching No erhead No yboarding No Misc. Restriction Sitting only Must use of Walking/S No driving	t/brace/sling/cast at work / crutches tanding as tolerated g heavy equipment/moving machine
Other Restrictions (if any):			,
Expected Follow-up Services Include:			
Next Appointment Date: 1/8/18 Time: 12:45Pf	Mat Gur	nee Office	•
☐ Diagnostic Studies Requested:	wa.www.ee	MY/8'-W	
Surgery Recommended:			
Rehab (PT/OT) Recommended:x per week	for	weeks sta	ting
Referral to:			
NONE. This is the last scheduled visit for this problem. At		urther medical c	



Patient Name: Cynthja L Levandoski

Appt. Date Appt. Tim	Location / Phone	Provider
12/01/2017 08:15 am	350 S. Greenleaf Ave. Suite 405, Gumee, IL / 84	7- Deleon MD, Seratin M
	336-3335	

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.



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•	
Date: 1/8/2018	Physician:
	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: Left wrist retained hardware and TFCC tear
Employer: Hobo	S/P removal of hardware as well as scar excision and left
Date of Injury: 5/22/17 Surgery:9/20/17	wrist arthroscopy and synovectomy
⊠ Employee can return to work as of 1/8/18	without restrictions.
Employee can return to work as of to last through If modified duty that me considered to be off work.	with the restrictions identified below which are expected eets these restrictions is not available, the patient should be
	and is expected to be off of work through: trment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any):	
Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day No Work Involving: Lift/Carry/Push/Pull Restriction Hand/Wrist/Arm R L Not to exceed lbs Leg R L No lifting/carrying Foot/Ankle R L No pushing/pulling Neck No pinching Back No grasping/squeezing	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Coverhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day West splint/brace/sling/cast at work R L Sitting only R L Walking only R L Walking/Standing as tolerated R L No driving
Climbing Restrictions ☐ No ladder ☐ No stairs ☐ No ramp	☐ No operating heavy equipment/moving machine ☐ R ☐ L ☐ No overhead work ☐ R ☐ L ☐ R ☐ L
Other Restrictions (if any):	
Expected Follow-up Services Include:	;
Next Appointment Date: 2/2/18	at Gurnee Office
Diagnostic Studies Requested:	1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-
Surgery Recommended:	
Rehab (PT/OT) Recommended: x per week	for weeks starting
Referral to:	
NONE. This is the last scheduled visit for this problem. At	
Note Compl	eted By: Clairie Chicas, CCMA



Workers' Compensation Work Status Report

P 847.336.3335 F 847.336.3249 Gurnee | Lake Bluff | Lindenhurst ibji.com

Date: 2/16/2018	Physician:
	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: Left wrist retained hardware and TFCC tear
Employer: Hobo	s/p removal of hardware, scar excision, arthroscopy and
Date of Injury: 5/22/17 DOS 9/20/17 & 6/8/17	ECU tendonitis
☑ Employee can return to work as of 2/16/18	without restrictions.
☐ Employee can return to work as of to last through If modified duty that me considered to be off work.	with the restrictions identified below which are expected eets these restrictions is not available, the patient should be
	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any): Standing	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Coverhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day Itions Misc. Restrictions R L Sitting only R L Sitting only R L Must use crutches R L Walking/Standing as tolerated R L No driving No operating heavy equipment/moving machine R L No overhead work R L R L
Other Restrictions (if any):	
Expected Follow-up Services Include:	•
Next Appointment Date: 3/16/18 Time: 8:15AM	at Gurnee Office
☐ Diagnostic Studies Requested:	
Rehab (PT/OT) Recommended:x per week	forweeks starting
Referral to:	
☐ NONE. This is the last scheduled visit for this problem. At	

Note Completed By: Adriana Cortez, CCMA



Case 18-30043 Claim 65-2 Filed 01/28/19 Desc Main Documenton, Mange 29 of 31

350 S. Greenleaf, Ste 405~ Gurnee, IL 60031 Phone (847) 336-3335~ Fax (847) 336-3249

WORKERS' COMP WORK STATUS REPORT

Patient Name:	Cynthia L Le	vandoski			DOV		
Employer:		r's Bargain Outlet			MR#		
Occupation:					Date of Injury	5/22/2017	
Diagnosis:	Left wrist ext	ensor carpi ulnaris te	ndinitis				
☐ Employee c	an return to wor ed duty meeting unable to returr	k as of without with restrictions is to work as of 1/14/2	estrictions not avails 019 and	s as iden able, the is expect	ted to be off of wo	Considered on	st through
OD:		appointment (listed be				oproval)	
OR:		ostic testing (listed be		complete	. (awaiting w/C a)	provary	
	until surge	ry. (awaiting W/C ap	provai)				
Posture/Motion			/2/		25 100	Not to exceed	hrs/day
☐ Bending/Sto	oping	Not to exceed	- Charles of Paragolis		Overhead	Not to exceed	hrs/day
☐ Climbing		Not to exceed	_ hrs/day	50 File 500 U.S.	Power Tools or ratory Tools	NOT to exceed	
☐ Crawling		Not to exceed	hrs/day		Pushing/Pulling	Not to exceed	hrs/day
The second secon	Water/Oil/Duet	Not to exceed			Reaching	Not to exceed	hrs/day
☐ Extreme Hot		Not to exceed			Sitting	Not to exceed	hrs/da
☐ Grasping	70014	Not to exceed	hrs/day		Squeezing	Not to exceed	hrs/da
☐ Keyboarding		Not to exceed	hrs/day		Standing	Not to exceed	hrs/da
☐ Kneeling/Squ		Not to exceed	hrs/day		Twisting	Not to exceed	hrs/da
☐ Lifting/Carryi	The second	Not to exceed	hrs/day		Walking	Not to exceed	hrs/da
No Work Involv	ina	Lift/Carry/Push/Pu	ıll Restr	ictions	Misc. Re	strictions	
Hand/Wrist/Arm	250	Not to exceed				splint/brace/sling/ca	st at work
.eg	DRDL	No lifting/carrying		JR D L			
Foot/Ankle	DRDL	No pushing/pulling		JR D L	The state of the s	TOWNS THE STREET	
leck		No Pinching		JR D L	AND SINGULARIES	g/standing as toler	ated
Back		No Grasping/squee	- A	JR 🗆 L			
Climbing Restri	The same	Weight Restriction			□ No op	erating heavy equiperhead work	o/machines
ther Restriction	ns (if any):						
	The art March Control of the Control						
xpected Follow			Lacatio		- 250 C CI-	-f Ct- 405D	
Diagnostic Stu		2 <u>019</u> Time: <u>12:15 pm</u>	Locatio	n. <u>Gurne</u>	e-330 S. Greenie	al, Ste 405B	
Surgery Recom		left extensor car	pi ulnaris	s release	SURG	SERY DATE: 1/14	10
		ed: x per week	· SKING-SOME SOME	C. T. SHOW AND DESCRIPTION	59-15-15-17/19/6	restriction the principal property of the second of the se	13
Referral to:	recommende	,d x por week	. 101	#66#	s starting		
	the last schedu	uled visit for this prol	olem At	t this time	e no further med	ical care is anticip	atad
S. lle for					2000 11 TOWN 18 18		

