Zacks Small-Cap Research

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# Aastrom Biosciences, Inc. (ASTM-NASDAQ)

***ASTM: REVIVE and RENEW Begin…***

| | |
|---|---|
| **Current Recommendation** | **Outperform** |
| Prior Recommendation | Neutral |
| Date of Last Change | 11/08/2010 |
| Current Price (08/08/12) | $1.88 |
| **Target Price** | **$5.00** |

## UPDATE

Over the next twelve months, we expect continued updates on the enrollment in the phase 3 REVIVE trial testing ixmyelocel-T for the treatment of CLI. Later this month, we expect the initiation of the phase 2b RENEW trial in ischemic DCM. These are two of the highest profile autologous stem cell therapy trials in the world, and they both are at Aastrom Bio.

Although we see limited upside over the near-term while these trial are only enrolling, a deal development and commercialization partnership notwithstanding, we see Aastrom as a core holding in biotech given its technology and the potential that ixmyelocel-T is a blockbuster drug.

## SUMMARY DATA

| | |
|---|---|
| **52-Week High** | **$2.75** |
| **52-Week Low** | **$1.78** |
| **One-Year Return (%)** | **-17.54** |
| **Beta** | **0.13** |
| **Average Daily Volume (sh)** | **330,392** |
| **Shares Outstanding (mil)** | **39** |
| **Market Capitalization ($mil)** | **$73** |
| **Short Interest Ratio (days)** | **14.01** |
| **Institutional Ownership (%)** | **10** |
| **Insider Ownership (%)** | **1** |
| **Annual Cash Dividend** | **$0.00** |
| **Dividend Yield (%)** | **0.00** |
| **5-Yr. Historical Growth Rates** | |
| **Sales (%)** | **N/A** |
| **Earnings Per Share (%)** | **N/A** |
| **Dividend (%)** | **N/A** |
| **P/E using TTM EPS** | **N/A** |
| **P/E using 2012 Estimate** | **N/A** |
| **P/E using 2013 Estimate** | **N/A** |

| | |
|---|---|
| **Risk Level** | **Above Average** |
| **Type of Stock** | **Small-Growth** |
| **Industry** | **Med-Biomed/Gene** |

## ZACKS ESTIMATES

**Revenue**
(In millions of $)

| | Q1 (Mar) | Q2 (Jun) | Q3 (Sep) | Q4 (Dec) | Year (Dec) |
|---|---|---|---|---|---|
| 2011 | 0 A | 0 A | 0 A | 0 A | 0 A |
| 2012 | 0 A | 0 A | 0 E | 0 E | 0 E |
| 2013 | | | | | 0 E |
| 2014 | | | | | 0 E |

**Earnings per Share**
(EPS is operating earnings before non-recurring items)

| | Q1 (Mar) | Q2 (Jun) | Q3 (Sep) | Q4 (Dec) | Year (Dec) |
|---|---|---|---|---|---|
| 2011 | -$0.13 A | -$0.26 A | -$0.05 A | -$0.07 A | -$0.51 A |
| 2012 | -$0.25 A | -$0.22 A | -$0.26 E | -$0.28 E | -$1.01 E |
| 2013 | | | | | -$1.13 E |
| 2014 | | | | | -$1.06 E |

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## WHAT'S NEW

**Recent Financials**

On August 7, 2012, Aastrom Bio reported financial results for the second quarter 2012. Aastrom reported no revenues in quarter. As a development-stage company, this was expected and in-line with our model. The company reported a net loss in the second quarter of $8.6 million, or 22 cents per share. Loss was lessened by a re-valuation in the outstanding warrant liability of $1.9 million in the quarter. As Aastrom's stock goes up, the warrant liability increases. As it goes down, the liability decreases. We note this re-valuation is a non-cash charge. Operating burn during the quarter was $8.0 million, in-line with our model and management's previous guidance.

Aastrom reported cash and cash equivalents at the end of June 30, 2012 of $28.7 million. We find the current cash balance as sufficient to fund operations into the second quarter of 2013. The company does have an at-the-market ("ATM") equity distribution financing in place for up to $20 million in aggregate offerings, and we expect that management will be opportunistically tapping the ATM over the next several months now that the capital structure has been improved. Depending on the pace at which management uses the ATM, Aastrom will either need to conduct another financing or will need to strike a development and commercialization alliance for ixmyelocel-T in either critical limb ischemia (CLI) or dilated cardiomyopathy (DCM) at some point in 2013.

