EDISON

Atossa Genetics

Quarterly update

Funded into Q417, endoxifen now in Phase I

Pharma & biotech

Atossa raised $4.4m in April 2017 in an equity raise consisting of common shares, Series A convertible preferred shares (SACPS), and warrants. We believe the proceeds should extend its cash runway into Q417 as it advances its 30-patient Phase II study on IDMC-delivering fulvestrant in patients scheduled for mastectomy or lumpectomy, and its 48-patient Phase I trial on endoxifen. We obtain an rNPV-based equity valuation of $9.3m.

Year end	Revenue ($m)	PBT* ($m)	EPS* ($)	DPS ($)	P/E (x)	Yield (%)
12/15	0.0	(9.8)	(5.15)	0.0	N/A	N/A
12/16	0.0	(7.3)	(2.46)	0.0	N/A	N/A
12/17e	0.0	(9.9)	(2.11)	0.0	N/A	N/A
12/18e	0.0	(11.2)	(2.17)	0.0	N/A	N/A

Note: *PBT and EPS are normalised, excluding amortisation of acquired intangibles, exceptional items and share-based payments.

Endoxifen now in Phase I studies

About 20% of the 300,000 US women currently taking tamoxifen (primarily to prevent recurrence of breast cancer) do not achieve sufficient concentrations of the active estrogen receptor blocking metabolite, endoxifen, and may have increased the risk of cancer recurrence. In March 2017, Atossa started a placebo-controlled, repeat dose 28-day Phase I study on 48 healthy females in Australia, which will evaluate the safety, tolerability, and pharmacokinetics of both an oral and a topical endoxifen formulation. Atossa plans to start a Phase II study in H217, and we estimate a pivotal study can begin in mid-2018.

IDMC-fulvestrant timelines pushed slightly back

Atossa's intraductal microcatheter (IDMC) intends to deliver fulvestrant to the breast with potentially higher local exposure and lower systemic risks vs the established intramuscular delivery approach. Atossa in early 2017 transferred the site of its ongoing Phase II study on IDMC-fulvestrant to the Montefiore Medical Center and expects to finish enrolment in August 2017 (vs its YE16 prior guidance). We have pushed back our pivotal study initiation and potential launch timelines by about six to nine months, to H218 and H121, respectively.

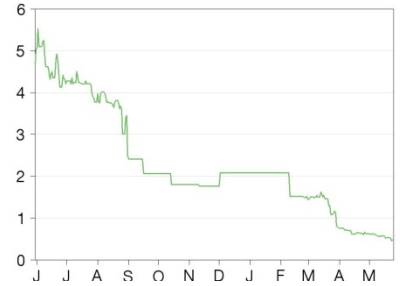
Valuation: Equity valuation of $9.3m

Atossa had $1.2m net cash at Q117 and following the recent equity offering, we estimate Q217 net cash of $3.0m (which assumes a Q217 burn rate of $2.1m), which we believe should maintain operations into Q417. Our model assumes a 2017 burn rate of $9.9m and that Atossa will raise an additional $16m in H217, which for modelling purposes we assign to long-term debt. After raising the probability of success estimate for endoxifen to 15.0% (from 12.5%) given the clinical advancement, rolling forward our forecast and pushing back our IDMC-fulvestrant estimates, we obtain a $6.3m rNPV (up from $6.2m, previously). After including Q217e net cash of $3.0m, we obtain an equity valuation of $9.3m, or $0.96 per fully diluted share (which assumes full conversion of the SACPS).

30 May 2017

Price	**US$0.47**
Market cap	**US$3m**
Net cash ($m) at Q217e	3.0
Shares in issue	6.0m
Free float	96%
Code	ATOS
Primary exchange	NASDAQ
Secondary exchange	N/A

Share price performance



%	1m	3m	12m
Abs	(22.5)	(68.8)	(88.3)
Rel (local)	(23.3)	(69.4)	(89.9)
52-week high/low	US$5.5		US$0.5

Business description

Based in Seattle, WA, Atossa Genetics is a clinical-stage pharmaceutical firm developing therapeutics and delivery methods to treat breast cancer and other breast conditions. Intraductal microcatheter-delivered fulvestrant and endoxifen are currently in Phase II and Phase I studies, respectively.

