

**Payment to Agency Report**

**A Public Document**

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b> San Gorgonio Memorial Hospital		Date Stamp	<b>California 801</b> <b>Form</b> For Official Use Only
Division, Department, or Region (if applicable) n/a			
Street Address 600 N. Highland Springs Avenue, Banning, CA 92220			
Area Code/Phone Number (951) 769-2160	Email bduffy@sgmh.org	<input type="checkbox"/> <b>Amendment</b> (explain in comment section)  Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title) Bobbi Duffy, Executive Assistant			

**2. Donor Name and Address**

Individual \_\_\_\_\_  Other Kronos Incorporated

Last Name	First Name	Name	
900 Chelmsford Street	Lowell	MA	01851
Address	City	State	Zip Code

Health care computer programs

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

n/a	\$ 0.00	n/a	\$ 0.00
Name	Amount	Name	Amount

**3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)**

**3.1 (a) Travel Payment**

<u>Scottsdale, AZ</u>	<u>March 2 - 4, 2019</u>
Location of Travel	Dates (month, day, year)

n/a \_\_\_\_\_  Rail  Air  Bus  Auto  Other Hyatt Regency

Check Applicable Boxes

\$ <u>1,591.56</u>	\$ <u>1,550.06</u>	\$ <u>66.00</u>	\$ <u>1,110.42</u>	\$ <u>4,318.04</u>
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

**3.1 (b) Payment(s) not related to travel:** n/a \$ 4,318.04

Dates (month, day, year)      Total Expenses

**3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.**

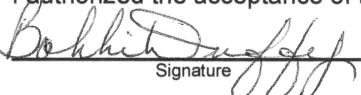
Sponsored 2 Hospital Directors for Kronos education

**3.3. Identify the officials who used the payment in Section 3.1** (See instructions)

<u>Brown</u>	<u>Patricia</u>	<u>Chief Nursing Officer</u>	<u>Administration</u>
Last Name	First Name	Position/Title	Department/Division
<u>Freude</u>	<u>Vivian</u>	<u>Director</u>	<u>Medical Surgical Unit</u>
Last Name	First Name	Position/Title	Department/Division

**4. Verification**

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

	<u>Bobbi Duffy</u>	<u>Executive Assistant</u>	<u>03/27/19</u>
Signature	Print Name	Title	(month, day, year)

Comment:  
(Use this space or an attachment for any additional information)

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