Zacks Small-Cap Research

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Aastrom Biosciences, Inc. (ASTM-NASDAQ)

ASTM: Full RESTORE-CLI Data Expected Next Week…Naysayers, Get Your Bowl Of Crow Ready.

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

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 confident in the design and outcome of the phase 3 REVIVE study now that the SPA is in hand. We believe once investors see the full data from RESTORE at AHA next week, significant enthusiasm will return to the name. We are excited about the opportunity to file for approval following the first phase 3 REVIVE study in "no options" patients.

We see Aastrom as meaningfully under-valued. We reiterate our Outperform rating. Our target remains $5 per share, conservatively.

SUMMARY DATA

52-Week High	**$4.20**
52-Week Low	**$1.40**
One-Year Return (%)	**71.71**
Beta	**-0.05**
Average Daily Volume (sh)	**591,218**
Shares Outstanding (mil)	**39**
Market Capitalization ($mil)	**$101**
Short Interest Ratio (days)	**10.93**
Institutional Ownership (%)	**12**
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

Third Quarter Financials

On November 8, 2011, Aastrom Bio reported financial results for the third quarter 2011. The company reported negligible revenues in the third quarter of $0.009. This was in-line with expectation. Operating expenses in the quarter were $7.5 million, driven by $5.8 million in R&D and $1.7 million in G&A. Aastrom reported a net loss of only $1.9 million in the third quarter, equating to ($0.05) per share, thanks to a $5.4 million gain of the fair-value in outstanding warrant liability.

Aastrom exited the third quarter 2011 with $11.9 million in cash and investments. We find this to be sufficient to fund operations only into the first quarter of 2012. We fully expect a dilutive cash raise in the near-term.

INVESTMENT THESIS

Ixmyelocel-T – Critical Limb Ischemia (CLI)

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

…Final RESTORE-CLI Data At AHA…

We remind investors that Aastrom plans to present full data from the RESTORE-CLI trial on November 19, 2011 at the American Heart Association (AHA) meeting. We believe there will be an opportunity to raise cash at higher levels following the release of this data. 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 p=0.0132 reported for the second interim update.

Although management did not release the actual event rate for ixmyelocel-T or the control, we encourage investors to look at the company's power assumptions for REVIVE. Management used an event rate for the control of 34.5% and a 22% target for ixmyelocel-T. When final top-line results on RESTORE-CLI were presented, management noted that the control group 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. Management also noted that the final event rate for the treatment group was consistent with what was seen after the 1st and 2nd interim update, or around 22-23%.

Finally, we will be looking for a subset analysis of the RESTORE-CLI data on Rutherford-5 patients only. RESTORE-CLI included both Rutherford-4 and -5 patients. We would not be surprised to see the statistical significance improve for the R5 patients, as we would expect that the separation between the Ixmyelocel-T and control group to have widened. We note the phase 3 REVIVE-CLI program aims to enroll only R5 patients.

…REVIVE-CLI SPA In Hand, Enrollment To Start Q4…

On July 26, 2011, Aastrom announced that it had reached an agreement with the U.S. FDA on a Special Protocol Assessment (SPA) for the design of the phase 3 REVIVE-CLI clinical trial of ixmyelocel-T in patients with critical limb ischemia (CLI) who have no other treatment options.

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 in the fourth quarter 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.

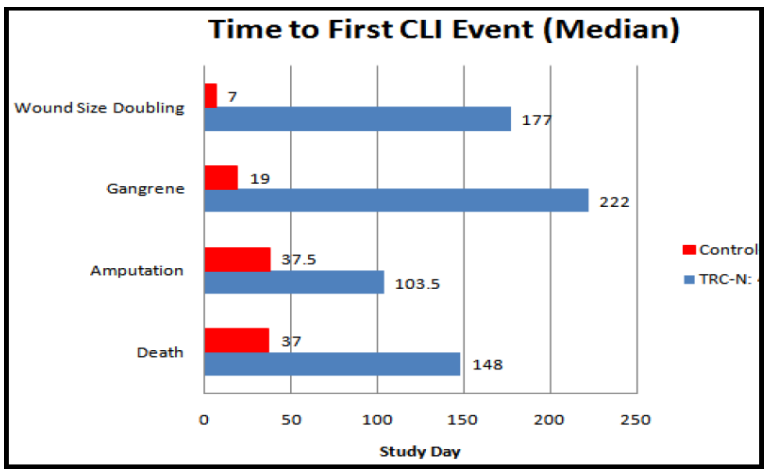
…Confident In REVIVE…

Based on the outcome of the phase 2b RESTORE-CLI trial, we are feeling confident in REVIVE-NO. 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:



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. 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.

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.