Next events

Q217 results	August 2017
IDMC-fulvestrant interim Phase II data	Q417

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Funding in place into Q417

Atossa completed a $4.4m (gross) equity raise in early April 2017, which including over-allotments, comprised 3,502 Series A convertible preferred shares (SACPS), 1.194m common shares (CS), and 5.86m common share warrants (CSW). Given that the underwriting fee was 7% and up to $0.16m in additional fees described in the prospectus, net proceeds were $3.9m. The SACPS are each convertible into 1,333.33 CS and hence, assuming their full conversion (into 4.67m CS) but without taking into account any exercise of the CSW, the offering increases Atossa's outstanding CS (3.79m on 27 March 2017) by 155%, to 9.65m. We believe the proceeds should extend Atossa's operating cash runway into Q417 as it advances its two active pipeline programs: its 30-pt Phase II study on its proprietary IDMC-delivering fulvestrant to breast ducts in patients scheduled for mastectomy or lumpectomy, and its endoxifen candidate, presently in a 48-patient Phase I safety study. Endoxifen is being investigated as a potential treatment for breast cancer patients refractory to tamoxifen. We expect Atossa to report initial data from the IDMC-fulvestrant study in Q417, and the company believes it could start human Phase II endoxifen studies in H217.

Review of recent combined class financing

The offering consisted of Class A units (comprising 1.194m CS and 1.194m CSW) and Class B units (comprising 3,502 SACPS of $1,000 face value, each convertible into 1,333.33 CS, and 4.67m CSW). The CSW all have an exercise price of $0.9375 and a five-year duration. Holders of SACPS are prohibited from converting such shares into CS if, following such conversion, the holder would own more than 4.99% of total outstanding CS. However, we do not believe that this clause would materially impede the long-term eventual conversion of the SACPS into CS. Assuming full conversion of the SACPS (to 4.67m CS), but without considering any CSW exercise, this offering increases fully-diluted (FD) CS outstanding by 155%, to 9.65m. Going forward, in our model we assume full conversion of the SACPS into CS when calculating FD CS and EPS. The proposed funding shores up Atossa's balance sheet, given it had disclosed on 16 March that it only had two to four months of cash resources at the time. We expect Atossa's cash on hand following the offering to last into Q417.

Endoxifen now in Phase I studies

In June 2016, Atossa began developing endoxifen as a treatment for breast cancer in patients refractory to tamoxifen. Atossa has since secured drug manufacturing supply, developed topical and oral formulations and filed composition of matter and methods of treatment patent applications (with patent lives potentially into 2036). In March 2017, Atossa started a Phase I safety study in Australia, engaging CPR Pharma Services pty Ltd (CPR) to conduct the trial. In addition to assessing safety and tolerability, the placebo-controlled, repeat dose 28-day study on 48 healthy female volunteers will evaluate the pharmacokinetics of both an oral and a topical endoxifen formulation. The first of six cohorts (comprising eight patients each) was enrolled in early April. On 20 April 2017, the firm announced a positive interim safety review from its independent safety committee, which had reviewed blinded data generated from the first cohort and determined that the trial could advance to a higher dosing level. On 19 May 2017, Atossa announced that it had completed enrolment of the topical arm of this Phase I dose escalation study. The firm is now recruiting participants in the other half of the trial, which consists of 24 patients receiving Atossa's proprietary oral endoxifen formulation.

ER modulation with tamoxifen reduces cancer recurrence risk

Following surgical treatment for atypical hyperplasia (AH) or non-invasive estrogen-receptor positive (ER+) breast cancers, additional treatment with a selective estrogen receptor modulation (SERM) drug such as tamoxifen or raloxifene (Evista) is often recommended. A large-scale randomized study (IBIS-I) found that tamoxifen reduced breast cancer incidence in high-risk women by 30-50% over five years of treatment, for ER+ cancer. Extended use of tamoxifen (10 years versus five years) may further reduce recurrence risk and mortality, so US clinical practice guidelines now recommend consideration of adjuvant tamoxifen therapy for 10 years.[1] [2] [3]

Tamoxifen is effective in both pre-menopausal and post-menopausal cancers, and raloxifene, a newer SERM drug,[4] is only approved for use in post-menopausal women. Given its well-documented long history of use and relatively inexpensive cost (ZenRx estimates that the wholesale cost of a daily 20mg tablet of generic oral tamoxifen can be as little as $0.15), tamoxifen remains the mainstay preventative or post-surgical treatment for ER+ breast cancers (or related conditions such as AH), particularly in pre-menopausal women.