Case 18-30043 Claim 65-2 Filed 01/28/19 Desc Main Decument Page 30 of 31



HAWTHORN SURGERY CENTER

Dr. DeLeon Hand, Wrist and Elbow POST-OPERATIVE HOME CARE INSTRUCTIONS

Gurnee | Lindenhurst | Lake Forest Phone: (847)336-3335 | Fax: (847)336-3249 | www.ibji.com

Begin with liquids and light foods - Ginger Ale, soup, jello, etc. Progress to a normal diet, if there is no nausea. If

	□ No restrictions on diet.
2.	MEDICATIONS: Resume all home medication(s), if applicable.
Du	Other instructions, if applicable: Use prescription as directed. If you have any problems taking the prescription medication, notify your physician. When taking pain medications be careful walking and climbing stairs. Dizziness is not unusual. *Pain medications may cause constipation. You may need a stool softener such as Senokot or Colace. Side effects information for new medications given. You have been prescribed OxyContin. It is a very powerful pain medication. Take it for severe pain not relieved by the Norco alone. You must wait 4 hours between taking doses of Norco and OxyContin. to the side effects of most pain medications, if you have been diagnosed with sleep apnea and are prescribed a CPAP/BiPAP, it is STRONGLY advised to be compliant with use post operatively to avoid complications.
3.	ACTIVITIES: Because of anesthesia, limit activities for 24 hours. Do not drive a motor vehicle, operate machinery, power tools or appliances. Do not make critical decisions. Do not sign any legal documents. Do not drink any alcoholic beverages. Resume normal activities as tolerated No activity restrictions See additional instructions below/attached
4.	HAND THERAPY: ☐ None until instructed further. ☐ Several times a day, try to bend and straighten your fingers and move your wrist and elbow to prevent stiffness.
5.	You may remove your bandage in 5 days and get incision wet. Do not remove your bandages. Wounds heal with the fewest problems if they are kept clean and dry. When bathing protect your bandage in a plastic bag.
	DANGER SIGNALS: Excessive pain, bleeding, swelling, temperature over 101 degrees, if extremity becomes cold to touch/tingly/numb, or here are ANY OTHER PROBLEMS IN REGARD TO YOUR SURGERY, please call your physician immediately.
7.	Post-operative appointment:
ADI	TIONAL INSTRUCTIONS:
Are	TRIVE FOR EXCELLENCE! IF YOU HAD A POSITIVE EXPERIENCE WHILE AT HAWTHORN SURGERY CENTER, ASE GIVE US RATINGS OF "STRONGLY AGREE" OR 9s AND 10s ON YOUR PATIENT SATISFACTION SURVEY! covery room nurse will call you in a day or two. This is a routine call to find out how you are progressing after surgery. We wish you a pleasant and uneventful recovery. Date Instructions understood by patient/authorized authority Date FM-06355 (07/17)

Case 18-30043 Claim 65-2 Filed 01/28/19 Desc Main Document Page 31 of 31



Serafin DeLeon, MD

350 S. Greenleaf, Ste 405~ Gurnee, IL 60031 Phone (847) 336-3335~ Fax (847) 336-3249

WORKERS' COMP WORK STATUS REPORT

5000 000				DOV:	1/21/2019	
	Cynthia L Levandoski			MR#:	1520501	
Grant Charles (1975)	lome Owner's Bargain Outlet		Date	of Injury:	05/22/2017	
Occupation: Diagnosis:	eft wrist extensor carpi ulnaris	s tendinitis stati	us post left wri	st extensor	carpi ulnaris rele	ase
The second and second and second second	A MARKATAN MARKAN TOTAL NO CONTROL TO A MARKAN TO A MARKAN A MARKA		_			
☐ Employee can re If modified do ■ Employee is unab	eturn to work as of with the work as	h restrictions as is not available <u>1/2019</u> and is e	s identified bel e, the patient s expected to be	off of work	3110100	st through k.
	until diagnostic testing (listed				roval)	
	until surgery. (awaiting W/C			9	MINOR COLVE	
		- рр. от с.,				
Posture/Motion Res ☐ Bending/Stooping	Not to exceed	hre/day	П Оh	۱ ۱	Not to exceed	hrs/day
☐ Climbing	Not to exceed	1.15.19 DEALERS OF 11.19 (1)	☐ Overhea		Not to exceed	
_ onbing	Not to exceed	ms/uay	☐ Power To Vibratory To		401 to excess	
☐ Crawling	Not to exceed	hrs/dav	☐ Pushing/		lot to exceed	hrs/day
☐ Exposure to Wate			☐ Reaching	9	lot to exceed	hrs/day
☐ Extreme Hot/Cold			☐ Sitting	9	lot to exceed	hrs/day
☐ Grasping	Not to exceed	CONTRACTOR OF THE PARTY OF THE	☐ Squeezir		lot to exceed	hrs/day
☐ Keyboarding	Not to exceed		☐ Standing	.5	lot to exceed	hrs/day
☐ Kneeling/Squatting			☐ Twisting		lot to exceed	A
☐ Lifting/Carrying	Not to exceed		☐ Walking		lot to exceed	
No Work Involving		- Jan Veolik Section	No dies	, mo		
Hand/Wrist/Arm ☐ R Leg ☐ R Foot/Ankle ☐ R Neck ☐	□ L No lifting/carrying	lbs □ R		Sitting on Must use	int/brace/sling/ca ly	
Back 🔲	No Grasping/squ			No driving		aled
Climbing Restrictions			-	Name of the last o	Carlo	Y = 1,12 2
			-	No overh	ting heavy equip	machines
Other Postrictions (if	anul.			1 NO Overn	ead work	
Other Restrictions (if a	15.0% ()					The same
Expected Follow-up S ■ Next appointment da □ Diagnostic Studies R □ Surgery Recommend	te: <u>2/20/2019</u> Time: <u>7:45 am</u> equested:	Location: <u>Gur</u>	rnee-350 S. G	reenleaf, S	Ste 405	1
Rehab (PT/OT) Reco	ommended: x per wee	-1-6	• • • • • • • • • • • • • • • • • • • •	1		
Referral to:	minerided, x per wee	ek for w	eeks starting			
NONE. This is the las	st schodulad visit for this	et t				
S. letan	st scheduled visit for this pro	oblem. At this	time, no furth	er medical	care is anticipa	ted.
Physician/Provider [Digital Signature Not	e prepared by	: Isabel Villarre	Date:	1/21/2019	

