Zacks Equity Research

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Jason Napodano, CFA
312-265-9421
jnapodano@zacks.com

111 North Canal Street, Chicago, IL 60606

Aastrom Biosciences, Inc. (ASTM-NASDAQ)

ASTM: Positive Top-Line RESTORE-CLI Data Provides Roadmap for Phase 3…

Current Recommendation	**Outperform**
Prior Recommendation	Neutral
Date of Last Change	11/08/2010
Current Price (06/02/11)	$3.07
Target Price	**$6.00**

UPDATE

We remain big fans of Aastrom Bio. Top-line results from the RESTORE trial re-enforce our belief that Ixmyelocel-T has blockbuster potential in CLI. We are meaningfully more confident in the outcome of the phase 3 REVIVE study now than after the 2nd Interim update from RESTORE, which turned out to be a premature analysis. We believe once investors see the full data at AHA in November 2011, significant enthusiasm will return to the name.

We see Aastrom as packed with catalysts over the next 6 months and we reiterate our Outperform rating. We are increasing our target on the stock to $6 per share. We believe the stock can get to this level by the end of the year.

SUMMARY DATA

52-Week High	**$4.20**
52-Week Low	**$1.40**
One-Year Return (%)	**93.63**
Beta	**-0.08**
Average Daily Volume (sh)	**855,591**
Shares Outstanding (mil)	**39**
Market Capitalization ($mil)	**$117**
Short Interest Ratio (days)	**6.60**
Institutional Ownership (%)	**11**
Insider Ownership (%)	**2**
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 2011 Estimate	**N/A**
P/E using 2012 Estimate	**N/A**
Zacks Rank	**1**

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)
2010	0 A	0 A	0 A	0.3 A	0.3 A
2011	0 A	0 E	0 E	0 E	0 E
2012					0 E
2013					0 E

Earnings per Share

(EPS is operating earnings before non-recurring items)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2010	-$0.10 A	-$0.13 A	-$0.21 A	-$0.44 A	-$0.91 A
2011	-$0.13 A	-$0.16 E	-$0.19 E	-$0.22 E	-$0.71 E
2012					-$0.68 E
2013					-$0.51 E

Zacks Projected EPS Growth Rate - Next 4 Years % **N/A**

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WHAT'S NEW

Positive Top-Line RESTORE-CLI Data

On June 1, 2011, Aastrom Bio reported final top-line results 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 (72 of which completed 12 months) in the trial. The trial met its primary safety and efficacy endpoints, demonstrating a statistically significant improvement in the time to first occurrence of treatment failure (TTF) at 12 months. TTM is a composite endpoint that includes four components:

- ✓ Major amputation of the treated leg
- ✓ All-cause mortality
- ✓ Doubling of wound size from baseline
- ✓ De novo gangrene

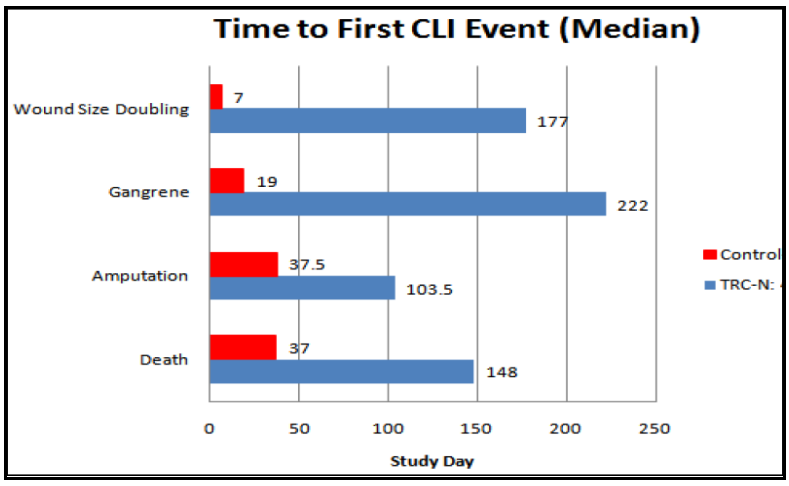
Management has not released the actual numbers or statistical significance. This is to preserve the data for presentation at a major medical meeting in the fourth quarter 2011 and publication in a peer-review journal. We understand that this may anger shareholders, but we can confirm that this has become standard practice, especially in a potential blockbuster indication with a revolutionary new therapeutic platform like ixmyelocel-T. Management wants to enroll patients at the best academic and private centers around the country with the best key opinion leaders and clinical investigators available. Unfortunately, to get these talented people and top-notch centers, Aastrom needs to promise them recognition in the ability to publish and present the data. We expect Aastrom will present the full data at the American Heart Association (AHA) meeting in November 2011.