Endoxifen intended for patients refractory to tamoxifen

Orally dosed tamoxifen is metabolized in the liver by enzymes (including cytochrome P450 isoforms) into multiple metabolites, yet only a few of these metabolites have an active ER antagonist effect (blocking estrogen from binding to its receptors). The most significant of these (in terms of ER antagonism contribution and plasma concentration in patients with normal tamoxifen metabolism) are endoxifen (4-hydroxy-N-desmethyltamoxifen) and, to a lesser extent, 4-hydroxytamoxifen;[5] [6] .Several research groups found that patients with deficiencies in certain cytochrome P450 enzymes (due to genetic factors, medication interactions or other factors) have an impaired ability to metabolize tamoxifen into endoxifen, and that up to 15-20% of Europeans carry genetic P450 CYP2D6 variants associated with an impairment in forming anti-estrogenic tamoxifen metabolites.[6]

Fox et al. found that in 122 patients taking 20mg/day of tamoxifen (the standard dose), 24% had blood endoxifen levels of below 15nmol/L, and suggests that 15nmol/L may be the critical level needed for anticancer effect.[7] Multiple study groups (Fox, Madlensky, Saladores) find that in patients taking tamoxifen, those with the lowest amounts of systemic endoxifen (resulting presumably from impaired tamoxifen metabolism), have higher risks of cancer recurrences (between 35% and 60% higher risk, depending on the study) than remaining tamoxifen-treated patients.[8],[9] The above studies form a basis for dosing endoxifen directly in such patients.

Phase II endoxifen study planned for H217

If results from the ongoing Phase I study are positive, Atossa plans to initiate a Phase II study on endoxifen in H217. The firm previously suggested that this study would be in pre-menopausal women with ER+ breast cancer in patients already taking tamoxifen (20mg/day). Patients below a

[1] Davies C, Pan H, Godwin J, et al. Lancet. 2012.

[2] Davies C, Pan H, Godwin J, et al. Lancet. 2013;381: 805-816.

[3] Burstein HJ, Temin S, Anderson H, et al. J Clin Oncol. 2014;32: 2255-2269.

[4] Vogel VG, Costantino JP, Wickerham DL, et al. JAMA. 2006 Jun 21; 295(23):2727-41.

[5] Clin Pharmacol Ther. 2011 May;89(5):708-17. doi: 10.1038/clpt.2011.27.

[6] Schroth W, Antoniadou L, Fritz P, et al. J Clin Oncol. 2007 Nov 20;25(33):5187-93.

[7] Fox P, Balleine RL, Lee C, et al. Clin Cancer Res. 2016 Jul 1;22(13):3164-71.

[8] Madlensky L, Natarajan L, Tchu S, et al. Clin Pharmacol Ther. 2011 May;89(5):718-25.

[9] Saladores P, Mürdter T, Eccles D et al. The Pharmacogenomics Journal (2015) 15, 84–94.

pre-specified threshold of systemic (plasma level) endoxifen will take the company's endoxifen formulation and those above that threshold will continue on tamoxifen (20mg/day). The study will compare blood endoxifen levels between both groups, as well as assess pharmacokinetics (PK) and safety.

Pivotal study under 505(b)2 could start in mid-2018

As tamoxifen has a long-established history of systemic use, and as endoxifen is a metabolite of this drug (and with a similar "active moiety"[10]), we believe it could be eligible for the 505(b)2 registration pathway and as such, a Phase III trial demonstrating endoxifen's efficacy may not be necessary for approval. We continue to assume that an additional study will be required for approval, beyond the currently planned Phase II study; we estimate it will begin in mid-2018 and could lead to approval in 2020. Rather than commercialize endoxifen itself, we continue to believe Atossa will seek to partner its endoxifen formulation with a pharma company in 2018 (prior to starting the pivotal trial), and we model that it will be entitled to 20% in net royalties.

