

ATOSSA GENETICS INC  
Form 10-K  
March 28, 2013

**UNITED STATES**

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark one)

**Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

**For the fiscal year ended December 31, 2012**

**OR**

**Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

**For the transition period from:                      to**

Commission File Number 001-35610

**ATOSSA GENETICS INC.**

**(Exact name of registrant as specified in its charter)**

**Delaware                      26-4753208**  
**(State or other              (I.R.S. Employer**  
**jurisdiction of              Identification No.)**  
**incorporation or**  
**organization)**

**4105 E. Madison Street, Suite 320**

**Seattle, Washington 98112**

**(Address of principal executive offices)**

Registrant's telephone number, including area code: **(206) 325-6086**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
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Common Stock, \$0.001 par value	The NASDAQ Capital Market
---------------------------------	---------------------------

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.  
Yes  No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes  No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes  No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

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Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer or a non-accelerated filer, as defined in Rule 12b-2 of the Exchange Act.

Large accelerated filer  Accelerated filer  Non-accelerated filer  (Do not check if a smaller reporting company)  Smaller reporting company x

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).  
Yes  No

As of June 29, 2012, the last business day of the registrant's most recently completed second fiscal quarter there was no public market for the registrant's common stock. The registrant's common stock began trading on The NASDAQ Capital Market on November 8, 2012.

The number of shares outstanding of the registrant's Common Stock, par value \$0.001, as of March 27, 2013 was 14,174,686.

**Documents Incorporated by Reference**

Portions of the registrant's Proxy Statement, which will be filed with the Securities and Exchange Commission (SEC) pursuant to Regulation 14A in connection with the registrant's 2013 Annual Meeting of Shareholders, expected to be held on or about May 6, 2013, are incorporated by reference in Part III of this Form 10-K.

**ATOSSA GENETICS INC.  
2012 FORM 10-K REPORT  
TABLE OF CONTENTS**

	<b>PAGE</b>
<b>PART I</b>	
Item 1. Business	5
Item 1A. Risk Factors	29
Item 1B. Unresolved Staff Comments	39
Item 2. Properties	39
Item 3. Legal Proceedings	39
Item 4. Mine Safety Disclosures	39
<b>PART II</b>	
Item 5. Market for the Registrant's Common Equity, Related Shareholder Matters and Issuer Purchases of Equity Securities	40
Item 6. Selected Financial Data	41
Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations	41
Item 7A. Quantitative and Qualitative Disclosures about Market Risk	48
Item 8. Financial Statements and Supplementary Data	48
Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	48
Item 9A. Controls and Procedures	48
Item 9B. Other Information	48
<b>PART III</b>	
Item 10. Directors, Executive Officers and Corporate Governance	49
Item 11. Executive Compensation	49
Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Shareholder Matters	49
Item 13. Certain Relationships and Related Transactions, and Director Independence	49
Item 14. Principal Accountant Fees and Services	49
<b>PART IV</b>	
Item 15. Exhibits and Financial Statement Schedules	49
Signatures	74

## NOTE REGARDING FORWARD-LOOKING STATEMENTS

Statements made in this report on Form 10-K that are not statements of historical information are forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the “*Securities Act*”) and Section 21E of the Securities Exchange Act of 1934, as amended (the “*Exchange Act*”). We have made these statements in reliance on the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. These statements are subject to certain risks and uncertainties, which could cause actual results to differ materially from those projected or anticipated. Although we believe our assumptions underlying our forward-looking statements are reasonable as of the date of this report we cannot assure you that the forward-looking statements set out in this report will prove to be accurate. We typically identify these forward-looking statements by the use of forward-looking words such as “expect,” “potential,” “continue,” “may,” “will,” “should,” “could,” “would,” “seek,” “intend,” “plan,” “estimate,” “an” negative version of those words or other comparable words. Forward-looking statements contained in this report include, but are not limited to, statements about:

- our ability to successfully sell our products and services at currently expected prices or otherwise at prices acceptable to us;

- our ability to successfully develop and commercialize new tests, tools and technologies currently in development and in the time frames currently expected;

- our ability to engage third-party suppliers to manufacture the MASCT or Microcatheter System and its components at quantities and costs acceptable to us;

- our ability to satisfy ongoing Food and Drug Administration requirements for the MASCT and Microcatheter System and to obtain regulatory approvals for our other products and services in development, including our ability to timely and adequately respond to the warning letter we received from the FDA on February 21, 2013 and any issues resulting therefrom;

- the benefits and clinical accuracy of the ForeCYTE and ArgusCYTE tests and whether any product or service that we commercialize is safer or more effective than competing products and services;

- our ability to establish and maintain intellectual property rights covering our products and services;

- the willingness of health insurance companies, including those who are members of the MultiPlan and FedMed networks, and other third-party payors to approve our products and services for coverage and reimbursement;

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our ability to establish and maintain an independent sales representative force, including with Clarity Women's Health, a division of Diagnostic Test Group LLC, and its distributors, to market our products and services that we may develop, both regionally and nationally;

- our expectations regarding, and our ability to satisfy, federal, state and foreign regulatory requirements;

the accuracy of our estimates of the size and characteristics of the markets that our products and services may address;

- our expectations as to future financial performance, expense levels and liquidity sources; and
- our ability to attract and retain key personnel.

Factors that could cause actual results or conditions to differ from those anticipated by these and other forward-looking statements include those more fully described in the "ITEM 1A. RISK FACTORS" section and elsewhere in this report. Except as required by law, we assume no obligation to update any forward-looking statements publicly, or to revise any forward looking statement to reflect events or developments occurring after the date of this report, even if new information becomes available in the future. Thus, you should not assume that our silence over time means that actual events are bearing out as expressed or implied in any such forward-looking statement.

## CORPORATE INFORMATION

Our corporate website is located at [www.atossagenetics.com](http://www.atossagenetics.com) and our laboratory website is located at [www.nrlbh.com](http://www.nrlbh.com). Information contained on, or that can be accessed through, our websites is not a part of this report. We make available, free of charge through our website or upon written request, our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and other periodic SEC reports, along with amendments to all of those reports, as soon as reasonably practicable after we file the reports with the SEC.

Unless otherwise noted, the term "Atossa Genetics" refers to Atossa Genetics Inc., a Delaware corporation, the terms "Atossa," the "Company," "we," "us," and "our," refer to the ongoing business operations of Atossa and its wholly-owned subsidiary, whether conducted through Atossa Genetics or its subsidiary. We were incorporated in Delaware in April 2009. Our principal executive offices are located at 4105 East Madison Street, Suite 320, Seattle, Washington 98112, and our telephone number is (206) 325-6086.

MASCT is our registered trademark and Oxy-MASCT and our name and logo are our trademarks. ForeCYTE, FullCYTE, NextCYTE, and ArgusCYTE are our service marks. This report also includes additional trademarks, trade names and service marks of third parties, which are the property of their respective owners.

## **PART I**

### **ITEM 1. BUSINESS**

#### **Overview**

We are a healthcare company focused on the prevention of breast cancer through the commercialization of diagnostic medical devices and laboratory developed tests that can detect precursors to breast cancer, and through the research, development, and ultimate commercialization of treatments for pre-cancerous lesions and ductal carcinoma in situ, or DCIS.

Our leading diagnostic test, the ForeCYTE Breast Health Test, consists of a patented medical device that can collect fluid samples from the breast milk ducts, where, according to the National Cancer Institute, over 95% of breast cancers arise. These samples are processed at our wholly-owned National Reference Laboratory for Breast Health, which has been certified pursuant to the Clinical Laboratory Improvement Amendments, or CLIA. CLIA certification is legally required to receive reimbursement from federal or state medical benefit programs, like Medicare and Medicaid, and is a practical requirement for most third-party insurance benefit programs. Our CLIA-certified laboratory, which is permitted to accept samples from all 50 states under its CLIA certification, its state licenses, or, in New York under recognized exemption provisions while its license application is pending, examines the specimens by microscopy for the presence of normal, pre-malignant, or malignant changes as determined by cytopathology and biomarkers that distinguish “usual” ductal hyperplasia, a benign condition, from atypical ductal hyperplasia, which may lead to cancer. These cytopathological results provide patients and physicians with information about the care path that should be followed, depending on the individual risk of future cancer as determined by the results. Our other diagnostic test is the ArgusCYTE Breast Health Test for breast cancer survivors. This is a blood sample test that provides information to help inform treatment options and to help monitor risk of recurrence. Other tests under development are the FullCYTE Breast Health Test and the NextCYTE Breast Cancer Test.

Additionally, we are conducting research on the treatment of these pre-cancerous cells and DCIS by using our patented and FDA-cleared microcatheters to deliver, directly into the milk ducts, pharmaceutical formulations that can be used to treat these conditions. By using this localized delivery method, patients are expected to receive high local concentrations of these drugs at the site of the pre-cancerous lesions or DCIS potentially promoting efficacy of the treatment while limiting systemic exposure, which has the potential to lower the overall toxicity of these treatments.

We launched our commercial operations in late 2011 and, as of December 31, 2012, have enrolled and sold MASCT System kits or provided ArgusCYTE collection kits to 37 doctors and clinics as providers of the ForeCYTE and/or ArgusCYTE tests. We have received, processed, and reported the results to physicians from 1,664 ForeCYTE samples



and 41 ArgusCYTE samples as of December 31, 2012. When we launched operations in December 2011, we did so as part of our field experience trial to collect information about the ease or difficulty of adoption of the ForeCYTE and ArgusCYTE tests in both mammography clinics and physicians' offices, the number of sales calls to receive the first orders, and the growth of sales of specimen collection kits on a monthly basis. We are using the data from this field experience trial to form our national marketing efforts as we scale up our commercial operations going forward.

In September 2012, we acquired the assets of Acueity Healthcare, Inc., which included 35 issued patents (18 issued in the U.S. and 17 issued in foreign countries) and 41 patent applications (32 in the U.S. and 9 in foreign countries), six 510(k) FDA marketing authorizations related to the manufacturing, use, and sale of the Viaduct Miniscope and accessories, the Manoa Breast Biopsy system, the Excisor Bioptome, the Acueity Medical Light Source, the Viaduct Microendoscope and accessories, and cash in the amount of \$400,000. In January 2013, we announced the launch of our national sales effort of the ForeCYTE Breast Health test through Clarity Women's Health, a division of Diagnostic Test Group LLC, or Clarity, which together with its subdistributors has over 5,000 sales representatives calling on 33,000 obstetric-gynecologists. As of the date of this report, we have entered into contracts with two reimbursement organizations, MultiPlan, Inc. and FedMed, Inc.

