Zacks Small-Cap Research

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MediciNova, Inc. (MNOV - Nasdaq)

MNOV: Presentation on ALS Phase 2 Study in December…

Current Recommendation	**Buy**
Prior Recommendation	N/A
Date of Last Change	05/12/2015
Current Price (11/02/15)	$2.93
Target Price	**$8.00**

UPDATE

On October 30, 2015, MediciNova, Inc. filed form 10-Q with financial results for the third quarter of 2015. The company reported no revenues and had a net loss of $1.6 million, or $0.06 per share. Total cash burn for the quarter was $1.1 million. The company exited the third quarter with $23.6 million in cash, thanks to a public offering in August 2015 that raised gross proceeds of $17.5 million.

In December 2015, an abstract will be presented regarding the ongoing Phase 2 clinical trial of MN-166 in ALS. While we are not exactly certain what will be presented, there is a possibility that we will get a look at interim efficacy data, which could serve as a large catalyst for the stock.

SUMMARY DATA

52-Week High	**$4.96**
52-Week Low	**$2.32**
One-Year Return (%)	**29.10**
Beta	**0.91**
Average Daily Volume (sh)	**94,694**
Shares Outstanding (mil)	**30**
Market Capitalization ($mil)	**$94**
Short Interest Ratio (days)	**1.11**
Institutional Ownership (%)	**8**
Insider Ownership (%)	**27**
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 2015 Estimate	**N/A**
P/E using 2016 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)
2014	0 A	0 A	0 A	0 A	0 A
2015	0 A	0 A	0 A	0 E	0 E
2016					0 E
2017					0 E

Earnings per Share

(EPS is operating earnings before non-recurring items)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2014	-$0.10 A	-$0.09 A	-$0.10 A	-$0.09 A	-$0.38 A
2015	-$0.09 A	-$0.09 A	-$0.06 A	-$0.08 E	-$0.32 E
2016					-$0.39 E
2017					-$0.44 E

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WHAT'S NEW

Financial Update

On October 30, 2015, MediciNova, Inc. (MNOV) filed form 10-Q with financial results for the third quarter of 2015. As expected, the company did not report any revenues for the quarter. Operating expenses for the quarter totaled $1.6 million and were comprised of $0.6 million of R&D and $1.0 million in G&A expenses, compared with $0.9 million in R&D and $1.5 million in G&A expenses for the corresponding time period of 2014. The decrease in R&D expenses was due primarily to less drug supply and manufacturing expense, while the decrease in G&A expense was due primarily to less stock compensation expense for performance options.

Net loss for the third quarter of 2015 was $1.6 million, or $0.06 per share, based on approximately 26.9 million shares of common stock outstanding. Cash burn for the quarter was $1.2 million and the company exited the third quarter of 2015 with approximately $23.6 million in cash and cash equivalents, which we believe is sufficient to fund operations through the end of 2017. The company's cash position was strengthened through a public offering in August 2015 where the company sold 5 million shares of common stock for $3.50 per share and raised gross proceeds of $17.5 million. Importantly, the company disclosed in an 8-K filing that Fidelity Investments (FMR LLC) acquired 3.5 million shares and now owns over 11% of the total number of shares outstanding.

MN-166 Update

MediciNova is developing MN-166 (ibudilast) for the treatment of primary and secondary progressive multiple sclerosis (PPMS and SPMS), amyotrophic lateral sclerosis (ALS), methamphetamine (MA) addiction, opioid dependence, and alcohol dependence. The drug is currently being tested in five separate clinical trials in the aforementioned indications.

MN-166 is an anti-inflammatory drug that has been utilized for over 20 years in Japan to treat asthma (Rolan *et al*., 2009). It acts as a phophodiesterase (PDE) inhibitor (Suzumura *et al*., 1999) and preferentially inhibits PDE-4 (Huang *et al*., 2006). The drug has shown anti-inflammatory activity in both the peripheral immune system and in the CNS via attenuation of glial cells, which play a role in certain neurological conditions. In addition, delivery of a PDE-4 inhibitor was shown to lead to enhanced differentiation of oligodendrocyte progenitor cells within areas of demyelination and a consequent acceleration of remyelination (Syed *et al*., 2013).

