

CONTACT

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PRACTICE PROFILE: MEDICAL DOCTOR

■ SELLER'S NAME:

■ E-MAIL:

■ CELL PHONE:

GENERAL INFORMATION

CLINIC NAME:

CLINIC ADDRESS:

YEARS IN PRACTICE:

AT THIS LOCATION:

DC'S MD'S DO'S PT'S LMT'S STAFF CA'S

PORP'SHIP PORP'SHIP "S" CORP "C" CORP PA

STRAIGHT: PORP'SHIP:

TREATMENT TECHNIQUE

PRIMARY:

SECONDARY:

OTHER:

HOW MANY PATIENT FILES ON HAND:

TOTAL NEW PATIENTS LAST YEAR:

LAST YEARS AVERAGE CHARGE PER VISIT:

OFFICE STATISTICS

| | | | | |
|---|------------------------------|----------------------|----------------------|----------------------|
| <input type="checkbox"/> USABLE SQFT: | <input type="text"/> | OWNED: | <input type="text"/> | |
| | LEASED: | <input type="text"/> | LEASE AMOUNT: | <input type="text"/> |
| <input type="checkbox"/> PATIENT PARKING SPACES | <input type="text"/> | | | |
| <input type="checkbox"/> FREE STANDING/MULTI-TENANT: | <input type="text"/> | | | |
| <input type="checkbox"/> LOCATION: | <input type="text"/> | | | |
| <input type="checkbox"/> SIGNAGE: | <input type="text"/> | | | |
| <input type="checkbox"/> ADDITIONAL DC CAPABILITY: | <input type="text"/> | | | |
| <input type="checkbox"/> DOES M.D. OWN OTHER CLINICS: | <input type="checkbox"/> YES | HOW MANY: | <input type="text"/> | |
| | <input type="checkbox"/> NO | | <input type="text"/> | |
| <input type="checkbox"/> OFFICE HOURS: | <input type="text"/> | | | |

ATTACH COMPLETE LISTING OF FEES FOR SERVICES PROVIDED

RATE YOUR OFFICE

| POOR | | | | | EXCELLENT | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|--|
| 1 | 2 | 3 | 4 | 5 | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HOW WELL EQUIPPED IS YOUR CLINIC | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DO YOU HAVE ENOUGH SPACE IN YOUR CLINIC | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IS YOUR CLINIC EASY TO FIND | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IS YOUR CLINIC ON A BUSY STREET | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IS YOUR CLINIC WELL MARKED | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IS YOUR CLINIC VISIBLE | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IS YOUR CLINIC ACCESSIBLE | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DOES YOUR CLINIC HAVE ADEQUATE PARKING | |

STAFF

NAME LENGTH OF EMPLOYMENT

MONTHLY PAY BONUS PAY

SALARY HOURLY

CONTRACT LABOR

SPECIAL CONDITIONS

GENERAL DUTIES

HOURS REQUIRED TO WORK

M.D.'S PERSONAL EVALUATION

POOR 1 2 3 4 5 EXCELLENT

NAME LENGTH OF EMPLOYMENT

MONTHLY PAY BONUS PAY

SALARY HOURLY

CONTRACT LABOR

SPECIAL CONDITIONS

GENERAL DUTIES

HOURS REQUIRED TO WORK

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POOR 1 2 3 4 5 EXCELLENT

STAFF

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POOR 1 2 3 4 5 EXCELLENT

NAME LENGTH OF EMPLOYMENT

MONTHLY PAY BONUS PAY

SALARY HOURLY

CONTRACT LABOR

SPECIAL CONDITIONS

GENERAL DUTIES

HOURS REQUIRED TO WORK

M.D.'S PERSONAL EVALUATION

POOR 1 2 3 4 5 EXCELLENT

INCOME STATS

| | <u> </u> | <u> </u> | <u> </u> |
|------------------|-----------------------------|-----------------------------|-----------------------------|
| ■ GROSS BILLING | | | |
| ■ GROSS RECEIPTS | | | |
| ■ OVERHEAD | | | |

NOTE: EXCLUDE ALL DEPRECIATION CHARGES AND ALL EXPENDITURES FOR M.D. SALARY, BONUS AND FRINGE BENEFITS (I.E. AUTOMOBILE, DUES, MEMBERSHIPS, LIFE-HEALTH-DISABILITY, INSURANCE, RETIREMENT PLAN CONTRIBUTIONS, ETC.)

