REMIT TO

A-1 PREFERRED SOURCES, INC.
1855 E. Dublin-Granville Rd., Suite 204
Columbus, Ohio 43229
(614) 266-3800
FAX (614) 261-3168

FID #: 31-1449264

Invoice # 001234

1

6/1/2011

7666

Services Rendered to:
COUNTY CORRECTION NOBLE
157208 STATE ROUTE 78 W
PO# DRC01-0000078251

INVOICE TO

OHIO SHARED SERVICE
4310 EAST . 5TH AVE.
PO# DRC01-0000078251
COULMBUS, OH 43219

TERMS:
NET UPON RECEIPT

AMOUNT ENCLOSED

110071

Date	Description		Provider	Lic./Location	Unit	Rate	Amount
	Balance Forward						5600.00
06/07-	F-2nd	Sh	DAVID N. HOWELL	LPN	8.00	35.00	280.00
06/10-	M-2nd	Sh	DAVID N. HOWELL	LPN	8.00	35.00	280.00
06/12-	W-2nd	Sh	DAVID N. HOWELL	LPN	8.00	35.00	280.00
						Total Current Charges …	840.00

BILL REPRESENTS WAGES AND IS PAYABLE UPON PRESENTATION
A-1 PREFERRED SOURCES, INC. (614) 266-3800

TOTAL AMOUNT DUE 6440.00

Adams Rural Electric Cooperative, Inc.
PO Box 247
West Union OH 45693-0247
www.adamsrec.com
Phone: 937-544-2305 or 800-283-1846

Important Information
OFFICE HOURS: 7:30 am to 4:00 PM Monday through Friday 24 hour drop box is available for your convenience. If paying by mail, please allow 3-5 days for arrival. To REPORT OUTAGES, check your fuses, breakers and equipment first. Then contact office at: 544-2305 (local) or 800-283-1846. For QUESTIONS ABOUT YOUR BILL, notify our billing department by the due date at 544-2305 (local) or 800-283-1846.

Account No.	Service Location	Map Location	Cycle	Service From/To	Days
3500384300	2787 CHESTNUT RIDGE RD	HIGHWAY PATRO	01	09/02/11 10/02/11	30

Meter Number	Pres Read	Prev Read	Mult	KWH Used	Rate	Type of Bill
T57124620	54719	53117	1.00	1602	A	REGULAR

Activity Since Last Bill	$Amount
Previous Balance	164.09
Payment	-164.09
Other Adjustments	.00
Balance Prior to this Billing	.00

Current Bill Information	$Amount
FACILITIES CHARGE	29.00
DISTRIBUTION CHARGE	49.42
GENERATION & TRANSMISSION CHG	76.42
GENERATION & TRANSMISSION ADJ	22.13
	$176.97

IMPORTANT MESSAGE

The Board of Trustees approved a capital credit retirement for years 1989 and part of 1990. If there is a past due balance on the account as of November 15th, the retirement will apply to that balance before a check will be mailed. Checks will be mailed on November 22nd.

Due Date	10/24/11	Net Due	$176.97
Gross Due After	10/24/11	Gross Due	$187.59

PLEASE RETURN BOTTOM PORTION WITH PAYMENT

PLEASE DO NOT STAPLE, FOLD OR ATTACH ANYTHING TO BOTTOM PORTION

Adams Rural Electric Cooperative, Inc.
PO Box 247
West Union OH 45693-0247

☐ Check here if your address or telephone number has changed. (Please print your new address on back)

IF PAYMENT BY CREDIT CARD FILL OUT BELOW	☐ MASTERCARD ☐ DISCOVER ☐ VISA	
CARD NUMBER	CW-CODE	AMOUNT
SIGNATURE		EXP DATE

ACCOUNT NUMBER	DATE OF BILL	DUE DATE
3500395100	10/07/11	11/04/11
NET DUE	GROSS DUE AFTER	GROSS DUE
$176.97	10/24/11	$187.59
ENTER AMOUNT PAID	**A 6% penalty is charged if not paid by 10/24/11**	

DAS/TELECOMMUNICATIONS 913
30 E BROAD ST FL 39 000317
MARCS/WEST UNION
STATE OF OHIO
COLUMBUS OH 43215-3414

Adams Rural Electric Cooperative, Inc.
PO Box 247
West Union OH 45693-0247

Advance Auto Parts

Professional Parts Supplier

Commercial Hotline (614) 801 - 2169

Specials this Month:
FILTER OIL PUROL
VALVOLINE OIL CHANGE SPECIAL
(prices good September 2 – September 29)

Store 010494041 Hoover Road, Grove City, OH 43123 Phone 614-801-2169

Pickaway Correctional Institute
11781 State Route 762
Orient, OH 43146
Phone 614-877-2441
Account ID: 1043068627

P.O. #: Taurus
Date: 6/1/2011
Register: 10
Store/Unit#:
Internet Order #:

Invoice / Trans: 1001-985647820
Time: 10:38:22AM
Delivery: Yes
Salesperson: Michael

Product Line	Part #	Description	SKU	Warranty	QTY	List	Cost	Extended
AutoCraft Silver	36R1	Battery Silver ATOCF	2040000	24 MO.FREE REPL 72 MO. PRORTED	1	113.78	76.98	76.98

Payment: Advance Comm Acct xxxxxxxxxxxx6517 011348 -76.98

Core Bank Account Summary – Items 2 Balance 132.00

Product Line	Part #	Description	Invoice/Trans.#	Date	QTY	Value	Days Out
Fenco	SG17925	PS GEAR BOX-RMFD 1 EA FE	1043025102340	6/15/2011	1	120.00	5
AutoCraft Silver	36R1	BATTERY SILVER ATOCF	1043024602219	6/18/2011	1	12.00	10

SUBTOTAL	76.98
TOTAL INVOICE	76.98
PAYMENT	Advance Comm Acct
CHANGE	0.00

Customer's signature below certifies that the tax free purchase items qualify for resale or other permitted tax or fee exemption. Customer will pay all taxes and government fees on taxable purchases, including interest and penalties if applicable. All cores need to be in the original box and in rebuildable condition to receive full core credit.
Invoice required as proof of purchase for all returns.

THANK YOU FOR YOUR BUSINESS!

Id.: 1700685

OPI FARM @ MANSFIELD CORRECTIONAL
1150 N MAIN
PO BOX 788
MANSFIELD, OH 44901
United States

The Andersons Marathon Ethanol LLC

Sales Settlement Sheet

Commodity: DDGS Corn Distillers Dried Grains
Date: 5/30/2014
Settlement No.: 4955264

The Andersons Marathon Ethanol LLC
5728 Sebring-Warner Road
Greenville, OH 45331
United States

Sold To: OPI FARM @ MANSFIELD CORRE
Phone: 937-316-3700
FAX: 419-897-6716

Contract / Ticket Summary

Contract						Ton			US$			
No.	Type	Date	Price	Shipment	FOB	Priced	Settled	Remaining	Gross	-Discounts	+ Charges	Settlement
910015583	DISTILLERS	5/27/2014	236.0000	MAY 14	Mansfield	25.0000	21.2075	3.7925	5,004.97		5.30	5,010.27
Totals for this settlement sheet:						25.0000	21.2075	3.7925	5,004.97		5.30	5,010.27

Special discounts: 1 Misc. 2 Product
Ticket detail for Contract: 910015563 Ref.: PO 123886 No. Tickets: 1

Ticket No. / Vehicle Id.	Date / Destination	Unload/ Share	%Split/ Shrink	Ton Applied	Grade	Special Disc.	Price/ Discount	Total Discount	Net Price/ xApplied	Total Charges	Settlement Amount
73115	5/29/2014	21.2075	100.00%				236.0000				
PO 123886	Maria Stein	21.2075	0.0000	21.2075					236.0000		
73707 73115		42,415.0000	LB	Ohio Tonnage Tax: 5.30					5,004.97	5.30	5,010.27
Totals:		21.2075		21.2075	Avg.:		Totals:		5,004.97	5.30	5,010.27

Deduction Summary

Contract No.	Settled Qty.	Total Gross	Total Discounts Quality	Total Discounts Drying	Total Charges Freight	Total Charges Other	Total Settlement	Less Advances	Net Settlement
910015563	21.2075	5,004.97				5.30	5,010.27		5,010.27
Total:	21.2075	5,004.97				5.30	5,010.27		5,010.27

Remit Funds To:
The Andersons Marathon Ethanol, LLC
P.O. Box 119
Maumer, OH 43537 United States

Pmt. Type: Check
Transit No.:
Amount 5,010.27

Net Settlement: 5,010.27

Amount of Final Settlement/Invoice: 5,010.27
Remit To: The Andersons Marathon Ethanol, LLC By: Check

Payment Terms: Net 15 Payment by Wire Due Date: 6/14/2014
Please reference Sales settlement# on payments
Please direct any questions to Marty Searle at 419-891-2793

Have a nice day!