Preclinical work performed with MN-166 showed that the compound can suppress neuronal cell death induced by activated microglia (Mizuno *et al*., 2004). MN-166 was shown to suppress the production of TNF-α and IL-6 by microglia as well as enhance the production of the anti-inflammatory cytokine IL-10 and neurotrophic factors such as NGF, GDNF, and NT-4. These data are in agreement with an earlier study of MN-166 in a chronic cerebral hypoperfusion model that showed it could inhibit the activation of microglia cells and prevent the formation of white matter lesions (Wakita *et al*., 2003). This inhibitory effect was shown to be dose dependent and involve the suppression of TNF-α production.

MN-166 for the Treatment of Multiple Sclerosis

Multiple sclerosis (MS) is a chronic autoimmune, inflammatory disease that affects axons in the central nervous system (CNS). There is no single diagnostic test for MS, with diagnosis based on the following criteria: 1) at least two different lesions in the white matter of the CNS, 2) at least two different episodes in the disease course, and 3) chronic inflammation of the CNS as determined by analysis of the cerebrospinal fluid (CSF). Having one or more of these criteria allows a general diagnosis of MS.

The pattern and course of the disease is characterized by the following patterns:

- ⇨ Primary progressive (PPMS): Characterized by disease progression from the onset with occasional plateaus and temporary minor improvements. It makes up approximately 10 percent of cases at onset. Patients typically experience a steady decline in function from the beginning and never have acute attacks. There are no currently approved medications for treating primary progressive MS.

- ⇨ Relapsing remitting (RRMS): Characterized by clearly defined relapses with full recovery. There is no disease

progression during the periods between relapses. This type of MS accounts for approximately 85 to 90 percent of MS cases at onset. However, most patients will then progress into secondary progressive phase.

- ⇨ Secondary progressive (SPMS): Characterized by an initial relapsing-remittance phase followed by progression with or without occasional relapses, minor remissions, and plateaus. Studies suggest that approximately 50% of patients with relapsing-remitting MS will go on to develop secondary progressive MS.

- ⇨ Progressive relapsing (PRMS): Characterized by progressive disease from the onset, with clear acute relapses, with or without full recovery. Disease progression continues to occur during the periods between disease relapses.

MN-166 was previously tested in a randomized, double blind, placebo controlled Phase 2a clinical trial to evaluate its safety and effectiveness in MS patients. The primary outcome of the study was the cumulative number of newly active lesions seen on bimonthly MRI scans over the first 12 months of treatment. Secondary outcomes included the time to first exacerbation, number of relapses, and annualized relapse rate over 12 months, and the cumulative volume of Gd-enhancing lesions over 12 months. The results showed that there was no difference in the number of newly active lesions or in the cumulative volume of Gd-enhancing lesions between treatment arms. Thus, MN-166 did not appear to have an effect on overt inflammation leading to a suppression of disease activity. However, MN-166 may exert a neuroprotective effect. A preplanned evaluation of brain atrophy showed a statistically significant dose-dependent decrease in atrophy progression in the 60-mg MN-166 group (mean -0.79) compared to placebo (mean -1.20, $P = 0.04$) after only one year of treatment.

Based on the results of the Phase 2a study, investigators from NeuroNEXT, an NIH funded clinical trial network that conducts studies of treatments for neurological diseases, have initiated the SPRINT-MS trial; a Phase 2b trial evaluating MN-166 in PPMS and SPMS patients titled **"**A Randomized, Double-Blind, Placebo-Controlled Study to Evaluate the Safety, Tolerability and Activity of Ibudilast (MN-166) in Subjects with Progressive Multiple Sclerosis" (NCT01982942).

The study is planning to enroll 250 individuals from 21 to 65 years of age and consists of a screening phase of up to 30 days followed by a treatment phase of 96 weeks and a follow up visit one month after the week 96 visit. Patients will receive either MN-166 (100 mg/day) or placebo twice a day (e.g., MN-166 50 mg or placebo taken once in the morning and once at night). The company recently announced that the trial is now fully enrolled and we estimate an interim analysis will take place in the second half of 2016 and the final results of the trial will be available in the second half of 2017. The primary outcome of the study is the rate of change in brain atrophy over 96 weeks as measured by brain parenchymal fraction (BPF) using MRI.

