

EXPENSE REPORT

Facility Corporate Location Name Carolina Therapy Services Facility # _____

Employee Name _____ Title _____

Mailing Address _____

Vendor # _____

| DATE | AMOUNT | TYPE OF EXPENSE | | | | | | ACCTG. CODE (ACCTG. ONLY) | PURPOSE OF EXPENSE (NAMES, DATES, ETC.) |
|------|--------|-----------------|---|---|---|---|---|---------------------------|---|
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |
| | | G | R | L | A | M | O | | |

| | | | | | |
|--------------------------|------|--|------|--|-------|
| TOTAL | \$ - | G Gas/Paid Mileage (0.50) R Rental Car L Lodging A Airfare M Meals/Beverage O Other - Explain in "Purpose Section" | CODE | | TOTAL |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| LESS ADVANCES | | | | | |
| LESS COMPANY PD. AIRFARE | | | | | |
| DUE EMPLOYEE <COMPANY> | \$ - | | | | |

DATE _____ EMPLOYEE SIGNATURE _____ DATE _____ SUPERVISORY APPROVAL _____