Northern District of Illinois Claims Register

18-30043 Belvidere Associates LLC

Honorable Judge: Jacqueline P. Cox Chapter: 11

Office: Eastern Division

Last Date to file claims:

Trustee:

Last Date to file (Govt):

Creditor: (27477857) Claim No: 65 Status:
Cynthia Levandoski Original Filed Filed by: CR

c/o Fonfrias Law Group Date: 01/24/2019 Entered by: Richard G. Fonfrias

125 S Wacker Dr. #300 Original Entered Modified:

Last Amendment Entered: 01/28/2019

Amount claimed: \$75000.00

History:

Details 65-1 01/24/2019 Claim #65 filed by Cynthia Levandoski, Amount claimed: \$75000.00 (Fonfrias,

Richard)

Details 65-2 01/28/2019 Amended Claim #65 filed by Cynthia Levandoski, Amount claimed: \$75000.00

(Fonfrias, Richard)

Description: Remarks:

Claims Register Summary

Case Name: Belvidere Associates LLC

Case Number: 18-30043

Chapter: 11

Date Filed: 10/25/2018 **Total Number Of Claims:** 1

Total Amount Claimed*	\$75000.00
Total Amount Allowed*	

^{*}Includes general unsecured claims

The values are reflective of the data entered. Always refer to claim documents for actual amounts.

	Claimed	Allowed
Secured		
Priority		
Administrative		

Fill in this information to identify the case:						
Debtor 1	Belvidere Associates LLC					
Debtor 2 (Spouse, if filing)						
United States	United States Bankruptcy Court for the: Northern District of Illinois					
Case number	18-30043					

Official Form 410

Proof of Claim 04/16

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

Part 1: **Identify the Claim** Who is the current Cynthia Levandoski creditor? Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor Has this claim been **☑** No acquired from ☐ Yes. From whom? someone else? Where should notices Where should notices to the creditor be sent? Where should payments to the creditor be sent? (if and payments to the different) creditor be sent? Cynthia Levandoski c/o Fonfrias Law Federal Rule of Name Bankruptcy Procedure 125 S Wacker Dr. #300 (FRBP) 2002(g) Street Number Number Street 60606 Chicago Ш State ZIP Code State ZIP Code 312-969-0730 Contact phone Contact email rfonfrias2025@gmail.com Contact email Uniform claim identifier for electronic payments in chapter 13 (if you use one): **☑** No Does this claim amend one already filed? ☐ Yes. Claim number on court claims registry (if known) ___ MM / DD / YYYY **☑** No 5. Do you know if anyone else has filed a proof ☐ Yes. Who made the earlier filing? of claim for this claim?

	Do you have any number you use to identify the debtor?	No Ses. Last 4 digits of the debtor's account or any number you use to identify	the debtor:					
7.	How much is the claim?	\$ Does this amount include interest	or other charges?					
		☐ No ☐ Yes_Attach statement itemizing i	nterest fees expenses or other					
		Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).						
3.	What is the basis of the	Examples: Goods sold, money loaned, lease, services performed, personal inju	ury or wrongful death, or credit card.					
	claim?	Attach redacted copies of any documents supporting the claim required by Bar	ng the claim required by Bankruptcy Rule 3001(c).					
		mation.						
		Work Injury as employee of Debtor						
— 9.	Is all or part of the claim secured?	✓ No ☐ Yes. The claim is secured by a lien on property. Nature of property:						
		Real estate. If the claim is secured by the debtor's principal resid	ence, file a Mortgage Proof of Claim					
		Attachment (Official Form 410-A) with this Proof of O						
		☑ Motor vehicle☑ Other. Describe:						
		Basis for perfection:						
		Basis for perfection: Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.)						
		Attach redacted copies of documents, if any, that show evidence of p example, a mortgage, lien, certificate of title, financing statement, or						
		Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.)						
		Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.) Value of property: Amount of the claim that is secured: \$	other document that shows the lien has The sum of the secured and unsecured					
		Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.) Value of property: Amount of the claim that is secured: \$	other document that shows the lien has The sum of the secured and unsecured mounts should match the amount in line 7.					
		Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.) Value of property: Amount of the claim that is secured: Amount of the claim that is unsecured: []	other document that shows the lien has The sum of the secured and unsecured mounts should match the amount in line 7.					
10	. Is this claim based on a	Attach redacted copies of documents, if any, that show evidence of prexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.) Value of property: Amount of the claim that is secured: Amount of the claim that is unsecured: Amount necessary to cure any default as of the date of the petit Annual Interest Rate (when case was filed) Fixed	other document that shows the lien has The sum of the secured and unsecured mounts should match the amount in line 7.					
110	. Is this claim based on a lease?	Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.) Value of property: Amount of the claim that is secured: Amount of the claim that is unsecured: Amount necessary to cure any default as of the date of the petit Annual Interest Rate (when case was filed)% Fixed Variable	other document that shows the lien has The sum of the secured and unsecured mounts should match the amount in line 7.					
	lease?	Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.) Value of property: Amount of the claim that is secured: Amount of the claim that is unsecured: Amount necessary to cure any default as of the date of the petit. Annual Interest Rate (when case was filed) Fixed Variable Ves. Amount necessary to cure any default as of the date of the petitic.	other document that shows the lien has The sum of the secured and unsecured mounts should match the amount in line 7.					
		Attach redacted copies of documents, if any, that show evidence of pexample, a mortgage, lien, certificate of title, financing statement, or been filed or recorded.) Value of property: Amount of the claim that is secured: Amount of the claim that is unsecured: Amount necessary to cure any default as of the date of the petit Annual Interest Rate (when case was filed) Fixed Variable Ves. Amount necessary to cure any default as of the date of the petitic	The sum of the secured and unsecured mounts should match the amount in line 7.					