Market Opportunity in MS

MS affects approximately 400,000 people in the U.S. (Tullman, 2013) and 700,000 people in the EU (European MS Platform). Approximately 10% of MS patients have the primary progressive form while approximately 85-90% are initially diagnosed with the relapse-remitting form (RRMS). Approximately 50% of those diagnosed with RRMS will go on to develop SPMS, although they still may suffer from relapses.

At the present time there are no approved medications for treating PPMS, however Roche recently announced positive clinical trial results with ocrelizumab in a Phase 3 clinical trial of patients with PPMS. Although they are not approved for SPMS (except for mitoxantrone), all of the medications approved to treat RRMS may be used off label in patients who have progressed to SPMS. For example, if a RRMS patient is taking a beta interferon they are likely to stay on treatment even after they have progressed to SPMS, at least until it is determined that the medication is no longer working. At that time, the patient may transition to Merck-KGa's Novantrone® (mitoxantrone), the only FDA approved medication specifically for the treatment of SPMS. However, as per the label, the cumulative lifetime dose is limited to 2-3 years of treatment. In practice, very few patients actually take this medication due to its potential for cardiotoxicity.

In the following figure we have compiled a list of the top selling MS medications and their total sales for 2014. Each of these medications is approved for treating RRMS, and given the fact that half of RRMS patients go on to develop SPMS, there is an enormous market opportunity for an effective SPMS drug to become a blockbuster medication.

Company	Product	WW 2014 Sales (Millions)	YoY Growth
Biogen	Tecfidera	$2,909	232%
Biogen	Tysabri	$1,960	39%
Biogen	Avonex	$3,013	0%
Novartis	Gilenya	$2,477	28%
Merck Serono	Rebif	$2,445	-3%
Sanofi	Aubagio	$575	160%
Bayer	Betaseron	$1,088	-21%
Copaxone	Teva	$4,237	-2%
	TOTAL	$18,704	

Source: Company reports / Zacks SCR (Bautz)

MN-166 for the Treatment of ALS

Amyotrophic lateral sclerosis (ALS) is a rapidly progressing neurodegenerative disease whereby the nerve cells in the brain and spinal cord that control muscle movement degenerate. This rapid degeneration of the motor neurons eventually leads to death, typically in three to five years after patients are first diagnosed. As the motor neurons cease to function properly, they can no longer send signals to the muscle fibers, and thus voluntary muscle action is progressively affected. Eventually, patients in later stages of the disease may become completely paralyzed which includes losing the ability to control their breathing. In the U.S., approximately 30,000 people are currently living with ALS.

The rate at which the disease progresses varies from patient to patient and is measured utilizing a scoring system called the "ALS Functional Rating Scale Revised" (ALSFRS-R) (Cedarbaum *et al*., 1999). This scoring system consists of a series of 12 questions on basic tasks (speech, salivation, swallowing, handwriting, cutting food, dressing and hygiene, turning in bed, walking, climbing stairs, dyspnea, orthopnea, and respiratory insufficiency) that are rated on a five-point scale where 0 = can't do and 4 = normal ability. The individual items are summed to produce a score of between 0 = death and 48 = best.

There is only one drug approved by the FDA for the treatment of ALS. Sanofi's Riluzole® (rilutek) has been shown to improve survival, but only for two to three months. The compound works by preferentially blocking tetrodotoxin (TTX)-sensitive sodium channels that are associated with damaged neurons (Song *et al*., 1997). Rilutek does not reverse damage already done to motor neurons, and people taking it must be monitored for liver damage (approximately 10% incidence). Sales of Riluzole® peaked at around $50 million per year. It is now available as a generic.

The remaining treatments for ALS are designed to relieve symptoms and improve quality of life. This supportive care includes a multidisciplinary approach that may include medications to reduce fatigue, control spasticity, reduce excess saliva and phlegm, limit sleep disturbances, reduce depression, and limit constipation. However, none of these treatments reduces disease progression or addresses the underlying cause of the disease.