We remind investors that we have already seen two interim updates from this program, the first in February 2010 and the second in October 2010. Data from the second interim update was presented at the VEITHsymposium in November 2010 by the principal investigator, Dr. Richard Powell. This data included an analysis of all 72 patients that completed six months in the study and 62 patients that completed all 12 months.

The composite endpoint of TTF was highly statistically significant after the 2nd interim update:

2nd Interim Update	Ixmyelocel-T (n=48)	Control (n=24)	
Treatment Failure	42%	63%	*p = 0.0132*

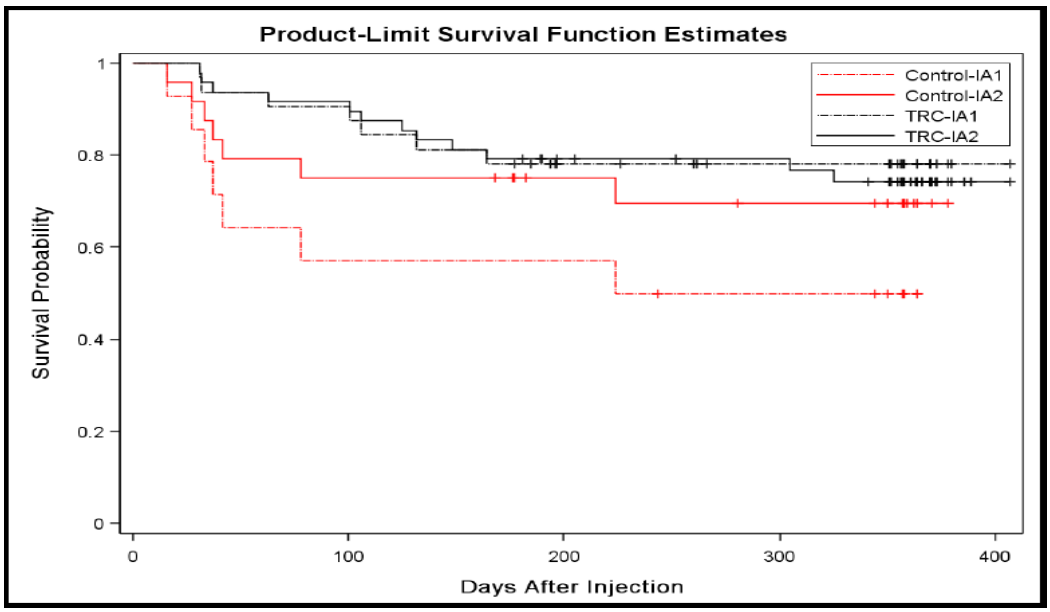
As were each of the individual components:



Conclusion ➔ For the final results, on all 72 patients at 12 months, management noted that statistical significance increased between the Ixmyelocel-T group and the control group, meaning we should see the final p-value less than the 0.0132 reported for the second interim update.