***…Cleaned Up Capital Structure…***

On June 27, 2012, Aastrom announced its intent to offer to exchange any and all outstanding warrants to purchase the company's common stock issued in connection with the December 2010 public offering. There were 10 million (no par value) five-year warrants issued in December 2010 with a "cashless" exercise option price of $3.22 per share. We viewed these toxic derivatives as highly dilutive with no residual value to Aastrom. The warrants contain anti-dilution provisions that adjust the exercise price (down) if Aastrom were to issue or sell new shares of common stock at a lower consideration. They also contained a right that allows the holder to put the warrants back to the company and receive cash in the event of a fundamental transaction, such as a change in control or a sale of all or substantially all of its assets.

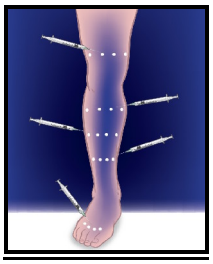
The cashless exercise option, the anti-dilutive reset provision, and the "Black-Scholes put" made these 10 million outstanding December 2010 warrants a noticeable eyesore on Aastrom's capital structure. The existence of warrants also presented the opportunity for warrant holders to hedge with a short stock position. In mid-June 2012, there were 2.66 million shares of Aastrom were held short (6.9% of the float).

Aastrom completed the tender offer on July 30, 2012 converting 9.69 million warrants in exchange for 4.84 million shares of common stock. Removal of 97% of these warrants does four things in our view:

- ✓ Firstly, it removes the future dilution of 4.84 million shares of common stock.
- ✓ Secondly, it removes a meaningful overhead with respect to a change in control. We do not believe Aastrom is "for sale" right now, nor do we think a take-out prior to the release of the phase 3 REVIVE data in late 2014 makes sense for a potential partner. However, the opportunity for a future change in control (exit strategy) should attract new investors to the story now that the "Black-Scholes put" warrants are gone.
- ✓ Thirdly, the removal of the anti-dilutive reset opens the door to future unencumbered financings for the company with these potential new investors. Above we noted $20 million available under an equity distribution agreement (ATM). We think Aastrom has cash to fund operations into the second quarter 2013. We believe the company has cash until April 2013, notwithstanding a partnership or use of the ATM.
- ✓ And finally, it removes the incentive for the warrant holders to enter into a common stock short hedge. As of August 6, 2012, 1.99 million shares of Aastrom were held short (4.7% of the float), down 22% from when Aastrom initiated the tender on the warrants.

We suspect that some of the recent downward pressure on the stock is a result of the warrant exchange. Warrant holders that exchanged into common stock have most likely been exiting their position, essentially taking the free money and moving on. The 4.84 million shares issued as part of the exchange is about 20 times the current three month average daily volume on the stock.

## Phase 3 REVIVE Initiated



On February 29, 2012, Aastrom Bio announced it had begun patient recruitment in its phase 3 clinical trial, REVIVE, designed to assess the efficacy and safety of ixmyelocel-T in the treatment of patients with critical limb ischemia (CLI). REVIVE will be conducted at 80 sites in the U.S. and will include 594 CLI patients who have no option for revascularization, and also have existing tissue loss due to ischemia. REVIVE will be the largest randomized, double-blind, placebo-controlled, multicenter study ever conducted in patients with CLI, larger than Sanofi's failed phase 3 TAMARIS study conducted in 525 patients. In May 9, 2012, Aastrom noted the first patient had been enrolled in the program.

Patients will be followed for a total of 18 months, including 12 months from randomization for efficacy and an additional six months for safety. The primary endpoint of REVIVE is amputation-free survival at 12 months (AFS-12). The trial is being conducted under a Special Protocol Assessment (SPA) from the U.S. FDA. REVIVE has also been granted Fast Track designation for CLI. Secondary endpoints include adverse events at 18 months, wound closure at 12 months, and incidence of major adverse cardiac events (MACE), including myocardial infarction, chest pain hospitalization, or stroke.

***...Statistical Powering Is Key...***

The trial is 90% powered to show superiority of ixmyelocel-T over the control (no cells). Management used an assumed treatment effect of 36% to design the trial (12% numerical separation). We remind investors that in the phase 2b RESTORE program, ixmyelocel-T showed a 62% risk reduction vs. the control (p=0.0032).

For the powering assumptions for REVIVE, management used an event rate for the control group of 34.5%, while expecting that ixmyelocel-T will come in around 22.2%.

**Key Phase 3 Statistical Assumptions**

Pivotal Phase 3 No-option protocol key statistical assumptions
- Ixmyelocel-T AFS event rate – 22.2%
- Placebo/control AFS event rate – 34.5%
- Assumed treatment effect – 36%

| | Amputation and Death Event Rate – RESTORE-CLI* | | | |
|---|---|---|---|---|
| **Treatment Group** | **Interim #1** | **Interim #2** | **Final Analysis** | **Wounds at BL** |
| Ixmyelocel-T | 22% | 25% | 25% | 21% |
| Control | 50% | 29% | 33% | 44% |

We think ixmyelocel-T works. Therefore, the biggest risk we see with REVIVE is control group doing better than management's assumption, which was based on the TAMARIS and RESTORE-CLI studies. We note, however, that during Aastrom's RESTORE-CLI program, at the company's second interim update, the control group event rate (29%) was trending below what was seen after the first interim update (50%). This, essentially, worked itself out by the end of the trial, where the event rate was 33% for the control. It is also the reason why management has instituted a strict entry criteria looking for patients with confirmed tissue loss - a true "no option" population.

Aastrom will have a blinded interim update after the first 297 patients have been enrolled in REVIVE and completed the 6 month follow-up. Management can add patients to the trial based if the overall blinded data is showing an event rate lower than expectations. An overall event rate lower than expect could mean the control is doing better, the treatment group is doing better, or both are doing better than the powering assumptions. We like the fact that management has baked in this blinded look after 297 patients; it provides the ability to enhance the power of REVIVE if necessary. We expect this to take place around the middle of 2013.

We also note at the data safety monitoring board (DSMB) will be monitoring the trial with unblinded data. The DSMB can stop the trial at any time for safety or efficacy reasons. Efficacy reasons can include futility, or clear statistical separation prior to enrolling the 594 patients.

We estimate the cost at around $30 million ($45-50k per patient). We expect that REVIVE will complete enrollment around the middle of 2014. We are expecting data in early 2015. This should put Aastrom in position to file the New Drug Application (NDA) by the middle of 2015, putting U.S. FDA action for the NDA of ixmyelocel-T for CLI around the middle of 2016.

***…Previous Data Supports Our Optimism…***

In November 2011, Aastrom reported the final analysis from the phase 2b RESTORE-CLI trial. The RESTORE-CLI clinical trial assessed the safety and ability of ixmyelocel-T, Aastrom's expanded, bone marrow-derived cellular therapy, to restore damaged tissue in a lower extremity affected by critical limb ischemia (CLI). The results include the final analysis from all 86 randomized patients.

The primary endpoint of RESTORE-CLI was time to first occurrence of treatment failure, defined as major amputation, all-cause mortality, doubling of total wound surface area from baseline, or de novo gangrene. A total of 48 patients were treated with ixmyelocel-T and 24 received a placebo. Adverse event rates in both groups were similar. Patients in the treatment arm showed a 62% reduction in risk relative to placebo in the primary efficacy endpoint of time to first occurrence of treatment failure (p =0.0032) with wounds at baseline resulted in a 77% risk reduction in time to first occurrence of treatment failure (p=0.0002) and a positive trend in the REVIVE endpoint of amputation-free survival (61% risk reduction, p=0.0915).

A post hoc analysis of the subgroup of 45 patients yielded impressive separation between the ixmyelocel-T group and the control. The Rutherford-5 AFS rate for the ixmyelocel-T group was 79%, lower than the AFS rate for the overall ixmyelocel-T population at 75%. Results showed even further separation from the control, which showed an AFS rate of 56%, down from the overall control population at 67%. This is a 61% risk reduction (hazard ratio of 0.391). Results were not statistically significant (p=0.0915), but we note the small sample size of only 45 patients, and remind investors that the phase 3 REVIVE program will be nearly 600 patients. And, we remind investors that Aastrom and the U.S. FDA came to an agreement for a Special Protocol Assessment (SPA) on the REVIVE program in July 2011.

All in all we are pleased with the final results from RESTORE-CLI. We think the trial demonstrates excellent proof-of-concept in patients with no option CLI, especially those with confirmed tissue loss. The design of REVIVE is solid. If Aastrom can reproduce similar results in REVIVE to what was presented at AHA on November 14, 2011, we believe the trial will be successful. Full data from RESTORE-CLI was published in the Journal of Molecular Therapy in March 2012 (doi:10.1038/mt.2012.52).

**Phase 2a DCM Study Encourages**

On May 10, 2012, Aastrom Bio presented the 12-month follow up results from the phase 2a dilated cardiomyopathy (DCM) study at the Society for Cardiovascular Angiography and Interventions (SCAI) Scientific Sessions. The data presentation, entitled "Safety and Efficacy of Ixmyelocel-T, An Expanded Patient-Specific Mixed Cell Therapy, in Dilated Cardiomyopathy" highlighted injection of Aastrom's expanded multicellular therapy using J&J's NOGA/MyoSTAR transendocardial catheter.

***…Design Background…***

The phase 2a program enrolled 22 patients with ischemic or non-ischemic DCM that had no other options available for revascularization (meaning the next available options are surgical – a heart transplant or LVAD). The study took place at three centers all in the U.S. Patients were randomized 2:1 to receive Ixmyelocel-T + standard of care vs. standard of care alone. Below we highlight some of the more important baseline characteristics of these 22 patients:

| | Ixmyelocel-T Group (n=15) | Control (n=7) |
|---|---|---|
| Body Mass Index | 28.8 | 27.5 |
| Ejection Fraction (from echo) | 23.9 | 22.3 |
| NYHA III/IV | 14/1 | 6/0 |
| Ischemic / Non-Ischemic DCM | 9 / 6 | 3 / 4 |

The primary endpoint of the study was safety, with a planned interim analysis conducted when all subjects completed 6 months. There was also a planned final analysis conducted when all subjects completed 12 months, with control patients being able to crossover to the Ixmyelocel-T group after 6 months.

***…Safety Improved…***

As noted above, a total of 22 subjects were randomized. One subject in the control with NIDCM withdrew prior to day-1 so was not included in the safety assessment. One subject in the Ixmyelocel-T group with NIDCM discontinued due to heart failure on day 322.

| | Ixmyelocel-T Group (n=15) | Control (n=7) |
|---|---|---|
| 12 Month Completers | 14 (93%) | 5 (83%) |

Investigators concluded that transendocardial injection of Ixmyelocel-T was well tolerated in patients with DCM. In fact, management noted that the tolerability of the procedure was significantly better than the previous study (IMPACT-DCM) conducted by Aastrom in which patients received the cells via a minithoracotomy. Adverse events were similar between the Ixmyelocel-T and control group, a clear positive considering the control group underwent no transendocardial injection procedure. We strongly feel that use of the NOGA/MyoSTAR transendocardial catheter is the superior delivery option for cell therapy.

Secondary objectives were included to investigate signs of efficacy, including:

- ✓ Major Adverse Cardiovascular Events (MACE) – The key clinical endpoint
- ✓ Cardiopulmonary stress and 6-minute walk – Key functional endpoints
- ✓ Echo and left-ventricle ejection fraction (LVEF) – Key structural endpoints
- ✓ New York Heart Associate (NYHA classification) – Subjective / Quality of Life endpoints

***…Proof-Of-Concept Evident…***

Proof-of-Concept was clearly evident by analyzing the data. Given the small size of the trial, no results are statistically significant, but the signs point to a reduction in MACE and improvement in quality of life measures with Ixmyelocel-T. Also, similar to the IMPACT-DCM results, the data shows an improved outcome for the IDCM patients far greater than for the NIDCM patients. We believe that efficacy observations related to structural and functional end points including major adverse cardiovascular events (MACE), New York Heart Association (NYHA) functional classification, 6-minute walk distance were consistent with improved function of impaired myocardium.

The key clinical endpoint is MACE. Below (Figure-1) is a graphical representation of the Time to First Occurrence of MACE. The results show an observational benefit in favor of the Ixmyelocel-T group, although not statistically significant due to the small number of patients (n=19) completing the study. The data in Figure-2 shows the clear separation of benefit for patients with IDCM verses NIDCM.

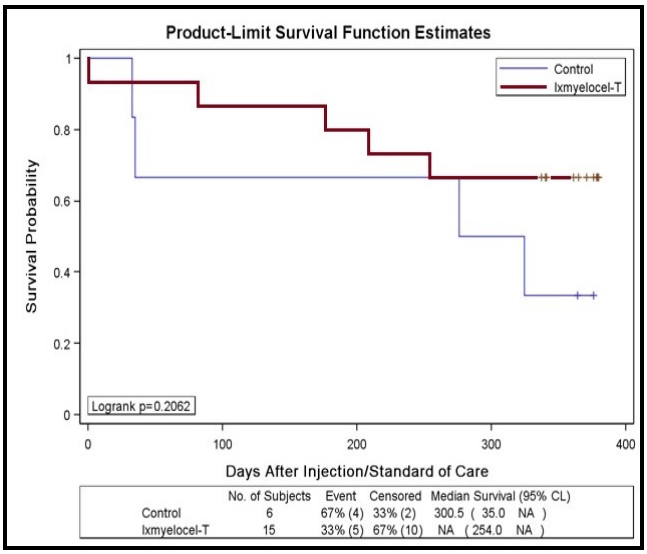



Figure-1

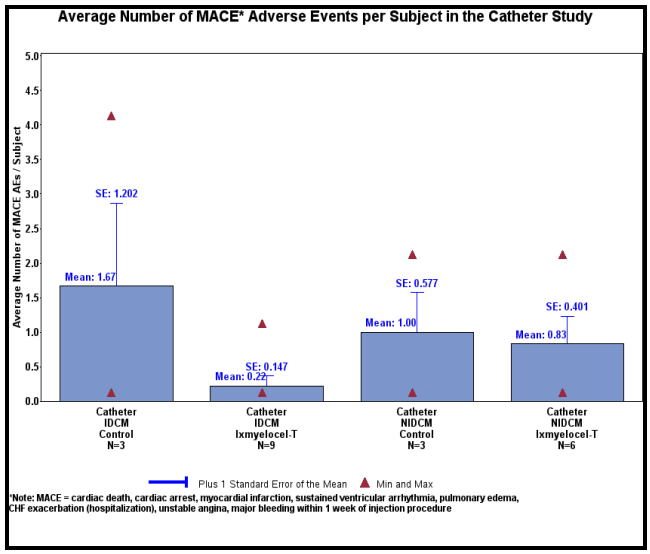



Figure-2

Additional functional and quality of life benefits also trended in favor of the Ixmyelocel-T group, specifically in patients with IDCM. However, no noticeable benefit in ejection fraction was observed in either group.

| | IDCM | NIDCM | Control |
|---|---|---|---|
| **Improvement in NYHA Class…** | | | |
| @ 3 Months | 7 of 9 | 3 of 6 | 0 of 5 |
| @ 6 Months | 7 of 9 | 3 of 6 | 1 of 5 |
| @ 12 Months | 9 of 9 | 2 of 5 | 0 of 5 |
| **Improvement in 6-Minute Walk Test…** | | | |
| @ 3 Month | 8 of 9 | 4 of 6 | 0 of 5 |
| @ 6 Months | 7 of 9 | 5 of 5 | 4 of 5 |
| @ 12 Months | 6 of 9 | 2 of 4 | 1 of 5 |
| **Increase in Echo Ejection Fraction…** | | | |
| @ 3 Months | 4 of 7 | 1 of 6 | 1 of 4 |
| @ 6 Months | 5 of 7 | 2 of 6 | 1 of 4 |
| @ 12 Months | 1 of 5 | 2 of 5 | 2 of 4 |
| **MACE Adverse Events…** | | | |
| Average Per Subject | 0.22 | 1.00 | 1.11 |

***…Phase 2b RENEW To Initiate Very Soon…***

Earlier in the year, Aastrom met with the FDA to outline the design and necessary endpoints for a phase 2b study. Management expects the phase 2b program to begin later this month. In fact, the company has already engaged in clinical site identification, training and initial screen for patient enrollment. The trial, called RENEW, will be randomized, placebo-controlled program using the NOGA/MyoSTAR transendocardial catheter, seeking to enroll about 108 ischemic DCM patients at around 15 to 20 sites all in the U.S. Identifying the right sites and investigators for RENEW will be key to its success.