In September 2014, MediciNova initiated a Phase 2 study of MN-166 in patients with ALS (NCT02238626). This is a single center, randomized, double blind, placebo controlled six-month study to evaluate the safety, tolerability, and clinical responsiveness of MN-166 (60 mg/day) when administered as an adjunct to riluzole (100 mg/day) in 60 subjects with ALS. Patients in the study will be randomized 2:1 to receive either MN-166 or placebo. The study will consist of a three month screening phase, a six-month double blind treatment phase, and an open label six-month phase and is taking place at the Carolinas Healthcare System in Charlotte, NC. The primary endpoint of the study is the safety and tolerability of MN-166 when administered with riluzole in ALS patients. A number of secondary endpoints are being evaluated including change in ALSFRS-R, respiratory function, muscle strength, and non-invasive ventilation.

On April 21, 2015, MediciNova announced positive interim safety data from the study that showed no difference in safety or tolerability between MN-166 and placebo in the first 21 subjects enrolled in the study following three months of treatment. Importantly, the independent safety medical monitor recommended that the study continue as planned. In February 2015 the company announced the enrollment of 30 of the 60 patients for the trial.

On September 2, 2015, MediciNova announced that the first ALS patient using non-invasive ventilation (NIV) was enrolled in the company's ongoing Phase 2 clinical trial of MN-166 (NCT02238626). As ALS progresses, the muscles that control breathing become weaker, which leads to impairment of breathing function and an increased susceptibility for lung infections. In addition, patients may experience shortness of breath, fatigue, sleep apnea, and weakened cough. NIV is administered through a removable face mask that is placed around the nose and mouth and is utilized by ALS patients that can still breathe on their own but are beginning to experience the

aforementioned effects of decreased breathing capabilities. The use of NIV typically signifies that a patient is more advanced in the course of the disease than a patient not using NIV.

MediciNova amended the clinical protocol to allow for the recruitment of 60 patients with advanced ALS using NIV in addition to the already planned recruitment of 60 patients with ALS that are not using NIV. Since the trial is now enrolling both NIV and non-NIV patients, we are unsure of when enrollment will be completed. We do anticipate that the two sets of patients (non-NIV and NIV) will be evaluated separately, thus depending upon the rate of enrollment, we are hopeful that the data for the non-NIV patients will be available in 2016, with the data for the NIV patients most likely not available until 2017.

The 26th International Symposium on ALS/MND (amyotrophic lateral sclerosis/motor neuron disease) is taking place December 11-13, 2015 in Orlando, FL. The company has announced that an abstract concerning the ongoing Phase 2 clinical trial of MN-166 in ALS will be presented at the meeting along with preclinical data showing that MN-166 is effective in two drosophila melanogaster models of ALS. At a minimum we expect an update on safety data from the Phase 2 trial, however how much clinical data will be presented is currently unknown. We look forward to reviewing whatever data is presented at the meeting and believe that any positive data presented could be a major catalyst for the stock.

Market Opportunity in ALS

ALS is diagnosed in approximately 5,600 people in the U.S. every year and there are an estimated 30,000 patients who are currently living with the disease. With the cost to care for a patient with advanced stage disease estimated to be as high as $200,000, this represents a direct cost of more than $6 billion each year to the healthcare system.

As mentioned previously, there are very limited treatment options for patients with ALS. Riluzole is the only FDA approved medication shown to slow the progress of ALS. Prior to loss of patent exclusivity, Rilutek® cost approximately $12,000 per year and had sales peak in 2012 of $50 million. This suggests that around 4,200 ALS patients were taking Rilutek® in 2012, or around 15% of the entire U.S. ALS population. Both baclofen and diazepam are used to control muscle spasms, stiffness, or tightening that interfere with daily activities. Trihexyphenidyl and amitriptyline are used to treat patients who have excess saliva and secretions as well as emotional changes. None of the aforementioned drugs alters the course of the diseases.

ALS is a highly complex disease that has multiple pathways of degeneration. Previous ALS drug development efforts have typically focused on one specific mechanism of action, and those have largely been met with failure. MediciNova is attempting to exploit the neuroprotective actions of MN-166 as well as the compounds ability to induce production of neurotrophic factors, which are specialized proteins that promote neuron growth, differentiation, and survival. Given the limited treatment options and high costs associated with patient care, we believe an effective ALS treatment would command a premium price, possibly as high as $100,000 per patient per year. Conservatively assuming that only one-third of ALS patients took the drug (10,000 patients), this would generate sales of $1.0 billion per year.