In terms of product safety and possible interactions, we note that some researchers have found that endoxifen, due to its effects on the protein kinase C (PKC) signaling system, can potentially have a therapeutic effect for treating patients with mania or bipolar disorder,[11] although other groups have also found similar effects with tamoxifen[12] as it also inhibits PKC; hence we do not believe the PKC effect is likely to hinder endoxifen's commercial or regulatory prospects.

NCI/Mayo Clinic group activity on endoxifen could provide competition

As stated in our 30 November 2016 note, a team of investigators at Mayo Clinic (Goetz M, Ames M, and collaborators) and the National Cancer Institute (NCI) is studying its own formulation of endoxifen hydrochloride in treating patients with ER+ breast cancer (but negative for HER receptors). While Atossa is filing patents for its own endoxifen formulation and methods of treatment, there is a material risk that competing studies from the Mayo/NCI investigators, should they lead to registration or commercialization-stage end products, could lead to intellectual property (IP) related competition challenges to Atossa's eventual endoxifen product.

Endoxifen revenue assumptions unchanged

Based on findings from Madlensky and Fox, we continue to assume that 20% of the 300,000 US women (and approximately one million women worldwide) currently taking tamoxifen do not achieve sufficient endoxifen concentrations, and thus reflect the potential target market for Atossa's endoxifen (thus 60,000 persons in the US), and that peak market share for Atossa's product would be 50% of this group, which would be attained within five years of launch (2025). As we model a starting net price of $200/month for the drug on launch (in 2020), we anticipate peak sales in 2025 of $91m and $161m in the US and worldwide, respectively which, at our 20% assumed royalty rate, leads to global net royalties of $32.1m to Atossa in 2025.

We reiterate that there is the potential for some variability in our market size estimates. A study[13] on 279 Polish women taking tamoxifen found that nearly 60% of these had endoxifen concentrations below the predefined threshold of therapeutic efficacy. If convincing clinical data can be developed for physicians, patients and stakeholders on the potential benefits of (oral or topical) endoxifen (vs

[10] The FDA defines "active moiety" as the part of "the molecule or ion" (excluding certain appended portions or other non-covalent attachments) "responsible for the physiological or pharmacological action of the drug substance".

[11] Ahmad A, Sheikh S, Shah T et al. Clin Transl Sci. 2016 Jun 27. doi: 10.1111/cts.12407

[12] Talaei A1, Pourgholami M, Khatibi-Moghadam H, et al. J Clin Psychopharmacol. 2016 Jun;36(3):272-5. doi: 10.1097/JCP.0000000000000492

[13] Hennig EE, Piatkowska M, Karczmarski J, et al. BMC Cancer. 2015 Aug 1;15:570.

tamoxifen) to a wider range of the current tamoxifen treatment population than we currently assume (20%), there could be upside to our peak sales estimates.

IDMC-fulvestrant timelines pushed back

Atossa's intraductal microcatheter (IDMC) intends to deliver therapeutics for breast cancer and/or precancerous conditions, with potentially higher local exposure and lower systemic exposure vs established therapies or delivery approaches. The current IDMC clinical program is designed to irrigate and deliver fulvestrant (marketed as Faslodex by AstraZeneca) to each of the five to seven breast ducts. Fulvestrant is FDA-approved for estrogen receptor-positive (ER+) metastatic breast cancer (with $830m in global 2016 sales, up 18% y-o-y) and is normally administered by intramuscular (IM) injection (to the buttocks), usually consisting of a monthly dose of two injections (costing $10,000-14,000 a month in the US).

Atossa in early 2017 transferred the site of its ongoing 30-pt open-label Phase II study on intraductal catheter (IDMC) administered fulvestrant to the Montefiore Medical Center in New York City, from the Columbia University Medical Center where it had been initiated in March 2016. This move follows the relocation of the study's primary investigator, Dr Sheldon M Feldman, from Columbia to Montefiore. Atossa believes this move will hasten patient recruitment, which had been slower than expected. Its revised timeline for completion of enrolment is August 2017, compared to its previously guided completion by YE16. Since moving the study site, Atossa has received positive approval from Montefiore's institutional review board to continue the trial.