STATE OF OHIO DRC
ATHENS APA OFC UNIT 2
ATTN DANIEL S SMITH
54 S MARKET ST
LOGAN, OH 43138 1231

Account Number 740 454-8097 434 8
Billing Date Nov 28, 2010

Business Hours Mon Fri 8 30 am-6pm EST

Invoice Number 740454809711

Monthly Statement

Oct 29 Nov 28, 2011

Bill-At-A-Glance

Previous Bill	$144.91
Payment –Thank You!	$255.11CR
Adjustments	.00
Balance	$110.20CR
Current Charges	$127.53
Balance	$17.33

Do Not Pay

Billing Summary

Billing Questions? Visit att.com/billing

Plans and Services	$127.53
1-800-480-2203	
Repair Service	
1-877-888-5622	
Telecommunications Relay System	
1-800-750-0750	
Other Inquiries & Services	
1-800-451-1569	
Promotions & Discounts	$13.87CR
Monthly Service	$137.12
Surcharges & Other Fees	$4.28
Total of Current Charges	**$127.53**

News You Can Use Summary

*Prevent Disconnect
*AT&T Privacy Policy
*Payment & Inquiries
*Paperless Billing
*Carrier Info
*Directory Assistance
*Lines and Trunks

See "News You Can Use" for additional information

Detail of Payments and Adjustments

Item

No	Date	Description	Adjustments	Payments
1	11/20	Payment	.00	$255.11
Totals				$255.11

Plans and Services

Promotions & Discounts

Item

No	Description	
1	Discount for MDA Total Volume Discount for Bill Period Nov 28, 2010 As of month 16 of your Term commitment Period for MDA Annual commitment, you have Met 119.00% of commitment	**13.87CR**

Monthly Service: Nov 28 throu Dec 27

Charges for 740-454-8097	
Monthly Charges	$28.90
Federal Access Charge	$5.38
Charges for 740-454-6827	
Monthly Charges	$28.90
Federal Access Charge	$5.38
Charges for 740-454-8098	
Monthly Charges	$28.90
Federal Access Charge	$5.38
Charges for 740-454-8162	
Monthly Charges	$28.90
Federal Access Charge	$5.38
Total Monthly Service	$137.12

Local Calls
Usage Service Agreement
72 Call(s) were placed this month
72 Call(s) were allowed

Surcharges and Other Fees

9-1-1 Emergency System	
Billed for Muskingum County	$.48
Federal Universal Service Fee	$3.72
Telecommunications Relay Service	$.08
Total Surcharges and Other Fees	$4.28
Total Plans and Services	**$127.53**

DO NOT PAY

Billing Date Nov. 28, 2010

Account Number **740 454-8097 434 8**

STATE OF OHIO DRC
ATHENS APA OFC UNIT 2
ATTN DANIEL S SMITH
54 S MARKET ST
LOGAN, OH 43138 1231

AT&T
PO BOX 8100
AURORA, IL 60507-8100

77400454080974341001700200210000011020000000173300000000000

STATE OF OHIO DRC
OHIO SHARED SERVICES
PO BOX 182880
COLUMBUS, OH 43218

Bill Payer 614R011370999
Invoice Number 000001970944
Contract Number 20070126-0413
Billing Date 01/01/2011

Monthly Statement

12/01/2010 – 12/31/2010

Bill-At-A-Glance

Previous Bill	$4,719.75
Payment	$1,543.00CR
Past Due	$3,176.75
Adjustments	$30.25
Current Charges	$1,512.75
Total Current Charges	**$1,543.00**
Total Amount Due	**$4,719.75**
Amount Due in Full By	***01/31/2011***

If your payment is not received by 01/31/2011 you will incur a late charge.

News You Can Use

Customer Care Hours: 8:00-4:30PM EST. Repair Service 1-800-252-6499

Billing Summary

Questions? Call 1-877-377-4071

AT&T LD	$72.04
AT&T MW	$1,440.71
Current Charges	**$1,512.75**

Please detach and return bottom portion when making a payment

Billing Date 01/01/2011 **Total Amount DUE BY 01/31/2011** **$4,719.75**

Account Number: 614R011370999

Please include your account number on your check. Make checks payable to:

AT&T
PO Box 989048
West Sacramento, CA 95798 9048

6691 1.0.60 1 SP 0.000 JX

STATE OF OHIO-DRC
OHIO SHARED SERVICES
PO BOX 182880
COLUMBUS OH 43218-2880

9120000113010111000000 4719759

ATLAS OIL COMPANY
Fuel Distribution & Supply Management
24501 ECORSE RD TAYLOR, MI 48180 (800) 878-2000

Invoice

Customer : STATE OF OHIO
Account Number : 809045555
Delivery Date : 11/20/2012
Invoice Date : 11/20/2012
Invoice Number : 555574 – 1
Invoice Terms : NET 30 DAYS
Due Date : 12/20/2012

SOLD TO :
STATE OF OHIO
LAKE ALMA STATE PARK – DIST 10
LAKE ALMA ROAD
WELLSTON, OH 45692

SHIP TO: Account: 42231
LAKE ALMA STATE PARK-DIST 10 – TW
LAKE ALMA STATE PARK
LAKE ALMA ROAD
WELLSTON, OH 45692

Current Invoice Amount Due	Total Amount Due
$1,446.09	$1,446.09

Product	Product Description	Delivered Quantity	Unit Price	Extended Price
Order Number : 282222	Purchase Order Number : none			
U87 E10	GASOHOL E10 87			
		406.00	3.2791	1,331.32

BOL Number(s) : 44444
Tax Summary :

Tax Description	Gallons	Rate	Extension
FED EXCISE TAX GAS	406.00	0.18300	0.00
OH GAS TAX	406.00	0.28000	113.68
FED UNDERGRND STRG TAX	406.00	0.00100	0.41
FED ENV RECOVERY FEE – GASOHOL	406.00	0.00171	0.69

No terms discount available for this invoice.

Current Invoice Amount: Due $1,446.09

We Appreciate Your Business

A FINANCE CHARGE will be added to all past due accounts. Requests for credit(s) must be received within 45 days of the date of delivery.
TAX FREE FUELD PURCHASED ON THIS INVOICE IS PURCHASED FOR THE PURPOSE INDICATED ON THE EXEMPTION CERTIFICATE
NO MICHIGAN TAX IS INCLUDED IN THE PRICE PER GALLON FIGURE. If your delivery includes fuel additive, please note that the sale tax calculation is based on the extended amount times the .06 sales tax rate, it is not calculated on the gallons.
IF YOU HAVE ANY QUESTIONS ABOUT YOUR DELIVERY, PLEASE CONTACT CUSTOMER SERVICE AT (800) 878-2000

ATLAS OIL COMPANY
Fuel Distribution & Supply Management
24501 ECORSE RD TAYLOR, MI 48180 (800) 878-2000

Payment Coupon

Please detach and enclose this portion with your payment – Do not send cash

Your Account Number
809045555

Invoice Date	Your Invoice Number
11/20/2012	555574 – 1

Atlas Oil Company
P.O. Box 672992
Detroit, MI 48267-2992

Due Date	Current Invoice Amount Due	Current Amount Due	Amount Paid
12/20/2012	$ 1,446.09	$1,446.09	

Please make Check Payable To
ATLAS OIL COMPANY

INVOICE

Date:	6/1/2011
Invoice:	6/1/2011
Customer No:	20232

B&C Communications

MOTOROLA Authorized Two-Way Radio Dealer

L-2787
Columbus, OH 43260-2787
Phone 614-276-5552

PO/Ref#:	VBL Brian Scudds
Ship To:	Pickaway Correctional Inst
	PO Box 209
	Orient, OH 43146-0000

Bill To: ODRC-Pickaway Correctional Inst
Ohio Shared Svcs
4310 E. Fifth Avenue
Columbus, OH 43219

Qty	Item ID	Description	Serial #	Price	Amount
1.0	L3223A	MC3000 Digital DESKSET	124CLT0007	700.80	700.80
1.0	L3223A	MC3000 Digital DESKSET	124CLT0087	700.80	700.80
1.0	L3208A	Digital Junction Box F	124CLP1114	541.45	541.45
1.0	*OTHER	FREIGHT		3.00	3.00

Work Detail:	Action Taken:

SubTotal	1946.05
Sales Tax	0.00
Freight	0.00
TOTAL	**1946.05**
Payment	0.00
Please remit – Invoice Total	1946.05

Please remit invoice total within 30 days to avoid finance charges.

Service Detail

Service For:	Model # -	Unit # -
	Serial # -	Description -

Signature: _____

INVOICE

Bob Barker

America's Leading Detention Supplier
Bob Barker Company, Inc.
PO Box 429
Fuquay-Varina, NC 27526-0429

Please Remit Payment To:
Bob Barker Company, Inc.
PO Box 890885
Charlotte, NC 28289-0885

Invoice #	Invoice Date
NC10000950001	6/3/2011
Cust Code:	**Due Date**
TRUOH0	6/3/2011
Related Order #	
NC1000895473	

Contact Info:
Phone: 800-235-8586
Fax: 888-772-0252
Email: ar@bobbarker.com

Bill To:
2110 1 MB 0.382 E0126X I0226 D301173184 P728793 0001:0001

Trumbull Corr Institution
Ohio Shared Svcs
PO Box 182880
Columbus, OH 43218-2880

Ship To:
Trumbull Corr Institution
5701 Burnett Road
Leavittsburg, OH 44430 US

PO Number	Ordered By	Ship Via	Terms	Sales Agent
PC2624	Donna Crawford		VISA	5090

Item Code	Item Description	Shipped Qty	Backord Qty	U/M	Unit Price	Amount
Z424-42DD	Bra, P/C, White, Sz 42DD	3	0	DZ	$33.51	$100.53
Z424-44DD	Bra, P/C, White, Sz 44DD	3	0	DZ	$24.13	$72.39
Z424-46DD	Bra, P/C, White, Sz 46DD	3	0	DZ	$24.13	$72.39
Z424-48DD	Bra, P/C, White, Sz 48DD	3	0	DZ	$24.13	$72.39
Z424-42C	Bra, P/C, White, Sz 42C	2	0	DZ	$19.45	$38.90
Z424-44C	Bra, P/C, White, Sz 44C	2	0	DZ	$19.45	$38.90
Z424-46C	Bra, P/C, White, Sz 46C	2	0	DZ	$19.45	$38.90