On March 27, 2013 we entered into a stock purchase agreement with Aspire Capital Fund, LLC, which provides that, upon the terms and subject to the conditions and limitations set forth therein, Aspire is committed to purchase up to an aggregate of \$30 million of shares of our common stock over the three-year term of the agreement. Under the agreement, Aspire purchased \$1,000,000 of our common stock on March 27, 2013 for \$12 per share. Before we can sell any additional shares under the agreement, we must register the shares and have the registration statement declared effective by the SEC. Other terms and conditions of the agreement, including our issuance of 250,000 shares to Aspire as a commitment fee, are described below.

Our operations began in December 2008 around acquiring the MASCT System patent rights and assignments and the FDA clearance for marketing, which was completed in January 2009. We were incorporated in Delaware in April 2009. Our operations to date have consisted primarily of securing manufacturing for the MASCT and the Mammary Duct Microcatheter Systems, establishing our CLIA-certified laboratory, validating the laboratory developed tests we use in the ForeCYTE and ArgusCYTE tests, conducting research and development on the FullCYTE and NextCYTE tests, beginning the national launch of the ForeCYTE test and preparing for the commercialization of our products.

### **Summary of Our Diagnostic Tests**

We currently offer two diagnostic tests and plan to offer two additional tests in 2013. The tests that we currently offer and that are in development consist of the following:

**ForeCYTE** The ForeCYTE Breast Health Test, launched in December 2011, provides personalized information about the 10-year and lifetime risk of breast cancer for women between ages 18 and 73. It involves collecting a specimen of nipple aspirate fluid, or NAF, using our patented *Mammary Aspirate Specimen Cytology Test*, or MASCT, System (our MASCT device received 510(k) clearance from the FDA in 2003). The NAF specimen is collected by a physician and returned to our CLIA-certified laboratory. We study the patient's NAF specimen and use a proprietary molecular and cellular biomarker test that detects basal or luminal cells to identify the presence of atypical ductal hyperplasia, or ADH, which is considered a precursor to breast cancer. We then input these cytopathological test results, together with the patient's personal medical and reproductive history and family history, into a clinically-validated risk assessment algorithm that calculates 10-year and lifetime risk of breast cancer and presents these results in one of three risk tiers developed by The National Comprehensive Cancer Network: Normal (<15% lifetime risk), Intermediate (15 – 20% lifetime risk), or High (>20% lifetime risk). The ForeCYTE Test results contain recommendations for care paths in each risk group and personalized information so that patients and healthcare providers can make more informed treatment decisions. The algorithm was developed from a Swedish registry of 158,041 individuals, in whom 3,257 cancers occurred, and was validated by E. Amir, D.G. Evans, A. Shenton, and others in an independent study of 3,150 women, 64 of whom developed breast cancer. The algorithm incorporates family history, personal reproductive history, and the presence or absence of usual ductal hyperplasia, or UDH (which is benign), ADH (which is pre-malignant), or malignant changes. The present methods used by pathologists to analyze traditional biopsy specimens, i.e., microscopy and, when needed, immunohistochemistry, are the same methods used to analyze ForeCYTE specimens and would be expected to achieve similar results for patients with similar medical conditions.

**ArgusCYTE** The ArgusCYTE Breast Health Test, launched in December 2011, provides information to help inform breast cancer treatment options and to help monitor potential recurrence. It involves collecting a blood specimen from a patient using our patented blood collection tube and submitting it to our CLIA-certified laboratory (our ArgusCYTE Breast Health Test blood collection tube was registered with the FDA in 2011 as a 510(k)-exempt device). It can monitor breast cancer distant recurrence by obtaining a "liquid biopsy" or blood sample, and analyzing it for the presence of circulating tumor cells, which can then be analyzed to determine the expression of ER/PR and Her2 in those cells, a predictor of the cancer's sensitivity to existing treatment options. The presence of circulating tumor cells in the blood sample may serve as an early indicator of the recurrence of breast cancer and the data obtained from the ArgusCYTE sensitivity analysis may help physicians better select which treatment options to use with a particular patient. The ArgusCYTE test uses a proprietary blood collection tube to obtain a blood sample for shipment and analysis at our CLIA-certified laboratory. The supplier of the blood collection tube owns patents with respect to the tube, while we own patents concerning laboratory features utilized in the testing process. Because the ArgusCYTE test involves the collection of a blood sample to be analyzed for the presence of circulating tumor cells, there is no comparable method relating to the analysis of traditional biopsy specimens that could be used to achieve results similar to or better than those provided by our ArgusCYTE test.

**FullCYTE** The FullCYTE Breast Health Test, which we intend to launch in 2013 and is currently in development, is designed to assess the individual breast ducts for pre-cancerous changes in women previously identified to be at high risk for breast cancer. It involves collecting ductal lavage samples from each of the 5 to 7 individual breast milk ducts using our patented Mammary Ductal Microcatheter System (our Microcatheter System received 510(k) clearances from the FDA in 1999 and 2000) and analyzing the samples by the same molecular and cellular biomarkers used in the ForeCYTE test described above. From these tests, we are able to ascertain which individual duct contains pre-malignant or malignant

changes, which may allow the physician to better target treatment to the specific duct with the pre-malignant changes or malignant changes and therefore avoid side effects associated with systemic treatment. Traditional biopsies, involving invasive procedures in which tissue is removed surgically, typically cut across the natural anatomy of the breast ductal system, making subsequent intraductal treatment difficult or, in certain cases, impossible. The present methods used by pathologists to analyze traditional biopsy specimens, i.e., microscopy and, when needed, immunohistochemistry, are the same methods used to analyze FullCYTE specimens and would be expected to achieve similar results for patients with similar medical conditions.

The NextCYTE Breast Cancer Test, which is in the prevalidation phase and which we intend to launch in 2013, is designed to profile breast cancer specimens for prediction of treatment outcomes and distant recurrence in women newly diagnosed with breast cancer. It involves using surgery specimens and advanced genome sequencing techniques to quantify and analyze the entire tumor genetic transcriptome, which represents all genes that are being actively expressed within the tumor. Because our NextCYTE test analyzes traditional biopsy specimens using advanced genome sequencing techniques, we believe that other present methods of analyzing traditional biopsy specimens would not achieve results similar to or better than results provided by our NextCYTE test and we expect that physicians will be able to use the *NextCYTE* information provided by the NextCYTE test to better customize treatment options for women, based on the genetic composition of the individual tumor. The NextCYTE Breast Cancer Test is intended to use microarray-based genome-wide transcriptome data from surgical breast cancer biopsy specimens to predict a patient's 10-year survival probability and response to treatment. The algorithm was created from 2,400 unique genome-wide microarrays and validated against a separate sample of over 1600 microarray data sets. A correct classification was obtained for over 85% of both estrogen receptor negative and positive tumors. We have signed a term sheet for the exclusive license of the intellectual property related to this algorithm and we expect to complete the license in the first half of 2013 and to complete validation of the test in our laboratory soon thereafter, with an intent to launch this product before year end 2013.

The Medicare reimbursement rates set forth in this report are the 2012 rates, unless otherwise noted. These rates may be different than the 2013 rates.

## **Our Diagnostic Tools**

The assets we acquired from Acueity included 35 issued patents (18 issued in the U.S. and 17 issued in foreign countries) and 41 patent applications (32 in the U.S. and 9 in foreign countries), six 510(k) FDA marketing authorizations related to the manufacturing, use, and sale of the Viaduct Miniscope and accessories, the Manoa Breast Biopsy system, the Excisor Bioprobe, the Acueity Medical Light Source, the Viaduct Microendoscope and accessories, and cash in the amount of \$400,000. The microendoscopes are less than 0.9 mm outside diameter and can be inserted into a milk duct. This permits a physician to pass a microendoscope into the milk duct system of the breast and view the duct system via fiberoptic video images. Abnormalities that are visualized can then be biopsied from inside the duct with the biopsy tools that are inserted adjacent to the microendoscope. The patents relate to intraductal diagnostic and therapeutic devices and methods of use. We did not, however, acquire an inventory of these diagnostic tools, manufacturing capabilities or any personnel to market and sell the tools. Following the launch of our four diagnostic tests in the U.S., we will then begin to allocate human and financial resources to further develop and ultimately commercialize these medical devices. We intend to complete the steps necessary to begin marketing and selling these tools, such as re-establishment of the supply chain of component parts, securing manufacturers, performing test builds and commercial scale manufacturing, in late 2013. This asset purchase is not expected to have an impact on the development and commercialization timetables of our existing product lines. We cannot, however, provide any assurances that delays related to the launch of our four diagnostic tests, independent of the asset purchase, would not delay the expected development of these diagnostic tools or that we will ultimately be successful selling these tools.

We may not, however, achieve commercial market acceptance of any of our products and services. We must first demonstrate to physicians and other healthcare professionals the benefits of our tests and the MASCT System for their practice and these physicians and healthcare professionals may be reluctant to introduce new services into their practice due to uncertainty regarding reliability of the results of a new product or the learning curve associated with adoption of new services and techniques. Moreover, if third-party payors continue to refuse to cover the cost of collection of the NAF sample, whether from our MASCT System or competitors' NAF collection devices, physicians may be less likely to recommend or use our products and services if the cost of performing a particular test will not be reimbursed. Even if we are successful in convincing physicians and other healthcare professionals to utilize our tests and services, we must obtain adequate capital to fund our operations until we become profitable and we may not be able to do so. Additionally, we have no prior experience with commercializing any products or services and will need to create an infrastructure to scale operations for commercialization, including hiring experienced personnel (including anatomic pathologists, cytologists, histotechnologists, skilled laboratory and information technology staff, and sales representatives) and building a network of regional, specialty distributors, each with a staff of independent sales representatives who have experience in women's health products to target physicians and mammography clinics in the United States.