The IDMC-fulvestrant study is comparing the safety, tolerability and pharmacokinetics following the IDMC instillation of fulvestrant (n=24), compared to intramuscular (IM) administration (n=6), in a neoadjuvant setting[14] in patients with breast cancer or ductal carcinoma in situ (DCIS) who are scheduled for mastectomy or lumpectomy. The primary outcome measure is the number and severity of adverse events at four weeks using the National Cancer Institute's CTCAE v4.0 protocol. The study will also measure changes in the expression of Ki-67[15] as well as estrogen and progesterone receptors, between biopsies taken prior to fulvestrant therapy, and post-treatment surgical specimen.

Now projecting IDMC-fulvestrant potential launch in H121

We continue to believe that after the current IDMC-fulvestrant trial, a larger (200- to 400-patient) pivotal study will be needed before approval, under the FDA 505(b)2 process. We project the company to partner the IDMC-fulvestrant program with an oncology-experienced medical devices and/or pharma firm before or in parallel to starting this pivotal study, with Atossa entitled to 20% royalties on net IDMC sales

While we previously modeled that the pivotal study could start in late 2017 or early 2018, given the push back in expected recruitment completion for the ongoing study, we now expect that the pivotal study would start in H218, which pushes back our potential launch forecast to H121 (from mid-2020 previously). We continue to estimate that the IDMC single-use device will be sold at launch at $3,500 per monthly application.

We reiterate that our launch forecasts differ somewhat from management's guidance, as it anticipates that the FDA may require fewer clinical data to approve IDMC-fulvestrant. If Atossa can obtain IDMC-fulvestrant approval earlier than our estimates, there could be upside to our forecasts.

[14] A neoadjuvant treatment refers to a therapy provided as a first step to shrink or control a tumor before the main (or more involved) treatment, usually surgery, is provided. In the ongoing Phase II IDMC-fulvestrant trial, the neoadjuvant treatment (fulvestrant by IM or IDMC administration) is provided 30-45 days before surgery.

[15] Ki-67 is a protein marker for cellular proliferation whose density level correlates with cancer growth and progression.

We assume that IDMC-fulvestrant will be used in the neoadjuvant setting in the treatment of ER+ breast cancers. The American Cancer Society (ACS) estimates that about 252,710 new cases of invasive breast cancer will be diagnosed in women per year. Approximately 75-80% of such breast cancers are ER+[16] (ie they grow in response to estrogen).

We anticipate that IDMC-fulvestrant will be used in a peak case of 25% of neoadjuvant treatment scenarios (reflecting only up to 40% of diagnosed ER+ breast cancers, primarily those at Stage II and III). We expect commercialization through 2030, when the IDMC technology's core patents expire.

While we have not changed our peak penetration forecasts (25%), given the push back in our launch and peak sales attainment timelines and a 2.45% increase in the estimated US prevalence of breast cancer (given more recent ACS data), we have changed our peak global IDMC-fulvestrant product sales estimate (consisting of the IDMC device and separate from the cost of the fulvestrant drug) from $183m in 2025, to $191m in 2026; this translates to peak royalties to Atossa of $38.3m in 2026.

Exhibit 1: IDMC-fulvestrant sales forecasts

Year end 31 December	2021	2022	2023	2024	2025	2026
US market						
Estimated breast cancer incidence (000)	270.7	274.8	278.9	283.1	287.3	291.6
Estrogen-receptor positive proportion (%)	75.0	75.0	75.0	75.0	75.0	75.0
Neoadjuvant therapy eligible proportion (%)	40.0	40.0	40.0	40.0	40.0	40.0
IDMC-fulvestrant market share (%)	3.1	9.3	14.4	19.4	24.1	25.0
Number of IDMC-fulvestrant units sold	2,543	7,632	12,033	16,460	20,746	21,874
Average IDMC selling price ($)	3,500	3,675	3,859	4,052	4,254	4,467
Total IDMC-fulvestrant product revenues ($000)	8,900	28,046	46,432	66,690	88,258	97,710
Royalty rate (%)	20.0	20.0	20.0	20.0	20.0	20.0
Net revenue to Atossa ($000)	1,780	5,609	9,286	13,338	17,652	19,542
Europe and ex-US markets						
Total IDMC-fulvestrant product revenues ($000)	8,530	26,882	44,504	63,921	84,595	93,654
Royalty rate (%)	20.0	20.0	20.0	20.0	20.0	20.0
Net revenue to Atossa ($000)	1,706	5,376	8,901	12,784	16,919	18,731
Worldwide IDMC-fulvestrant sales ($000)	17,430	54,929	90,936	130,611	172,853	191,364
Worldwide IDMC-fulvestrant royalties to Atossa ($000)	3,486	10,986	18,187	26,122	34,571	38,273