During the conference call, management noted that tissue loss (double size) and de novo gangrene are the two biggest predictors of future amputation. In fact, patients with increased tissue loss and gangrene are 5X more likely to experience a major amputation than patients with stable disease. It is clear to us that Aastrom (and the FDA) are looking at tissue loss as a key enrollment criteria for the phase 3 trial. The delicate balance for management will be finding patients that are clearly "no option" with confirmed tissue loss, but are not so far gone that amputation is a foregone conclusion. Aastrom must find "no option" patients that can be saved by Ixmyelocel-T. This is the reason that the company will employ an independent steering committee of outside physicians who have direct experience with CLI programs to help oversee and monitor the phase 3 trial. Aastrom will also utilize a centralized review committee comprised of experienced vascular surgeons to monitor patients and set a standardized disease progression and amputation criteria.

Investors know the primary endpoint for the planned phase 3 REVIVE-NO trial will be amputation free survival at 12 months (AFS-12). This is a composite endpoint of major amputation and all-cause mortality. The phase 2b RESTORE trial was not powered for statistical significance on this endpoint. However, what management noted is that the outcome of the Ixmyelocel-T group was consistent with what we saw after the 1st and 2nd interim update – represented by the black lines below. We expect the final AFS-12 numbers for Ixmyelocel-T to come in around 75%. For the control group, management noted that the event rate (1 – AFS-12) was consistent with what has been reported in previous literature (~35%) and what was seen in Sanofi's phase 3 TAMARIS trial (~33%). This is consistent with what Aastrom saw in the 1st interim update represented by the dotted red line below.



…Estimated Final Results on AFS-12…

Parameter	TRC (n=48)	Control (n=24)	
Amputation Free Survival @ 12-Months	~ 75%	~ 65%	*p = ?*

Conclusion ➔ We do not know what the final numbers will look like, but our best guess is above based on what management said on the call. With only 72 patients, the results may not be statistically significant. However, we remind investors that the phase 3 REVIVE-NO trial will seek to treat 500 patients. If Aastrom can show this 10% difference between the treatment and control group in a 500+ patient trial, the numbers will absolutely be statistically significant. We note that Dr. William R. Hiatt, MD, Novartis Foundation endowed professor for cardiovascular research at the University of Colorado School of Medicine and president of CPC Clinical Research, who was the lead investigator in Sanofi's TAMARIS study, believes the results clinically meaningful.

Full final data from RESTORE-CLI will be presented at a medical meeting in the fourth quarter 2011, most likely at the American Heart Association (AHA) meeting in November. We are expecting to see all the statistical analysis and number on each component of TTF and AFS-12 at that time, as well as subset analysis, including the differences between Rutherford 4 and 5 patients.

Although we are disappointed we do not get to see the final data until November 2011 at AHA, we are very pleased with the things management is saying regarding the final analysis. We are expecting Aastrom to announce it has reached a special protocol assessment (SPA) with the U.S. FDA for REVIVE-NO, the "no option" phase 3 trial, within the next few weeks. The trial should start shortly thereafter. We remind investors that the U.S. FDA has granted Ixmyelocel-T Fast Track development status for this program.

The Phase 3 REVIVE

REVIVE-NO: This program will seek to treat 500 patients with severe CLI. These "no option" patients must have confirmed tissue loss and disease progression to qualify for enrollment. These will be primarily Rutherford 5 patients. We expect the primary endpoint of the program to be amputation-free survival at 12-months (AFS-12). Other endpoints will include major amputation, de novo gangrene, wound size, and all cause mortality. Management has taken a number of steps to improve the trial design compared to the phase 2b RESTORE trial.

1) Aastrom will employ an independent steering committee of outside physicians who have direct experience with CLI programs to help oversee and monitor the trial.
2) Aastrom will utilize a centralized review committee comprised of experienced vascular surgeons to monitor patients and set a standardized disease progression and amputation criteria.
3) Management has established rigorous entry criteria to help standardize the baseline characteristics of each "no option" patient. This establishes a second layer of qualification beyond the treating physician.
4) To limit geographical variability and standard of care variability, the trial will be conducted at approximately 80 sites in only the U.S.

We expect this trial to begin enrollment around the middle of the year. We expect that Aastrom may need to screen as many as 700 patients in order to enroll (treat) the target 500 number. The trial should take 15 to 18 months to complete. Based on the outcome of the phase 2b RESTORE-CLI trial, we are feeling very confident in REVIVE-NO

In late May 2011, Aastrom announced a collaborative agreement with CPC Clinical Research (CPC), a non-profit, academic research organization led by William Hiatt, M.D. CPC will provide services related to the execution of REVIVE. CPC will manage and oversee the activities of the Eligibility Review Committee, which will be responsible for identifying and confirming the eligibility of no-option and poor option patients for participation in the REVIVE clinical trials. They will also provide wound core laboratory services. In addition to his role as president of CPC, Dr. Hiatt is the Novartis Foundation endowed professor for cardiovascular research at the University of Colorado School of Medicine, Division of Cardiology, with a clinical focus in vascular medicine. He also serves on the editorial board of the Journal of Vascular Medicine, and has received many awards of excellence including the Julius H. Jacobson II, MD Physician Excellence Award from the Vascular Disease Foundation. Dr. Hiatt was a principle investigator in Sanofi's phase 3 TAMARIS study.

REVIVE-POOR: This program remains somewhat of a wildcard. We expect management will seek to treat 200 patients with moderate CLI. These "poor option" patients will have disease progression with a clear path toward amputation. These will be primarily Rutherford 4 patients. Conversations around the primary endpoint here are ongoing. We believe the FDA wants to see AFS-12 as the primary endpoint. Management is hoping to include revascularization or MALEFS (major adverse limb event free survival) as an endpoint. In the end, we expect Aastrom and the FDA to come to an agreement on a hybrid-AFS-12 endpoint that includes some aspects of revascularization or MALEFS for secondary analysis.

In total, REVIVE will seek to treat (mITT) 700 patients total. That means the ITT number may be 100-150 patients higher. However, as long as the randomization between placebo and test group is in-place, it should have no effect on the statistical outcome.

Market Remains Wide Open

The total cost should be roughly $25 million, or $30-40k per patient. We note this is relatively inexpensive for a pivotal phase 3 program. The design and costs are more in-line with a medical device than a small molecule pharmaceutical. In late October 2010, Aastrom Bio signed a new strategic manufacturing partnership with ATEK Medical. ATEK will supply the disposable cassettes used during the cell therapy procedure. The relationship puts a more comprehensive and long-term supply agreement into place ahead of the phase 3 program. This should work to alleviate supply or logistic issues that could materialize during the program.

Also in October 2010, the U.S. FDA granted a Fast Track designation to Aastrom's cell therapy development program for CLI. The FDA's fast track program is designed to facilitate the development and expedite the review of new drugs and biologics intended to treat serious or life-threatening conditions and that demonstrate the potential to address unmet medical needs. CLI clearly falls into this category.

- Critical limb ischemia (CLI) affects approximately 1 million people in the U.S. each year -- roughly 2% of the population over the age of 50. Over 25% of patients with PAD will eventually development CLI. CLI is defined as inadequate blood flow to the limbs, and if left untreated can result in tissue loss, gangrene, amputation and death. In fact, CLI leads to an average of 160,000 major limb amputations each year. CLI has a high mortality rate: 20% after 6-months after initial diagnosis and 25% after 12-months. Nearly 30% of all patients who undergo a major limb amputation will require another amputation at some point in the future. The mortality rate post-amputation remains high, at roughly 25%.

Therapeutic options for patients with CLI are limited. Besides being at significantly increased risk for heart attack, stroke or vascular death, patients with CLI often live with several other co-morbidities, including diabetes, angina, dyslipidemia, hypertension and renal disease. For less severe forms of PAD, physicians will typically recommend smoking cessation (when applicable), and changes to diet and exercise.

Medications such as aspirin, statins and clopidogrel (Plavix) are common first-line therapies for early-stage PAD. Many patients will also be on medications for diabetes and heart failure as well. However, once PAD progresses to the point of CLI, the only real options available to patients are surgical. Patients are passed from the cardiologist, diabetologist or podiatrist to the care of the vascular surgeon. Surgical procedures include percutaneous transluminal angioplasty, plaque excision, stenting and bypass grafting. Patients living with CLI suffer from severe pain as a result of the neuropathy, tissue loss and ischemia. The healthcare burden associated with PAD-related amputations in the U.S. is greater than $10 billion per year.

…When To Partner…

Aastrom will need cash to complete the entire REVIVE trial. This may come in the form of a dilutive offering. However, if Aastrom forms a development partnership, the risk of dilution is reduced. On the first quarter call, management noted being in discussion with several interested parties. Interest in the cell therapy and regenerative medicine area has been growing among larger specialty and pharmaceutical companies. We point to Cephalon's $220 million investment for 20% ownership in Mesoblast and Shire's $750 million acquisition of privately-held Advanced BioHealing as two recent deals showing M&A in regenerative medicine is clearly heating up. Aastrom is looking for a partner with commercial development capabilities and market reach who can complement Aastrom's expertise in manufacturing and clinical development.

We fully expect Aastrom to initiate both phase 3 trials in CLI alone. We are not expecting a partnership before both SPAs are in place. However, once these trials are underway, we believe the potential for Aastrom to partner ixmyelocel-T either in the U.S., outside the U.S., or both, is significant. We note that pharmaceutical companies seeking to partner with Aastrom can go under a "CDA" (confidential disclosure agreement) to view the full data analysis from RESTORE. We think the p2b RESTORE data is very attractive, and the changes and increased oversight that Aastrom plans to make for REVIVE only work to increase the likelihood of success. In our valuation section we attempt to quantify what a deal could look like for shareholders.

IMPACT-DCM Data

In January 2011, at the Sixth International Conference on Cell Therapy for Cardiovascular Disease, Aastrom Bio presented interim data from the first 40 patients at 6-months from the company's IMPACT-DCM program. As a reminder, the phase 2 IMPACT-DCM (surgical) program looked at the safety and efficacy of direct injection of TRCs into damaged areas of the myocardium. The trial was a prospective, open-label program with a crossover extension study for the control patients. Baseline patient characteristic show a good distribution between both ischemic and non-ischemic subjects, with the majority of patients having significantly impaired ejection fraction (<30%) and are classified as NYHA Class-III. These are "no option" patients heading towards transplant.

IMPACT-DCM Baseline Characteristics

	TRC Group (n=24)	Control (n=15)
Ischemic / Non-Ischemic	12 / 12	7 / 8
Ejection Fraction	28.4%	25.8%
NYHA Class-III	96%[1]	100%
Male / Female	60% / 40%	73% / 27%
Mean Age	60	58
Mean BMI	29	30

1 patient was NYHA Class IV

…Proof-Of-Concept Clearly Evident…

Proof-of-Concept is clearly evident by analyzing the data. Given the small size of the trial, no results are statistically significant, but the signs point to a quality of life benefit with TRCs. This will be explored further in a larger-scale phase 2b program to start later in 2011. The data notes an improved outcome for the ischemic DCM patients far greater than for the non-ischemic DCM patients.

	TRC Group	Control
Improvement in NYHA Class…		
@ 1 Month	67%	14%
@ 3 Months	67%	9%
@ 6 Months	79%	20%
@ 12 Months	85%	40%
Improvement in 6-Minute Walk Test…		
@ 1 Month	45%	42%
@ 6 Months	68%	50%
@ 12 Months	77%	60%

…Safety Assessment Looks Clean…

Given the baseline characteristics of very sick patients, that fact that there were no discontinuations due to adverse events and that events were pretty similar between the control and TRC group is highly encouraging. Post-surgery, there was no difference in the incidence of AEs across the TRC and control groups.

	TRC Group	Control
Patients with Any AE	96%	93%
Discontinuations Due To AE	0%	0%
Serious AE	60%	60%
All Cause Mortality	12%	13%
Post-Op AEs per Patient	~7	~7

Management will present full data from this program at the 12-month timeframe in September 2011.

…Cather-DCM Continues…

Management is also continuing enrolling patients in the phase 2 Catheter-DCM study to determine the safety and tolerability of administering expanded autologous cell therapy via a catheter (J&J's NOGA) to patients with heart failure due to dilated cardiomyopathy. This trial completed enrollment at 23 patients in December 2010. Interim 6 month data from the Catheter study should be available in September 2011. The next step in DCM will be for Aastrom to meet with the FDA to outline the design for a phase 2b study.

We expect the phase 2b program will be a fully-control catheter program using the NOGA device. The trial will most likely seek to enroll about 100-150 patients with clearly objective endpoints such as cardio-pulmonary function, VO_2 max, exercise capacity, 6-minute walk test, or MACE. This will be large enough to clearly provide a roadmap for the phase 3 program, which we expect management will secure an SPA. We remind investors that the FDA has granted Orphan Drug designation to Aastrom for use of its TRCs in DCM. We are tentatively modeling this program to start in the calendar fourth quarter 2011, with data late 2012.

…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, 1/3rd of patients exhibit improved cardiac function, 1/3rd have stable cardiac dysfunction, and 1/3rd progress to significant cardiac dysfunction. These 1/3rd that progress to severe cardiac dysfunction will require a heart transplant.

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 3 or 4 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.

RECOMMENDATION & VALUATION

Remaining Bullish On Aastrom…

We've first upgraded Aastrom Bio after the stock sold off hard following release of the 2nd interim update from the phase 2b RESTORE trial. At the time we believed the data was not representative of what the final outcome would be, and as it turns out we were right. The final data from RESTORE will look significantly better than the 2nd interim update that caused investors to flee the name. We think when investors see the final data presentation at the American Heart Association (AHA) meeting in November 2011, the stock will soar.

In the meantime, there are a number of catalysts to continue to drive the shares higher, including the finalized SPA for REVIVE-NO, initiating enrollment in REVIVE-NO, final 12 month data from the DCM surgical study, interim 6 month data from the DCM catheter study, the finalized SPA on the REVIVE-POOR trial, and initiating the REVIVE-POOR trial should all still happen this year.

…Raising Price Target to $6…

Aastrom Biosciences has two clinical programs ongoing, one for vascular applications in critical limb ischemia (CLI), the most severe (end-stage) of peripheral arterial disease (PAD), and another for cardiac applications in dilated cardiomyopathy (DCM), the leading cause of heart transplantation, with Ixmyelocel-T.

- ✓ For CLI, management has presented very encouraging proof-of-concept data from a phase 2b program, RESTORE-CLI, on FDA-validated endpoints for CLI – major amputation and amputation-free survival (AFS). The FDA has granted Aastrom 'Fast Track' designation for the CLI indication. We expect the first trial in the phase 3 program ("no option" patients) to begin under a special protocol assessment (SPA) around the middle of the year.

  Major Amputations: 160,000 / year
  → Savable by ASTM's cell therapy: 50%
  → Market share: 20%
  → Cost: $50k / treatment ➔ Peak Sales: $800 Million

  NPV Assumptions CLI Program: Upfront payment of $50 million in 2012 with significant backend regulatory and sales-related milestone, plus 20% royalty on sales. FDA approval in 2014, with peak in 2019 and a risk adjustment rate of 40%.

  Value of CLI Program ➔ $160 million

- ✓ For DCM, management has demonstrated promising trends from IMPACT-DCM, which show meaningful improvements in NYHA function class, quality of life, and other functional parameters for patients on therapy. The U.S. FDA has granted Aastrom 'Orphan Drug' designation for the DCM indication.