			*			
12. Is all or part of the claim entitled to priority under	☑ No					n edu
11 U.S.C. § 507(a)?	Yes. Check	cone:			Amount	entitled to priority
A claim may be partly priority and partly		tic support obligations (inclu C. § 507(a)(1)(A) or (a)(1)(E		upport) undei	\$	
nonpriority. For example, in some categories, the law limits the amount entitled to priority.		2,850* of deposits toward pu al, family, or household use.		of property o	r services for \$	
Children to phony.	bankrup	salaries, or commissions (uptcy petition is filed or the de C. § 507(a)(4).	ip to \$12,850*) earned w btor's business ends, w	vithin 180 day hichever is ea	rs before the arlier. \$	
	81-108	or penalties owed to governr	nental units. 11 U.S.C. §	507(a)(8).	\$	
	☐ Contrib	utions to an employee bene	fit plan. 11 U.S.C. § 507	(a)(5).	\$	
	Other.	Specify subsection of 11 U.S	S.C. § 507(a)() that ap	plies.	\$	
	* Amounts	are subject to adjustment on 4/0	1/19 and every 3 years afte	r that for cases	begun on or after the date of	adjustment.
Part 3: Sign Below						
Turtor organization						
The person completing	Check the appro	opriate box:				
this proof of claim must sign and date it.	☐ I am the cre	editor.				
FRBP 9011(b).	I am the cre	editor's attorney or authorize	ed agent.			
If you file this claim				uptcy Rule 30	004.	
electronically, FRBP	 I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004. I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005. 					
5005(a)(2) authorizes courts to establish local rules		,,,,,	•			
specifying what a signature is.	I understand the	at an authorized signature or laim, the creditor gave the d	n this <i>Proof of Claim</i> servebtor credit for any payn	ves as an ack nents receive	nowledgment that when o	alculating the
A person who files a fraudulent claim could be fined up to \$500,000,		d the information in this <i>Proc</i>				true
imprisoned for up to 5 years, or both.	I declare under					
18 U.S.C. §§ 152, 157, and 3571.		0.1/0.1/00.10				
	Executed on da	te 01/24/2019 MM / DD / YYYY				
		IMA	7			
	Signature	-LOHE			-	
	Signature					
	Print the name	of the person who is com	pleting and signing th	s claim:		
	Name	Heath S. Isaacs	Middle name		Last name	
	Title	Paralegal	made name			
	Company	Fonfrias Law Group)			
	seems to mid-	Identify the corporate service	er as the company if the au	thorized agent i	s a servicer.	
	Address	125 S Wacker Dr.,	#300			
		Number Street				
		Chicago		IL	60606	
		City		State	ZIP Code	
	Contact phone	801-726-7704		Email he	ath@casedriver.com	

Case 18-30043 Claim 65-1 Filed 01/24/19 Desc Main Document Page 4 of 28 ILLINOIS WORKERS' COMPENSATION COMMISSION

APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Trease type of print. This wer	all questions. File three copies	s of this form.	
Workers' Compensation Act X. Occupational Diseases Act	Fatal case? No X Yes	Date of death	
	1 19 2017		
	Case #	1740030	
Cynthia Levandoski Employee/Petitioner	(Office use only)	0000	/79
v.		· · · · · · · · · · · · · · · · · · ·	
		ing Mayanti sestipung mengangka	n nederlander. Generale Abbertiste
Home Owners Bargain Outlet Belvidere Associates, LLC	Location of accident	Waukegan	<u>lL</u>
Employer/Respondent	or last exposure	City, State	
Cynthia Levandoski 2206 Waverly Pla	ce Wauke	gan IL	60084
Cynthia Levandoski Injured employee's name 1 Home Owners Bargain Outlet Belvidere Associates, LLC Street address 2650 Belvidere Ro	City, Sta	te, Zip code	
Home Owners Bargain Outlet 2650 Belvidere Ro	oad Wauke	gan II	60085
Employer's name Street address	City, Sta	te, Zip code	
Employee information: State Employee? Yes No _X_	Male Female	X Married	Single X
# Dependents under age 18 0 Birthdate 05/03/1963	Ave	erage weekly wage \$	630.00
	er was notified of the accide	eran in a la caracter de la Contra de la companya	ting
What part of the body was affected? Left hand/wrist.	and the second of the second o	and the second s	
What is the nature of the injury? To be determined.			
what is the nature of the injury?	temperature control of the control o		
No.		707 O	
Is a Petition for an Immediate Hearing attached? Yes No X		1 2 5	
Is the injured employee currently receiving temporary total disability	y benefits? Yes	No X	
If a prior application was ever filed for this employee, list the case n	umber and its status		
ATTENTION, PETITIONER. This is a legal document. Be sure all			the statements befo
you sign this. Refer to the Commission's Handbook on Workers' Co	ompensation and Occupation	nal Diseases 4 for more	information.
Limithia Kovandoski	8/28		
Signature of petitioner	Date		
APPEARANCE OF P Please attach a copy of the A	ETITIONER'S ATTORN ttorney Representation Agreen	EY nent.	
$\omega = \omega$	0.44C M. Clm Chr	ener i gran en	
Signature of attorney	3416 W. Elm Street address		and the state of t
Mark J. Vogg 1919	McHenry	<u>L</u>	60050
Attorney's name and IC code #5 (please print)	City, State, Zip code	er de Service de la companya de la Companya de la companya de la compa	
Law Offices of Thomas J. Popovich	815-344-3797	E-mail ad	droce
Firm name	Telephone number	E-mail ao	u1655

Case 18-30043 Claim 65-1 Filed 01/24/19 Street Main Document Page 5 of 28

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized. If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, Mark J. Vogg	, affirm tha	t I delivered	mailed with	proper postage X
in the city of McHenry, IL		a copy of this f	form	
at 5:00 AM/PM on 10-10-	17 to the	e respondent liste	ed on this applic	cation and to each
additional party, if any, at the address list	ed below.			
	All Commences			
		W_		
		Signature of p	person completing	Proof of Service
Signed and sworn to before me on				
Notary Public		नम् । त्राप्तः । भे अकृष्टि		
		in the part		

IC1 page 2

¹ In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

² This may be the date of the accident, last exposure, disability, or death.

³ If the employee has not returned to work, leave this space blank.

⁴ The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.

⁵ The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.



EMPLOYEE NAME: CLANT RESERVE 7 (1) /7 Admit Time: 1 7 4 EMPLOYER: 180 1800 Date: WORK STATUS II Work Status to be determined by Specialist □ Regular Work as of: 🖒 Can Work with the Restrictions Specified Below: COff Work Rest of Today Only □ Off Work Until: WALK/SIT/STAND ARMS/SHOULDERS LIFTING/BENDING INo work using RIGHT/LEFT arm □ Sitting job, minimum of walking CINo lifting, pushing or pulling over lbs □ Limited use of RIGHT/LEFT arm □ Uses crutches ☐ No repetitive lifting Get up from sitting position every half hour D No reaching while lifting Till No lifting above the shoulder level □ Alternate standing/sitting positions every □ No working with RIGHT/LEFT arm ☐ Gradually increase lifting to above chest level [] half hour | | as needed lbs over the next _____ days □ Wear sling for _____ days Claimit bending, stooping and twisting SKIN HANDS/WRISTS SQUAT/CLIMB D Keep wound clean and dry Mo use of RIGHT/LEFT hand ☐ No squatting or kneeling DLimit use of RIGHT/LEFT hand O No climbing Avoid exposure to: D Ground level work only C) No tight gripping with RIGHT/LEFT hand MACHINE/VEHICLE NECK UNo repeat twisting/bonding of ☐ No hazardous or fast moving machinery Avoid repeated acok motions RIGHT/LEFT wrist D No driving Wear splint on RIGHZ/LEFT WRIST/FINGER PATIENT INSTRUCTIONS CI Exercises/stretches as instructed ri Start PT/OT In Ibuprofen: (mg; every fins; take with food Bacitracia to wound twice daily O Cyclobenzaprine: mg; every hrs; take at bedtime ONLY; DO NOT drive within 8 hrs of each dose - may make drowsy ADDITIONAL INSTRUCTIONS DIAGNOSIS: who dignat common horace MD/PA Signature: ti DISCHARGED Next Appointment: Time: Date: Physical/Occupational Date: Therapy Doctor: Referral to Specialist Location: UYES DNO DN/A Discharge Time: Drug Screen given and discussed Call Corporate Health at 847.360.2860 or 847.356.4746 Vista West 2615Washington St., Waukegan Vista Lindenburst 1050 Red Oak Lane, Lindenburst