Effective immediately, please change the remittance address for payments only to:
Bob Barker Company, Inc.
P.O. Box 890885
Charlotte, NC 28289-0885

Visit us online at www.bobbarker.com and www.officersonly.com
Federal ID Number: 56-1558062
OH Sales Tax License: 99048125

Subtotal	$434.40
Tax	$ 0.00
Other	$ 0.00
Freight	$ 0.00
TOTAL DUE	**$434.40**

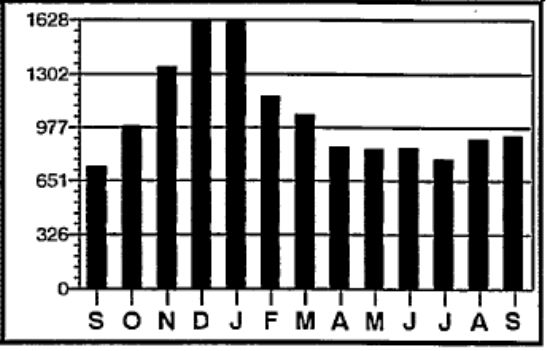
Butler Rural Electric Cooperative, Inc.
3888 Stillwell Beckett Road
Oxford OH 45056-9338
Your Touchstone Energy® Partner

Phone: 867-4400 or 1-800-255-BREC

KWH USAGE HISTORY

Current Month's Average KWH Per Day 30

Average Cost Per Day 4.73



You are a member-owner of your not-for-profit electric cooperative. Abiding by the Cooperative Principle-Member Economic Participation-the board of trustees determines the retirement of capital credits, based on the cooperative's financial stability. Capital Credits are just one difference that set cooperatives apart from other business models.

4528 1 MB 0.390 4 4528
STATE OF OHIO-DAS/OIT C-20 P-30
MARCS - OXFORD
30 E BROAD ST FL 39
COLUMBUS OH 43215-3414

Account No.	Serv. Status	Cycle	Rate	Service Location	Map Location
4355400	1	2	1	05255 WAYNE MADISON	07-24-043

Meter Number	Pres Rd Dt	Pres Read	Prev Read	Mult	KWH Used	Dist Rate	G&T Rate
239	04/10/11	9393	8344	1.0000	1049	0.04615	0.07240

Activity Since Last Bill	$ Amount
Previous Balance	234.97
Payment	-163.51
Other Adjustments	0.00
Balance Prior to this Billing	71.46

Current Bill Information	$ Amount
BALANCE FORWARD AS OF 04/14/2011	71.46
DISTRIBUTION BASE CHARGE	33.00
DISTRIBUTION ENERGY CHARGES	48.41
GENERATION/TRANSMISSION CHARGE	75.95
TOTAL CURRENT BILL CHARGES	157.36

Due Date	05/02/2011	Net Due	$228.82
Gross Due After	05/02/2011	Gross Due	$228.82

Retain this copy for your records.

Account No.	Serv. Status	Cycle	Reference
4355400	1	2	COOP READ
Service Location			Map Location
05255 WAYNE MADISON			07-24/043

ENTER AMOUNT PAID	

Billing Date	04/14/2011	see back for credit card payment options Credit Card ____ Cash ____ Check ____	
Due Date	05/02/2011	Net Due	$228.82
Gross Due After	05/02/2011	Gross Due	$228.82

00004355400000002179900000217995

Phone: 867-4400 or 1-800-255-BREC

1 of 1

Please print change of address or phone # and check box >>> ☐

STATE OF OHIO-DAS/OIT 614-466-7343
MARCS - OXFORD
30 EAST BROAD STREET
FLOOR 39
COLUMBUS OH 43215-3414

Butler Rural Electric Cooperative, Inc. 2
P O Box 179
Hamilton OH 45012-0179

CARQUEST AUTO PARTS

Great people, great products, great prices!℠

CQ OF WEST LIMA OH # 9358
3901 ELIDA RD.
LIMA, OH 45807
(419) 228-2231
GREAT PEOPLE!
GREAT PRODUCTS!
GREAT PRICES!

PAGE 1 OF 1
REF# 230609

212010072302524000015282800002306097 16

ANY PRODUCT RETURNED FOR CREDIT MUST BE ACCOMPANIED BY THIS RECEIPT.

SEE CARQUEST STORE FOR DETAILS OF THE COAST TO COAST GUARANTEE.

BILL TO
ALLEN CORRECTIONAL INSTITUTION
2338 N WEST ST
LIMA, OH 45801

SHIP TO
ALLEN CORRECTIONAL INSTITUTION
2338 N WEST ST
LIMA, OH 45801

INVOICE NO.	CUSTOMER NO.	DATE	CUST. P.O. NO.	SALES ID	TEAMMATE ID	FORM OF PYMT.
2524-152003	580135	7/1/2011			JS1152	CHARGE

	MFG. PART NUMBER	ORDERED	SHIPPED	LIST PRICE	NET	NET CORE	EXT. AMOUNT	TAX
1	CCM CQP46-8 PAG 46 VISCOSITY 8 OZ	1	1	13.94	7.27	0.00	7.27	N/N
	* CAR # 13-888							

WARRANTY DISCLAIMER: "The factory warranty constitutes all of the warranties with respect to the sale of all items. The seller hereby expressly disclaims all warranties, either expressed or implied, including any implied warranty of merchantability or fitness for a particular purpose, and the seller neither assumes nor authorizes any other person to assume for it any liability in connection with the sale of all items."

SHIP VIA	DELV. TIME	DELV. ID	FREIGHT	TAXABLE AMT.	SALES TAX	TOTAL CORE	PREV. DEPOSIT
				0.00	0.00		

10:32 AM

RECEIVED BY X *Eric Brownlee*

CUSTOMER COPY

PAY THIS AMOUNT ▶ 7.27

OPI INDUSTRIAL TRAINING PROGRAM
1221 MCKINLEY AVE
COLUMBUS OH 43222
800-237-3454

Invoice Number: 623001
Page: 2 of 2
Date: 7/13/2011
Salesperson:

Blanket Invoice

3 - 5		70.00	70.00	**0.00**	4.00000	280.00
	Item:	149365	**Description:**	BEV; BEVERAGE DRINKS;5 GAL; 1/ 2 PINTS		
	U/M:	CS	**Date Shipped:**	04/17/2011		
3 - 6		84.00	84.00	**0.00**	4.00000	336.00
	Item:	149365	**Description:**	BEV; BEVERAGE DRINKS;5 GAL; 1/ 2 PINTS		
	U/M:	CS	**Date Shipped:**	04/19/2011		
3 - 7		70.00	70.00	**0.00**	4.00000	280.00
	Item:	149365	**Description:**	BEV; BEVERAGE DRINKS;5 GAL; 1/ 2 PINTS		
	U/M:	CS	**Date Shipped:**	04/24/2011		
3 - 8		84.00	84.00	**0.00**	4.00000	336.00
	Item:	149365	**Description:**	BEV; BEVERAGE DRINKS;5 GAL; 1/ 2 PINTS		
	U/M:	CS	**Date Shipped:**	04/26/2011		
4 - 5		25.00	25.00	**0.00**	8.75000	218.75
	Item:	149365	**Description:**	MILK;1%MILK;5GAL		
	U/M:	CS	**Date Shipped:**	04/17/2011		
4 - 6		25.00	25.00	**0.00**	8.75000	218.75
	Item:	149365	**Description:**	MILK;1%MILK;5GAL		
	U/M:	CS	**Date Shipped:**	04/19/2011		
4 - 7		25.00	25.00	**0.00**	8.75000	218.75
	Item:	149365	**Description:**	MILK;1%MILK;5GAL		
	U/M:	CS	**Date Shipped:**	04/24/2011		
4 - 8		25.00	25.00	**0.00**	8.75000	218.75
	Item:	149365	**Description:**	MILK;1%MILK;5GAL		
	U/M:	CS	**Date Shipped:**	04/26/2011		

ATTENTION: PLEASE REVIEW YOUR ORDER FOR ACCURACY. FOR QUESTIONS CALL A SALES REPRESENTATIVE AT 1-800-237-3454 OR 752-0287. ALL DUE DATES SUBJECT TO CHANGE.