MN-001 Update

MN-001 is a novel, orally available small molecule compound that works through several mechanisms to produce anti-fibrotic and anti-inflammatory effects in preclinical models. The compound is a leukotriene (LT) receptor antagonist, a PDE inhibitor (mainly 3 and 4), and also inhibits 5-lipoxygenase (5-LO). The 5-LO/LT pathway is though to be a pathogenic factor in fibrosis development (Zeldin *et al*., 2002). Previously, the company had tested MN-001 as a treatment for asthma and completed a Phase 2 study with positive results. The compound has been tested in over 600 subjects and was considered generally safe and well tolerated.

Medicinova has recently announced clinical trial details for MN-001 in the treatment of both idiopathic pulmonary fibrosis (IPF) and nonalcoholic steatohepatitis (NASH).

IPF: The study will be a single center, randomized, placebo controlled, double blind 6-month study followed by a 6-month open-label extension phase to examine the safety and efficacy of MN-001 in moderate to severe IPF patients (NCT02503657). The drug will be administered twice daily at 750 mg per dose over a 26-week period. The study is expected to enroll 15 patients that will be randomized 2:1 to receive MN-001 or placebo. After the 26-week double-blind period, there will be a 26-week open label extension phase where patients who received placebo will be administered drug and those who previously received drug will be allowed to stay on treatment. The primary outcome of the study is change from baseline in forced vital capacity (FVC) at 26 weeks, a measure of lung function. There are a number of secondary outcomes including safety and tolerability of MN-001 and various

measures of the rate of decline in disease activity. We anticipate results from the double-blind portion of the study to be available in the first half of 2017.

NASH: The Phase 2 trial will be a single center, proof-of-concept, open label study designed to evaluate the efficacy, safety, and tolerability of MN-001 in NASH patients with hypertriglyceridemia. Approximately 20 patients between the ages of 21 and 65 with a histologically confirmed diagnosis of NASH within 6 months prior to the baseline visit and an elevated serum triglyceride level (> 150 mg/dL) will be enrolled. Patients will be given 250 mg MN-001 orally once a day for the first 4 weeks and then 250 mg twice a day for an additional 8 weeks. The study timeline consists of a 4 month screening phase followed by a 12 week treatment phase and a follow-up visit one week after the last dose. The primary endpoints of the study are to evaluate the effect of MN-001 on triglyceride levels and cholesterol efflux capacity in NASH subjects with hypertriglyceridemia. Secondary endpoints include safety and tolerability of MN-001, pharmacokinetic profile of MN-001/MN-002 (a metabolic by-product of MN-001), effects of MN-001 on high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C), and total cholesterol level, and effects of MN-001/002 on liver enzymes and percent fat in liver assessed using MRI at week 12.

In April 2015, the company announced the FDA had granted Fast Track Designation for MN-001 for the treatment of NASH patients with fibrosis. Then, in September 2015, the company announced the FDA had granted Fast Track Designation for MN-001 for the treatment of IPF. Fast Track designation is given to drugs that are intended for the treatment of a serious or life-threatening disease or condition and that demonstrate the potential to address unmet medical needs for the disease or condition. Importantly, a company with a drug that receives Fast Track designation may be eligible for some or all of the following:

- Increased interactions with the FDA to discuss the drug's development plan and ensure collection of appropriate data needed to support approval.
- Accelerated Approval - approval based on an effect on a surrogate, or substitute endpoint reasonably likely to predict clinical benefit, or on a clinical endpoint that can be measured earlier than irreversible morbidity or mortality.
- Priority Review - with an FDA goal for completing review within six months of submission.
- Rolling Review - which means that a sponsor can submit completed sections of its New Drug Application (NDA) for review by the FDA, rather than waiting until every section of the application is completed before the entire application can be reviewed.

The FDA had previously granted MN-001 Orphan Drug Designation for the treatment of IPF. Orphan drug designation carries a number of incentives for the company, including increased feedback from the FDA regarding clinical trial design, seven years of market exclusivity following approval for the treatment of IPF, tax credits, and a waiver of PDUFA fees.