WHITE - CHS

SIGNATURES - PATIENT &



Workers' Compensation Work Status Report

P 847.336.3335 F 847.336.3249

Gurnee | Lake Forest | Lindenhurst | Ibji.com

Date: 5/24/2017	Physician:
and the second s	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: Left distal radius fracture
Employer: Home Owner's Bargain Outlet	
Date of Injury: 05/22/17	
☐ Employee can return to work as of	without restrictions.
⊠ Employee can return to work as of 5-29-17 to last through 5-30-17 considered to be off work.	with the restrictions identified below which are expected neets these restrictions is not available, the patient should be
Employee is unable to return to work as of 5-24-17	and is expected to be off of work through: intment (listed below) and will be assessed then. stic testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any): Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Overhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day
No Work Involving: Hand/Wrist/Arm R L Not to exceed Ibs Leg R L No lifting/carrying Foot/Ankle R L No pushing/pulling Neck No pinching Back No grasping/squeezing Climbing Restrictions No ladder No stairs No ramp	
Other Restrictions (if any):	
Expected Follow-up Services Include:	
Next Appointment Date: 5-30-17	n at Gurnee Office
Diagnostic Studies Requested:	
Surgery Recommended:	
Rehab (PT/OT) Recommended: x per wee	ek forweeks starting
Referral to:	
NONE. This is the last scheduled visit for this problem.	
	pleted By: Krystal Perez



F 847.336.3249

E & JOINT

TITE* Gumee | Lake Forest.| Lindenhurst

ibji.com

P 847.336.3335

Date: 5/30/2017	Physician:
100 - 100 -	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: left distal radius fracture
Employer: Home Owner's Bargain Outlet	
Date of Injury: 05/22/17	
☐ Employee can return to work as of	without restrictions.
Employee can return to work as of 5-30-17 to fast through pending surgery . If modified duty that me considered to be off work.	with the restrictions identified below which are expected eets these restrictions is not available, the patient should be
	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)
Standing	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Not to exceed hrs/day Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Wear splint/brace/sling/cast at work R L Sitting only R L Walking/Standing as tolerated R L No driving No operating heavy equipment/mov/ng machine R L No overhead work R L No overhead work
Other Restrictions (if any): Patient may not work at the requ	ster
Expected Follow-up Services Include: Next Appointment Date: pending surgery Time: Diagnostic Studies Requested:	
	and internal fixation; PENDING APPROVAL
	forweeks starting
Referral to:	
$\hfill\square$ NONE. This is the last scheduled visit for this problem. At	

Hawthorn Surgery Center

Patient Centered, Extraordinary Care.

		\	
To the Patient or Guardian:			
Your physician may dispense an orthoped These products include but are not limited	ic soft good or bracing o to:	device as part of your treatment at Haw	thom Surgical Center.
Arm Sling		Shoulder Abduction Sling	
CAM Walker Boot		Crutches	·
Knee Immobilizer		Post-Op Shoe/APB	
TED Compression Hose	٠	4-Prong Walker	
These products are very common conserve charges for a soft good or bracing device who Hawthorn Surgical Center. Payment for benefits. For example, you may be charged INC.	vill be billed directly to your the soft good or bracin	our insurance company by Specialty M g device will be made according to you	edical Services, INC. ir members plan
If you have any questions regarding you bil Services, Inc., at the number below. There Services, Inc. and Hawthorn Surgery Center	is no financial interest of	ease contact you insurance carrier dire- or other business association between	ctly or Specialty Medica Specialty Medical
Please read the assignment of insurance betten sign below.	enefits for the soft good	or bracing device that you may receive	e from you physician,
Specialty Medical Services, Inc. has inst Portability and Accountability Act.	tituted privacy practic	e that are in compliance with the He	alth Insurance
The rules in our office are intended to safet process your claim for benefits and paymer product and pertinent information necessar it is a business associate, Specialty Medica prescribing your orthotic, soft good or dural	nt. This include: demogr y to process your claim al Services, Inc. complie	aphic information, the nature of treatm with your insurance carrier/responsible	ent requiring our party for payment. As
PATIENT AUTHORIZATION TO USE O		CTED HEALTH INFORMATION, RELIGINMENT DISCLOSURE FORM	EASE OF MEDICAL
SPECIALTY MEDICAL SERVICES, INC. is at this facility. I authorize the release of my provided to me. Additionally, I authorize as I will be responsible for any co-payment	medical information ne- signment of my insuran	cessary to process the resulting claim to be benefit to Specialty Medical Service	or the product(s) . Inc. I understand tha
•		Date: 0-8.)
Physician Signature: V.O.pex D	or. Deleon	Date: 6.8.1	}-
SPECIALTY MEDICAL SERVICES, INC	,	•	
479 Business Center Dr.			•
Mount Prospect, IL 60056		"	
(847) 720-4310 - Billing Department		•	

Specialty Medical keep the original- one copy to patient, one copy remains in patient's chart



7

Р 847.336.3335 F 847.336.3249

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	S. Detwo
Date: 6/19/2017	Physician:
Name I avandanti Contain	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: Status Post Left ORIF of 3-Part Intra-Articular
Employer: Home Owner's Bargain Outlet	Distal Radius Fracture
Date of Injury: 5/22/17 DOS: 6/8/17	
Employee can return to work as of	without restrictions.
⊠ Employee can return to work as of 6/26/17 to last through NEXT APPT . If modified duty that me considered to be off work.	with the restrictions identified below which are expected eets these restrictions is not available, the patient should be
	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any): Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day No Work Involving: Hand/Wrist/Arm R L Not to exceed lbs	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Overhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Misc. Restrictions R L Wear splint/brace/sling/cast at work
Leg R L No lifting/carrying Foot/Ankle R L No pushing/pulling Neck No pinching Back No prinching No grasping/squeezing Climbing Restrictions No ladder No stairs No ramp	R □ L Sitting only R □ L Must use crutches R □ L Walking/Standing as tolerated R □ L No driving No operating heavy equipment/moving machine R □ L No overhead work R □ L R □ L
Other Restrictions (if any): No use of arm sling	
Expected Follow-up Services Include:	•
Next Appointment Date: 7/17/17	d Gurnee Office
Diagnostic Studies Requested:	, see the second
Surgery Recommended:	
⊠ Rehab (PT/OT) Recommended: 2 x per week	for 4 weeks starting pending WC approval
Referral to:	
NONE, This is the last scheduled visit for this problem. At	
Note Compl	eted By: Ofelia Diaz, CCMA