Source: Edison Investment Research

Financials and valuation

Atossa reported Q117 results on 11 May 2017, with a net loss of $1.7m ($0.45 per share given 3.79m average Q117 shares outstanding), and an operating cash burn rate of $1.86m. Q117 R&D costs were $0.54m, which given that 2016 full-year R&D costs were $0.77m, indicates that spending for both clinical trial programs ((IDMC-fulvestrant and endoxifen) are ramping up. We expect R&D costs to increase further in coming quarters as recruitment for the ongoing fulvestrant and endoxifen studies progress.

Atossa had $1.2m net cash at Q117 and with the $3.9m net proceeds from the recently-completed equity offering, we calculate pro-format Q117 net cash at $5.1m, and estimate Q217 net cash of $3.0m (which assumes a Q217 burn rate of $2.1m). We assume the funds on hand should maintain operations into Q417.

Our model assumes a 2017 burn rate of $9.9m, and that Atossa will raise an additional $16m in funding in H217, and $15m in 2018. As per our usual policy, for modeling purposes, we assign these financings to long-term debt. However, the company may need to issue equity instead, at a pricing that may not be favorable for current shareholders and could lead to significant dilution. For

[16] Onitilo AA, Engel JM, Greenlee RT, et al. Clin Med Res. 2009 Jun; 7(1-2): 4–13.

instance, raising $31m in equity at today's market prices could dilute shareholders by about 85%. Further, in the event the company is unable to raise the required funds, we believe it may need to delay or deprioritize one of its programs. This would have a negative effect on the pipeline valuation.

Exhibit 2: Atossa Genetics rNPV assumptions

Product contributions (net of R&D costs)	Indication	rNPV ($m)	rNPV/share ($)	Probability of success	Launch year	Peak US market share	Peak WW sales (US$m)
Intraductal microcatheter (for fulvestrant)	Breast cancer	21.0	2.17	25.0%	2020	25%	191 in 2026
Endoxifen	Breast cancer	14.8	1.53	15.0%	2020	12.5% of patients taking tamoxifen	161 in 2025
Corporate costs & expenses							
SG&A expenses		(22.6)	(2.34)				
Net capex, NWC & taxes		(6.9)	(0.71)				
Total rNPV		6.3	0.65				
Net cash (debt) (Q217e*)		3.0	0.31				
Total equity value		9.3	0.96				
FD shares outstanding (000) (Q217e**)		9,650					

Source: Edison Investment Research. Note: *Pro forma inclusive of funding from April 2017 offering; **Following completion of April 2017 equity offering and giving effect of full conversion of 1,352 Series A Convertible Preferred shares.

Our rNPV valuation continues to include the prospects of the company's endoxifen and the IDMC-fulvestrant programs. We assume that Atossa will spend $4.6m in R&D on the IDMC-fulvestrant program in 2017 and H118 before partnering it, and that it will spend $6.4m on endoxifen R&D across 2017 and Q318 (prior to entering a license agreement on this program). As the endoxifen program is now in Phase I studies, we have raised our probability of success estimate for this program to 15.0% (from 12.5% previously); this continues to take into account product development risk, as well as the IP risk and competitive risk from the Mayo/NCI investigations and trials for their own endoxifen formulation. We continue to apply a 25% probability for the IDMC-fulvestrant program. We now obtain an rNPV of $6.3m (up from $6.2m previously). Upward effects on rNPV valuation from rolling forward our forecasts and increasing the endoxifen success probability are offset by the pushback in our IDMC-fulvestrant timing estimates. After including Q217 estimated net cash of $3.0m, we obtain an equity valuation of $9.3m, or $0.96 per FD share.