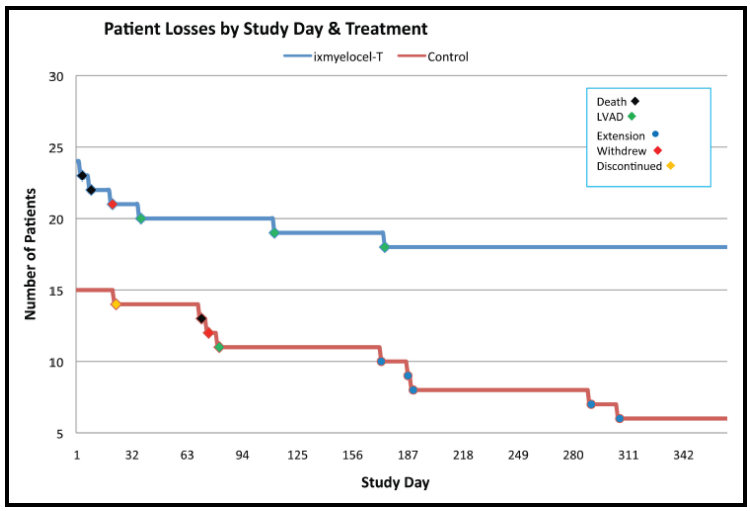
We expect Aastrom to initiate the phase 3 REVIVE trial in CLI alone. However, once these trials are underway, we believe the potential for Aastrom to partner ixmyelocel-T either in the U.S., outside the U.S., or both, is significant. Management has noted several companies under "CDA" (confidential disclosure 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.

Ixmyelocel-T – Dilated Cardiomyopathy (DCM)

In September 2011, Aastrom Bio announced 12-month follow up data from the phase 2 IMPACT-DCM clinical trial testing ixmyelocel-T as a treatment for DCM. Results show ixmyelocel-T was well-tolerated and that efficacy observations were consistent with improved function of impaired myocardium in patients DCM, including those with ischemic cardiomyopathy (ICM) and idiopathic dilated cardiomyopathy (IDC). Data was presented by Amit N. Patel, MD, MS, associate professor of surgery at the University of Utah School of Medicine and national principal investigator for IMPACT-DCM in a poster presentation at the 15th Annual Heart Failure Society of America Scientific (AHFS) Meeting.

In the study, 40 patients diagnosed with ICM or IDC were randomized 3 to 1 to either a single administration of ixmyelocel-T or standard of care and were followed for 12 months. Patient retention was a key endpoint in the study. The data show that 21 of the 25 (84%) ixmyelocel-T patients completed the 12-month visit vs. 7 of 15 (47%) for the control. An additional 5 of 15 (33%) of the control patients enrolled into the extension phase of the study and received ixmyelocel-T treatment.



Results showed no difference in adverse events in treatment and control group patients after the initial post-operative period. ICM patients treated with ixmyelocel-T showed improved outcomes compared to control.

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 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 quality of life benefit with TRCs. This will be explored further in a larger-scale phase 2b program. The data notes an improved outcome for the ICM patients far greater than for the IDC patients. 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, and septal wall thickening, were consistent with improved function of impaired myocardium.

	ICM	IDC	Control
Improvement in NYHA Class…			
@ 1 Month	9/10	5/11	2/14
@ 3 Months	9/10	5/11	1/11
@ 6 Months	8/10	7/9	2/10
@ 12 Months	9/10	7/9	3/6
Improvement in 6-Minute Walk Test…			
@ 1 Month	8/10	1/10	5/12
@ 6 Months	6/10	7/9	5/10
@ 12 Months	6/10	8/9	3/6
Increase in MRI/CT Septal Thickness…			
@ 6 Months	7/10	3/9	6/9
Decrease in MRI/CT End-Diastolic Diameter			
@ 6 Months	6/10	3/9	4/9
Increase in Echo Ejection Fraction…			
@ 1 Month	3/6	4/8	5/10
@ 3 Months	4/7	6/9	5/8
@ 6 Months	2/7	3/8	3/7
@ 12 Months	3/7	4/7	1/4
MACE Adverse Events…			
All MACE Events	6/12	5/12	7/15

We view the results as encouraging, especially for ischemic (ICM) patients, demonstrating improvements in NYHA functional class and clinically relevant outcomes such as the 6-minute walk test. 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 ixmyelocel-T group is highly encouraging. Post-surgery, there was no difference in the incidence of AEs across the ixmyelocel-T and control groups.

Later this year, at the AHA meeting, management expects to present 6-month data from the ongoing phase 2a catheter DCM study. This trial is designed 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 DCM. The trial completed enrollment at 23 patients in December 2010. Interim data suggest safety superior to the surgical IMPACT data.