### **Intraductal Treatment Research**

Our Intraductal Treatment Research Program comprises our patented microcatheter-delivery technology and our patented pharmaceutical formulations for the intraductal treatment of breast pre-cancerous changes and DCIS. The method uses our Mammary Ductal Microcatheter System, invented by Dr. Susan Love, President of the Dr. Susan Love Research Foundation, and her colleagues, and acquired by us, to administer proprietary pharmaceutical formulations into milk ducts that display pre-cancerous changes or DCIS with high local concentrations of the drugs in order to promote greater efficacy and limited systemic exposure, potentially lowering the overall toxicity of the treatment.

An October 2011 peer-reviewed paper published in *Science Translational Medicine* documented a study conducted at the Johns Hopkins Medical School demonstrating the prevention of breast cancer in rats with intraductal non-systemic chemotherapy, and a proof-of-principle Phase 1 clinical trial involving 17 women with breast cancer who subsequently received surgery. An accompanying editorial commented that “intraductal treatment could be especially useful for women with premalignant lesions or those at high risk of developing breast cancer, thus drastically improving upon their other, less attractive options of breast-removal surgery or surveillance (termed ‘watch and wait’).”

In a December 2012 peer-reviewed paper published in *Cancer Prevention Research*, Dr. Susan Love and her colleagues report a Phase I clinical trial to show the safety and feasibility of intraductal administration of chemotherapy drugs into multiple ducts within one breast in women awaiting mastectomy for treatment of invasive cancer. Thirty subjects were enrolled in this dose escalation study conducted at a single center in Beijing, China. Under local anesthetic, one of two chemotherapy drugs, carboplatin or pegylated liposomal doxorubicin (PLD), was administered into five to eight ducts at three dose levels. Pharmacokinetic analysis has shown that carboplatin was rapidly absorbed into the bloodstream, whereas PLD, though more erratic, was absorbed after a delay. Pathologic analysis showed marked effects on breast duct epithelium in ducts treated with either drug compared with untreated ducts. The investigators concluded the study showed the safety and feasibility of intraductal administration of chemotherapy into multiple ducts for the purpose of breast cancer prevention and that this was an important step toward implementation of this strategy as a "chemical mastectomy", potentially eliminating the need for surgery.

We intend to build on these academic studies with a research program targeted initially as neoadjuvant therapy in DCIS and to begin preclinical studies during 2013. We may partner with a third party to provide the pharmaceutical for the program. However, we have not as of the date of this report contracted with such a partner nor have we begun the process of applying for FDA approval of our Intraductal Treatment Research Program.

### **Our Commercialization Strategy**

The ForeCYTE Test provides us with two revenue sources:

- (i) revenue from the sale of the MASCT System device and patient kits to physicians, breast health clinics, mammography clinics and distributors; and
- (ii) service revenue from the preparation and interpretation of the NAF samples sent to our laboratory for analysis.

The ArgusCYTE test provides only laboratory service revenue.

We offer each component of the MASCT System for sale separately. Our NAF sample collection devices are currently priced to physicians at approximately \$299 per starter kit, which includes the pump device and five patient collection kits, and our patient collection kits are currently priced at approximately \$35 per kit, however, our sale prices to our distributors are significantly below these prices and these prices are subject to change. During our initial launch, we plan to provide a rebate to the physician after the physician submits patient collection kits to our lab. The cytology and molecular diagnostics testing and analysis services are billed to federal and/or state health plans at the 2012 Medicare reimbursement rates of either \$384 or \$1,275 per patient, depending on the complexity of the analysis performed and at higher rates for patients covered by private insurance plans as is customary for our industry. We expect that the substantial majority of patients will be billed at the \$384 rate and that we would perform the more complex tests, corresponding with a reimbursement rate of \$1,275, for only those patients who have an initial test result that requires further analysis. Currently, Medicare and certain insurance carriers do not reimburse for the NAF collection procedure by our MASCT System or for other NAF collection device systems similar to our MASCT System, although Medicare and certain insurance carriers do reimburse for the laboratory analysis of the NAF sample. Although we have received reimbursement from insurance carriers and Medicare for our ForeCYTE test, any lack of Medicare or insurance coverage for the NAF collection procedure will require patients to bear the full costs of the NAF sample acquisition process used with the MASCT System, which may result in physicians and other healthcare professionals not adopting the MASCT System or recommending its use in patients. If this were to occur, we may be forced to reduce the price of the MASCT System, provide discounted pricing arrangements to secure sales, or we may not be able to sell the product and services components of the MASCT System at acceptable margins, all of which could limit our ability to generate revenue.

During our initial marketing efforts we are not charging for our ArgusCYTE collection kits and we currently price the ArgusCYTE test at approximately \$1,500. Because we do not currently have sufficiently reliable prior history of reimbursement with respect to the ArgusCYTE test, we currently do not recognize revenue until we have received reimbursement. We have billed the testing and analysis regarding the 41 ArgusCYTE samples processed through December 31, 2012 at \$1,500 per patient. We have received reimbursement from insurance carriers for our ArgusCYTE test.

### **Our National Launch Through Clarity**

In September 2012, we entered into a co-exclusive marketing agreement with Diagnostic Test Group LLC, or DTG, for the supply and distribution of the MASCT System, under the DTG Clarity brand. Under the terms of the agreement, DTG will purchase the MASCT System from us and will use its best efforts to establish product codes and contracted agreements for the sale and placement of the Clarity branded MASCT product line with the following distributors: Henry Schein, McKesson, PSS World Medical, Cardinal Health, VWR, Vaxserve, Mercedes Medical, Fisher, NDC members, Imco members, B&H Surgical, Marshall Medical and Cascade HealthCare Products. These distributors have collectively over 5,000 employee sales representatives and/or independent sales representatives selling their products to a target market of 33,000 obstetric-gynecologists in the United States.

We will coordinate the sales and marketing effort, plan, and budget with DTG, with us paying agreed expenses. We can terminate the agreement if DTG fails to achieve set minimum sales over a certain period of time. In consideration for DTG's marketing of the MASCT System, we have agreed to pay DTG a minimal cash fee for each test performed by us on MASCT samples sold by DTG, as well as warrants to purchase our common stock, which warrants are earned based on the annual number of ForeCYTE tests performed by the National Reference Laboratory for Breast Health, provided that the total number of warrants cannot exceed 1,000,000. These warrants have an exercise price equal to the fair market value of our common stock on the day of issuance.

In January 2013, we launched the ForeCYTE Breast Health Test with Clarity and its distributors, however, we may not be successful in selling the Clarity branded MASCT product line and we may not achieve any level of commercial success from their efforts.

### **Our Common Stock Purchase Agreement with Aspire Capital Fund, LLC**

On March 27, 2013 we entered into a stock purchase agreement with Aspire Capital Fund, LLC, which provides that, upon the terms and subject to the conditions and limitations set forth therein, Aspire is committed to purchase up to an aggregate of \$30 million of shares of our common stock over the three-year term of the agreement. Under the agreement, Aspire purchased 83,333 shares of our common stock on March 27, 2013 for \$12 per share. Before we can sell any additional shares under the agreement, we must register the shares and have the registration statement declared effective by the SEC. Other terms and conditions of the agreement are described below.

Concurrently with entering into the purchase agreement, we also entered into a registration rights agreement with Aspire. The registration rights agreement provides that the Company will file one or more registration statements, as necessary, to register under the Securities Act of 1933, as amended, the sale of the shares of common stock that have been and may be issued to Aspire under the purchase agreement. The Company agreed to file an initial registration statement registering the sale of the shares by Aspire with the SEC within 10 days of entering into the purchase agreement with Aspire. We further agreed to keep the registration statement effective and to indemnify Aspire for liabilities in connection with the sale of the shares under the terms of the registration rights agreement.

As described in more detail below, generally under the purchase agreement we have two ways we can elect to sell shares of common stock to Aspire on any business day we select: (1) through a regular purchase of up to 100,000 shares (but not to exceed \$400,000) at a known price based on the market price of our common stock prior to the time of each sale, and (2) through a volume-weighted average price ("VWAP") purchase of a number of shares up to 30% of the volume traded on the purchase date at a price equal to the lesser of the closing sale price or 95% of the VWAP for such purchase date.



Under the purchase agreement we issued 250,000 shares of our common stock to Aspire in consideration for entering into the purchase agreement. Immediately upon executing the purchase agreement, we also sold 83,333 shares of common stock for \$12 per share, for an aggregate purchase price of \$1,000,000. After the SEC declares the initial registration statement effective, on any business day on which the closing sale price of our common stock equals or exceeds \$2.00 per share, over the three-year term of the purchase agreement, we have the right, in our sole discretion, to present Aspire with a purchase notice directing Aspire to purchase up to 100,000 shares of our common stock per business day; however, no sale pursuant to such purchase notice may exceed \$400,000 per business day. The purchase price per share is the lower of (i) the lowest sale price for our common stock on the purchase date or (ii) the arithmetic average of the three lowest closing sale prices for our common stock during the 12 consecutive business days ending on the business day immediately preceding the purchase date. The applicable purchase price will be determined prior to delivery of any purchase notice.

In addition, on any date on which we have submitted a purchase notice to Aspire in the amount of 100,000 shares, we also have the right, in our sole discretion, to present Aspire with a volume-weighted average price purchase notice, or a "VWAP Purchase Notice" directing Aspire to purchase an amount of our common stock equal to a percentage (not to exceed 30%) of the aggregate shares of common stock traded on the next business day subject to a maximum number of shares determined by us. The purchase price per share pursuant to such VWAP Purchase Notice shall be generally the lower of (i) the closing sale price on the purchase date and (ii) 95% of the VWAP of our common stock traded on the Nasdaq Capital Market on the purchase day.

We have the right to sell up to \$30 million of our shares of common stock to Aspire, including the 83,333 shares sold to Aspire on March 27, 2013 and the 250,000 shares issued to Aspire as a commitment fee. We are obligated to register these shares with the SEC. Also, we have agreed to initially register 2,500,186 additional shares which we may sell to Aspire in the future. Under the rules of the Nasdaq Capital Market, in no event may we issue more than 19.99% of our shares outstanding (which is approximately 2,833,519 shares based on 14,174,686 outstanding on March 27, 2013) under the purchase agreement unless we obtain stockholder approval.