The primary endpoint of the study will be major adverse cardiovascular events (MACE), with 80% powering for statistical significance. Secondary endpoints are expected to include cardio-pulmonary function through imaging, exercise capacity, 6-minute walk test, and safety. We view this as a “registration quality” study, as the data should give Aastrom – and potential partners – a clear sign on the profile of Ixmyelocel-T before proceeding into phase 3. We expect 12 months to enroll, with top-lie data expected late 2014. We estimate the trial will cost Aastrom around $5 million ($50k per patient).

***…DCM Backgrounder…***

DCM is a condition in which the heart becomes weakened and enlarged, and cannot pump blood efficiently. The expansion of the heart and the decreased function results in poor blood circulation and affect the lungs, liver, and other body systems. In patients with DCM, the left or right ventricular systolic pump function of the heart becomes impaired, leading to progressive cardiac enlargement and hypertrophy, a process called remodeling.

There are an estimated 200k to 250k people living (prevalence) in the U.S. with DCM, with roughly 20,000 new cases (incidence) each year. About one in three cases of congestive heart failure (CHF) is due to DCM. The 1-year survival rate for a patient diagnosed with DCM is roughly 75%. The 5-year survival rate drops to only 30% because many patients with DCM go un-diagnosed until the disease has progressed to the most severe stages.

As a general rule for idiopathic DCM, after 1-year, 1/3$^{rd}$ of patients exhibit improved cardiac function, 1/3$^{rd}$ have stable cardiac dysfunction, and 1/3$^{rd}$ progress to significant cardiac dysfunction. These 1/3$^{rd}$ that progress to severe cardiac dysfunction will require a heart transplant. We remind investors that the FDA has granted Orphan Drug designation to Aastrom for use of its ixmyelocel-T in patients with DCM.

Standard of care for patients with DCM is often to treat secondary co-morbid conditions such as hypertension or renal failure. As such, patients with DCM are often prescribed angiotensin-converting enzyme (ACE) inhibitors, diuretics, beta-blockers, and sometimes digitalis. Anticoagulants may also be used. Artificial pacemakers and left ventricular assist devices (LVADs) may be used in patients with intra-ventricular conduction delay, and implantable cardioverter-defibrillators in those at risk of arrhythmia. These forms of treatment have been shown to improve symptoms and reduce hospitalization. They can cost upward of $75,000 each, and many patients will require re-implantation or an upgraded or new device in a year.

However, for patients with advanced disease who are refractory to medical therapy, cardiac transplantation is the only option. LVAD are commonly known as a "bridge to transplantation". The problem however, and the reason this is such as a significant medical problem, is that only about 2,000 heart transplants are done in the U.S. each year. That means of the estimated 150k NYHA Class III or IV patients with dilation, over 95% will never get a transplant. Accordingly, this is why mortality rates start to rise dramatically after a patient has been diagnosed with DCM.

**Preclinical Studies**

Aastrom has been working diligently, both internally and with outside investigators, to improve its understand of the mechanism of action and market potential for ixmyelocel-T. Earlier in the year, management reported results of preclinical research demonstrating the ability of ixmyelocel-T to protect heart tissue from damage in a murine model of heart failure in a poster presentation at the 18th Annual International Society for Cellular Therapy Meeting.

Just recently, outside investigators at the University of Michigan School of Dentistry and the Michigan Center for Oral Health completed a study in patients who required jawbone reconstruction. The positive results from the clinical trial were recently published in the peer-reviewed journal *Cell Transplantation* and showed that patients receiving ixmyelocel-T tolerated the treatment well, and had greater bone density and quicker bone repair than those who received traditional bone generation therapy.

The majority of investor focus is currently on the phase 3 REVIVE trial. But we think Aastrom's ixmyelocel-T represents a pipeline-product. The RENEW DCM trial should officially initiate by the end of the month, and recent preclinical work suggests that Aastrom's platform has broad application in potentially several new areas of regenerative medicine. We think this presents upside to investors and potential partners.