P 847.336.3335 √ F 847.336.3249

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	S. W. Ju								
Date: 7/17/2017	Physician: Serafin DeLeon,MD								
	Diagnosis: Left three-part intraarticular distal radius								
Name: Levandoski, Cynthia									
Employer: Home Owner's Bargain Outlet	Fracture S/P Open Reduction Internal Fixation								
Date of Injury: 5/22/17 DOS: 6/8/17									
Employee can return to work as of	without restrictions.								
Employee can return to work as of 7/17/17 to last through 8/15/17 . If modified duty that me considered to be off work.									
☐ Employee is <u>unable to return to work</u> as of ☐ (date) ☐ until next appoin ☐ until surgery. (awaiting W/C approval). ☐ until diagnost	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)								
Posture/Motion Restrictions (if any): Standing Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day Not to exceed hrs/day Not to exceed hrs/day Kneeling/Carrying Not to exceed hrs/day Not to exceed hrs/day	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Overhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Nosceed hrs/day Nosceed hrs/day Nos/day Nosceed hrs/day Nos/day Nosceed hrs/day Nos/day Nosceed hrs/day Nos/day Nosceed hrs/day Nosceed hrs/day								
Other Restrictions (if any):									
Expected Follow-up Services Include:	4 th , FC								
Next Appointment Date: 8/15/17 Time: 8:15AM	at Gurnee Office								
Surgery Recommended:									
Rehab (PT/OT) Recommended:x per week	c forweeks starting								
Referral to:									
NONE. This is the last scheduled visit for this problem. Al	t this time no further medical care is anticipated. leted By: Clairie Chicas, CCMA								



Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
07/17/2017	12:15 pm	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-	Deleon MD, Serafin M
<u> </u>		336-3335	

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.

01/14/19 17:59:27 04772449499 65-1 Filed 01/24/19 Desc Main Document Page 13 of 28 009

Create Date:

6/19/2017

Due Date: 7/19/2017

Procedure:

OT

Facility: IBJI Rehab Gurnee

Ordering Provider: Serafin DeLeon - NPI # 1326091414



ILLINOIS BONE AND JOINT INSTITUTE, LLC OCCUPATIONAL THERAPY ORDER

Patient N	lame: Leva	ndoski	Cynthia		t.,	atient iC): 152050			T-T-T-T-T-T-T-T-T-T-T-T-T-T-T-T-T-T-T-	[]R		⊠ Le nosis:		33-31 - 2 - <u> </u>		
	t Frequency:			□ х3 ре			atment Di] 1	□ 2	□3	⊠ 4	□5	□ 6	⊠ weeks	n	nonths
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□ Right □ Elbow	⊠ Left ⊠ Wrist	□ мсі	Ps []PIPs [] D!Ps	☐ Thu		<u>IERAP)</u> Index		ong	Rin	ng [] \$m	all			
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							NOT	res									
I certify tha	ledical Necess at the above pr of this patient's	escribed		nt, lts setur	o and re	lated pati	ent educa	tion are ग	redical	ly India	cated an	d nece:	ssary to	o the acc	cepted stand	jards o	of .
Signed		W	2		<u> </u>					D	ate <u>6/</u>	19/20 <u>1</u>	7				
_ [Serafin De	Leon,N	1D	ver the word of the second	-										•		

For your information, the Physical Therapists, Occupational Therapists and Athletic Trainers at IBJI are financially integrated. If you are referred to a clinician in IBJI for any related services, you may request and receive a referral for these services outside or independent of IBJI

JULY 25+

TR

40720-NVC Gurnee IL 15 Tower Court, Suite 235 Gurnee, IL 60031 Phone: (847) 336-7468 Fax: (847) 336-3923

•	Jul 27, 2017	Jul 25, 2017	Jul 21, 2017	Jul 20, 2017	Jul 18, 2017	Jul 14, 2017	Jul 12, 2017	Jul 10, 2017	Jul 06, 2017	Date
	04:30 PM	03:30 PM	02:00 PM	04:30 PM	03:00 PM	11.30 AM	09:30 AM	12:30 PM	08:30 AM	Time
	Scheduled	Scheduled	Arrived	Void	Arrived	Arrived	Void	Arrived	Rescheduled	Appt. Status
-34es	Leipold, PT , Tracy	Leipold, PT, Tracy	Bastable, PTA, Todd	Leipold, PT , Tracy	Leipold, PT, Tracy	Bastable, PTA, Todd	Bastable, PTA, Todd	Leipold, PT , Tracy	Almanza, PT , Stacy	Clinician
LATE ST PI	40720-NVC Gumee IL	40720-NVC Gumee IL	40720-NVC Gumee IL	40720-NVC Gurnee II.	40720-NVC Gumee IL	40720-NVC Gumee IL	40720-NVC Gumee IL	40720-NVC Gurnee IL	40720-NVC Gurnee IL	Location
per mikt	\$.00 Jul 21, 2017	\$.00 Jul 21, 2017	\$.00 Jul 19, 2017	\$.00 Jul 17, 2017	\$.00 Jul 17, 2017	\$,00 Jul 10, 2017	\$.00 Jul 10, 2017	\$.00 Jul 06, 2017	\$.00 Jun 27, 2017	Copay Date Created
	Jul 21, 2017	Jul 21, 2017	Jul 21, 2017	Jul 19, 2017	Jul 18, 2017	Jul 14, 2017	Jul 11, 2017	Jul 11, 2017	Jul 06, 2017	Last Changed Date
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NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee , IL 60031 Phone: (847) 336-7468 Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Additional Instructions:

-TUESPZW

JULY 20th - 430 pm

Thank you.

NovaCare Rehabilitation

NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee, IL 60031 Phone: (847) 336-7468

Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Сорау
Wed, Jul 12, 2017	09-80 AM	Workers Comp	Bastable, PTA , Todd	0.00
Fn, Jul 14, 2017	11:30 AM	Workers Comp	Bastable, PTA , Todd	0.00

Additional Instructions:

-TUESPZM

Thank you, NovaCare Rehabilitation

NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee, IL 60031 Phone: (847) 336-7468

Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

Date Time	Appointment Type	Clinician	Сорау
Wed, Aug 23, 2017 12:0	PM Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 29, 2017 04:0		Leipold, PT , Tracy	0.00
Wed, Aug 30, 2017 04:0		Bastable, PTA , Todd	0.00
Thu, Aug 31, 2017 12:00		Leipold, PT , Tracy	0. <u>0</u> 0

Additional Instructions:

Thank you, NovaCare Rehabilitation

NovaCare Rehabilitation

15 Tower Court, Suite 235 Gurnee , IL 60031 Phone: (847) 336-7468 Fax: (847) 336-3923

Appointment list for Levandoski, Cindy

Thank you for visiting NovaCare Rehabilitation. If we can be of any further assistance, please let us know.

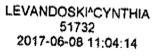
Date Tin	ne	Appointment Type	Clinician	Copay
Tue, Aug 01, 2017 12:	:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed-Aug 02, 2017-04	:30 PM	Workers Comp	Bastable, PTA , Todd	0.00
Mon, Aug 07, 2017 09:	:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Wed, Aug 09, 2017 11:	:30 AM	Workers Comp	Bastable, PTA , Todd	0.00
Tue, Aug 15, 2017 12:	:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Wed, Aug 16, 2017 04:	:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
Tue, Aug 22, 2017 04:	:00 PM	Workers Comp	Leipold, PT . Tracy	0.00
***	:00 PM	Workers Comp	Bastable, PTA, Todd	0.00
Tue, Aug 29, 2017 04:	:00 PM	Workers Comp	Leipold, PT , Tracy	0.00
	:00 PM	Workers Comp	Bastable, PTA , Todd	0.00

Additional Instructions:

Thank you, NovaCare Rehabilitation

01/14/19 10:34:30049472440400 65-1 Filed 01/24/19 Desc Main Document van loski 19 of 28 002

LEVANDOSKI^CYNTHIA 51732 2017-06-08 11:04:40







LEVANDOSKI^CYNTHIA 51732 2017-06-08 11:04:14





Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
08/15/2017	08:15 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-	Deleon MD, Serafin M
		336-3335	

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.



F 847.336.3249

P 847.336.3335

Gurnee | Lake Bluff | Lindenhurst ibji.com

Date: 9/21/2017	Physician:
Name: Levandoski, Cynthia	Serafin DeLeon,MD Diagnosis: Left distal radius retained hardware as well as
Employer: Home Owner's Bargain Outlet	possible triangular fibrocartilage complex tear.
Date of Injury: 05/22/17	
Employee can return to work as of	without restrictions.
Employee can return to work as of to last through If modified duty that me considered to be off work.	with the restrictions identified below which are expected
Employee is unable to return to work as of 09/28/17	tment (listed below) and will be assessed then.
Posture/Motion Restrictions (if any):	
Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day No Work Involving: Lift/Carry/Push/Pull Restric Hand/Wrist/Arm R L No lifting/carrying Leg R L No pushing/pulling Neck No pinching Back No grasping/squeezing Climbing Restrictions No ladder No stairs No ramp	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Overhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day Keyboarding Not to exceed hrs/day tions Misc. Restrictions R L Wear splint/brace/sling/cast at work R L Sitting only R L Must use crutches R L Walking/Standing as tolerated R L No driving No operating heavy squipment/moving machine R L No overhead work R L No overhead work
Other Restrictions (if any):	
Expected Follow-up Services Include:	
	at Gurnee Office
Next Appointment Date: 10/06/17 Time: 8:45 AM Diagnostic Studies Requested: ☐ Diagnostic Studies Request	
Surgery Recommended; left distal radius removal of hards	
Rehab (PT/OT) Recommended: x per week	for weeks starting
Referral to:	
☐ NONE. This is the last scheduled visit for this problem. At	this time no further medical care is anticipated.



Patient Name: Cynthia L Levandoski

Appt. Date	Appt. Time	Location / Phone	Provider
10/06/2017	08:45 am	350 S. Greenleaf Ave. Suite 405, Gurnee, IL / 847-	Deleon MD, Serafin M
		336-3335	

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.



Workers' Compensation Work Status Report

P 847.336.3335 F 847.336.3249 Gurnee | Lake Bluff | Lindenhurst ibji.com

	S. De Jeur
Date: 11/3/2017	Physician:
Name: Levandoski, Cynthia	Serafin DeLeon,MD Diagnosis: Left distal radius retained hardware as well as
Employer: Home Owner's Bargain Outlet	possible triangular fibrocartilage complex tear.
Date of Injury: 05/22/17 DOS 9/28/17	s/p removal of hardware, arthroscopy & synovectomy
After and an internal control of the	
Employee can return to work as of	without restrictions.
Employee can return to work as of 11/3/17 to last through next appt . If modified duty that me considered to be off work.	with the restrictions identified below which are expected ets these restrictions is not available, the patient should be
	and is expected to be off of work through: tment (listed below) and will be assessed then c testing (listed below) is complete. (awaiting W/C approval)
Standing	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Keyboarding Not to exceed hrs/day ### Misc. Restrictions ### No wear splint/brace/sling/cast at work ### No driving ### No operating heavy equipment/moving machine #### No overhead work #### No overhead work #### No overhead work ###################################
Other Restrictions (if any): ***NO REGISTER***	
Expected Follow-up Services Include:	
Next Appointment Date: 11/3/17 Time: 8:15 AM	at Gurnee Office
☐ Diagnostic Studies Requested:	
Surgery Recommended:	
Rehab (PT/OT) Recommended:x per week	forweeks starting
Referral to:	
$\hfill \square$ NONE. This is the last scheduled visit for this problem. At	