The number of Purchase Shares covered by, and the timing of, each purchase are determined by us, at our sole discretion. We may deliver multiple purchase notices to Aspire from time to time during the term of the purchase agreement, so long as the most recent purchase has been completed. There are no trading volume requirements or other restrictions under the purchase agreement. Aspire has no right to require any sales from us, but is obligated to make purchases as directed in accordance with the purchase agreement.

The purchase agreement contains customary representations, warranties, covenants, closing conditions and indemnification and termination provisions. The purchase agreement may be terminated by us at any time, at our discretion, without any cost or penalty. Aspire has covenanted not to cause or engage in any manner whatsoever, any direct or indirect short selling or hedging of our common stock. We did not pay any additional amounts to reimburse or otherwise compensate Aspire in connection with the transaction other than the commitment shares. There are no limitations on use of proceeds, financial or business covenants, restrictions on future financings, rights of first refusal, participation rights, penalties or liquidated damages in the purchase agreement. Dawson James Securities, Inc. acted as our placement agent in connection with the transaction and we agreed to pay Dawson James a cash fee equal to 3% of proceeds from any sales of shares to Aspire and a four-year warrant to purchase a number of shares equal to 3% of the total shares actually sold to Aspire. The warrant may not be exercised on a cashless basis.

Our gross proceeds will depend on the purchase prices and the frequency of sales of shares to Aspire; *provided, however*, that the maximum aggregate proceeds from sales of shares, including the initial 83,333 shares sold to Aspire on March 27, 2013, is \$30 million. Our delivery of purchase notices will be made subject to market conditions, in light of our anticipated capital needs from time to time and under the limitations contained in the purchase agreement. We expect to use proceeds from sales of shares for general corporate purposes and working capital requirements.

The issuance of the all shares to Aspire under the purchase agreement is exempt from registration under the Securities Act, pursuant to the exemption for transactions by an issuer not involving any public offering under Section 4(2) of the Securities Act and Rule 506 of Regulation D promulgated thereunder.

### **Reimbursement Organizations**

As of the date of this report, we have two contracts with third parties to facilitate the reimbursement process from insurers, one with MultiPlan, Inc. and another with FedMed, Inc. MultiPlan is a leading provider of healthcare cost management solutions for diagnostic laboratory testing involving our tests. Approximately 20% of Americans are covered by MultiPlan. The agreement allows us to participate in the MultiPlan, PHCS and PHCS Savility Networks. In March of 2013, we entered into an agreement with FedMed, which is a National Provider Network and Healthcare Financial Services Organization. FedMed is one of the largest proprietary Preferred Provider Organization (PPO) networks in the U.S. for diagnostic laboratory testing. FedMed's network is comprised of over 550,000 total providers, including 4,000 hospitals and more than 60,000 ancillary facilities, serving over 40 million Americans.

Our agreements with MultiPlan and FedMed will give their participating providers and their patients greater access to our tests, including the ForeCYTE and ArgusCYTE Breast Health Tests. We anticipate that the agreements with MultiPlan and FedMed will help ensure that more doctors and their patients have access to the ForeCYTE and ArgusCYTE Breast Health Tests and that patients will receive insurance reimbursement for the laboratory costs associated with these tests.

Our agreements with MultiPlan and FedMed provide that reimbursement will be provided to us at a prescribed rate when insurers agree to reimburse for the ForeCYTE and ArgusCYTE Breast Health Tests. The prescribed rates of reimbursement are within the range of reimbursement that we have historically received. Our agreements do not, however, ensure that each test performed will be deemed medically necessary and ultimately reimbursed by insurers as the insurers may still determine the medical necessity of each test on a case-by-case basis. Our strategy is to contract with additional reimbursement organizations and insurers.

### **Clinical Development and FDA-clearance of the MASCT System**

Under the direction of Steven Quay, a clinical trial of the MASCT System was conducted at the State University of New York, Stony Brook, New York in 2003 to test the efficiency of NAF collection in normal women. Thirty-one healthy, non-pregnant, pre-menopausal female volunteer subjects were tested with the MASCT System device for the ability to collect NAF samples and to observe the morphology of breast gland cells in the NAF (cytological examination), using the NAF cytology classification system of the College of American Pathologists, or CAP, as described in the table below.

<b>Category</b>	<b>Interpretation</b>	<b>Cytology Characteristics</b>
Category 0	Scant ductal epithelial cells and negative for atypical or malignant cells	No or <10 ductal cells.
Category I	Normal ductal cytology	Normal ductal epithelial cells.
Category II	Usual ductal hyperplasia	Cell groups with >10 – 50 cells.
Category III	Atypical ductal hyperplasia	Distinct large nuclei with irregular nuclear borders.
Category IV	Suspicious for malignancy	Single cells and groups of cells suspicious for cancer.

Of the 31 subjects, 30, or 97%, had measurable NAF; 24 from both breasts and six from only one breast. NAF samples ranged from less than one to 37 microliters, and all samples collected were deemed to be clinically useful. 58 of 60 NAF samples were reported as cytology Category I, and two of 60 were reported as cytology Category II under the CAP's classification system for NAF cytology. No adverse events were reported in the study. Based on the results of the study, a premarket notification for the intended use of the MASCT System for the collection of NAF for cytological testing was submitted to the FDA and subsequently cleared by the FDA, indicating that the NAF collected using the MASCT System can be used in the determination and/or differentiation of normal versus premalignant versus malignant cells.

### **The ForeCYTE Breast Health Test**

The ForeCYTE Test uses the patented, FDA-cleared MASCT System medical device for the collection, shipment and clinical laboratory analysis of NAF. The ForeCYTE test involves cytopathology and five biomarkers of hyperplasia and one biomarker of sample integrity and has been validated to CLIA standards. The product components of the MASCT System consist of a reusable hand-held pump for the collection of NAF, single-use patient kits that include two NAF sample collection tools per kit, and shipment boxes for the transportation of NAF samples to the National Reference Laboratory for Breast Health, our wholly-owned, CLIA-certified specialized cytology and molecular diagnostics laboratory in Seattle, Washington. Through our laboratory we provide the ForeCYTE Test, which consists of receiving and accessioning the two NAF samples from each patient, preparing routine and immunohistochemistry, or IHC, staining of slides from the NAF samples, and generating a report of the findings. The NAF is analyzed by microscopy for cytological abnormalities and by a patent-pending IHC staining technique for five biomarkers of hyperplasia and a sample integrity marker.

We offer each component of the MASCT System for sale separately. Our NAF sample collection devices are currently priced to physicians at approximately \$299 per starter kit, which includes the pump and five patient collection kits, and our patient collection kits are priced currently at approximately \$35 per kit, however, our sale prices to our distributors are significantly below these prices and these prices are subject to change. During our initial launch, we plan to provide a rebate to the physician after the physician submits patient collection kits to our lab. The cytology and molecular diagnostics testing and analysis services are billed to federal and/or state health plans at the 2012 Medicare reimbursement rates of either \$384 or \$1,275 per patient, depending on the complexity of the analysis performed. We expect that the substantial majority of patients will be billed at the \$384 rate and that we would perform the more complex tests, corresponding with a reimbursement rate of \$1,275, for only those patients who have an initial test result that requires further analysis. We have billed the testing and analysis regarding the 1,664 ForeCYTE samples processed through December 31, 2012 (which is equivalent to 832 patients). We bill third-party payors at higher rates, as is customary for our industry. Currently, Medicare and certain insurance carriers do not reimburse for the NAF collection procedure by our MASCT System or for other NAF collection device systems similar to our MASCT System, although Medicare and certain insurance carriers do reimburse for the laboratory analysis of the NAF sample. We have received reimbursement from insurance carriers and Medicare for our ForeCYTE test.

### **The ArgusCYTE Breast Health Test**

The ArgusCYTE test has been tested and validated and provides information to help inform breast cancer treatment options and to help monitor potential recurrence. It uses a proprietary blood collection tube to obtain a blood sample for shipment and analysis at the NRLBH. In June 2011, we entered into a non-exclusive supply agreement with Biomarkers LLC for the blood collection tubes and laboratory reagents and supplies for the ArgusCYTE test. The agreement provides for fixed purchase prices which decrease as we place larger orders. The ArgusCYTE test consists of a two-step “Combination-of-Combinations-Principle” involving (1) cell isolation, whereby tumor cells are enriched by a three antibody-mix linked to magnetic particles and mRNA is isolated from the selected tumor cells, and (2) molecular biological detection and analysis, whereby the isolated mRNA is transcribed into cDNA and a multiplex

PCR is carried out for the analysis of epithelial cell related transcripts and tumor associated gene expression. Due to the combination of different selection and tumor markers, both the heterogeneity of the tumor cells and possible individual or therapy-induced deviations in the expression patterns are taken into account.

As far as we know, the ArgusCYTE test is the only CLIA-certified circulating breast tumor cell test available that identifies mRNA expression levels for estrogen receptors (ER), progesterone receptors (PR), and HER-2 antigen in a single blood draw to help guide treatment selection by determining which of the most commonly used therapies may be effective for the individual patient. The test can identify circulating tumor cells immediately after a woman begins breast cancer therapy or at the time of diagnosis or biopsy so that she and her healthcare provider can make better-informed decisions about effective treatment options. Analytical validation studies demonstrated a sensitivity of 94% and specificity of 100% at the 5 cancer cell/5 mL blood sample level (n=106). Clinical validation has been performed by unaffiliated research institutions in breast cancer patients in trials in Europe and the United States over the last eight years.

We provide the proprietary, blood collection tube free of charge and currently charge approximately \$1,500 for the ArgusCYTE test. Because we do not currently have a sufficiently reliable prior history of reimbursement with respect to the ArgusCYTE test, we currently do not recognize revenue until we have received reimbursement. We have billed the testing and analysis regarding the 41 ArgusCYTE samples processed through December 31, 2012 at \$1,500 per patient. We have received reimbursement from insurance carriers for our ArgusCYTE test.

### **The FullCYTE Breast Health Test**

The FullCYTE Breast Health Test uses our patented Mammary Duct Microcatheter System, invented by Dr. Susan Love, author, breast surgeon, and founder of the Dr. Susan Love Research Foundation, Santa Monica, California to lavage, or irrigate, each of the five to seven breast ducts and to collect the lavage fluid for analysis of biomarkers of hyperplasia by immunohistochemistry for protein biomarkers, Next Generation Sequencing for somatic DNA mutations, and transcriptome microarray analysis for mRNA expression patterns.

