

Information Request Form

PROVIDER INFORMATION			
Name of Legal Entity Generating Revenue		DBA	
Address	City	State	Zip
Contact Person:	First	Last	Title
Telephone () - Ext.	Fax () -	Alternative Number () -	
Web Site		E-Mail	
<ul style="list-style-type: none"> • Please provide a list of additional legal entities, including addresses, phone numbers, and contact information, to be considered for financing. • If legal entity generating revenue is a wholly owned subsidiary, list parent company: _____ 			
LICENSURE			
Is your company licensed in the state(s) in which it practices? Yes / No			
How many years have you been in business? ____ Years			
Has the company ever had its license to perform healthcare services revoked or suspended? Yes / No			
TYPE OF BUSINESS		TYPE OF LEGAL ENTITY	
Please describe the type of service(s) you provide. _____ _____ _____ _____		Is your institution a: ____ Partnership ____ Corporation ____ C or ____ S ____ Sole Proprietorship ____ LLC ____ Profit ____ Nonprofit	
OWNERSHIP STRUCTURE			
Please list all owners (individuals and legal entities) and their respective ownership percentages (for those > 20%)		(1) _____ % (2) _____ % (3) _____ % (4) _____ %	
BILLING SYSTEM			
Can your billing/AR detail system produce an aging summary in 30 day buckets out to 150 days, summarized by major payor class aged by either invoice date or service date? Yes ____ No ____			
Can this billing summary be produced on a weekly basis? Yes ____ No ____ N/A ____			
Are contractual adjustments and write-offs recorded at the time of payment? Yes ____ No ____ N/A ____			
Is billing done in-house? Yes ____ No ____			
Is the billing process centralized or maintained by each facility? _____			

COST REPORTS

Does the company file Medicare and/or Medicaid Cost Reports such that there are frequently receivables/payables due upon filing/desk review? Yes _____ No _____

Are you currently on a payment plan to pay-off Medicare/Medicaid cost report liabilities? Yes _____ (mo. payment \$ _____) No _____

Are there any amounts due to Medicare/Medicaid for which a payment plan has not been established? Yes _____ No _____

BILLING HISTORY (please provide information for each facility on separate pieces of paper)

	Year to Date 2006	2005	2004
Gross Billing	\$ _____	\$ _____	\$ _____
Collections	\$ _____	\$ _____	\$ _____

ANTICIPATED USE OF PROCEEDS

What is the amount of financing requested? \$ _____	What is the proposed use of funds?
	Debt Pay-off \$ _____
	Vendor Paydown \$ _____
	Payroll Taxes \$ _____
	Acquisition \$ _____
	Other \$ _____

LIENS

• Do any liens exist against your accounts receivable?	Yes	No	List Lien-holders & Payoff amounts: (1) _____ \$ _____ (2) _____ \$ _____ (3) _____ \$ _____ (4) _____ \$ _____
• Have any creditors filed a blanket lien on all assets?	Yes	No	
• Have any of your vendors filed a lien on "inventory and proceeds"?	Yes	No	

If your receivables are currently encumbered, please provide a copy of the financing agreement/loan agreement affecting the accounts receivable.

RECENT FINANCIAL PERFORMANCE

	Year to Date 2006	2005	2004
Net Revenue	\$ _____	\$ _____	\$ _____
Operating Income	\$ _____	\$ _____	\$ _____
Net Income (Loss)	\$ _____	\$ _____	\$ _____

Please provide a summary balance sheet and income statement for current YTD and most recent fiscal year end.

PAYROLL TAXES

Are federal payroll taxes current? Yes _____ No _____ -- Past due amount \$ _____
 Are state payroll taxes current? Yes _____ No _____ -- Past due amount \$ _____
 Do you use a payroll service? Yes _____ No _____

KEY MANAGEMENT

Name of President/CEO:		Title:	
Home Address	City	State	Zip
Telephone: () -	Social Security Number: - -		
Name of Top Ranking Finance/Accounting Person:		Title:	
Home Address	City	State	Zip
Telephone: () -	Social Security Number: - -		

If any of the Provider's officers have been the subject of an administrative action, enforcement action, civil lawsuit or criminal prosecution brought by any federal, state or county agency, bureau or department, including, but not limited to, the Securities and Exchange Commission, the Federal Bureau of Investigation, the Environmental Protection Agency, Internal Revenue Service, the Federal Trade Commission or any equivalent state or local authority, including but not limited to all state and local blue sky and taxing authorities, then the names of such officer(s) is listed below. For each such director or officer, the dates and an explanation of the circumstances are attached as an addendum to this application.

- (i) _____
- (ii) _____
- (iii) _____

If any of the Provider's officers have been named a defendant to a civil or criminal RICO complaint, then the names of such officer(s) is listed below. For each such director or officer, the dates and an explanation of the circumstances have been attached as an addendum to this application.