Sales Amount	9,194.50
Misc Charges	0.00
Delivery	0.00
Sales Tax	0.00
Prepaid Amount	0.00
Total	9,194.50

Explanation of Review

Client	CORRECTIONAL HLTHCR AMBULANCE – CHAS PROD CareWorks USA Attn: Self-Insured Division PO Box 182808 Columbus, Ohio 43218-2808

Bill: CW1-CHAS-232

Provider	EASTERN AREA SPECIALTY TRANSPORT INC 1000 INDUSTRIAL DR LEESBURG, OH 45135-0368

Claimant	DOE, JOHN

Tax ID: 123456789 Type: AT

Claim Number: L123456
DOI/DOL: 09-16-1954

Rendering Provider: JANE ROE
Patient Account: 654321

Employer/Insured: OHIO DEPT. REHAB & CORRECTION

Bill Details

Dates of Service: 01-23-2013
Post Date: 02-14-2013

Reviewer: NR/
Pay Auth: AU
Client Type of Bill: AMBUL

File: 00000000/00000000/00000000
Other: HCF

Dx1: 518.82 OTHER PULMONARY INSUFF Dx2: 786.05 SHORTNESS OF BREATH Dx3: 786.07 WHEEZING
Dx4: 414.90 CHR ISCHEMIC HRT DIS NOS

Line	Date	POS	TOS	Rev./Proc. Code	Charges	Dx.	Units	BR	Description	Explanation Code(s)	Allow.
1	01-23-2013	41	1	A0427-RH	800.00	1234	1	634.45	ALSI-EMERGENCY		165.55
2	01-23-2013	41	1	A0425-RH	24.00	1234	2	21.06	GROUND MILEAGE		2.94

Totals

Total Charges: 824.00
Bill Review Reductions: 655.51
Recommended Allowance: 168.49

Notes

*Unless otherwise noted, all reductions are due to the charges exceeding the Medicaid Fee Schedule in the state of Ohio.

CAREWORKS USA, ATTN: SELF-INSURED DIVISION, PO BOX 182808, COLUMBUS, OHIO 432182808

ENVELOPE 1, INC.
41969 State Route 344
Columbiana, OH 44408
Phone: (330) 482-3900
Fax: (330) 482-0388

Remit To:
Envelope 1 Inc.
P.O. Box 92657
Cleveland, OH 44193-0657

Invoice No. **448002**
Customer No. STATE001

Bill To:
DAS State Printing
4200 Surface Road
Columbus, OH 43228

Ship To:
State Printing Fulfillment Servi
Attn: Bob Allberry
2088 Integrity Drive N
Columbus, OH 43209

Date	Ship VIA	F.O.B.	Terms
6/8/2011	Best Way	Destination	Net 30

Purchase Order Number	Order Date	Salesperson	Our Order Number
02455	6/1/2011	House Account	44809

Required	Quantity Shipped	B.O.	Item Number	Description	Unit Price	Amount
				Federal ID: 34-1790943		
				PO# 8823		
540.000	480.000	60.000	4408-W	#10 4-1/8 X 9-1/2 DSS S24 WW Window Pack 500/2500 Window: 1-1/8 X 4-1/2 Position: 7/8-L 5/8-B Poly Patched Seal Gum: Full Print: Black Form: BMV 1724I 2/10	13.38	6422.40
				INVOICE SUBTOTAL		6422.40
				INVOICE TOTAL		6422.40

Service Slip / Invoice

Environment Plus Pest Control
P.O. Box 83545
Columbus, OH 43203
614-263-0202

Invoice: 15001
Date: 7/8/2011
Order: 7103

Bill To:

(100196)
Division of Office Services
Russ Money
4200 Surface Road
Columbus, OH 43228

Work Location:

(100196) 814-752-8381
Division of Office Services
Russ Money
4200 Surface Road
Columbus, OH 43228

Work Date	Time	Target Pest	Technician	Time In
01/31/11	09:00AM		MB	

Purchase Order	Terms	Last Service	Map Code	Time Out
DAS01-0000008676		01/31/11		

Service	Description	Price
CONTROL	Treatment/Inspections	$100.00

Subtotal	**$100.00**
Tax	$0.00
Total	**$100.00**

***Charges outstanding over 30 days from the date of service are subject to a 1 ½% Finance Charge per month or annual percentage rate of 18%. Customer agrees to pay accrued expenses in the event of collection.**

I hereby acknowledge the satisfactory completion of all services rendered, and agree to pay the cost of services as specified above.

X_____

Customer Signature

PLEASE PAY FROM THIS INVOICE

Auto Value Parts Stores

GENUINE AUTO PARTS
32 FRANKLIN ST.
DAYTON, OHIO 45402
PH# 223-5293 FX# 228-2443

CHECK OUR OIL & A/F PRICES

Bill to
DAYTON CORRECTION INSTITUTION
ATTN ACCTS PAY
DAYTON, OH 45417

Ship to
DAYTON CORRECTION INSTITUTION
GERMANTOWN STREET DAYTON, OH 45417

1 OF 1

INVOICE NO.	CUSTOMER NO.	DATE	CUST. PO. NO.	SALES NO.	CNTR. NO.	SHIP VIA	TERMS
A477001	137825	6/8/2011		0	3		SALE-CHARGE

	MFG.-PART NO	ORDERED	SHIPPED	BKO	LIST PRICE	NET	NET COR	EXT. AMOUNT	
1	MIL 413-50 1-1 /4T. T. VALVE	50	50	0	1.13	0.84		42.00	
2									
3									
4									
5									

1/19

FREIGHT	LABOR	SHOP	TOTAL CORE	TAXABLE AMT.	SALES TAX		SUBTOTAL
0.00	0.00	0.00	0.00	0.00	0.00	0.00	42.00

9:17AM

RECEIVED BY X

LIST TOTAL ▶ 56.70

PAY THIS AMOUNT ▶ 42.00

GFS
gordon food service

Dept CH 10490 Palatine, IL 60055-0490 986 CUST COPY #1 Invoice

Invoice No.	Date
133404003	7/1/2011

Routing Code	Stop #	Customer #	Purchase Order #	Sales #	Representative	Terms*
				986	TJ WYBRANOWSKI II #7488 (800) 905-2304	
8210	96	335680901	DRC01-0000075381	828	JUDITH MILLER #5512 (800) 968-6261	Net 30 Days

Ship To:
Toledo Correctional Institution
2001 E Central Avenue
Toledo, OH 43608

Ohio Dept of Rehab & Corrections
Attn: Business Office
PO Box 80033
Toledo, OH 43229

Item Code	Qty	Description	Cost Control Guide	SPECS	Unit Price (Inc Specs)	Tax	Amount
220051	2	Case 4-5# GFS Cottage cheese SM CU 525083 DY	6.75		26.98		53.96
428353	1	Each 5# Fresh Peeled Garlic 96000 / 96001 PR	9.01		9.01		9.01
		Total Cooler Pieces 3					
247669	2	Case 1 15# KE SLCD BCN 18-22CT / 14840 / 331 MT	34.85		34.85		69.70
		Total Freezer Pieces 2					
108197	1	Case 1-10# GFS ridged Curly Lasagna 2 1/8 GR	12.43		12.43		12.43
499943	1	Case 6 - .5Gal Jalapeno Peppers SLCD Z739 GR	3.98		23.87		23.87
513768	1	Case 1-3.75# Red Pepper Crushed Trade EAS GR	27.48		27.48		27.48
714350	2	Case 8-25CT Shell Taco YEL 5" GFS 20395 GR	1.33		10.62		21.24
357220	1	Case 12-1# Bacon Crumbles CKD GFS 357220 MT	5.37		64.40		64.40
122910	2	Case 4-250 Triumph 1# PPR Food TR 19111 DS	7.97		31.90		63.80
122940	2	Case 2-250 Triumph 3# PPR Food TR 19101 DS	15.70		31.40		62.80
		Total Warehouse Pieces 10					

Grocery	Frozen	Meat	Seafood
$85.02		$134.10	
Poultry	**Dairy**	**Disposables**	**Sanitation**
	$53.96	$126.60	
Disp. Bevg	**Produce**	**Tabletop**	
	$9.01		

NUMBER OF PIECES
2 Freezer | 3 Cooler | 10 Warehouse | Misc. | 15 Bill

Customer's signature evidences receipt of all items listed and its promise to pay the amount due to GFS. Customer agrees that if a check, draft and/or order of payment ("Transaction") issued for payment of this invoice is dishonored, GFS may revoke the Transaction and issue a debit against the account upon which the Transaction is drawn for a fee up to the maximum permitted by law.

RECEIVED BY

SUBTOTAL	$408.69
TAX	
Pay This Amount	$408.69

The perishable agricultural commodities shown on this invoice are sold subject to the statutory trust authorized by section 5(c) of the Perishable Agricultural Commodities Act, 1930 (7 U.S.C. 499e(c)). The seller of these commodities retains a trust claim over these commodities, all inventories of food or other products derived from these commodities and any receivable or proceeds from the sale of these commodities until full payment is received. Eggs delivered in the state of Illinois include an Illinois Egg Inspection Fee in the price. MDA Inspection Fees at a rate of $.08 per 30 dozen applicable.

*Acceptance constitutes agreement to a time price differential of 1 1/2% per month on the unpaid balance after the due date.

FOLD AND TEAR ALONG PERFORATION THEN RETURN BOTTOM PORTION.

Thank you for your order.
Please enclose this stub with payment.

FOLD AND TEAR ALONG PERFORATION THEN RETURN BOTTOM PORTION.