In April 2011 we acquired from Hologic, Inc. all of the ownership rights to the U.S. trademark, FirstCYTE, the 23 U.S. issued patents and 84 issued foreign counterparts (in Europe, France, Germany, Ireland, United Kingdom, Australia, Canada, Israel, Italy, The Netherlands, Spain, and Switzerland) covering the manufacture, use, and sale of the FirstCyte™ Breast Aspirator, the Micro-Stylet Dilator, and the FullCYTE Microcatheter for ductal lavage, the related manufacturing documentation, and the related regulatory documentation, including the FDA marketing authorization for these medical devices. We also paid an up-front fee and are obliged to pay patent-based royalties between 2% and 6% on aggregate net sales in the countries with issued patents. The FDA-cleared indications for use of the Breast Aspirator are to elicit fluid from multiple ductal orifices for subsequent cytological evaluation and/or to identify ductal orifices for subsequent cannulation with the microcatheter. The FDA-cleared indication for use of the Micro-Stylet Dilator is to dilate breast milk ducts prior to enhanced radiography (i.e., ductography) or ductal lavage procedures. The FDA-cleared indication for use of the microcatheter is to perform contrast enhanced radiography of breast milk ducts; it may also be used for the collection of cells and/or fluid for cytological analysis.

This project is in the research and development phase, and the Company has studied the use of the FullCYTE microcatheter in six patients to establish the feasibility of performing next-generation tests on samples taken with the microcatheters. The purpose of the study was to see if ductal lavage specimens provided sufficient quantities of DNA and RNA to perform full genome sequencing and transcriptome profiling. All specimens from the six patients contained sufficient, high-quality DNA and RNA to proceed to sequencing and transcriptome profiling. Results are expected in the first half of 2013 and the Company intends to launch the FullCYTE test in 2013.

In August 2011, we entered into an agreement with Accellent to perform development work to re-establish the supply chain for the FullCYTE microcatheter and manufacture the microcatheter for commercialization. The agreement divided the development work into three phases with a fixed time and budget for each phase. In aggregate, the budget to complete all phases is approximately \$713,000. The agreement also contains a fixed price schedule for manufacturing the microcatheter following commercial launch. The price schedule contains a volume-based reduction in the cost per microcatheter.

### **The NextCYTE Breast Cancer Test**

The NextCYTE Breast Cancer Test, which is in the prevalidation phase and which we intend to launch in 2013, is designed to profile breast cancer specimens for prediction of treatment outcomes and distant recurrence in women newly diagnosed with breast cancer. It involves using surgery specimens and advanced genome sequencing techniques to quantify and analyze the entire tumor genetic transcriptome, which represents all genes that are being actively expressed within the tumor. Because our NextCYTE test analyzes traditional biopsy specimens using advanced genome sequencing techniques, we believe that other present methods of analyzing traditional biopsy specimens would not achieve results similar to or better than results provided by our NextCYTE test and we expect that physicians will be able to use the information provided by the NextCYTE test to better customize treatment options for women, based on the genetic composition of the individual tumor. The NextCYTE Breast Cancer Test is intended to use microarray-based genome-wide transcriptome data from surgical breast cancer biopsy specimens to predict a patient's 10-year survival probability and response to treatment. The algorithm was created from 2,400 unique

genome-wide microarrays and validated against a separate sample of over 1,600 microarray data sets. A correct classification was obtained for over 85% of both estrogen receptor negative and positive tumors. We have signed a term sheet for the exclusive license of the intellectual property related to this algorithm and we expect to complete the license in the first half of 2013 and to complete validation of the test in our laboratory soon thereafter, with an intent to launch this product before year end 2013.

## **Our Diagnostic Tools**

On September 30, 2012, we acquired substantially all of the assets of Acueity Healthcare, Inc. (“Acueity”). The acquisition was effected through an asset purchase in which we acquired 35 issued patents (18 issued in the U.S. and 17 issued in foreign countries) and 41 patent applications (32 in the U.S. and 9 in foreign countries), and six 510(k) FDA marketing authorizations related to the manufacturing, use, and sale of the Viaduct Miniscope and accessories, the Manoa Breast Biopsy system, the Excisor Biotome, the Acueity Medical Light Source, the Viaduct Microendoscope and accessories, and cash in the amount of \$400,000; no liabilities were assumed in the transaction. In consideration for the assets, we issued 862,500 shares of common stock (valued at \$5.00 per share) and warrants to purchase up to 325,000 shares of common stock at an exercise price of \$5.00 per share, subject to a six-month lock up agreement. The warrants, which have a five-year term, do not have a cashless exercise provision. The warrants were valued at \$2.3457 per warrant, using a Black-Scholes-Merton valuation technique based on the following assumptions: fair value of common stock on date of grant of \$5.00 per share, the exercise price of the warrants is \$5.00, the expected life of the warrants is 5 years, the dividend yield is 0.0%, the expected volatility is 56.54%, the risk-free interest rate is 0.62%, and the expected forfeiture per year is 0%. The risk-free interest rate reflects the interest rate for United States Treasury Note with similar time-to-maturity to that of the warrants. The expected life of the warrants was derived from the output of the valuation model and represents the period of time that the warrants are expected to be outstanding. We did not have a historical trading history sufficient to develop an internal volatility rate for use in the model. As a result, as required by FASB ASC 718-10-30, the Company has accounted for the warrants using the calculated value method. The Company identified seven public entities in a similar industry for which share price information was available, and considered the historical volatilities of those public entities’ share prices in calculating the expected volatility appropriate to the Company. There are no future financial obligations from us to Acueity from the commercialization of the acquired assets.

The acquired patents and patent applications relate to intraductal diagnostic and therapeutic devices and methods of use. The microendoscopes are less than 0.9 mm outside diameter and can be inserted into a milk duct. This permits a physician to pass a microendoscope into the milk duct system of the breast and view the duct system via fiberoptic video images. Abnormalities that are visualized can then be biopsied from inside the duct with the biopsy tools that are inserted adjacent to the microendoscope.

We did not, however, acquire an inventory of these diagnostic tools, manufacturing capabilities or any personnel to market and sell the tools. Following the launch of our four diagnostic tests in the U.S., we will then begin to allocate human and financial resources to further develop and ultimately commercialize these medical devices. We intend to complete the steps necessary to begin marketing and selling these tools, such as re-establishment of the supply chain of component parts, securing manufacturers, performing test builds and commercial scale manufacturing, in late 2013. This asset purchase is not expected to have an impact on the development and commercialization timetables of our existing product lines. We cannot, however, provide any assurances that delays related to the launch of our four diagnostic tests, independent of the asset purchase, would not delay the expected development of these diagnostic tools or that we will ultimately be successful selling these tools. Acueity never achieved commercial success with these products and we have no experience marketing and selling diagnostic tools; we therefore may not be successful commercializing them.

## **The Market**

### **United States Market for ForeCYTE Test**

#### ***Testing in Women at High Risk for Breast Cancer***

The Company expects that the MASCT System will initially be adopted by physicians and other healthcare professionals for use in women at high risk for breast cancer.

*Women Undergoing Diagnostic Mammograms.* Breast cancer screening by mammography involves performing a screening mammogram and typically reviewing the mammogram while the patient is still present in the clinic. If the screening mammogram shows suspicious changes, a more extensive diagnostic mammogram is performed, usually on the same day. In an audit of 46,857 consecutive mammograms performed in the radiology department at the University of California, San Francisco between 1997 and 2000, 10,007, or 21%, were diagnostic mammograms. The audit also documented an increased incidence of future cancer in those women who underwent a diagnostic mammogram, regardless of the diagnosis at the time. Applying this frequency to the estimated 39.0 million total mammograms performed each year in the United States yields approximately 8.1 million diagnostic mammograms. The Company believes all women undergoing a diagnostic mammogram, who may be at higher risk of developing breast cancer in the future, would be candidates for MASCT System testing.

*Breast Cancer Survivors.* Women who have had breast cancer are at a higher risk for the recurrence of cancer or for a new malignancy. The American Cancer Society, or ACS, has estimated that as of 2012, there were approximately 2.9 million breast cancer survivors in the United States. The Company believes these women would be candidates for regular MASCT System screening.



*High Risk Women.* The Breast Cancer Risk Assessment Tool (based on the Gail model) has been established by the NCI and the National Surgical Adjuvant Breast and Bowel Project, or NSABP, to identify women with an increased risk of breast cancer. The risk factors included in the test are: personal history of breast abnormalities, age, age at first menarche, age at first live birth, breast cancer among first-degree relatives (sisters, mother, or daughters), breast biopsies, obesity and race. Approximately 12 million women in the United States are in the high risk group. A study of 6,904 women for an average follow up of 14.6 years demonstrated that NAF cytology may be most useful for women at highest absolute risk by the Risk Assessment Tool because modest differences in relative risk are amplified. In this group, the incidence of breast cancer detected by NAF cytology ranged from 5.3 to 10.3 per 1,000 women (non-yielder to hyperplasia/atypia).

### ***Breast cancer risk stratification***

The Company believes that if it is able to develop, produce and successfully market the MASCT System for use as an additional test in conjunction with all mammography and all cervical cancer screenings (Pap smear), the potential annual U.S. market size for breast cancer risk stratification would be between 39.3 million and 55 million women. This conclusion is based on the following data:

*MASCT System in conjunction with mammography, all ages.* According to the Mammography Quality Standards Act (MQSA) National Statistics, the total annual mammography procedures in the United States, as of January 1, 2012, was 39,311,535.

*MASCT System in conjunction with cervical cancer screening (Pap smear), all ages.* According to the National Cancer Institute, as of December 2011, approximately 55 million Pap smear examinations are performed annually in the United States.

### **United States Market for ArgusCYTE Test**

*Breast Cancer Survivors.* The ACS has estimated that, as of 2012, there were more than 2.9 million breast cancer survivors, who we believe would be potential candidates for a blood test for circulating tumor cells.

*Newly diagnosed breast cancer patients.* According to the National Cancer Institute, as of 2012, approximately 232,340 women are diagnosed with breast cancer each year. These women would be candidates for a blood test for circulating tumor cells during the staging of their tumor and as a method to monitor treatment effects.



## United States Laboratory Testing Market

*Anatomic Pathology* . Anatomic pathology involves the diagnosis of cancer and other medical conditions through the examination of tissues (biopsies) and the analysis of cells (cytology) taken from patients. Generally, the anatomic pathology process involves the preparation of slides by trained histo-technologists or cytologists and the review of those slides by anatomic pathologists. Although anatomic pathologists do not treat patients, they establish a definitive diagnosis and may also consult with the referring physician. As a result of the greater degree of complexity and sophistication in anatomic pathology services, 2012 Medicare reimbursement rates for the anatomic pathology services of the type that the Company expects to perform are either \$384 or \$1,275 per patient. The patient fee schedule for self-pay or private payors for these tests is typically higher.

*Molecular Diagnostics*. Molecular diagnostics typically involve unique and complex genetic and molecular tests performed by skilled personnel using sophisticated instruments. As a result, molecular diagnostics are typically offered by a limited number of commercial laboratories. According to PriceWaterhouseCoopers, molecular diagnostics represents one of the fastest growing segments of the \$37 billion market for *in vitro* diagnostics, which includes test tube diagnostics such as glucose monitoring for diabetes care but excludes diagnostics for research use. The Medicare reimbursement rate in 2011 for microarray-based molecular diagnostics tests is \$1,250, while the reimbursement rate for fluorescent cellular probe-based tests is \$479 per probe. According to PriceWaterhouseCoopers, this market segment is expected to grow 14% annually between 2007 and 2012, from \$2.6 billion to \$5.0 billion.

## Commercialization Strategy

The Company's commercialization strategy is based on creating two main revenue sources: (i) product sales-based revenue from the sale of the MASCT System, including the NAF specimen collection kits, to physicians, breast health clinics, mammography clinics and distributors, and (ii) service-based revenue for the preparation and interpretation of the NAF samples sent to the Company's laboratory. This is intended to result in revenue from both the sale and the use of the MASCT System.

In order to achieve its two-pronged revenue base, the Company manufactures, through medical device suppliers, the MASCT System components (i.e., the collection device and patient NAF specimen kits) and will establish a network of independent sales representatives to call on physicians and breast health and mammography clinics to market and sell the MASCT System. The collection device is reusable when sanitized between patients. The kit contains the patient contact materials, preservative fluid for the collected samples, and bar-coded patient identification labeling. The kit components are designed to work properly with the collection device and the Company is not aware of any commercially available parts or components which could be substituted for the Company's kits.

The Company's product- and service-based income plan is intended to provide revenue from multiple, different sources with different timing in the procedure cycle. The Company expects to generate product revenue from the sale of kits in bulk to distributors and to clinics and physicians for the testing of their patients, and laboratory service revenue after its laboratory analyzes the results of these tests and renders a diagnosis.

### **Specialty Sales Team**

To market the MASCT System and its related laboratory diagnostic services, the Company will need to hire independent sales representatives with technical knowledge in, for example, molecular diagnostics, mammography, obstetrics/gynecology office practices, and women's health clinics. As a result, the Company will expect its sales representatives to develop long-lasting, consultative relationships with the referring physicians they serve.

The Company will focus its marketing and sales efforts on encouraging physicians and breast health and mammography clinics to use the MASCT System in conjunction with other health screening examinations, including annual physical examinations and regularly scheduled cervical Pap smears and mammograms. The sales representatives will concentrate on a geographic area based on the number of physician clients and prospects, which will be identified using several national physician databases that provide physician address information, patient demographic information, and other data. The Company also expects to use the FDA website containing contact information on the approximately 8,600 MQSA-certified clinics to identify potential clients.

In September 2012 we entered into a co-exclusive marketing agreement with Diagnostic Test Group (DTG), operating through its division Clarity Women's Health (Clarity) for the supply and distribution of the MASCT System under the Clarity brand. Under the terms of the agreement, we granted to DTG the co-exclusive right to sell and distribute our MASCT breast health test in the Territory (U.S., Canada, and Puerto Rico, with other territories available with written consent). We retain co-exclusive rights to sell and distribute the MASCT breast health test in the Territory under the terms of the agreement. DTG has agreed to purchase all breast health tests only from us during the term of the agreement. DTG also has a 30-day right of first refusal for the co-exclusive right to sell our other products on terms and conditions to be negotiated by us and DTG. The term of the agreement is a rolling six years, with automatic extension if DTG achieves its annual minimum sales requirements. Following an initial launch period, minimum sales have been set for the first 12-month period.

Under the terms of the agreement, DTG will purchase the MASCT System from us at a fixed price and will use its best efforts to market and sell the MASCT System, including establishing product codes and contracted agreements, if these are deemed necessary by DTG, for the sale and placement of the Clarity branded MASCT product line with the following distributors: Henry Schein, McKesson, PSS World Medical, Cardinal Health, VWR, Vaxserve, Mercedes Medical, Fisher, NDC members, Imco members, B&H Surgical, Marshall Medical and Cascade HealthCare Products. These distributors have collectively over 5,000 employee sales representatives and/or independent sales representatives selling their products and calling on 33,000 obstetric-gynecologists in the United States.



We will coordinate the sales and marketing effort, plan, and budget with DTG, with us paying agreed expenses, as well as a marketing and sales fee that is less than 10% of the Medicare reimbursement rate for the ForeCYTE test. DTG earns warrants in Atossa common stock based on a low, double-digit percentage of the annual number of ForeCYTE tests performed by the National Reference Laboratory for Breast Health, priced at the fair market value on the date of issuance, with a maximum number of warrants issuable under the life of the agreement equal to 1,000,000 shares of common stock.

We announced the launch of our national sales effort of the ForeCYTE test with DTG in January 2013. DTG and its distributors, however, may not be successful in selling the Clarity branded MASCT product line and we may not achieve any level of commercial success from their efforts.

### **The National Reference Laboratory for Breast Health**

The Company has established the National Reference Laboratory for Breast Health, a wholly-owned CLIA-certified clinical laboratory for the cytology and molecular diagnostics testing and reading of results of collected NAF samples and ArgusCYTE blood samples. The Company believes that by maintaining its own clinical laboratory, it will be positioned to generate substantial additional service revenue through cytology and molecular diagnostic testing, in addition to the sale of the MASCT System pumps and specimen collection kits.

The Company has established a comprehensive quality assurance program for its laboratory, designed to drive accurate and timely test results and to ensure the consistent high quality of its testing services. In addition to the compulsory proficiency programs and external inspections required by CMS and other regulatory agencies, the Company intends to develop a variety of internal systems and procedures to emphasize, monitor, and continuously improve the quality of its operations. The Company also participates in externally administered quality surveillance programs.

### **Growth Strategy**

The Company launched the ForeCYTE and ArgusCYTE Tests at the end of the fourth quarter of 2011. The Company markets to both mammography clinics and physicians' offices. The Company conducted a field experience trial to collect information about the ease or difficulty of adoption of the products in each location, the number of sales calls needed to receive the first orders, and the growth of sales of specimen collection kits on a monthly basis. We are using the outcome of this initial marketing efforts to form our national marketing strategies, for example, we may decide to emphasize physicians' offices over mammography clinics.

The Company plans to market the ForeCYTE Test nationally through DTG and other distributors and sales representatives.

## Research and Development

### Our Intraductal Treatment Research

Our Intraductal Treatment Research Program comprises our patented microcatheter-delivery technology and our patented pharmaceutical formulations for the intraductal treatment of breast pre-cancerous changes and DCIS. The method uses our Mammary Ductal Microcatheter System, invented by Dr. Susan Love, President of the Dr. Susan Love Research Foundation, and her colleagues, and acquired by us, to administer proprietary pharmaceutical formulations into milk ducts that display pre-cancerous changes or DCIS with high local concentrations of the drugs in order to promote greater efficacy and limited systemic exposure, potentially lowering the overall toxicity of the treatment.

An October 2011 peer-reviewed paper published in *Science Translational Medicine* documented a study conducted at the Johns Hopkins Medical School demonstrating the prevention of breast cancer in rats with intraductal non-systemic chemotherapy, and a proof-of-principle Phase 1 clinical trial involving 17 women with breast cancer who subsequently received surgery. An accompanying editorial commented that “intraductal treatment could be especially useful for women with premalignant lesions or those at high risk of developing breast cancer, thus drastically improving upon their other, less attractive options of breast-removal surgery or surveillance (termed ‘watch and wait’).”

In a December 2012 peer-reviewed paper published in *Cancer Prevention Research*, Dr. Susan Love and her colleagues report a Phase I clinical trial to show the safety and feasibility of intraductal administration of chemotherapy drugs into multiple ducts within one breast in women awaiting mastectomy for treatment of invasive cancer. Thirty subjects were enrolled in this dose escalation study conducted at a single center in Beijing, China. Under local anesthetic, one of two chemotherapy drugs, carboplatin or pegylated liposomal doxorubicin (PLD), was administered into five to eight ducts at three dose levels. Pharmacokinetic analysis has shown that carboplatin was rapidly absorbed into the bloodstream, whereas PLD, though more erratic, was absorbed after a delay. Pathologic analysis showed marked effects on breast duct epithelium in ducts treated with either drug compared with untreated ducts. The investigators concluded the study showed the safety and feasibility of intraductal administration of chemotherapy into multiple ducts for the purpose of breast cancer prevention and that this was an important step toward implementation of this strategy as a "chemical mastectomy", potentially eliminating the need for surgery.

We intend to build on these academic studies with a research program targeted initially as neoadjuvant therapy in DCIS and to begin preclinical studies during 2013. We may partner with a third party to provide the pharmaceutical for the program. However, we have not as of the date of this prospectus contracted with such a partner nor have we begun the process of applying for FDA approval of our Intraductal Treatment Research Program.

## **Billing and Reimbursement**

### **Billing for the MASCT System Medical Device and Patient Kits and the NAF Collection Procedure**

Medicare and certain insurance carriers do not currently cover the cost of collecting the NAF sample. We intend to work with physicians and other interest groups to attempt to obtain coverage for the procedures but this process can be lengthy, costly, and might not be successful. Failure to receive reimbursement could limit the adoption and utilization of the MASCT System. Because the process can be done by a nurse or physician's assistant, takes less than five minutes, and the MASCT System supplies will contain everything to obtain, label, and ship the NAF samples, the charge for collecting NAF samples should be below the average cost of a mammogram.

### **Billing for Diagnostic Services**

Although Medicare and certain insurance carriers do not currently cover the cost of collecting the NAF sample, Medicare and certain insurance carriers do reimburse for the laboratory analysis of the NAF sample. We have received reimbursement from insurance carriers and Medicare for the ForeCYTE test and from insurance carriers for the ArgusCYTE test. Billing for diagnostic services is generally complex. As a result, we rely on a third-party billing company to perform all of our billing and collection services. Laboratories must bill various payors, such as private insurance companies, managed care companies, governmental payors such as Medicare and Medicaid, physicians, hospitals, and employer groups, each of whom may have different billing requirements. We expect to be obligated to bill in the specific manner prescribed by the various payors. Additionally, the audit requirements that must be met to ensure compliance with applicable laws and regulations, as well as internal compliance policies and procedures, add further complexity to the billing process. Other factors that complicate billing include:

- additional billing procedures required by government payor programs;
- variability in coverage and information requirements among various payors;
- missing, incomplete or inaccurate billing information provided by referring physicians;
- billings to payors with whom we do not have contracts;
- disputes with payors as to who is responsible for payment;
- disputes with payors as to the appropriate level of reimbursement;
- training and education of employees and clients;



- compliance and legal costs; and
- costs related to, among other factors, medical necessity denials and the absence of advance beneficiaries' notices.

In general, we perform the requested tests and report test results even if the billing information is incorrect or missing. We will subsequently attempt to obtain any missing information and correct incomplete or erroneous billing information received from the healthcare provider. Missing or incorrect information on requisitions adds complexity to and slows the billing process, creates backlogs of unbilled requisitions, and generally increases the aging of accounts receivable and the length of time to recognize revenue. When all issues relating to the missing or incorrect information are not resolved in a timely manner, the related receivables will be written off to the allowance for doubtful accounts.

## **Reimbursement**

Depending on the billing arrangement and applicable law, the party that reimburses us for our services will be (i) a third party who provides coverage to the patient, such as an insurance company, managed care organization, or a governmental payor program; (ii) the physician or other authorized party (such as another laboratory) who ordered the test or otherwise referred the test to us; or (iii) the patient.

The National Reference Laboratory for Breast Health, our wholly-owned subsidiary, bills Medicare for the laboratory services provided for the ForeCYTE and ArgusCYTE testing.

Reimbursement for services under the Medicare program is based principally on two sets of fee schedules. Generally, anatomic pathology services, including most of the services we provide, are paid based on the Medicare physician fee schedule. The physician fee schedule is designed to set compensation rates for those medical services provided to Medicare beneficiaries that require a degree of physician supervision. Outpatient diagnostic laboratory tests are typically paid according to the laboratory fee schedule.

For the anatomic pathology services that we will provide, we will be reimbursed under the Medicare physician fee schedule, and beneficiaries are responsible for applicable coinsurance and deductible amounts. The physician fee schedule is based on assigned relative value shares for each procedure or service, and an annually determined conversion factor is applied to the relative value shares to calculate the reimbursement. The formula used to calculate the fee schedule conversion factor has resulted in significant decreases in payment levels in recent years.

Future decreases in the Medicare physician fee schedule are expected unless Congress acts to change the fee schedule methodology or mandates freezes or increases each year. Because the vast majority of our laboratory services will be reimbursed based on the physician fee schedule, changes to the physician fee schedule could result in a greater impact on our revenue than changes to the Medicare laboratory fee schedule.

We expect to bill the Medicare program directly. Generally, we will be permitted to directly bill the Medicare beneficiary for clinical laboratory tests only when the service is considered not medically necessary and the patient has signed an Advanced Beneficiary Notice, or ABN, reflecting acknowledgment that Medicare is likely to deny payment for the service. In most situations, we are required to rely on physicians to obtain an ABN from the patient. When we are not provided an ABN, we are generally unable to recover payment for a service for which Medicare has denied payment for lack of medical necessity.

In billing Medicare, we are required to accept the lowest of: our actual charge, the fee schedule amount for the state or local geographical area, or a national limitation amount, as payment in full for covered tests performed on behalf of Medicare beneficiaries. Payment under the laboratory fee schedule has been limited by Congressional action such as freezes on the otherwise applicable annual Consumer Price Index, or CPI, update to the fee schedule amount. The CPI update of the laboratory fee schedule for 2010 was minus 1.9%.

The Medicare statute permits Federal Health and Human Services Centers for Medicare and Medicaid Services, or CMS, to adjust statutorily prescribed fees for some medical services, including clinical laboratory services, if the fees are “grossly excessive.” Medicare regulations provide that if CMS or a carrier determines that an overall payment adjustment of less than 15% is needed to produce a realistic and equitable payment amount, then the payment amount is not considered “grossly excessive or deficient.” However, if a determination is made that a payment adjustment of 15% or more is justified, CMS could provide an adjustment of 15% or less, but not more than 15%, in any given year. We cannot provide any assurance that fees payable by Medicare for clinical laboratory services could not be reduced as a result of the application of this rule or that the government might not assert claims for recoupment of previously paid amounts by retroactively applying these principles.

The payment amounts under the Medicare fee schedules are important not only for reimbursement under Medicare, but also because the schedule is often used as a reference for the payment amounts set by other third-party payors. For example, state Medicaid programs are prohibited from paying more than the Medicare fee schedule limit for laboratory services furnished to Medicaid recipients, and insurance companies and managed care organizations typically reimburse at a percentage of the Medicare fee schedule.

Our reimbursement rates also vary depending on whether we are considered an “in-network,” or participating, provider. If we enter into a contract with an insurance company, our reimbursement will be governed by our contractual relationship, and we will typically be reimbursed on a fee-for-service basis at a discount from the patient fee schedule. If we do not have a contract with an insurance company, we will be classified as “out-of-network,” or as a

non-participating provider. In such instances, we would have no contractual right to reimbursement for services.

## **Reimbursement Strategy**

### ***CPT Code for MASCT System NAF Collection Procedure***

The NAF collection procedure of the MASCT System does not currently have a procedure-specific Category I CPT code, which is important for reimbursement by Medicare for eligible patients, and which is part of the basis by which insurance companies make reimbursement decisions. A non-specific Category I CPT code, 19499 (unlisted procedure, breast), can be used initially by physicians and insurance carriers will often pay for such procedures with proper documentation. Medicare does not typically reimburse for CPT 19499 procedures.

### ***CPT Code for ForeCYTE Cytology and IHC Biomarker Testing***

Category I laboratory procedure codes for cytology and IHC biomarker tests currently exist and reimbursement for these codes by Medicare has been established for 2012 at either \$384 or \$1,275, depending on the complexity of the test.

Laboratories typically set patient fee schedules at higher rates for the same procedure.

## **Intellectual Property**

As of the date of this report, we own 178 issued patents (56 in the United States and 122 in foreign countries), and 50 pending patent applications (38 in the United States, 11 pending foreign applications and 1 pending International Patent Cooperation Treaty (PCT) application) directed to our products, services, and technologies. We have eleven 510(k)-cleared medical devices and two 510(k)-exempt medical devices, six of which were acquired in the Acueity asset purchase. The Acueity asset purchase also provided 35 of the issued patents (18 issued in the United States and 17 issued in foreign countries) and 41 of the patent applications (32 in the U.S. and 9 in foreign countries).

Description	United States			Foreign/PCT		
	Issued (1)	Expiration	Pending (1)	Issued (1)	Expiration	Pending
MASCT (ForeCYTE) Test	6	2016-2031	1	11	2016-2031	1
Microcatheter (FullCYTE) Test	19	2019-2031	2	55	2019-2031	0
NextCYTE Test	0	2031	0	0	2031	1
ArgusCYTE Test	1	2020	0	1	2031	0
Intraductal Treatment Program	11	2030	1	34	2030	1
Carbohydrate biomarkers	1	2022	2	3	2022	0
Microendoscopes	18	2015-2027	32	17	2015-2027	9

(1) The total patents issued or pending, as applicable, exceed the totals in the respective columns because some patents and applications contain claims directed to more than one technology.

MASCT is our registered trademark and we have applied with the United States Patent and Trademark Office for registration of the use of the marks Atossa (word and design), ForeCYTE, FullCYTE, NextCYTE, ArgusCYTE, and Oxy-MASCT.

## Competition

We believe that the MASCT System for NAF collection will compete in the medical device product industry with Neomatrix and with academic scientists and physicians who use “homemade” NAF fluid collection systems for research purposes. The Neomatrix device is automated and provides warmth and nipple aspiration simultaneously and is the only non-“homemade” NAF collection system of which we are currently aware. The advantages of the MASCT System compared to the Neomatrix device include a lower acquisition cost and portability. The disadvantages of the MASCT System compared to the Neomatrix device include the requirement that a nurse or other healthcare provider manually operate the device, which may result in increased risks of human error and improper sample collection, and the reduced availability of experience with the device among the medical community.

We believe we will compete in the anatomic pathology laboratory industry based on the patent portfolio for the MASCT System, the technical expertise provided by our focus on diagnoses utilizing NAF, service-focused relationships with referring physicians, and our advanced technology. Based on the scope of our patent claims and the terms of use accompanying the MASCT System, we do not believe that our competitors can transport or process NAF samples collected with the MASCT System without infringing our patent estate and the contractual terms of use.

Laboratories that could process NAF samples not collected with the MASCT System include thousands of local and regional pathology groups, national laboratories, hospital pathologists, and academic laboratories. The largest such competitors include Laboratory Corporation of America and Quest Diagnostics Incorporated.

Characteristics of each source of competition include:

***Local and Regional Pathology Groups.*** Local and regional pathology groups focus on servicing hospitals, often maintaining a staff of pathologists on site that can provide support in the interpretation of certain results. The business models of these laboratories tend to be focused on the efficient delivery of individual tests for a multitude of diseases rather than the comprehensive assessment of only NAF samples, and their target groups tend to be hospital pathologists as opposed to community physicians.