■ HMO/PPO GROUPS CURRENTLY WORKING WITH:

■ APPROXIMATE DOLLAR AMOUNT COLLECTED FROM THE HMO/PPO GROUPS LAST YEAR

■ ATTORNEYS:

■ LEGAL NETWORKERS:

■ SPECIALIZED REFERRALS FROM OTHER SOURCES:

ACCOUNTS RECEIVABLE

PRESENT BALANCE:

AGING SCHEDULE:

| | | | |
|---------|-------------------------|----------|-------------------------|
| CURRENT | \$ <input type="text"/> | 91-120 | \$ <input type="text"/> |
| 31-60 | \$ <input type="text"/> | 121-120 | \$ <input type="text"/> |
| 61-90 | \$ <input type="text"/> | 181 PLUS | \$ <input type="text"/> |

RECEIVABLE PROFILE:

| | |
|----------------------|-------------------------|
| PATIENTS DIRECT PAY | \$ <input type="text"/> |
| PRIVATE INSURANCE | \$ <input type="text"/> |
| WORKMAN'S COMP | \$ <input type="text"/> |
| HMO/PPO (BY CARRIER) | \$ <input type="text"/> |
| PERSONAL INJURY | \$ <input type="text"/> |
| MEDICARE/MEDICAID | \$ <input type="text"/> |
| OTHER | \$ <input type="text"/> |

CLINIC NET ASSETS:

NOTE: INCLUDE ONLY THOSE ASSETS OWNED OR LEASED BY THE CLINIC. LAND AT COST, BUILDING NET OF ACCUMULATED DEPRECIATION, FURNITURE, FIXTURES, EQUIPMENT, LEASEHOLD IMPROVEMENT AND CAPITALIZED LEASES NET OF ACCUMULATED DEPRECIATION. EXCLUDE CASH, MARKETABLE SECURITIES (IF ANY) AND ACCOUNTS RECEIVABLE.

STATISTICAL SUMMARY

PLEASE LIST YOUR PRACTICE STATISTICS FOR THE LAST 12 MONTHS

| MONTH/YEAR | COLLECTIONS | SERVICES | NEW PATIENTS | TOTAL VISITS |
|----------------|-------------|----------|--------------|--------------|
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| | | | | |
| 12 MONTH TOTAL | | | | |

SGR, INC. USE ONLY

| COLLECTIONS RATIO | CASE AVERAGE | VISIT AVERAGE | NEW PATIENTS AVERAGE | RETENTION RATIO |
|-------------------|--------------|---------------|----------------------|-----------------|
| | | | | |

HMO/PPO COLLECTIONS REPORT

IF YOU ARE AN HMO/PPO PROVIDER, PLEASE COMPLETE THE FOLLOWING INFORMATION. IF YOU DO NOT HAVE EXACT FIGURES, PLEASE ESTIMATE, BUT BE AS ACCURATE AS POSSIBLE. THIS FORM WILL BE PRESENTED TO QUALIFIED PROSPECTIVE PURCHASERS AND THEIR ADVISORS. IF ANY OF YOUR FIGURES ARE AN ESTIMATE, PLEASE PLACE "EST." AFTER EACH AMOUNT.

| PROVIDER | AMOUNT COLLECTED | YEAR |
|------------------------------|------------------|------|
| PHCS | | |
| BEECH ST. | | |
| BLUE CHOICE | | |
| ASHN | | |
| AMERICA WHOLE HEALTH NETWORK | | |
| CCN | | |
| HNA | | |
| CIPA | | |
| OMNI | | |
| CHPA | | |
| SPN | | |
| FCA | | |
| PHN | | |
| IHP | | |
| CHPS | | |
| AETNA | | |
| AFFORDABLE | | |
| ANTHEM | | |
| CAPP-CARE | | |
| AHP | | |
| | | |
| | | |

M.D. OBSERVATION

WHAT DO YOU SEE AS THE STRONGEST TWO AREAS IN YOUR PRACTICE?

WHAT DO YOU SEE AS THE WEAKEST TWO AREAS IN YOUR PRACTICE?

WHAT DO YOU SEE AS YOUR TWO STRONGEST ATTRIBUTES AS THEY RELATE TO YOUR PRACTICE?

WHAT DO YOU SEE AS YOUR TWO WEAKEST ATTRIBUTES AS THEY RELATE TO YOUR PRACTICE?

MISCELLANEOUS OBSERVATIONS:

M.D. SCHOOL/COLLEGE/YEAR:

POST M.D. SCHOOL/COLLEGE EDUCATION: