Zacks Small-Cap Research

November 14, 2011
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Aastrom Biosciences, Inc. (ASTM-NASDAQ)

ASTM: Full RESTORE-CLI Data Looks Solid.

Current Recommendation	**Outperform**
Prior Recommendation	Neutral
Date of Last Change	11/08/2010
Current Price (11/14/11)	$2.64
Target Price	**$5.00**

UPDATE

This morning at the American Heart Association (AHA) meeting, Aastrom Bio presented the full analysis from the company's phase 2b RESTORE-CLI program. We believe results are solid, showing strong statistical significance in the primary endpoint of time-to-treatment failure, and show a clear trend in the secondary endpoint of amputation-free survival (AFS). Subset analysis from RESTORE-CLI shows greater separation between ixmyelocel-T and the control in Rutherford-5 (more sick) patients. We note AFS is the primary endpoint in the company's planned phase 3 REVIVE study. REVIVE will seek to enroll only Rutherford-5 patients.

We remain enthusiastic about the potential for Aastrom Bio. Our rating is 'Outperform' with a $5 target.

SUMMARY DATA

52-Week High	**$4.20**
52-Week Low	**$2.01**
One-Year Return (%)	**-34.52**
Beta	**0.04**
Average Daily Volume (sh)	**250,150**
Shares Outstanding (mil)	**39**
Market Capitalization ($mil)	**$106**
Short Interest Ratio (days)	**13.67**
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**

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 A	0 A	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	-$0.26 A	-$0.05 A	-$0.18 E	-$0.63 E
2012					-$0.63 E
2013					-$0.58 E

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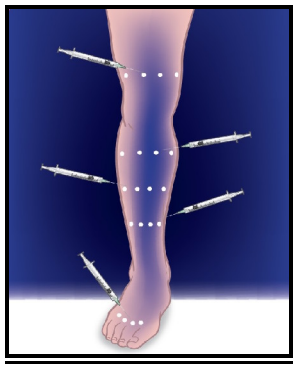
WHAT'S NEW

Full Data From RESTORE-CLI Presented at AHA

On November 14, 2011, Aastrom Bio 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.

Of the 86 patients enrolled, 77 underwent the bone marrow aspiration procedure and 72 received treatment injections, 48 ixmyelocel-T and 24 placebo. Patient characteristics where as follows:

- ✓ Age 18-90
- ✓ Diagnosed with CLI
  - o Ischemic rest pain > 2 weeks duration
  - o Ulcerations or gangrene of toe / foot
  - o Toe systolic pressure <50 mmHg
  - o Ankle systolic pressure < 70 mmHg
- ✓ No previous amputation or exposed tendon or bone in wound.
- ✓ No active infection of target extremity
- ✓ HbA1c < 10%
- ✓ No option for revascularization



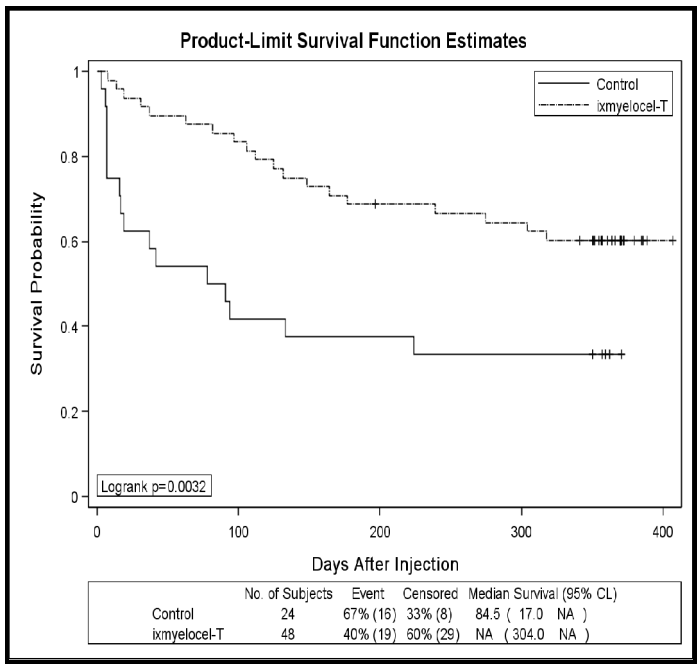
The study was powered as a safety trial with the primary endpoint in adverse events. However, there were significant efficacy endpoints, which include the primary endpoint time to first occurrence of treatment failure (TTF) at 12 months. TTF is a composite endpoint that includes four components:

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

Below are graphical representations of the primary efficacy endpoint:

The chart to the right depicts the product-limit survival function showing a 62% risk reduction (hazard ratio 0.38, 95% CI = 0.20-0.74) in the composite endpoint of time to first occurrence of treatment failure (TTF) for patients taking ixmyelocel-T vs. the placebo.

There were 19 events (40%) for the ixmyelocel-T group vs. 16 events (67%) for the placebo group, this equated to a p-value = 0.0032.

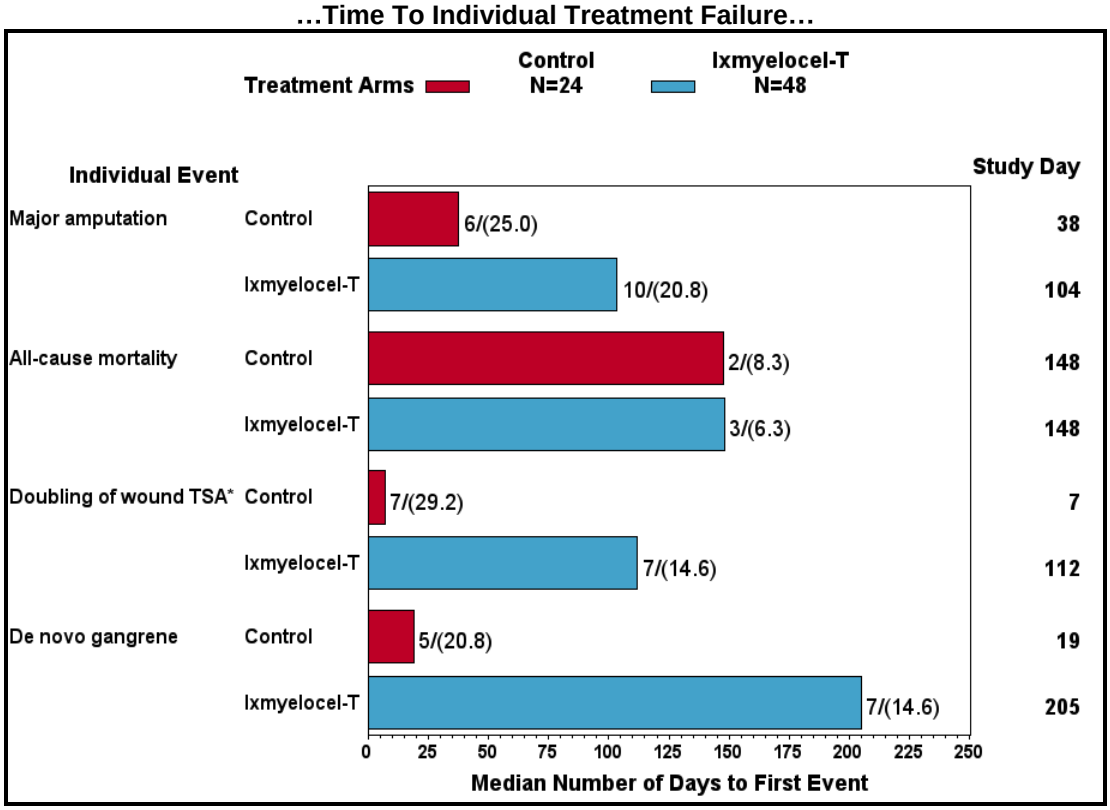


Events within the composite TTF endpoint include:

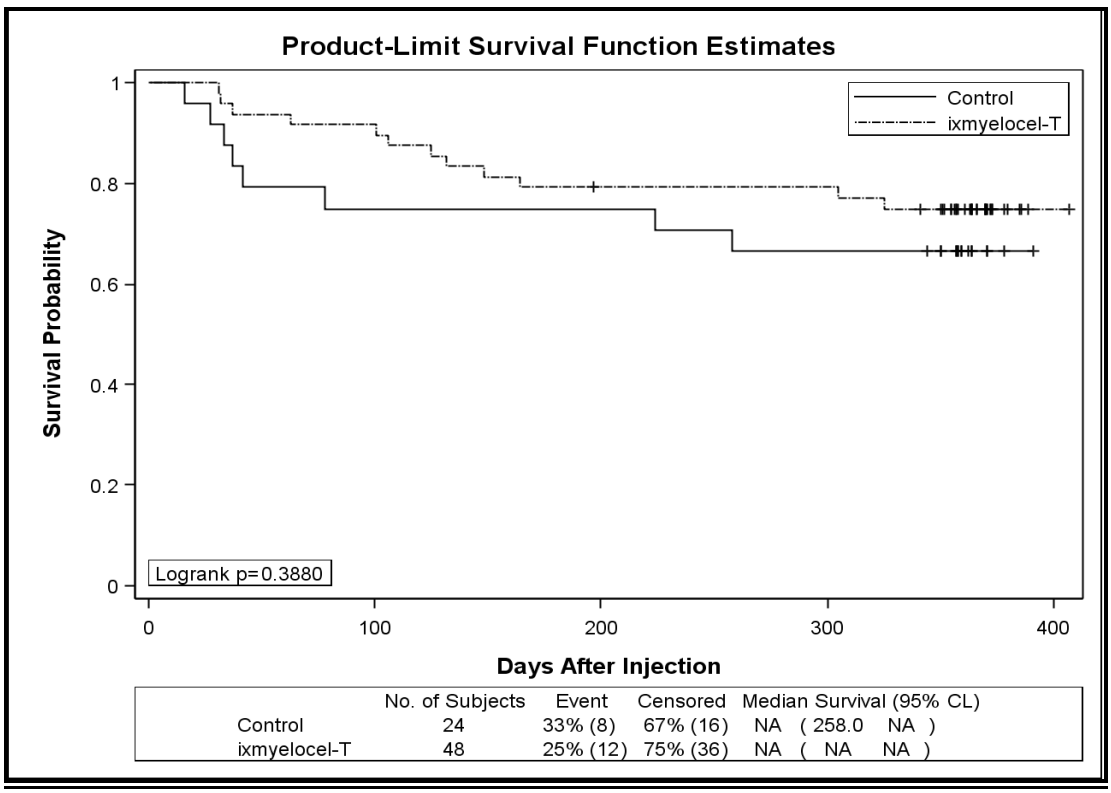
	Ixmyelocel-T (n=48)	Control (n=24)
Major Amputation	12.5%	16.7%
All-Cause Mortality	4.2%	4.2%
Wound Size	10.4%	29.2%
De Novo Gangrene	12.5%	16.7%
Total TTF Composite	**39.6%**	**66.7%**

Below is a graphical representation of each composite endpoint comparing ixmyelocel-T to the placebo control. It shows the time to individual treatment failure on study day vs. the median number of days to first event.

…Time To Individual Treatment Failure…



The secondary efficacy endpoint was Amputation-Free Survival (AFS) at 12 months. This is important because AFS at 12 months will be the primary endpoint in the companies phase 3 REVIVE trial.

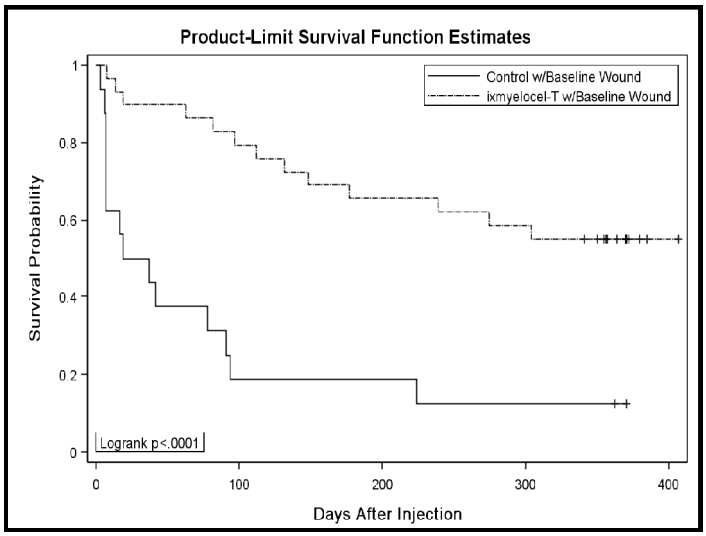


Based on the data above, the AFS-12 for the ixmyelocel-T group was 75% vs. 67% for the placebo control group. This accounts to a 32% risk reduction (hazard ratio 0.68, 95% CI 0.28-1.65). Results were not statistically significant (p-value 0.3880) given the small sample size.

…Subset Analysis Sheds Additional Light On Data…

The phase 2b RESTORE-CLI program enrolled both Rutherford-4 and Rutherford-5 patients. We note that the phase 3 REVIVE program will focus solely on "more sick" Rutherford-5 patients. From RESTORE-CLI, 45 of the 72 patients qualified as Rutherford-5 (29 in the ixmyelocel-T group and 16 in the control).

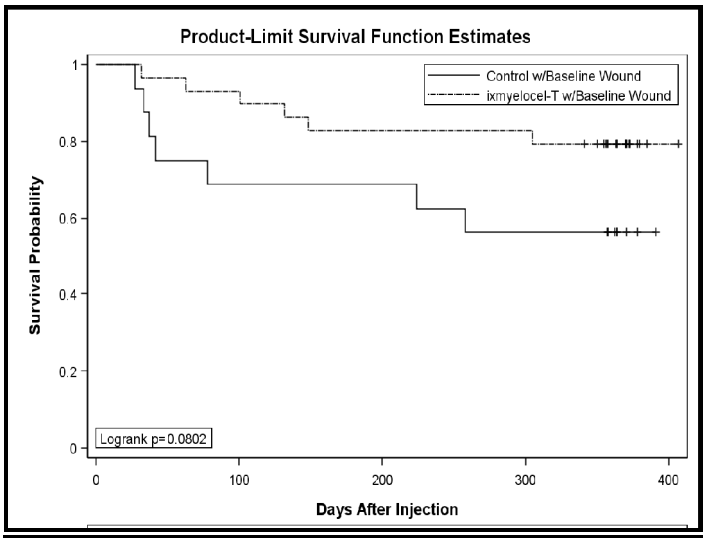
For the primary composite endpoint of TTF, Aastrom saw greater separation between the ixmyelocel-T group and the control. Results show a TTF for ixmyelocel-T at 44.8% vs. 87.5% for the control, p-value < 0.0001. This equated to a 77% risk reduction (hazard ratio = 0.225). This was greater statistical significance than in the total population.



For the primary composite endpoint of TTF, Aastrom saw greater separation between the ixmyelocel-T group and the control. Results show a TTF for ixmyelocel-T at 44.8% vs. 87.5% for the control, p-value < 0.0001. This equated to a 77% risk reduction (hazard ratio = 0.225). This was greater statistical significance than in the total population.

	Ixmyelocel-T (n=48)	Control (n=24)
Total TTF Composite	**39.6%**	**66.7%**
		p-value = 0.0032
	Ixmyelocel-T (n=29)	Control (n=16)
Rutherford-5 Subset	**44.8%**	**87.5%**
		p-value < 0.00012

The subset analysis of the Rutherford-5 patients on the secondary endpoint 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=0.0802), 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.



	Ixmyelocel-T (n=48)	Control (n=24)
Total AFS-12	**75%**	**67%**
		p-value = 0.3880
	Ixmyelocel-T (n=29)	Control (n=16)
Rutherford-5 Subset	**79%**	**57%**
		p-value = 0.0802

We are particularly enthused by this subset analysis of Rutherford-5 patients. As noted above, Aastrom's phase 3 REVIVE program will seek to enroll only patients that qualify as Rutherford-5. 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. Ixmyelocel-T could be under review by the end of 2014.

…REVIVE Ready To Initiate…

REVIVE-NO will seek to enroll up to 594 patients and approximately 80 clinical centers across the U.S. with severe CLI. These "no option" patients must have confirmed existing tissue loss (e.g. ulcerations and/or dry gangrene) and disease progression to qualify for enrollment. The trial is 90% powered to show superiority of ixmyelocel-T over the control (no cells). Management used an event rate for the control group of 34.5%, while expecting that ixmyelocel-T will come in around 22%, to calculate the power assumptions. The primary endpoint of the program will be amputation-free survival at 12-months (AFS-12). Other secondary endpoints will include de novo gangrene and wound healing.

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. The goal will be to enroll only Rutherford-5 patients.
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 shortly with the majority of sites to come online shortly after the trial initiates. We expect that Aastrom may need to screen as many as 750 patients in order to enroll (treat) near the target 594 number. The trial should take 18 months to complete and cost between $20 and $25 million. If the results are positive, based on the agreed upon SPA with the FDA, management plans to file the Biologic License Agreement (BLA) seeking approval for this "no option" patient population. We consider the ability to file after only one phase 3 program as positive news, as management can now focus on this trial and seek approval with positive data while negotiations with the FDA on the "poor option" trial separately.

We note that tissue loss 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. Final results from RESTORE-CLI show that patients with confirmed tissue loss (Rutherford-5) actually responded better than "less sick" patients.

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. He also serves on the editorial board of the Journal of Vascular Medicine. Dr. Hiatt was a principle investigator in Sanofi's phase 3 TAMARIS study.

…REVIVE-POOR Discussion Ongoing…

Management is continuing discussions with the FDA on the SPA for the second phase 3 REVIVE program in "poor" options patients. We expect these discussions will continue into early 2012. The look of REVIVE-POOR remains somewhat in question. We expect management will seek to enroll up to 250 patients with moderate CLI. These "poor option" patients will have disease progression with a clear path toward amputation.

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. If positive, we expect that management will look to file the data from REVIVE-POOR as either a supplement to the REVIVE-NO BLA filing, or as an expansion to the label for use in patients with CLI if the BLA has been approved in "no option" patients before the "poor option" application is filed.

Market Remains Wide Open

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. Between the cost of the amputation ($30-40k), a prosthetic ($25-75k), and the subsequent rehabilitation ($30-50k), the total cost per episode could be north of $100k.

…When To Partner…

Aastrom will need cash to complete the entire REVIVE trial. As noted above, the cash position is running low. A raise may come in the form of a dilutive offering. However, if Aastrom forms a development partnership, the risk of dilution is reduced. Management has 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 expect Aastrom to initiate the phase 3 REVIVE trial in CLI alone. 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. Management has noted several companies under "CDA" (confidential disclosure agreement) to date. 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. The fact that the U.S. FDA has agreed upon an SPA and will allow Aastrom to file for approval after only REVIVE-NO is very positive.

In the meantime, Aastrom has an existing At the Market Sales Agreement (ATM) with McNicoll, Lewis & Vlak LLC (MLV), where management may elect to sell shares of common stock through MLV, as sales agent, in registered transactions for aggregate proceeds of up to $20 million. As of September 30, 2011, the company had not sold any shares under the ATM, but we think the potential exists for Aastrom to begin using the ATM in the coming weeks to maintain a comfortable cash cushion while REVIVE begins enrollment, discussions with the FDA on the "poor option" SPA continue, and partners monitor progress on both phase 3 trials.

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 (presented above) is impressive in our view.

In the meantime, there are a number of catalysts to continue to drive the shares higher, including initiating enrollment in REVIVE-NO, finalizing the SPA for REVIVE-POOR, final 12 month data from the DCM surgical study, interim 6 month data from the DCM catheter study, and initiating the REVIVE-POOR trial. News that management may seek to file for approval of ixmyelocel-T after REVIVE-NO is a significant positive in our view and greatly lowers the risk of investing at this stage.

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 $395 million, or $6.43 per share. Our published target is $5 to be conservative ahead of potential dilutive financing in the near-term.

Our DCF Model

Aastrom Bio (ASTM)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Global Ixmy-T CLI Sales	**$0**	**$0**	**$0**	**$0**	**$38**	**$137**	**$287**	**$457**	**$655**	**$846**	**$961**	**$1,056**
YoY Growth	-	-	-	-	-	*259%*	*109%*	*59%*	*43%*	*29%*	*14%*	*10%*
Global Ixmy-T DCM Sales	**$0**	**$0**	**$0**	**$0**	**$0**	**$57**	**$146**	**$241**	**$341**	**$434**	**$499**	**$555**
YoY Growth	-	-	-	-	-	-	*156%*	*65%*	*42%*	*27%*	*15%*	*11%*
Royalties	**$0**	**$0**	**$0**	**$0**	**$8**	**$39**	**$87**	**$140**	**$199**	**$256**	**$292**	**$322**
YoY Growth	-	-	-	-	-	*408%*	*122%*	*61%*	*43%*	*29%*	*14%*	*10%*
Licensing & Collaborative	**$0**	**$30**	**$0**	**$35**	**$50**	**$30**	**$10**	**$0**	**$20**	**$10**	**$20**	**$10**
Revenues (in Millions)	**$0**	**$30**	**$0**	**$35**	**$58**	**$69**	**$97**	**$140**	**$219**	**$266**	**$312**	**$332**
YoY Growth	-	-	-	-	*65%*	*20%*	*40%*	*44%*	*57%*	*21%*	*17%*	*6%*
CoGS	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
R&D	*$22*	*$25*	*$25*	*$25*	*$24*	*$22*	*$20*	*$20*	*$26*	*$32*	*$37*	*$40*
SG&A	*$8*	*$9*	*$10*	*$11*	*$12*	*$13*	*$14*	*$15*	*$22*	*$27*	*$31*	*$33*
Other Expenses	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
EBITDA	($30)	($4)	($35)	($1)	$22	$34	$63	$104	$171	$207	$243	$259
Depreciation and amortization	*$1*	*$1*	*$1*	*$1*	*$2*	*$2*	*$3*	*$3*	*$4*	*$4*	*$5*	*$5*
EBIT	**($30)**	**($4)**	**($35)**	**($2)**	**$20**	**$32**	**$60**	**$101**	**$167**	**$203**	**$239**	**$254**
EBITDA margin	-	-	-	*-5.1%*	*35.2%*	*46.3%*	*61.9%*	*72.3%*	*76.3%*	*76.4%*	*76.5%*	*76.4%*
Cash Taxes	$0	$0	$0	$0	($6)	($10)	($19)	($32)	($53)	($65)	($76)	($81)
Tax Rate	*0%*	*0%*	*0%*	*0%*	*32.0%*	*32.0%*	*32.0%*	*32.0%*	*32.0%*	*32.0%*	*32.0%*	*32.0%*
Balance Sheet												
Capital Expenditures	$0	$0	$5	$5	$5	$5	$4	$3	$2	$1	$0	($1)
Working Capital	$1	$2	$2	$3	$3	$4	$4	$5	$5	$6	$6	$7
Interest & Other Expenses	$5	$2	$3	$3	$4	$4	$5	$5	$6	$6	$7	$7
Non-Cash Adjustments	($1)	($1)	($1)	($1)	($2)	($2)	($2)	($2)	($2)	($2)	($3)	($3)
Capital demployed	**$5**	**$3**	**$8**	**$9**	**$10**	**$11**	**$11**	**$10**	**$10**	**$10**	**$10**	**$10**
ROIC	*603.2%*	*-130.9%*	*-420.7%*	*-5.5%*	*223.3%*	*318.3%*	*590.8%*	*997.0%*	*1659.1%*	*2043.4%*	*2434.2%*	*2629.6%*
Discounted Cash Flow												
Net Income	($30)	($4)	($35)	($2)	$14	$22	$41	$69	$114	$138	$162	$173
Depreciation and amortization	$1	$1	$1	$1	$2	$2	$3	$3	$4	$4	$5	$5
Net Cash Changes	($5)	($3)	($8)	($9)	($10)	($11)	($11)	($10)	($10)	($10)	($10)	($10)
Post-Tax Operating Cash Flow	**($35)**	**($6)**	**($43)**	**($10)**	**$6**	**$13**	**$33**	**$61**	**$107**	**$132**	**$157**	**$168**
Dividends	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Free Cash Flow	**($35)**	**($6)**	**($43)**	**($10)**	**$6**	**$13**	**$33**	**$61**	**$107**	**$132**	**$157**	**$168**

Assumptions	
Beta:	1.50
Equity Risk Premium:	8%
Risk Free Rate:	3%
Firm Risk Premium:	50.0%
Discount Rate:	**15.0%**

Valuation	
10-Year Model:	$150.6
Terminal Growth:	0%
Terminal Value:	$240.7
Net Cash - LT Debt:	$3.6
Firm Value:	**$395.0**

Price Target	
Basic Outstanding:	38.6
Warrants / Options:	23.2
AMT / Dilution:	10.0
Fully Diluted:	61.4
Target Price:	**$6.43**

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

EVENTS TO WATCH

EVENTS TO WATCH	TIMING
Interim 6-Month DCM (Surgical) Results	January 2011
Top-Line 12-Month Data from RESTORE-CLI	June 2011
Finalized SPA on Phase 3 “no option” CLI Trial	July 2011
Final 12-Month DCM (Surgical) Results	September 2011
Interim 6-Month DCM (Catheter) Results	September 2011
Present Full RESTORE-CLI data at AHA	November 2011
Initiate 1st Phase 3 CLI Trial in “No Option” Patients	Q4-2011
Finalized SPA on Phase 3 “poor option” CLI Trial	Q4-2011
Meet with FDA to Design Phase 2b for DCM (Catheter)	Q4-2011
Initiate Phase 2b in DCM (Catheter)	H1-2012
Initiate 2nd Phase 3 CLI Trial in “Poor Option” Patients	H1-2012
Partnership For DCM / CLI	2012 / 2013
Interim Data From Phase 2b DCM (Catheter)	Late-2012
Data From 1st Phase 3 CLI “no option” Trial	Early 2014
Data from 2nd Phase 3 CLI “poor option” Trial	Early 2014
File BLA for CLI	Mid 2014

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 A	Q3 A	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	$5.3	$5.8	$6.6	$22.0	$25.0	$25.0	$25.0
% R&D		-	-	-	-	-	-	-	-
Selling, General, and Admin	$6.2	$1.9	$2.2	$1.7	$1.9	$7.7	$8.6	$9.5	$10.5
% SG&A		-	-	-	-	-	-	-	-
Operating Income	($21.0)	($6.3)	($7.5)	($7.4)	($8.5)	($29.7)	($33.6)	($34.5)	($35.5)
Operating Margin		-	-	-	-	-	-	-	-
Other Income (Expenses)	($4.7)	$1.3	($2.5)	$5.5	$0.2	$4.5	$2.0	$2.5	$3.0
Pre-Tax Income	($25.7)	($5.0)	($10.0)	($1.9)	($8.3)	($25.2)	($31.6)	($32.0)	($32.5)
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)	($10.0)	($1.9)	($8.3)	($25.2)	($31.6)	($32.0)	($32.5)
Net Margin		-	-	-	-	-	-	-	-
Reported EPS	**($0.91)**	**($0.13)**	**($0.26)**	**($0.05)**	**($0.18)**	**($0.63)**	**($0.63)**	**($0.58)**	**($0.54)**
YOY Growth		-	-	-	-	-	-	-	-
Weighted Ave. Shares Out	28.3	38.6	38.6	38.6	45.0	40.2	50.0	55.0	60.0

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

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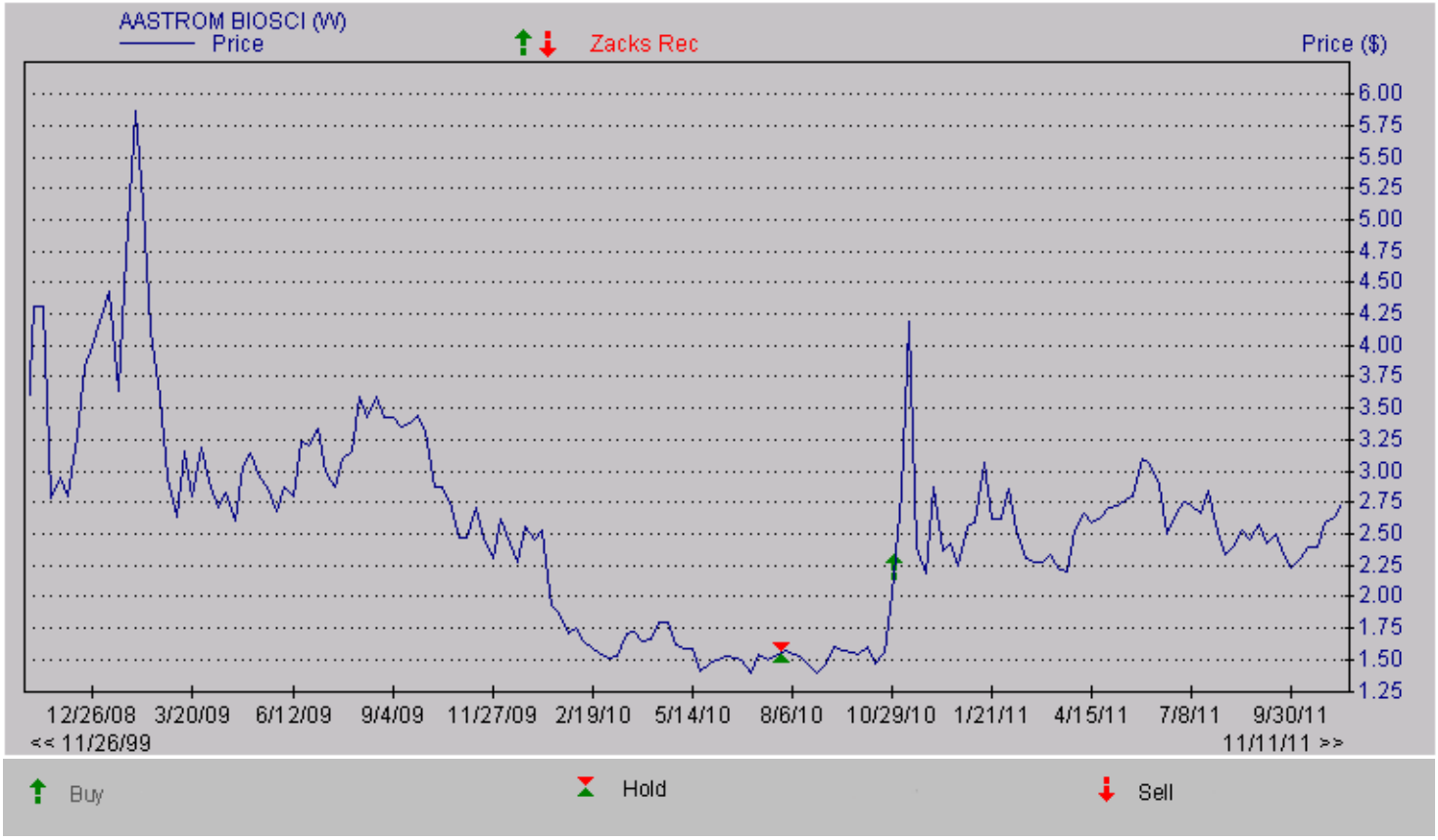
HISTORICAL ZACKS RECOMMENDATIONS



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