## RECOMMENDATION & VALUATION

***Remaining Optimistic On Aastrom…***

Now that Aastrom has completed its financing and the REVIVE trial is underway, we see little risks over the near-term. Results at the 12 month period from the DCM catheter program show encouraging results. We think the market is assigning little value to Aastrom for its DCM program. We see the real value driver for the shares following the phase 2b data. In the meantime, we've outlined our belief above that the REVIVE trial has an excellent chance at demonstrating statistical significance. We see the company as well-funded, at least until mid-2013, and we believe that talks on a development and commercialization partnership for Ixmyelocel-T, in CLI, in DCM, or for both, continue. We see a potential major re-valuation of the shares – significantly higher – in 2014 and 2015 on data from the REVIVE and RENEW programs.

We have performed a discounted cash flow (DCF) analysis based on our assumptions for ixmyelocel-T in both CLI and DCM. We arrive at a full value of around $300 million, or $5+ per share. At today's price of only $1.88 per share, Aastrom represents a compelling long-term opportunity. Upside over the near-term may be limited while these trials are only enrolling, but this does not change our view that ixmyelocel-T is a potential blockbuster drug and Aastrom Bio is a core holding in the stem cell industry.

## PROJECTED FINANCIALS

**Aastrom Biosciences**
Income Statement

| *Aastrom Biosciences* | Dec-10 | Dec-11 | Mar-13 | Jun-12 | Sep-12 | Dec-12 | Dec-12 | Dec-13 | Dec-14 | Dec-15 |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2010 A | 2011 A | Q1 A | Q2 A | Q3 E | Q4 E | 2012 E | 2013 E | 2014 E | 2015 E |
| **R&D Agreements / Grants** | **$0.3** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| *YOY Growth* | | *0%* | - | - | - | - | *0.0%* | *0%* | *0%* | *0%* |
| **Product Sales** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| *YOY Growth* | | *0.0%* | - | - | - | - | *0.0%* | *0.0%* | *0.0%* | *0.0%* |
| **Total Revenues** | **$0.3** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** | **$0** |
| *YOY Growth* | | - | - | - | - | - | - | - | - | - |
| Research & Development | $15.1 | $21.3 | $6.8 | $7.1 | $7.6 | $8.2 | $29.7 | $35.0 | $35.0 | $35.0 |
| *% R&D* | | - | - | - | - | - | - | - | - | - |
| Selling, General, and Admin | $6.2 | $7.7 | $1.8 | $2.2 | $2.1 | $2.1 | $8.2 | $8.3 | $8.5 | $8.6 |
| *% SG&A* | | - | - | - | - | - | - | - | - | - |
| Operating Income | ($21.0) | ($29.1) | ($8.6) | ($9.3) | ($9.7) | ($10.3) | ($37.9) | ($43.3) | ($43.5) | ($43.6) |
| *Operating Margin* | | - | - | - | - | - | - | - | - | - |
| Other Income (Expenses) | ($4.7) | $9.4 | ($1.2) | $0.7 | ($0.5) | ($0.5) | ($1.5) | ($2.0) | ($1.5) | ($1.0) |
| Pre-Tax Income | ($25.7) | ($19.7) | ($9.7) | ($8.6) | ($10.2) | ($10.8) | ($39.3) | ($45.3) | ($45.0) | ($44.6) |
| Taxes | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| *Tax Rate* | *0%* | *0%* | *0%* | *0%* | *0%* | *0%* | *0%* | *0%* | *0%* | *0%* |
| Net Income | ($25.7) | ($19.7) | ($9.7) | ($8.6) | ($10.2) | ($10.8) | ($39.3) | ($45.3) | ($45.0) | ($44.6) |
| *Net Margin* | | - | - | - | - | - | - | - | - | - |
| **Reported EPS** | **($0.91)** | **($0.51)** | **($0.25)** | **($0.22)** | **($0.24)** | **($0.25)** | **($0.96)** | **($1.01)** | **($0.95)** | **($0.89)** |
| *YOY Growth* | | - | - | - | - | - | - | - | - | - |
| Weighted Ave. Shares Out | 28.3 | 38.6 | 38.7 | 38.9 | 42.8 | 43.0 | 40.9 | 45.0 | 47.5 | 50.0 |