Workers' Compensation Work Status Report

P 847.336.3335 F 847.336.3249 Gurnee | Lake Bluff | Lindenhurst ibjl.com

Date: 11/7/2017 *Updated*	Physician:
TITTES TO SECTION AND ADDRESS OF THE PROPERTY	Serafin Del.eon,MD
Name: Levandoski, Cynthia	Diagnosis: Left distal radius retained hardware and
Employer: Home Owner's Bargain Outlet	possible triangular fibrocartilage complex tear.
Date of Injury: 05/22/17 DOS 9/28/17	s/p removal of hardware, arthroscopy & synovectomy
Employee can return to work as of	without restrictions.
⊠ Employee can return to work as of 11/3/17 to last through next appt If modified duty that me considered to be off work.	with the restrictions identified below which are expected ets these restrictions is not available, the patient should be
	and is expected to be off of work through: ment (listed below) and will be assessed then. c testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any): ☐ Standing Not to exceed hrs/day ☐ Sitting Not to exceed hrs/day ☐ Kneeling/Squatting Not to exceed hrs/day ☐ Bending/Stooping Not to exceed hrs/day ☐ Twisting Not to exceed hrs/day ☐ Pushing/Pulling Not to exceed hrs/day ☐ Lifting/Carrying Not to exceed hrs/day No Work Involving: Lift/Carry/Push/Pull Restrict Hand/Wrist/Arm R L No lifting/carrying Foot/Ankle R L No pushing/pulling Neck No grasping/squeezing Climbing Restrictions ☐ No stairs No ramp	Walking Not to exceed hrs/day □ Climbing Not to exceed hrs/day □ Grasping Not to exceed hrs/day □ Squeezing Not to exceed hrs/day □ Reaching Not to exceed hrs/day □ Overhead Not to exceed hrs/day □ Keyboarding Not to exceed hrs/day ■ Keyboarding Not to exceed hrs/day ■ Restrictions Noserseling/cast at work □ Restrictions Walking only □ Restrictions Noserseling/cast at work □ Restrictions Noserseling/cast at work
Other Restrictions (if any): ***NO REGISTER***	
Expected Follow-up Services Include:	
Next Appointment Date: 12/01/17	at Gumee Office
Diagnostic Studies Requested:	
Surgery Recommended:	
Rehab (PT/OT) Recommended:x per week	forweeks starting
Referral to:	
☐ NONE. This is the last scheduled visit for this problem. At	this time no further medical care is anticipated.
Note Comple	eted By: Isabel Villarreal,CCMA



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Date: 12/1/2017	Physician:	Serafin DeLe	L.J.
Name: Levandoski, Cynthia	Diagnosis:	,	is retained hardware and
Employer: Home Owner's Bargain Outlet	possible tria	ngular fibrocarti	age complex tear.
Date of Injury: 05/22/17 DOS 9/28/17	s/p removal	of hardware, år	hroscopy & synovectomy
Employee can return to work as of 12/1/17	without res	trictions.	f^*
VIII VIII VIII VIII VIII VIII VIII VII	with the res eets these res	trictions identil trictions is not a	ied below which are expected vailable, the patient should be
 ☐ Employee is <u>unable to return to work</u> as of ☐ (date) ☐ until next appoint ☐ until surgery. (awaiting W/C approval). ☐ until diagnosti 		celow) and will t	
Standing	Clii Gri Sq Re Ov Ke	mbing No asping No ueezing No aching No erhead No yboarding No Misc. Restriction Sitting only Must use of Walking/S No driving	t/brace/sling/cast at work / crutches tanding as tolerated g heavy equipment/moving machine
Other Restrictions (if any):			,
Expected Follow-up Services Include:			
Next Appointment Date: 1/8/18 Time: 12:45Pf	Mat Gur	nee Office	•
☐ Diagnostic Studies Requested:	wa.www.ee	MY/8'-W	
Surgery Recommended:			
Rehab (PT/OT) Recommended:x per week	for	weeks sta	ting
Referral to:			
NONE. This is the last scheduled visit for this problem. At		urther medical c	



Patient Name: Cynthja L Levandoski

Appt. Date Appt. T	me Location / Phone	Provider
12/01/2017 08:15 ar	a 350 S. Greenleaf Ave. Suite 405, Gurn	ee, IL / 847- Deleon MD, Scrafin M
	336-3335	

If you need to cancel or reschedule your appointment we kindly ask that you call us 24 hours in advance of appointment.

Please arrive 15 minutes early for your appointment and bring your insurance card.

Co-payment and outstanding balances are due at time of visit.



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Date: 1/8/2018	Physician:
	Serafin DeLeon,MD
Name: Levandoski, Cynthia	Diagnosis: Left wrist retained hardware and TFCC tear
Employer: Hobo	S/P removal of hardware as well as scar excision and left
Date of Injury: 5/22/17 Surgery:9/20/17	wrist arthroscopy and synovectomy
⊠ Employee can return to work as of 1/8/18	without restrictions.
Employee can return to work as of to last through If modified duty that me considered to be off work.	with the restrictions identified below which are expected eets these restrictions is not available, the patient should be
	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any):	
Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day No Work Involving: Lift/Carry/Push/Pull Restric Hand/Wrist/Arm R L No lifting/carrying Foot/Ankle R L No lifting/carrying Foot/Ankle R L No pushing/pulling Neck No grasping/squeezing Climbing Restrictions No ladder No stairs No ramp	
Other Restrictions (if any):	
Expected Follow-up Services Include:	
Next Appointment Date: 2/2/18	at Gurnee Office
Surgery Recommended:	
Rehab (PT/OT) Recommended: x per week	for weeks starting
Referral to:	
$\hfill\square$ NONE. This is the last scheduled visit for this problem. At	
Note Cornol	eted By: Clairie Chicas, CCMA



Workers' Compensation Work Status Report

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	S. We Jun
Date: 2/16/2018	Physician:
Name Layandaski Cynthia	Serafin DeLeon,MD Diagnosis: Left wrist retained hardware and TFCC tear
Name: Levandoski, Cynthia	
Employer: Hobo	s/p removal of hardware, scar excision, arthroscopy and
Date of Injury: 5/22/17 DOS 9/20/17 & 6/8/17	ECU tendonitis
☐ Employee can return to work as of 2/16/18	without restrictions.
☐ Employee can return to work as of to last through If modified duty that me considered to be off work.	with the restrictions identified below which are expected eets these restrictions is not available, the patient should be
Employee is <u>unable to return to work</u> as of (date)until next appoin until surgery. (awaiting W/C approval)until diagnost	and is expected to be off of work through: tment (listed below) and will be assessed then. ic testing (listed below) is complete. (awaiting W/C approval)
Posture/Motion Restrictions (if any): Standing Not to exceed hrs/day Sitting Not to exceed hrs/day Kneeling/Squatting Not to exceed hrs/day Bending/Stooping Not to exceed hrs/day Twisting Not to exceed hrs/day Pushing/Pulling Not to exceed hrs/day Lifting/Carrying Not to exceed hrs/day	Walking Not to exceed hrs/day Climbing Not to exceed hrs/day Grasping Not to exceed hrs/day Squeezing Not to exceed hrs/day Reaching Not to exceed hrs/day Overhead Not to exceed hrs/day Keyboarding Not to exceed hrs/day
No Work Involving: Hand/Wrist/Arm	
Other Restrictions (if any):	
Expected Follow-up Services Include:	
Next Appointment Date: 3/16/18 Time: 8:15AM	at Gurnee Office
Diagnostic Studies Requested:	
Surgery Recommended:	
Rehab (PT/OT) Recommended:x per week	forweeks starting
Referral to:	
☐ NONE. This is the last scheduled visit for this problem. At	
	eted By: Adriana Cortez, CCMA