The next step in DCM will be for Aastrom to meet with the FDA to outline the design and necessary endpoints for a phase 2b study. Management expects to have this meeting before the end of the year 2011. We expect that the phase 2b program will be a fully-control catheter program using the NOGA device. The trial will most likely seek to enroll about 60-80 ischemic (ICM) DCM 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 ixmyelocel-T in DCM. We are tentatively modeling this program to start during the first half of 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 move higher.

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%*	*-130.5%*	*-420.7%*	*-5.5%*	*223.3%*	*318.3%*	*590.8%*	*997.0%*	*1659.1%*	*2043.4%*	*2434.2%*	*2629.8%*
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
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
Present Full RESTORE-CLI data at AHA	November 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

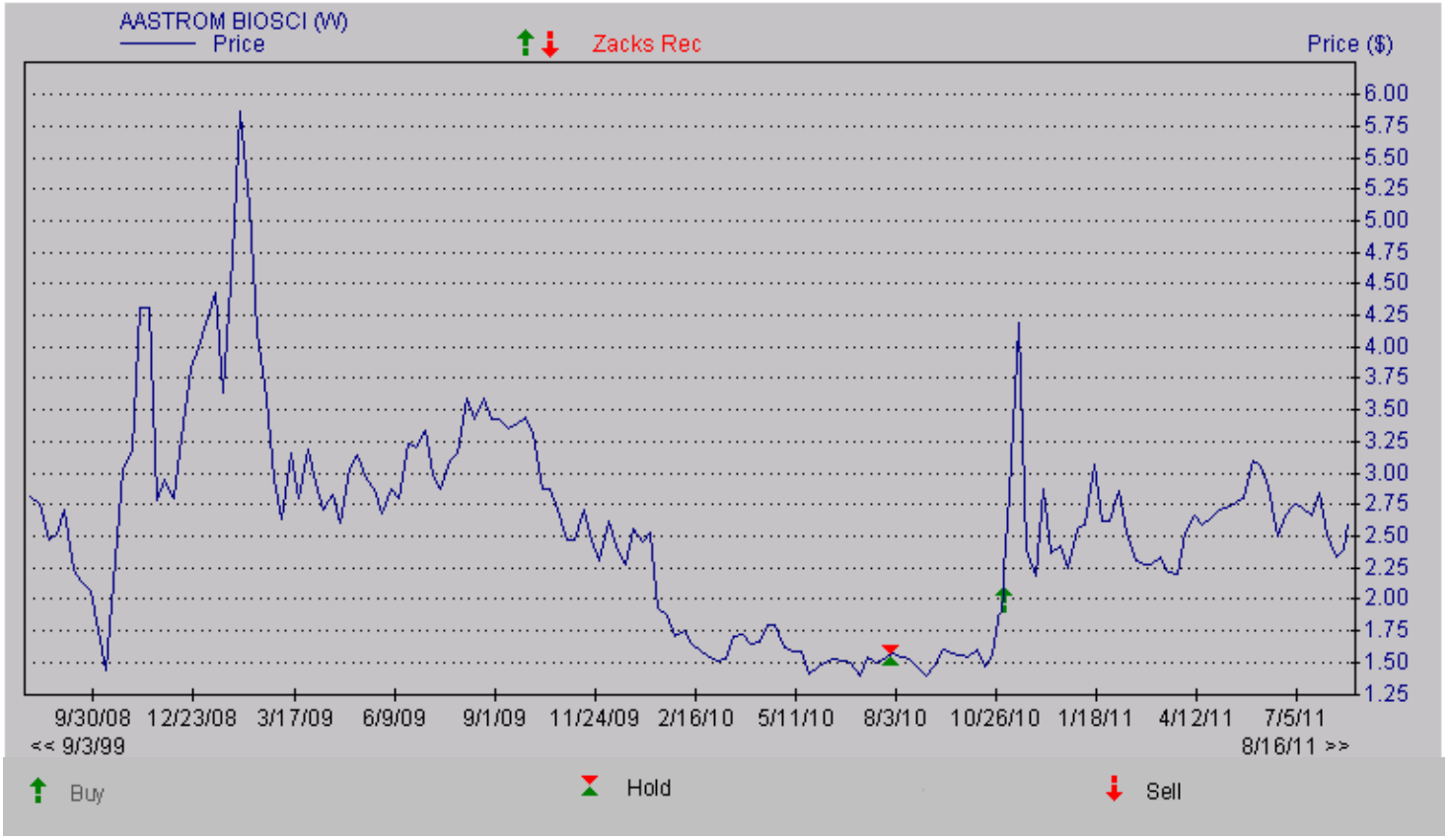
Aastrom Biosciences
Income Statement

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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