Gordon Food Service, Inc.
Payment Processing Center
Dept CH 10490
Palatine, IL 60055-0490

8210 96 986 203.85 LB

Customer #	Invoice #	Date
335680901	133404003	7/1/2011

Date Due 7/22/2011

PAY THIS AMOUNT
$408.69

OHIO DEPT OF REHAB & CORRECTIONS
(419) 726-7977

3356809016101334004060000408670000040867904

Invoice

GREAT LAKES PETROLEUM

Remit To:
Great Lakes Petroleum
4478 Johnston Parkway
Cleveland, OH 44128

Ph: (800) 686-3455
Fax: (216) 478-0510

Invoice Number: 987654001
Invoice Date: 7/1/2011
BOL No. / Comment:
Order Number:
Order Date:
Salesperson: OHG
Customer Number: 01-1001442

Sold to:
CORRECTIONAL RECEPTION CENTER
BUSINESS OFFICE
P.O. BOX 300
ORIENT, OH 43146
(614) 877 – 2441

Ship To:
CORRECTIONAL REC-DEL
11271 ST RT 762
ORIENT, OH 43146

Confirm To:
MARLA

Customer P.O.	Ship VIA	F.O.B.	Terms
	GLP		Net 30

Item Number	Unit	Shipped	Price	Amount
60	GAL	3,000.1	2.5404	7,621.45
87 OCTANE – 10% ETHANOL		Truck: 743		
FED LUST TAX – GASOLINE			0.00100	3.00
FED ENVIRON FEE – ETH GAS			0.00171	5.13
OH STATE EXCISE TAX – GASOLI			0.28000	840.03
			2.82311	8,469.61

Business Unit DRC01 - - OSS DRC Origin – 688
OAKS Vendor ID 62114 FY 11 PO# 70065
OAKS Receipt # 31852
If Non-PO Voucher, check all applicable:
_____Due Now
_____MBE Set-Aside
_____Return to Agency for Mailing
Approved By Kenneth McAllist Date 7/20/2011
Print Name Kenneth McAllist Phone 877-2441

Net Invoice:	8,469.61
Less Discount:	0.00
Freight:	0.00
Sales Tax:	0.00
Invoice Total:	8,469.61

Invoice Due Date: 8/1/2011

All past due balances are subject to a Finance Charge of 1 ½ % per month.

OHO DEPARTMENT OF JOB AND FAMILY SERVICES

P.O. BOX 178960
Columbus, OH 43218-2404
(614)467-7777

REIMBURSING EMPLOYER'S MONTHLY STATEMENT

Employer Account Number. 0001411-11-1
Statement Date: 02/07/2017

001499/9/ RE
DAYTON CORRECTIONAL INSTITUTION
ATTN: BUSINESS OFFICE
3124 GERMANTOWN AVE
DAYTON OH 45445-622A

Account Summary

Prior statement Balance:	$3,692.28
Reductions to Balance:	$(3,715.13)
Additions to Balance:	$1,937.52
Current Balance:	$1,914.87

Recent payments may not be reflected in your current balance. If you have already sent us your payment, we apologize for the Inconvenience and thank you for your payment. To check the current status of your account and make your payment on-line, please visit www. unemolovment.ohio.gov

Date	Transaction Type	Description	Total
01/05/2017	Payment Received		$(1,95839)
01/22/2017	Benefit Charges Assessed	Dec/2016	$1,937.52
01/31/2017	Payment Received		$(1,733.89)
	Interest Assessed	Month/Accrued Interest	$(22.85)

If you are a member or a reimbursing group, the agent of the group will be billed for charges. If not paid by the agent, the charges are the responsibility of the individual members.

Please return your payment made payable to ODJF with the coupon below to assure proper credit to your account.

C938619 015001629
Page 1 or 1

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
P.O. BOX 178960
Columbus. OH 43218-2404

(614) 467-7777

Agency Use Only

Reimbursing Employer's Remittance

14

Employer Account Number:0801411-00-0

DAVTON CORRECTIONAL I NSITITUTION
ATTN: BUSINESS OFFICE
3124 GERMANTOWN AVE
DAYTON OH 45445-6123

Due 02/28/2017 * $ 1,914.67

Amount Enclosed $

Any unpaid amount due will accrue interest at the rate of 1.167% on the first of each month (14% annually, compounded monthly).

140801411DDDD22D17DDDDOOO1914679

JFS 20156[R.9/2010)

American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☒ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☒ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

John Smith
2544 River Lane

Columbus OH 43223

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist) 765.4321

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	11/14/2012	JP		11	F	D2150	Health Fee	95
2	11/14/2012	JP		12	DF	D2150	Health Fee	95
3	11/14/2012	JP		14	MF	D2150	Health Fee	95
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee 285

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X SIGNATURE ON FILE 1/7/2013
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X SIGNATURE ON FILE 1/7/2013
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☒ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) 00 Oral Image(s) 00 Model(s) 00

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☒ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

Dr. Jane Johnson Dental Clinic
1425 Spring Drive

Columbus OH 43252

49. NPI 6366545698 | 50. License Number 18546 | 51. SSN or TIN 356897488

52. Phone Number (614) 444 - 4465 | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X SIGNATURE ON FILE 1/7/2013
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code 221100000X

1425 Spring Drive
Columbus OH 43252

57. Phone Number (614) 444 - 4465 | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☒ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

COLUMBUS BEHAVIORAL HEALTH
652 SPRING ROAD

COLUMBUS OH 43210

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☒ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
	☐ M ☐ F	

9. Plan/Group Number	10. Patient's Relationship to Person Named in #5
	☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

COLUMBUS BEHAVIORAL HEALTH
652 SPRING ROAD

COLUMBUS OH 43210

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
01/01/1901	☒ M ☐ F	

16. Plan/Group Number	17. Employer Name
	OHIO DEPT. OF HEALTH

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Student Status
☐ Self ☐ Spouse ☐ Dependent Child ☒ Other	☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

FARRIS, JAMIE
200 MAIN STREET

COLUMBUS OH 43210

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
02/05/1976	☐ M ☒ F	26062

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	05/22/2014	JP				D0563	Health Fee	72
2	05/22/2014	JP		6		D0652	Health Fee	27
3	05/22/2014	JP		8		D0321	Health Fee	20
4	05/22/2014	JP		11		D0235	Health Fee	20
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee 139

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X SIGNATURE ON FILE — Patient/Guardian signature — 05/23/2014 — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X SIGNATURE ON FILE — Subscriber signature — 05/23/2014 — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s): 0 Oral Image(s): Model(s):

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☒ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

COLUMBUS DENTAL DEPOT
78 ATHENS ROAD

Columbus OH 43252

49. NPI	50. License Number	51. SSN or TIN
	27891	205459875

52. Phone Number	52A. Additional Provider ID
(614) 598 - 4465	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X SIGNATURE ON FILE — Signed (Treating Dentist) — 05/23/2014 — Date

54. NPI	55. License Number	27891
56. Address, City, State, Zip Code	56A. Provider Specialty Code	4321F0000X

78 ATHENS ROAD
COLUMBUS OH 43252

57. Phone Number	58. Additional Provider ID
(614) 598 - 4465	

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

NCCI
987 MARION STREET

MARION, OH 43223

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): SMITH 654321
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH 654321/CRRCTNL, NORTH CENTR	3. PATIENT'S BIRTH DATE MM DD YY SEX M [ ] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): CORRECTIONAL INSTITUTE, NORTH CENTR
5. PATIENT'S ADDRESS (No., Street): 987 MARION STREET	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 987 MARION STREET
CITY: MARION STATE: OH	8. RESERVED FOR NUCC USE	CITY: MARION STATE: OH
ZIP CODE: 43223 TELEPHONE (Include Area Code): ( )		ZIP CODE: 43223 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: 0000060777
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: SMITH 654321
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 12/23/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): MARION GEN HSP ER TO OSU MAIN HSP ER		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. 922A B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: 43223

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	12	23	15	12	23	15	41		A6532	HH	1	100 00	1		NPI	0000060777
2	12	23	15	12	23	15	41		A6533	HH	1	135 00	45		NPI	1654220542 / 0000060777
3															NPI	1654220542
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER: 356442333 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: 7654321	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 235.00	29. AMOUNT PAID: $ 0.00	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): JUDY A FRANKLIN SIGNED 12/31/15 DATE	32. SERVICE FACILITY LOCATION INFORMATION: MARION HSP 1232 MAIN STREET MARION, OH 43223 a. NPI b.		33. BILLING PROVIDER INFO & PH #: (740) 2563654 AMBULANCE SERVICE, INC JOHNSTON TOWN STREET MARION, OHIO 43210 a. NPI b.		

Dental Claim Form

1. ☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services
2. ☒ Medicaid Claim Prior Authorization #
☐ EPSDT

3. Carrier Name

4. Carrier Address

5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Johnson, John | 9. Address | 10. City | 11. State

12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code

17. Relationship to Subscriber/Employee:
☐ Self ☐ Spouse ☐ Child ☐ Other_____

18. Employer/School
Name_____ Address_____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #

22. Subscriber/Employee Name (Last, First, Middle)

23. Address | 24. Phone Number ( )

25. City | 26. State | 27. Zip Code

28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical | 32. Policy #

33. Other Subscriber's Name

34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name

37. Employer/School
Name_____ Address_____

38. Subscriber/Employee Status
☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

40. Employer/School
Name_____ Address_____

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: Dr. Jane Johnson Dental Clinic | 43. Phone Number ( ) | 44. Provider ID #: 7654321 | 45. Dentist Soc. Sec. or T.I.N.: 356897488

46. Address: 1425 Spring Drive | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☒ECF ☐Other

50. City: Columbus | 51. State: OH | 52. Zip Code: 43252 | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No
If service already commenced:
Date appliances placed _____ Total mos. of treatment remaining _____

55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No
If no, reason for replacement: _____
Date of prior placement: _____

56. Is treatment result of occupational illness or injury? ☐No ☐ Yes
Brief description and dates_____

57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither
Brief description and dates_____