*Source: Zacks Investment Research, Inc.* *Jason Napodano, CFA*

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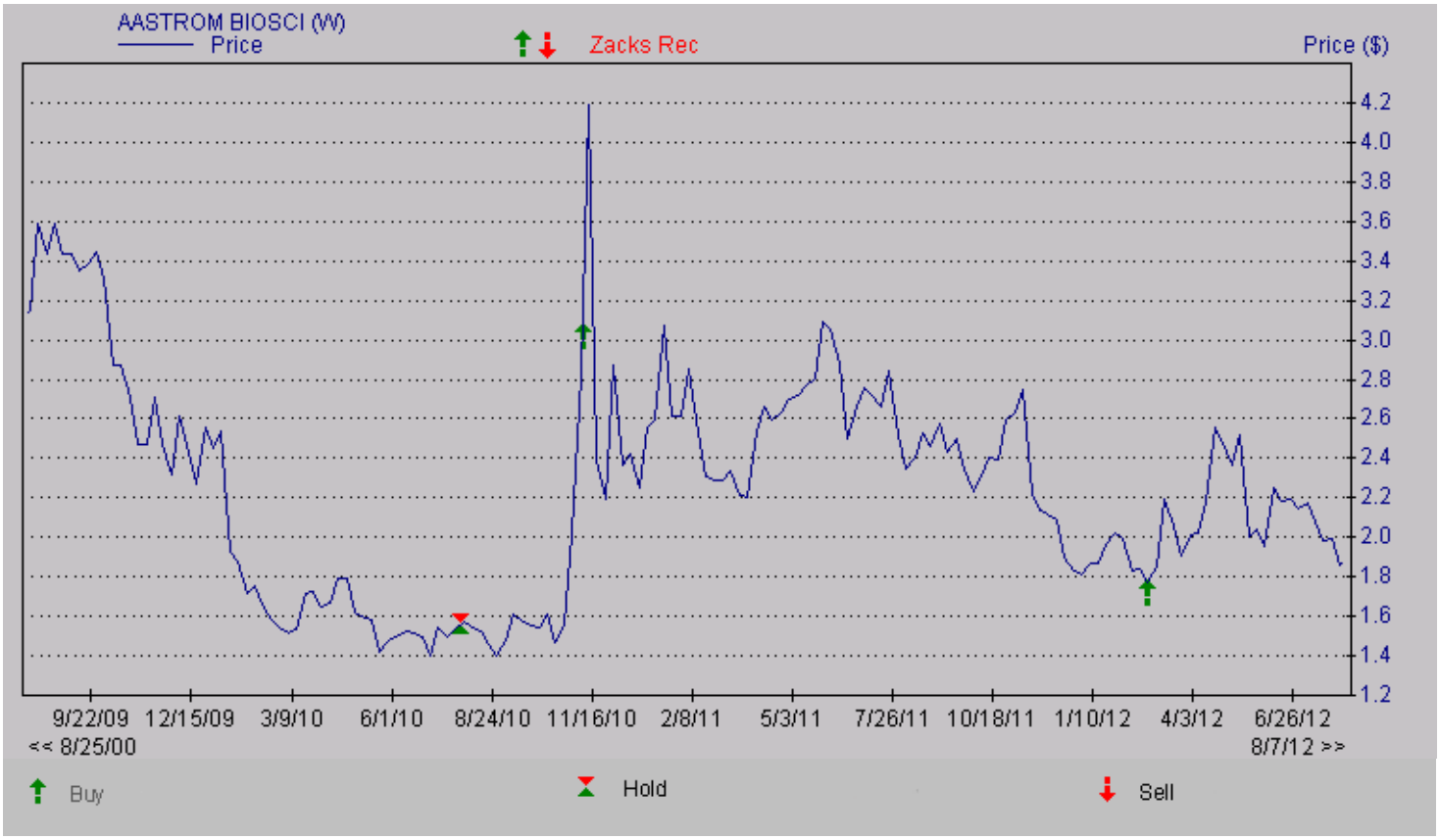
## HISTORICAL ZACKS RECOMMENDATIONS

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