  Living with DCM: 200,000 / year
  → Savable by ASTM's cell therapy: 50%
  → Market share: 25%
  → Cost: $50k / treatment ➔ Peak Sales: $500 Million

  NPV Assumptions DCM Program: Upfront payment of $30 million in 2013 with significant backend regulatory and sales-related milestone, plus 20% royalty on sales. FDA approval in 2015 with peak sales level in 2019, and a risk adjustment rate of 50%.

  Value of DCM Program ➔ $50 million

Total Technology Value for Aastrom Bio: $210 million + $20 million in cash = $230 million market capitalization. Based on roughly 39 million shares outstanding, we see fair-value at $6 per share.

EVENTS TO WATCH

EVENTS TO WATCH	TIMING
Interim 6-Month DCM (Surgical) Results	Completed!
Top-Line 12-Month Data from RESTORE-CLI	Completed!
Finalized SPA on Phase 3 “no option” CLI Trial	Q2-2011
Initiate 1st Phase 3 CLI Trial in “No Option” Patients	Q2 / Q3-2011
Final 12-Month DCM (Surgical) Results	September 2011
Interim 6-Month DCM (Catheter) Results	September 2011
Finalized SPA on Phase 3 “poor option” CLI Trial	Q3-2011
Meet with FDA to Design Phase 2b for DCM (Catheter)	Q3 / Q4-2011
Present Full RESTORE-CLI data at AHA	November 2011
Initiate Phase 2b in DCM (Catheter)	Q4-2011
Initiate 2nd Phase 3 CLI Trial in “Poor Option” Patients	Q4-2011
Partnership For DCM / CLI	2011 / 2012
Interim Data From Phase 2b DCM (Catheter)	Mid-2012
Data From 1st Phase 3 CLI “no option” Trial	Early 2013

PROJECTED FINANCIALS

Aastrom Biosciences
Income Statement

Aastrom Biosciences	Dec-10	Mar-11	Jun-11	Sep-11	Dec-11	Dec-11	Dec-12	Dec-13	Dec-14
	2010 A	Q1 A	Q2 E	Q3 E	Q4 E	2011 E	2012 E	2013 E	2014 E
R&D Agreements / Grants	**$0.3**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth		-	-	-	-	*0%*	*0%*	*0%*	*0%*
Product Sales	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth		-	-	-	-	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Total Revenues	**$0.3**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth		-	-	-	-	-	-	-	-
Research & Development	$15.1	$4.4	$4.8	$6.0	$7.0	$22.2	$25.0	$20.0	$20.0
% R&D		-	-	-	-	-	-	-	-
Selling, General, and Admin	$6.2	$1.9	$1.8	$1.8	$1.9	$7.4	$7.8	$8.2	$8.8
% SG&A		-	-	-	-	-	-	-	-
Operating Income	($21.0)	($6.3)	($6.6)	($7.8)	($8.9)	($29.6)	($32.8)	($28.2)	($28.8)
Operating Margin		-	-	-	-	-	-	-	-
Other Income (Expenses)	($4.7)	$1.3	$0.2	$0.2	$0.2	$1.9	$2.0	$2.5	$3.0
Pre-Tax Income	($25.7)	($5.0)	($6.4)	($7.6)	($8.7)	($27.7)	($30.8)	($25.7)	($25.8)
Taxes & Other Charges	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tax Rate	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*
Net Income	($25.7)	($5.0)	($6.4)	($7.6)	($8.7)	($27.7)	($30.8)	($25.7)	($25.8)
Net Margin		-	-	-	-	-	-	-	-
Reported EPS	**($0.91)**	**($0.13)**	**($0.16)**	**($0.19)**	**($0.22)**	**($0.71)**	**($0.68)**	**($0.51)**	**($0.47)**
YOY Growth		-	-	-	-	-	-	-	-
Weighted Ave. Shares Out	28.3	38.6	38.8	39.0	39.2	38.9	45.0	50.0	55.0