Conclusion and Recommendation

In addition to targeting ALS and MS, MN-166 is also currently being tested as a treatment for various addiction disorders. Earlier in 2015, the company announced positive results in the treatment of both heroin addicts and those with alcohol dependence. The treatment of MS and ALS are both blockbuster opportunities for the drug, with potential peak sales of $5 billion for MS and $2.5 billion for ALS. We are intrigued that the ALS study has been expanded to include patients that are further along in the course of their disease. While we are unsure if this is due to a trend developing in the unblinded data from patients not using NIV, we may learn more when available data from the study is presented in December 2015. IPF and NASH represent additional multi-billion dollar market opportunities, and we anticipate Phase 2 clinical trials initiating for those indications in 2016.

With the recent financing, MediciNova is perhaps moving away from the strategy the company had been employing of using investigator-sponsored early-stage clinical trials for testing the company's compounds, as opposed to financing larger studies. While we think the company will always be open to working with investigators who acquire government or private funding, now that the company has approximately $23 million in cash there are many more options available for moving the company's assets through clinical testing in a timely manner. Upcoming catalysts include the presentation on the ALS study in December 2015, the initiation of clinical trials for MN-001 in IPF and NASH, and the interim data from the MS study in the second half of 2016. Our probability adjusted discounted cash flow model gives a target price of $8 per share, and with multiple clinical studies both underway and set to be initiated in large target markets, we believe the stock is currently undervalued and we are maintaining a 'Buy' rating.

PROJECTED FINANCIALS

MediciNova Inc.
Income Statement

MediciNova, Inc.	2014 A	Q1 A	Q2 A	Q3 A	Q4 E	2015 E	2016 E	2017 E
MN-166 (Multiple Sclerosis)	$0	$0	$0	$0	$0	$0	$0	$0
YOY Growth	-	-	-	-	-	-	-	-
MN-166 (ALS)	$0	$0	$0	$0	$0	$0	$0	$0
YOY Growth	-	-	-	-	-	-	-	-
MN-166 (Addiction)	$0	$0	$0	$0	$0	$0	$0	$0
YOY Growth	-	-	-	-	-	-	-	-
MN-001 (NASH)	$0	$0	$0	$0	$0	$0	$0	$0
YOY Growth	-	-	-	-	-	-	-	-
MN-001 (IPF)	$0	$0	$0	$0	$0	$0	$0	$0
YOY Growth	-	-	-	-	-	-	-	-
Grants & Collaborative Revenue	$0	$0	$0	$0	$0	$0	$0	$0
YOY Growth	-	-	-	-	-	-	-	-
Total Revenues	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth	-	-	-	-	-	-	-	-
Cost of Sales	$0	$0	$0	$0	$0	$0	$0	$0
Product Gross Margin	-	-	-	-	-	-	-	-
Research & Development	$3.260	$0.720	$0.797	$0.587	$0.900	$3.003	$5.000	$7.000
General & Administrative	$5.963	$1.495	$1.480	$1.007	$1.600	$5.583	$8.000	$10.000
Other Expenses	$0	$0	$0	$0	$0	$0	$0	$0
Operating Income	($9.223)	($2.215)	($2.277)	($1.594)	($2.500)	($8.586)	($13.0)	($17.0)
Operating Margin	-	-	-	-	-	-	-	-
Non-Operating Expenses (Net)	$0.028	$0.00	($0.01)	($0.01)	($0.01)	($0.03)	($0.5)	($0.5)
Pre-Tax Income	($9.195)	($2.212)	($2.285)	($1.607)	($2.510)	($8.614)	($13.5)	($17.5)
Income Taxes Paid	$0	$0	$0	$0	$0	$0	$0	$0
Tax Rate	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*
Net Income	**($9.195)**	**($2.215)**	**($2.287)**	**($1.608)**	**($2.510)**	**($8.614)**	**($13.5)**	**($17.5)**
Net Margin	-	-	-	-	-	-	-	-
Reported EPS	**($0.38)**	**($0.09)**	**($0.09)**	**($0.06)**	**($0.08)**	**($0.32)**	**($0.39)**	**($0.44)**
YOY Growth	-	-	-	-	-	-	-	-
Basic Shares Outstanding	24.068	24.539	24.828	26.932	30.000	26.574	35.000	40.000