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)			Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
10	31	12	24			D2365		extraction	$95.00
10	03	12	04			D4563		extraction	$95.00
10	03	12	02	DO		D7623		filling 1 to 4 surf.	$95.00
10	17	12	28	DF		D7856		filling 1 to 4 surf.	$95.00
10	17	12	29	MF		D5448		filling 1 to 4 surf.	$95.00
10	17	12	31	MODL		D7865		filling 1 to 4 surf.	$95.00

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent									Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	$570.00
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services
Johnson, John - //287.0673 - cc

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed

64. City | 65. State | 66. Zip Code

1	2	3a PAT CNTL #	4 TYPE OF BILL
THE METROHEALTH SYSTEM	THE METROHEALTH SYSTEM	87654321B	
2563 METROHEALTH LANE	P.O. BOX 65412 OH 43223	b. MED REC. #	131
CLEVELAND OH 4322		5 FED. TAX NO. / 6 STATEMENT COVERS PERIOD FROM / THROUGH / 7	
		956214321 / 032516 / 032516	

8 PATIENT NAME	9 PATIENT ADDRESS
a SMITH JOHN	a 3125 LEXINGTON RD
b	b NORTHFIELD c OH d 43223 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
				3	1		01													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
11	065412													

38

NORTH BEHAVORIAL HLT
1652 MAIN ROAD
ATTN BOB WILLIAMS
NORTHFIELD OH 43223

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	A3	494.00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300	LAB	32145	032516	1	13		
2	0301	LAB/CHEMISTRY	36541	032516	1	95		
3	0301	LAB/CHEMISTRY	98756	032516	1	174		
4	0510	CLINIC	12356	032516	1	209		
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0301	*PAGE* 1 *OF* 1		*CREATION DATE* 040316	*TOTALS*	491.00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1900854462
A							57	
B	NORTH BEHAVORIAL HLT		Y	Y			OTHER	956214321
C							PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B	SMITH JOHN	18		NORTH BEHAVORIAL HL	
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX	A	B	C	D	E	F	G	H	68
	54321	4254	4025	6523					
	I	J	K	L	M	N	O	P	Q

69 ADMIT DX		70 PATIENT REASON DX	45620	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1921230542	QUAL	
LAST GOLDLING		FIRST JAMIE	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
POSTTHE44	a		B3212N00000X
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9213257

1	2	3a PAT. CNTL #	4 TYPE OF BILL
THE METROHEALTH SYSTEM	THE METROHEALTH SYSTEM	87654321B	
2563 METROHEALTH LANE	P.O. BOX 65412	b. MED. REC. #	131
CLEVELAND OH 4322	OH 43210	5 FED. TAX NO. 956214321	6 STATEMENT COVERS PERIOD FROM 032516 THROUGH 032516

8 PATIENT NAME	9 PATIENT ADDRESS
a SMITH JOHN	a 3125 LEXINGTON RD
b	b NORTHFIELD c OH d 43223 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
				3	1		01													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
11	065412													

38

NORTH BEHAVORIAL HLT
1652 MAIN ROAD
ATTN BOB WILLIAMS
NORTHFIELD OH 43223

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	A3	494.00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300	LAB	32145	032516	1	13		1
2	0301	LAB/CHEMISTRY	36541	032516	1	95	10.74	2
3	0301	LAB/CHEMISTRY	98756	032516	1	174	41.07	3
4	0510	CLINIC	12356	032516	1	209	70.18	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	0301	PAGE 1 OF 1	CREATION DATE	040316	TOTALS	491.00	121.99	23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1900854462
A							57	
B	NORTH BEHAVORIAL HLT		Y	Y			OTHER	956214321
C							PRV ID	

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B	SMITH JOHN	18		NORTH BEHAVORIAL HL	
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX	54321	4254	4025	6523							68
	I	J	K	L	M	N	O	P	Q		

69 ADMIT DX		70 PATIENT REASON DX	45620	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1921230542	QUAL	
LAST GOLDLING		FIRST JAMIE	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
POSTTHE44	a	B3212N00000X	
PO BOX 5212	b		
MARION, OH 43301	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9213257

Agency Payment Request

FY2014 John R. Justice Payments

Bill To:	**INVOICE NUMBER:** JRJFY14Andrews **INVOICE DATE:** 12/1/2014 **VENDOR ID #:** 0000160729 **LENDOR ACCOUNT #:** E865786702 **SPEEDCHART #:** BORJRJ **PAY TERMS:** DUE NOW **Address Code:** 1 **Location:** CHK
BOR-OSS-K23 **Ohio Shared Services** **P.O. Box 182880** **Columbus, Ohio 43218-2880**	

INVOICE DESCRIPTION:
FY2014 John R. Justice payment for:
Beeler-Andrews, Jill

Awardee OAKS ID#: 187674

Agency Comments: **Return to Agency (RA). Place Awardee OAKS id on the Invoice Tab, and Lender OAKS id on the Payments Tab.**

Payment Message: **Awardee Name and Lender Account Number**

SpeedChart#	**Line Amounts**
BORJRJ	$ 1197.00
INVOICE AMOUNT:	$ 1197.00

Vendor Remit to Address:
US Department Of Education
PO Box 5609
Greenville, Texas 75403-5609

Authorized by: Dawn Gatterdam **Date: December 1, 2014**

TOTAL DUE	$590.00

Mansfield / Stark Summit
[redacted]

ITEMIZED INVOICE

[redacted]

Mansfield / Stark Summit
[redacted]

TO ASSURE PROPER CREDIT, RETURN THIS PORTION WITH YOUR PAYMENT
Ticket # : 165652455:1

Statement Date	Patient ID	AMOUNT PAID
06/24/16	[redacted]	

DETACH HERE

MAKE CHECKS PAYABLE TO: Mansfield / Stark Summit

BALANCE	$590.00

DOS	Description	Patient Name	QTY	Rate	Charge(s)	Payment(s)
Charges						
06/16/16	*ALS NON EMERGENCY	[redacted] A0426	$1.00	$590.00	$590.00	
		Charge Total:			$590.00	

A355978

Richland Correctional

Purchase Order# [redacted]

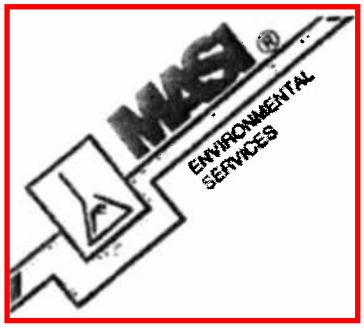
Contract# [redacted]

OAKS ID or Vendor# [redacted]

BALANCE $590.00

From:
[redacted]

To:
[redacted]



P.O. Box 1440 Dublin, OH 43017 Phone (614) 873- 4654

Please refer to this Invoice No. on your remittance.

Invoice	0001214587-IN
Date	7/27/2011
Customer	0000001270

Bill To:
SOUTHERN OHIO CORRECTIONAL
WWTP MIKE MILLS
PO BOX 45699
LUCASVILLE, OH 45699-0001

Results To:
SOUTHERN OHIO CORRECTIONAL
WWTP MIKE MILLS
PO BOX 45699
LUCASVILLE, OH 45699-0001

Terms: Due Upon Receipt
Client PO: DRC01-000002870 **Tax:** N/A

Line Code	Reported	U/M	Quantity	Price	Extension
001 AR	7/20/2011				
A110036123	7/20/2011 PO-DRC01-000002		1.00	19.80	19.80

Extension:	19.80
Freight:	0.00
Sales Tax:	0.00
Total:	**19.80**

INVOICE

mooremedical
Supporting Health & Care

PO Box 4066
Farmington, CT 06032-4066
www.mooremedical.com
800-234-1464

1210 = 370 John Downey Drive, New Britain, CT 06051
1270 = 8100 Westside Industrial Drive, Bldg 4, Jacksonville, FL 32219
1250 = 7950 West Doe Avenue, Visalia, CA 93291
1220 = 495 Woodcreek Drive, Bolingbrook, IL 60440

#BWNNFWW
#210 5123 82#
Corrections Medical Center
Business Office
PO Box 182880
Columbus, OH 43218

Invoice #	Invoice Total	Invoice Date
96659003 RI	110.05	7/14/2011
Customer #	**Customer PO #**	**Order #**
21051238	DRC01-0000081784	15465166
Order Date	**Due Date**	**Terms**
7/1/2011	04/03/11	Net 30 Days

Ship To:
Corrections Medical Center
Storeroom / Edward Murphy
1990 Harmon Avenue
Att Ed Murphy Laboratory
Columbus, OH 43223

(96659594210512380001100 54

Send Payment To: Moore Medical, LLC - PO Box 99718, Chicago, IL 60696

==========

Please detach here and return with your remittance

Item	UM	Description	Qty Ord	Qty Ship	Itm Sts	Unit Price	Extension	Disc. Amt	Ship From
75153	EA	Packing Strips ½" Iodo #3412 EA 1	1	1		2.6500 Per EA	2.65		1210
12861	EA	Rechargeable Handle 71000-A EA 1	1	1		107.4000 Per EA	107.40		1210

The purchase listed on this invoice may be subject to a discount or other promotional consideration that may require you to report the value of such discount or promotional consideration, if any, as a discount. In addition, the prices on this invoice may include fees for services that may not be reimbursable under the Medicare / Medicaid statutes. You can receive an itemized list of any fees in the included prices upon request.

Bill to	**Invoice #**	**Invoice Total**	
21051238	96659594 RI	110.05	
Ship To	**Invoice Date**	**Customer PO #**	**Order #**
21051238	7/14/2011	DRC01-0000081784	15465166

On this invoice you have saved 43.20

Subtotal	110.05
Handling Charge	.00
ShipOnIce /Hazmat	.00
Freight	.00
Tax	.00
Restock Fee	.00
Fuel Surcharge	.00
Total	**110.05**

Late Payments are subject to a 1.5% finance charge. Moore DEA# PP0040167
For your convenience, MOORE MEDICAL accepts Mastercard, VISA, & American Express

INVOICE

819 BUSCH COURT
COLUMBUS OH 43229-0000

Invoice Number	Purchase Order No.
47201001	DRC01-81440

Ordered by: Ed Phillips

Sub-Total:	100.86
Shipping, Handling & Surcharge*:	0.00
Sales Tax:	0.00
Total:	$100.86

Customer Number: 00626028

61958

Original Packing Slip # 4720152

Bill To:
ODRC: ROSS CORRECTIONAL
OHIO SHARED SERVICES
PO BOX 182880
COLUMBUS, OHIO 43218-2880

Ship To:
ROSS CORRECTIONAL FACILITY
WAREHOUSE HOURS 8-11/1-3
16149 STATE ROUTE 104
CHILLICOTHE, OHIO 45601

Any questions or concerns? Please call your local branch or 1-800-645-7270 between 7:00AM and 11:00PM EST

Packing Slip No.	Order Date	Invoice Date	Ship Via	Merchandise Total
4720152	7/5/2011	7/6/2011	UPS GROUND	100.86

Quantity Ordered	Quantity Shipped	Unit of Measure	MSC Item/ Description	Manufacturer Item	Your Item	Unit Price	Discounted Unit Price	Extended Price	Tax
36	36	EA	06386437 4.5X5.25 CLEAR POLYCAR WELDING LENS Item Purchased Open Market	SO765 upc code: 07520161		2.40	2.1600	77.76	N
2	2	EA	06358311 2.0 LEN SILVER/BLK FRM BX SAFETY EYEWEAR	11375-000000-20 upc code: 07837111375		11.55		23.10	N

Thank You For Your Order

*A fuel surcharge has been included due to recent escalations in fuel prices. MSC products and services are subject to U.S. export control laws and regulations. Diversion contrary to U.S. Law is prohibited. See MSC's standard terms and conditions of sale for further information.

IMPORTANT – Please detach and return this portion to ensure proper credit. Be sure to include your customer number on your check.

This purchase is governed exclusively by MSC's Terms and Conditions that can be found in MSC's current catalog and at www.mscdirect.com. MSC's acceptance of your order is predicated on your assent to MSC's Terms and Conditions, unless you have entered into a separate product purchase agreement with MSC that continues to be in effect on the date of your order. Such agreement, depending upon its terms, may supersede MSC's Terms and Conditions.

Ordered By:	ED PHILLIPS
Payment Terms:	OPEN ACCOUNT N/30
Invoice Type:	Open Account
Due Date:	03/18/11

Sub-Total:	**100.86**
Shipping, Handling & Surcharge*:	**0.00**
Sales Tax:	**0.00**
TOTAL:	**$100.86**

Customer Name	
ODRC: ROSS CORRECTIONAL	
Customer Number	**Invoice Number**
00626028	47201001
Amount Due	**Amount Enclosed**
$100.86	

Remit To:

MSC INDUSTRIAL SUPPLY CO.
DEPT CH 0075
PALATINE IL 60055-0075

0062602800000100863000104720152 19

NAPA AUTO PARTS

STORE

100001231
T&K Auto Parts
315 W STREET
CALDWELL, OH 43724
(749) 732-7400

Time: 11:11 Date: 04/03/2014 Page 1/1

Employee: 7 , CHRIS
Sales Rep: 57, PERFERRED
Accounting Day: 4

SOLD TO

19440
Noble County Correctional Inst
15708 St Rt 78 West
Caldwell, OH 43724-8902

Anticipated Time:
Attention:
Tax Exemption:
PO#: 121028
Terms: NET 30

PART NUMBER	LINE	DESCRIPTION	QUANTITY	PRICE	NET	TOTAL	CODE
234-4668	DEN	Oxygen (02) Sensor - OE	1.00	78.40	41.9900	41.99	
21066	NGK	Oxygen (02) sensor - OE	2.00	103.18	66.5900	133.18	
DC9071	DEW	BATTERY PACK	1.00	95.33	85.4900	85.49	

Subtotal		260.66
TABLE 3	7.2500%	0.00
Total		260.66
Charge Sale		

Invoice Number 326860

Customer Signature

ALL GOODS RETURNED MUST BE ACCOMPANIED BY THIS INVOICE

STORE COPY

4/1/2014

Wildfire Invoice

Ohio Department of Natural Resources
Division of Forestry

Bill To: ODNR Forestry, 2045 Morse Road, H1,
Columbus, OH 43229

Fire Department Contact Information

Department	New Concord FD
Fire Department ID Number	60211
Department Address	P.O. Box 10, 2 West Main St New Concord, OH 437562

Details

Payment is being provided to New Concord FD for the timely, accurate, and full report of a wildfire responded to on 3/23/2014 in Union Township, Muskingum County, Ohio.

Fire No.	41-60211-P-38-03/23/2014			
Payment Report ID	7962	Start Time	March 23, 2014	2:50 pm
County	MUSKINGUM	End Time	March 23, 2014	3:30 pm
Amount Due	$70.00	Hours worked	1	
Land Ownership	Private			

Calculated as: Base rate of $70.00 (where land ownership is Private) for first 2 hours (or any part there of) + 35.00/hr for each additional hour (1.00 – 2 = -1.00hr) up to a maximum of 12 hours = $70.00

Date Report Submitted	March 24, 2014
Date Approved	April 01, 2014
Approved By	Lynn Prater

INVOICE

Pipe-Valves, Inc.
Branch: 01 Columbus
PO Box 1865
Columbus, OH 43216

PipeValves

INVOICE	
5357001	
Invoice Date	Page
7/13/2011 16:30:02	1 of 1
ORDER NUMBER	
2361571	

(614) 294-4971

Bill To:

Marion Correctional Institution
Dept of Rehab & Corrections – 0000071180
PO Box 182880
Columbus, OH 43218-2880
USA

Ship To:

Marion Correctional Institution
Attn: Don Janes
670 Marion-Williamsport Road
Marion, OH 43302
USA

Customer ID: 10000363

PO Number	Terms Description	Net Due Date	Disc Due Date	Discount Amount
CGM523	1% 15 Days, Net 30	8/14/2011	7/28/2011	2.63

Order Date	Pick Ticket No	Primary Salesrep Name	Taker
7/12/2011 11:53:50	3353017	Joe Ward	Gene Hickle

Quantities				*Item ID* *Item Description*	Pricing UOM Unit Size	Unit Price	Extended Price
Ordered	*Shipped*	*Remaining*	*UOM Unit Size*	*Disp.*			

Carrier: 1 OUR TRUCK *Tracking #: TRK 1029RR INV 10/29*

84.0000	*84.0000*	*0.0000 FEET*	*1.0*	*PD021400* *2 STD BLK A53-B ERW PIPE PE*	*FEET* *1*	*3.1288*	*262.82*

Total Lines: 1

Sub-Total:	*262.82*
Tax:	*0.00*
Fuel Surcharge:	*4.30*
Amount Due:	*267.12*

ORIGINAL

possitiv!ty
unlimited possibilities

H

4860 Blazer Parkway
Dublin, Ohio 43017
614/846-4877
Fax 614/846-9523
FTID (EIN) 31-0805739

INVOICE	PAGE
036001	1
DATE	
7/21/2011	
CUSTOMER NO:	
1531	
AS OF:	

Sold To:
Ohio Shared Services
Dept of Rehab & Corrections
PO Box 182880
Columbus, OH 43218

Ship To:
Madison Correctional Inst
LOCI Staff QM – Randy Strong
1851 ST RT 56
London, OH 43140 – 0740

P.O. NO.	SHIP VIA	SLMN	ORDER NO	ORDER DATE	TERMS
DRC01-72103	CRP				NET 30 DAYS

An asterisk (*) indicates that an item is fully or partially back ordered ▼

ITEM NUMBER	DESCRIPTION	SHIP	U/M	UNIT PRICE	EXTENDED AMOUNT
SPEC6	EMBROIDERED ITEM GRAFFITTI SOLID CAPS EMBROIDERED – BLACK WITH GOLD THREAD DRC OF OHIO SEAL ON FRONT CENTER OF CAP	96	EACH	11.6100	$1,114.56
9010 EMB	FREIGHT DELIVERY CHARGE	96	EA	0.39	$37.44

NET SALES	INVOICE DISCOUNT	SPECIAL CHARGES	STATE TAX	COUNTY TAX	CITY TAX	AMOUNT DUE
$1,152.00	$.00	$.00	$.00			$1,152.00

INVOICE

proteam
WORKFORCE SOLUTIONS

Invoice Date	7/5/2011
Weekend Date	7/3/2011
Invoice No.	128001
Customer No.	398

Net Due on Receipt

Ohio Dept of Rehabilitation and Corrections
Ohio Shared Services
C/O ODRC/CO
Columbus, OH 43218-2880

Contract No. OT903309
Department Name: Medical Services PO Number: DRC01-0000074620
Location: 1050 Freeway Dr. North Suite 100 Columbus, OH 43229
Job Description: Mail Clerk