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

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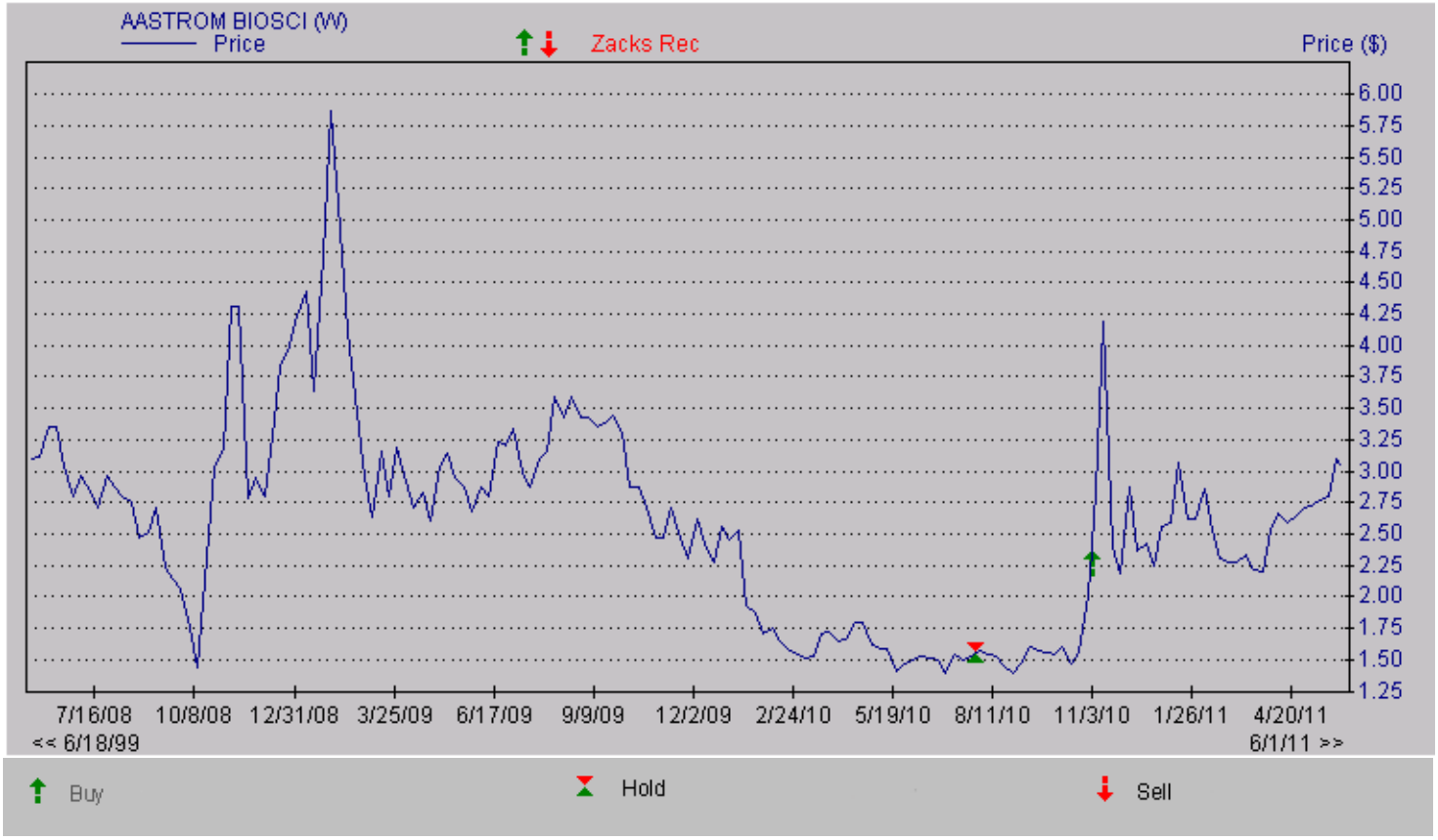
HISTORICAL ZACKS RECOMMENDATIONS



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