Source: Zacks Investment Research, Inc. *David Bautz, PhD*

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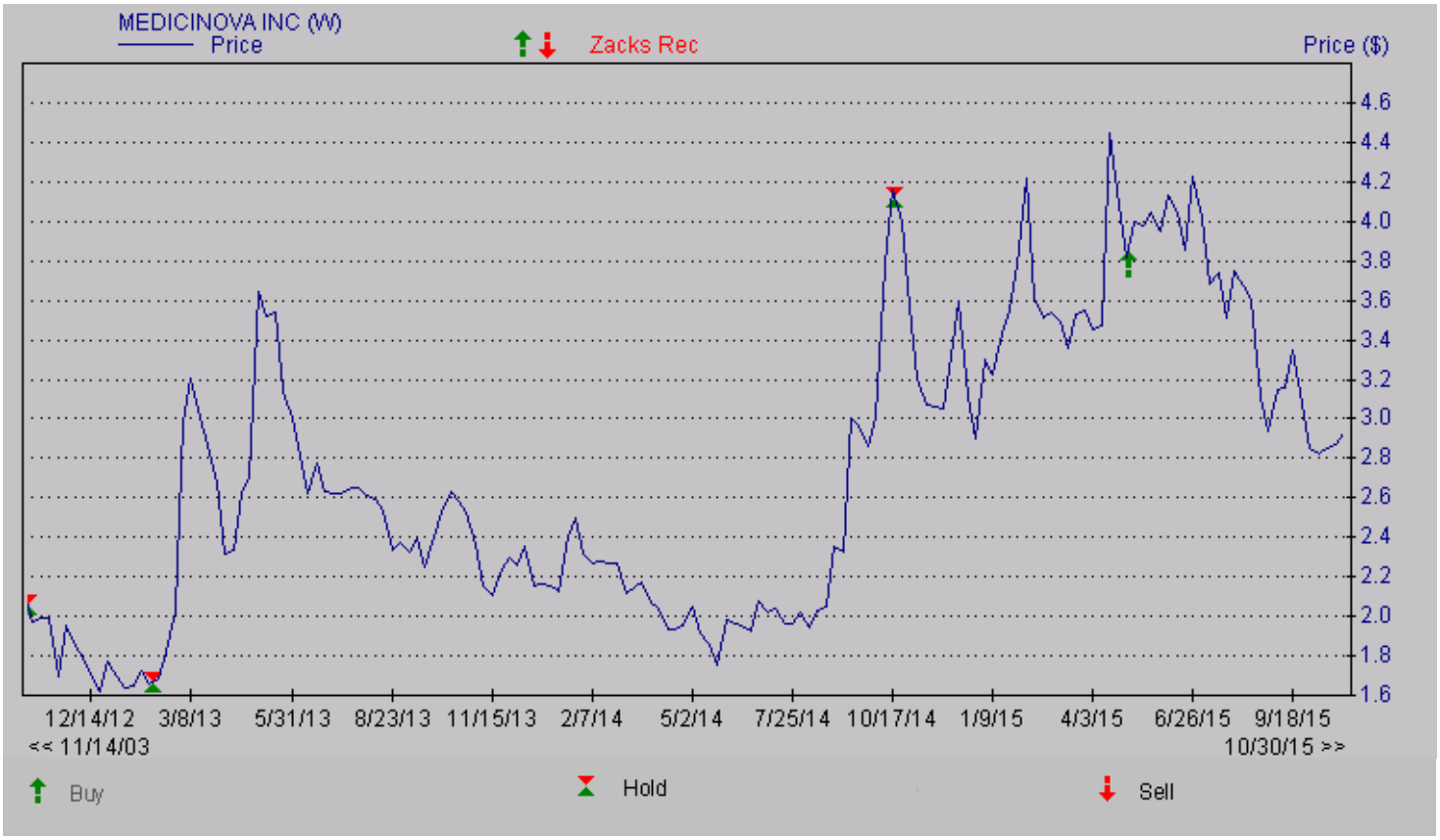
HISTORICAL ZACKS RECOMMENDATIONS



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Buy/Outperform: The analyst expects that the subject company will outperform the broader U.S. equity market over the next one to two quarters.
Hold/Neutral: The analyst expects that the company will perform in line with the broader U.S. equity market over the next one to two quarters.
Sell/Underperform: The analyst expects the company will underperform the broader U.S. Equity market over the next one to two quarters.

The current distribution is as follows: Buy/Outperform- 26.2%, Hold/Neutral- 54.3%, Sell/Underperform – 16.0%. Data is as of midnight on the business day immediately prior to this publication.