- (i) _____
- (ii) _____
- (iii) _____

If any of the Provider's officers have been charged with a violation of any state or federal criminal law or regulation, then the names of such officer(s) are listed below. For each such director or officer, the dates and an explanation of the circumstances have been attached as an addendum to this application.

- (i) _____
- (ii) _____
- (iii) _____

If Provider company and/or related entities and predecessor companies have been investigated by MEDICARE or MEDICAID for billing practices, a description of any investigation, whether closed or ongoing, and the outcome (including the amount of any settlement) are listed below. For each investigation, the dates and explanation of the circumstances are attached as an addendum to this application.

- (i) _____
- (ii) _____
- (iii) _____

If any of the Provider's officers have sought personal bankruptcy protection under Title 11 of the United States Code or been otherwise personally subject to a foreclosure proceeding (judicial or otherwise), an appointment of a receiver, or a forced liquidation, then the names of such officer(s) is listed below. For each such director or officer, the dates and an explanation of the circumstances are attached as an addendum to this application.

- (i) _____
- (ii) _____
- (iii) _____

If any of the Provider's officers have sought bankruptcy protection under Title 11 of the United States Code for any business in which he or she had an ownership interest of 20% or more, or which businesses were otherwise the subject of a foreclosure, an appointment of a receiver, or a forced liquidation, then the names of such officer(s) is listed below. For each director or officer, the dates and an explanation of the circumstances is attached as an addendum to this application.

(i) _____

(ii) _____

(iii) _____

CERTIFICATION AND AGREEMENT

Provider certifies that the information contained in this credit application reflects a true and complete account of the financial status of the Provider(s). Permission is hereby granted to Meridian Commercial Healthcare Finance (MCHF) and its affiliated companies, or agents, to examine data, records, obtain credit histories and any other information in connection with the credit review process. MCHF agrees to the confidentiality of this information unless disclosure is reasonably required in MCHF's business activities. This authorization, or a copy thereof, shall serve as permission by the undersigned to individuals, accountants, insurance, credit agencies and others for the release of all information required to MCHF and affiliated companies or agents.

Provider hereby authorizes the filing by MCHF of a UCC-1 financing statement describing the collateral as "all assets".

Provider understands that MCHF is relying on this information to enter into a financing agreement with it. Provider agrees to inform MCHF immediately of any matter which will cause a material change to the Provider's financial condition or operations. Provider understands that MCHF will retain this application.

[NAME OF PROVIDER]

Date

By: _____

Name: _____

Title: _____

Please carefully review your information prior to submitting your application. The information should be legible, complete and accurate. If a question does not apply, please acknowledge by inserting "NA". Should you need to elaborate on any item(s) please attach additional documents. Once complete, please submit your application via mail or facsimile to:

Customer Services
Meridian Commercial Healthcare Finance
4320 La Jolla Village Drive, Suite 250
San Diego, CA 92122.
(858) 200-2051 Facsimile

Thank you for choosing Meridian Commercial Healthcare Finance. We know that you have other financing options available to you and we appreciate you working with us.

Please let us know how you heard about Meridian:

- | | | |
|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> E-Mail | <input type="checkbox"/> Direct Mail | <input type="checkbox"/> Web Site |
| <input type="checkbox"/> Magazine | <input type="checkbox"/> Conference | <input type="checkbox"/> Meridian Representative |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Trade Show | <input type="checkbox"/> Financial Institution |
| <input type="checkbox"/> Colleague | <input type="checkbox"/> Broker | <input type="checkbox"/> Other |

Please provide the name of the person, organization, or media source that referred you to Meridian:

What other financial institutions have you applied to for financing?

Interest In: Financing Patient Accounts Yes No

Additional Comments:

ACCOUNTS RECEIVABLE INFORMATION (Gross Values rounded to the nearest hundred dollars)											
	0-30	31-60	61-90	91-120	121-150	151-180	181+	Total Gross Receivable < 150	Percentage expected to Collect ¹	Total of net charges ²	Average Days to Collect ³
EXAMPLE	\$ 100,000	75,000	50,000	25,000	10,000	12,000	20,000	\$260,000	60%	\$156,000	90
Medicare	\$									\$	
Medicaid (ADC)	\$									\$	
Worker Comp.	\$									\$	
Commercial	\$									\$	
HMO/PPO	\$									\$	
BC/BS	\$									\$	
Managed Care	\$									\$	
Personal Injury	\$									\$	
Patient Pay	\$									\$	
Other _____	\$									\$	
Totals:	\$									\$	

¹ Please provide the percentage that you expect to collect for each payor type (example: If you bill \$1,000 to Medicare and on average collect \$700, the number you would place in this cell would be 70%.)

² This is the total of the outstanding net accounts receivable for that payor type.

³ This represents the average number of days it takes to collect a payment, from date of billing, for that payor type.