Exhibit 3: Financial summary

US$(000)	2014	2015	2016	2017e	2018e	2019e
31-December	IFRS	IFRS	IFRS	IFRS	IFRS	IFRS
PROFIT & LOSS						
Revenue	40	2	0	0	0	0
Cost of Sales	0	(132)	0	0	0	0
General & Administrative	(8,360)	(9,996)	(6,176)	(4,552)	(3,800)	(3,000)
Research & Development	(1,110)	(2,360)	(770)	(5,144)	(7,125)	(400)
EBITDA	(6,943)	(9,484)	(6,946)	(9,697)	(10,925)	(3,400)
Depreciation	(388)	(273)	(303)	(194)	(170)	(147)
Amortization	0	0	0	0	0	0
Operating Profit (before exceptionals)	(7,331)	(9,756)	(7,250)	(9,891)	(11,095)	(3,547)
Exceptionals	(2,352)	0	881	(17)	0	0
Other	(2,487)	(3,002)	0	0	0	0
Operating Profit	(12,171)	(12,758)	(6,369)	(9,907)	(11,095)	(3,547)
Net Interest	0	0	0	18	(123)	(233)
Profit Before Tax (norm)	(7,331)	(9,756)	(7,250)	(9,873)	(11,218)	(3,780)
Profit Before Tax (FRS 3)	(12,171)	(12,758)	(6,369)	(9,889)	(11,218)	(3,780)
Tax	0	0	0	0	0	0
Profit After Tax and minority interests (norm)	(7,331)	(9,756)	(7,250)	(9,873)	(11,218)	(3,780)
Profit After Tax and minority interests (FRS 3)	(12,171)	(12,758)	(6,369)	(9,889)	(11,218)	(3,780)
Average Number of Shares Outstanding (m)	1.6	1.9	2.9	4.7	5.2	5.4
EPS - normalised ($)	(4.57)	(5.15)	(2.46)	(2.11)	(2.17)	(0.70)
EPS - normalised and fully diluted ($)	(4.57)	(5.15)	(2.46)	(2.11)	(2.17)	(0.70)
EPS - (IFRS) ($)	(7.59)	(6.73)	(2.16)	(2.11)	(2.17)	(0.70)
Dividend per share (C$)	0.0	0.0	0.0	0.0	0.0	0.0
BALANCE SHEET						
Fixed Assets	2,424	1,948	890	637	542	478
Intangible Assets	1,887	1,701	640	610	610	610
Tangible Assets	537	248	249	27	(68)	(132)
Current Assets	9,340	4,295	3,255	13,380	17,028	28,473
Short-term investments	0	275	55	55	55	55
Cash	8,501	3,716	3,028	13,031	16,678	28,123
Other	839	304	172	295	295	295
Current Liabilities	(2,263)	(2,502)	(1,047)	(775)	(388)	(388)
Creditors	(2,263)	(2,502)	(1,047)	(775)	(388)	(388)
Short term borrowings	0	0	0	0	0	0
Long Term Liabilities	(2)	0	0	(16,000)	(31,000)	(46,000)
Long term borrowings	0	0	0	(16,000)	(31,000)	(46,000)
Other long term liabilities	(2)	0	0	0	0	0
Net Assets	9,498	3,742	3,097	(2,757)	(13,818)	(17,437)
CASH FLOW						
Operating Cash Flow	(10,555)	(13,953)	(5,375)	(9,911)	(11,154)	(3,239)
Net Interest	0	0	0	18	(123)	(233)
Tax	0	0	0	0	0	0
Capex	(5)	(131)	(9)	(5)	(75)	(83)
Acquisitions/disposals	(339)	(158)	0	0	0	0
Financing	13,156	9,457	4,696	3,900	0	0
Net Cash Flow	2,257	(4,785)	(688)	(5,997)	(11,352)	(3,555)
Opening net debt/(cash)	(6,327)	(8,501)	(3,991)	(3,083)	2,914	14,267
HP finance leases initiated	0	0	0	0	0	0
Other	(83)	275	(220)	0	0	0
Closing net debt/(cash)	(8,501)	(3,991)	(3,083)	2,914	14,267	17,822

Source: Edison Investment Research; Company reports

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