Last Name, First Init	Emp#	Reg Hrs	OT Hrs	Reg Rate	OT Rate	Total
Jackson, Lester	6889	32.00	0.00	$14.92	$22.38	$477.44
	Total Hrs	**32.00**	**0.00**			

Total Amount Due: $477.44

Make check payable to **Proteam Workforce Solutions**

Phone (614) 497 – 2180
4006 Alum Creek Drive
Columbus OH 43207-5137
Fax (6140 497 – 2181

D-U-N-S 09-4738007
FED. ID 58-2608861

SimplexGrinnell BE SAFE.
A Tyco International Company

District # 583
6175 SHAMROCK COURT STE S
DUBLIN,OH,43016-3250
614-602-2000

CUSTOMER PO
DAS01-0000009202

INVOICE DATE	INVOICE NO.
7/18/2011	73832001

Bill To: 583-13607389
Ohio Shared Services
PO Box 182880 c/o Dept of Admin Services
Columbus, OH 43228-2880

Ship To:
*** Various Locations ***

CONTRACT DESCRIPTION	CONTRACT START DATE	CONTRACT END DATE
STATE OF OHIO DAS 246 N HIGH ST – 0774829	7/1/2011	6/30/2011

Invoice Notes:

WE ACCEPT ALL MAJOR CREDIT CARDS

Invoice Amount	$7,721.84
Sales Tax	$407.44
Total Invoice Amt	$8,129.28
Payment Received	$0.00
TOTAL AMOUNT DUE ►	***$8,129.28***

Remittance Copy

Total Amount Due
$8,129.28

SimplexGrinnell BE SAFE.
A Tyco International Company

583-13607389
Bill To: Ohio Shared Services
PO Box 182880 c/o Dept of AD
Columbus, OH 43228-2880

Invoice Number 73832001
Invoice Date 7/18/2011
Customer No. 1360738

REMIT TO SimplexGrinnell
Dept. CH 10320
Palatine ,IL 60055-0320

800081292837383204O

☐ Check Box and Complete Reverse Side for Credit Card Payments OR Pay Online at **www.simplexgrinnell.com**

D-U-N-S 09-4738007
FED ID 58-2608861

SimplexGrinnell BE SAFE.

A Tyco International Company

INVOICE NO.	INVOICE DATE	CUSTOMER PO
40288001	7/20/2011	DAS01 - 0000009440

TERMS	INVOICE TYPE
NET30	Standard Invoice

COLUMBUS
6175 Shamrock Ct, Suite S
Dublin, OH 430163250
Phone: (614) 602 – 2000

Bill To: 583-013607389
Ohio Shared Services
PO Box 182880
c/o Dept of Admin Service
Columbus, OH 43228-2880

Project: 583-954355505
State of Ohio DAS – 35 E. Chestn
35 E. Chestnut ST Floor 6
Columbus, OH 43215-2541

INVOICE SUMMARY

Total P.O.	$1,269.00	Invoice Subtotal	$470.03
Invoiced to date	$470.03	Less Retainage	$0.00
Due this Invoice	$470.03	Subtotal	$470.03
Remaining to Invoice	$798.97	Sales Tax	$0.00
		Total Invoice	$470.03
Please direct inquiries to our local branch office listed above.		**Pay This Amount ▶**	**$470.03**

INVOICE DETAIL

Labor Progress	OHIO DAS 35 E CH			
			Total Labor this Invoice	**$291.49**
Material	Fire Alarm	Material	$178.54	
			Total material this Invoice	**$178.54**

Comments

SimplexGrinnell BE SAFE.

A Tyco International Company

REMITTANCE COPY

PLEASE TEAR OFF AND RETURN THIS PORTION WITH YOUR PAYMENT - WRITE INVOICE NO. ON YOUR CHECK.

INVOICE AMOUNT
$470.03

Bill To 583-013607389 Ohio Shared Services

Ship To 583-000550666 State of Ohio DAS – 35 E. Chest

Invoice Number 40288151

Invoice Date 7/20/2011

Customer PO DAS01-0000009440

REMIT TO SimplexGrinnell
Dept. CH 10320
Palatine, IL 60055-0320

2000047003340288151

☐ Check Box and Complete Reverse Side for Credit Card Payments OR Pay Online at **www.simplexgrinnell.com**

TIME WARNER CABLE
Business Class
1015 OLENTANGY RIVER RD
COLUMBUS, OHIO 43212-3148

Account Number	Service Period	Due Date	Amount Due
10202 474726101 7001	01/01/11 01/31/11	01/26/11	**$122.95**

STATE OF OHIO DIV OF PAROLE &
SERVICE ADDRESS: 121 W BROWN ST NEW LEXINGTON, OH 43764-1241-21

ACCOUNT SUMMARY

PRIOR MONTH

12/02	Previous Balance	$122 95
12/27	Payment Received…Thank You	$122 95 CR
	Total Prior Month History	**$0.00**

CURRENT MONTHLY CHARGES

MONTHLY DATA CHARGES

01/01 – 01/31	2 Year Term Discount	$47 00 CR
01/01 – 01/31	BusClass HSD 8M x 1 5M	$169 95
	Total Monthly Data Charges	**$122.95**

TOTAL AMOUNT DUE……$122.95

IMPORTANT INFORMATION:

Now the same company that delivers your Internet, Cable TV and Security offers you a great choice in phone service!

*Unlimited Local & Long Distance (US, Canada, Puerto Rico)
*Unlimited In-State Calling Plans
*Unlimited Local Calling Plans
*Call Forward
*Call Waiting
*Caller ID
*Three-way Call Transfer
*Toll Free
*Voicemail
*Enhanced 911
*Directory Assistance
*Operator Assistance
*Crystal Clear Connections
*24/7 Customer Support
*One Monthly Bill

CONTACT US:

Billing, Service and Sales Inquiries:
1-614-255-4997 or toll free
At 1-877-283-8091
www.twcbc.com/midohio

Federal Tax ID#: 13 3666-92

Local Franchising Authority: CITY OF NEW LEXINGTON 125 S MAIN ST NEW LEXINGTON, OH 43764CUID# Phone: 740-324-2177
Please detach and enclose this coupon with your payment.

TIME WARNER CABLE
Business Class
1015 OLENTANGY RIVER RD
COLUMBUS, OHIO 43212-3148

Account Number	Payment Due Date	Total Amount Due
10202 474726101 7001	01/26/11	$122.95

**Please allow 7 to 10 days for delivery and payment processing.
See reverse side for more convenient payment options

0000743 1 AT 0 357
SRE B S: T:000003, 22698
AUTO**3-DIGIT 432
STATE OF OHIO DIV OF PAROLE &
P O BOX 182880
COLUMBUS OH 43218-2880

TIME WARNER CABLE
P O BOX 0916
CAROL STREAM, IL 60132-0916

10202001002474726101720012295O916

Warrant Date: 08/28/2014 **Vendor Number:** 0000208799 **Warrant No:** 0027433624

Invoice Number	Voucher ID	Gross Amount	Discount Taken	Late Charge	Paid Amount
E2-06	00271162	24939.57	0.00	0.00	24939.57

Call Ohio Shared Services 1-877-644-6771 with questions

REGULR1815000135001OG

Warrant Number	Date	Total Gross Amount	Total Discounts	Total Late Charges	Total Paid Amount
0027433624	08/28/2014	$24,939.57	$0.00	$0.00	$24,939.57

PLEASE TEAR AT PERFORATION BEFORE CASHING CHECK.

THIS IS OHIO WATERMARKED PAPER - DO NOT ACCEPT WITHOUT NOTING OHIO WATERMARK - HOLD TO LIGHT TO VERIFY OHIO WATERMARK

OH Dept of MH & Addiction Svcs
Central Office
30 East Broad Street
Columbus OH 43215-3430 **135**
(877) 644-6771

Date 08/28/2014 Fund **503** Warrant No. 0027433624 67 R
25 - 217 / 4

Pay Amount $24,939.57***

Pay ****TWENTY-FOUR THOUSAND NINE HUNDRED THIRTY-NINE AND 57/100 DOLLARS ****

To The Order Of

INDEPENDENT CONTRACT PROVIDERS
12900 LAKE AVE APT 1227
LAKEWOOD, OH 44107-1554

Timothy S. Keen

Timothy S. Keen, Director
Office of Budget Management

VOID AFTER 90 DAYS

Original Invoice

Invoice 986001

WEAVER BROS., INC.

Phone 937-526-3331
45060

P.O. Box 333
Versailles, Ohio 45380

Sold To: Pickaway Correctional Ins
11781 St. Rte. 762
P.O. Box 209
Orient, OH 43146

Date 7/3/2011

PO 198157

1 1/5% Service Charge per month or 18% annually on Invoices over 14 days old

TERMS: NET 14 DAYS

PRODUCT NO.	DESCRIPTION	CASES/ UNITS	QUANTITY PER UNIT	DOZENS/ UNITS	PRICE	AMOUNT
71106	Med A Loose USDA/30 DOZ Keep at 45 Degrees F. ID#34-4468606 614-877-4362 Certified UEP #176	50	30	1500	.87833	1317.50
	Pick Up All Empty Racks & Skids	50		1500	**TOTAL**	1317.50

PRODUCT NO.	LEFT	RETURNED	SHIPPING INSTRUCTIONS
PALLETS BASKETS CASES			RECEIVED BY Ruth L Loeff (INITIALS NOT ACCEPTABLE)