***National Laboratories.*** National laboratories typically offer a full suite of tests for a variety of medical professionals, including general practitioners, hospitals, and pathologists. Their emphasis on providing a broad product portfolio of commoditized tests at the lowest possible price often limits such laboratories' ability to handle difficult or complex specimens requiring special attention, such as NAF samples. In addition, national laboratories typically do not provide ready access to a specialized pathologist for interpretation of test results.

***Hospital Pathologists.*** Pathologists working in a hospital traditionally provide most of the diagnostic services required for hospital patients and sometimes also serve non-hospital patients. Hospital pathologists typically have close interaction with treating physicians, including face-to-face contact. However, hospital pathologists often do not have the depth of experience, specialization, and expertise necessary to perform the specialized services needed for NAF samples.

***Academic Laboratories.*** Academic laboratories generally offer advanced technology and know-how. In fact, the vast majority of NAF sample processing over the last several years has been in academic laboratories primarily for research purposes. These laboratories typically pursue multiple activities and goals, such as research and education, or are generally committed to their own hospitals. Turn-around time for specimen results reporting from academic laboratories is often slow. This limits the attractiveness of academic laboratories to outside physicians who tend to have focused specialized needs and require results to be reported in a timely manner.

***Alternative Diagnostic Tools.*** We also anticipate that the MASCT System will face challenges in market adoption due to the reliance of physicians and other medical professionals on existing diagnostic tools for breast cancer, including mammograms, ultrasound examinations, magnetic resonance imaging, or MRI, fine needle aspiration and core biopsies, among others. These methods are currently more widely used and accepted by physicians, and may continue to be more widely used than our proposed products and services because they are currently reimbursed by third-party payors. In addition, physicians and other medical professionals may view the MASCT System as a screening tool for existing breast cancer, like mammography, rather than as an adjunctive procedure to mammography. As a result, the MASCT System could be deemed to compete directly with mammography, an established procedure, which could impair market adoption of the MASCT System. The advantages of the MASCT System compared to ultrasound, mammography, or magnetic resonance imaging include obtaining cytology and molecular information, the ease and simplicity of the procedure, and the cost, especially compared to MRI. The disadvantages of the MASCT System compared to ultrasound, mammography, and MRI include a lower sensitivity to detection of cancer. The advantage of the MASCT System compared to fine needle aspiration and core biopsies include the ease and simplicity of the procedure, the cost, and the patient comfort. The disadvantages of the MASCT System compared to fine needle aspiration and core biopsies include the reduced sample size and the consequent limitation of the range of molecular studies that can be conducted.

In addition to facing competition with respect to our MASCT System and the processing of collected NAF samples, we also face competition regarding our ArgusCYTE diagnostic test. The detection and analysis of circulating tumor cells, or CTCs, in the blood of patients with breast cancer is an active area of medical research, and many companies and academic research institutes that have substantially greater financial and research resources than we do are involved in such detection and analysis. For example, The Massachusetts General Hospital, Harvard Medical School, received a multimillion dollar grant from Stand Up To Cancer in 2009 for a CTC chip to diagnose cancer. Additionally, Johnson & Johnson markets an FDA-cleared test for breast cancer CTCs and Clariant Laboratories, a GE Healthcare company, also markets a breast cancer CTC test.

## **Information Systems**

We have acquired and implemented a third-party pathology laboratory report management system that supports our operations and physician services. Our information systems, to the extent such systems hold or transmit patient medical information, are believed to operate in compliance with state and federal laws and regulations relating to the privacy and security of patient medical information, including a comprehensive federal law and regulations referred to as HIPAA. While we have endeavored to establish our information systems to be compliant with such laws, including HIPAA, such laws are complex and subject to interpretation.

## **Government Regulation**

### **United States Medical Device Regulation**

The Federal Food, Drug, and Cosmetic Act, or FDCA, and the FDA's implementing regulations, govern registration and listing, manufacturing, labeling, storage, advertising and promotion, sales and distribution, and post-market surveillance. Medical devices and their manufacturers are also subject to inspection by the FDA. The FDCA, supplemented by other federal and state laws, also provides civil and criminal penalties for violations of its provisions. We manufacture and market a medical device that is regulated by the FDA, comparable state agencies and regulatory bodies in other countries. We also operate a clinical and diagnostic laboratory which uses reagents and test kits some of which are regulated medical devices.

The FDA classifies medical devices into one of three classes (Class I, II or III) based on the degree of risk the FDA determines to be associated with a device and the extent of control deemed necessary to ensure the device's safety and effectiveness. Devices requiring fewer controls because they are deemed to pose lower risk are placed in Class I or II. Class I devices are deemed to pose the least risk and are subject only to general controls applicable to all devices, such as requirements for device labeling, premarket notification, and adherence to the FDA's current good manufacturing practice requirements, as reflected in its QSR. Most pathology staining kits, reagents, and routine antibody-based immunohistochemistry protocols which we intend to use initially are Class I devices. Class II devices are intermediate risk devices that are subject to general controls and may also be subject to special controls such as performance standards, product-specific guidance documents, special labeling requirements, patient registries or postmarket surveillance. The MASCT System is a Class II device. Class III devices are those for which insufficient information exists to assure safety and effectiveness solely through general or special controls, and include life-sustaining, life-supporting, or implantable devices, and devices not "substantially equivalent" to a device that is already legally marketed.

Most Class I devices, including the laboratory staining kits and reagents we use, and some Class II devices are exempted by regulation from the 510(k) clearance requirement and can be marketed without prior authorization from FDA. Class I and Class II devices that have not been so exempted are eligible for marketing through the 510(k) clearance pathway. By contrast, devices placed in Class III generally require premarket approval, or PMA, approval prior to commercial marketing. To obtain 510(k) clearance for a medical device, an applicant must submit a premarket notification to the FDA demonstrating that the device is "substantially equivalent" to a predicate device legally marketed in the United States. A device is substantially equivalent if, with respect to the predicate device, it has the same intended use and (i) the same technological characteristics, or (ii) has different technological characteristics and the information submitted demonstrates that the device is as safe and effective as a legally marketed device and does not raise different questions of safety or effectiveness. A showing of substantial equivalence sometimes, but not always, requires clinical data. In the case of the MASCT System, a clinical trial was conducted. Generally, the 510(k) clearance process can exceed 90 days and may extend to a year or more. After a device has received 510(k) clearance for a specific intended use, any modification that could significantly affect its safety or effectiveness, such as a significant change in the design, materials, method of manufacture or intended use, will require a new 510(k) clearance or (if the device as modified is not substantially equivalent to a legally marketed predicate device) PMA approval. While the determination as to whether new authorization is needed is initially left to the manufacturer, the FDA may review this determination and evaluate the regulatory status of the modified product at any time and may require the manufacturer to cease marketing and recall the modified device until 510(k) clearance or PMA approval is obtained. The manufacturer may also be subject to significant regulatory fines or penalties.

All clinical trials must be conducted in accordance with regulations and requirements collectively known as Good Clinical Practice, or GCP. GCPs include the FDA's Investigational Device Exemption, or IDE, regulations, which describe the conduct of clinical trials with medical devices, including the recordkeeping, reporting and monitoring responsibilities of sponsors and investigators, and labeling of investigation devices. They also prohibit promotion, test marketing, or commercialization of an investigational device, and any representation that such a device is safe or effective for the purposes being investigated. GCPs also include FDA's regulations for institutional review board approval and for protection of human subjects (informed consent), as well as disclosure of financial interests by clinical investigators.

Required records and reports are subject to inspection by the FDA. The results of clinical testing may be unfavorable or, even if the intended safety and effectiveness success criteria are achieved, may not be considered sufficient for the FDA to grant approval or clearance of a product. The commencement or completion of clinical trials, if any, that the Company may sponsor, may be delayed or halted, or be inadequate to support approval of a PMA application or clearance of a premarket notification for numerous reasons, including, but not limited to, the following:

- the FDA or other regulatory authorities do not approve a clinical trial protocol or a clinical trial (or a change to a previously approved protocol or trial that requires approval), or place a clinical trial on hold;
- patients do not enroll in clinical trials or follow up at the rate expected;
- institutional review boards and third-party clinical investigators may delay or reject the Company's trial protocol or changes to its trial protocol;
- third-party clinical investigators decline to participate in a trial or do not perform a trial on the Company's anticipated schedule or consistent with the clinical trial protocol, investigator agreements, good clinical practices or other FDA requirements;
- third-party organizations do not perform data collection and analysis in a timely or accurate manner;
- regulatory inspections of clinical trials or manufacturing facilities, which may, among other things, require the Company to undertake corrective action or suspend or terminate its clinical trials;
- changes in governmental regulations or administrative actions;
- the interim or final results of the clinical trial are inconclusive or unfavorable as to safety or effectiveness; and
- the FDA concludes that the Company's trial design is inadequate to demonstrate safety and effectiveness.

After a device is approved and placed in commercial distribution, numerous regulatory requirements apply. These include:

- establishment registration and device listing;
- the QSR, which requires manufacturers to follow design, testing, control, documentation and other quality assurance procedures;
- labeling regulations, which prohibit the promotion of products for unapproved or "off-label" uses and impose other restrictions on labeling;
- medical device reporting regulations, which require that manufacturers report to the FDA if a device may have caused or contributed to a death or serious injury or malfunctioned in a way that would likely cause or contribute to a death or serious injury if malfunctions were to recur; and



corrections and removal reporting regulations, which require that manufacturers report to the FDA field corrections and product recalls or removals if undertaken to reduce a risk to health posed by the device or to remedy a violation of the FDCA caused by the device that may present a risk to health.

The FDA enforces regulatory requirements by conducting periodic, announced and unannounced inspections and market surveillance. Inspections may include the manufacturing facilities of our subcontractors. Failure to comply with applicable regulatory requirements, including those applicable to the conduct of our clinical trials, can result in enforcement action by the FDA, which may lead to any of the following sanctions:

- warning letters or untitled letters;
- fines and civil penalties;
- unanticipated expenditures;
- delays in clearing or approving or refusal to clear or approve products;
- withdrawal or suspension of FDA clearance;
- product recall or seizure;
- orders for physician notification or device repair, replacement, or refund;
- production interruptions;
- operating restrictions;

injunctions; and  
criminal prosecution.

We and our contract manufacturers, specification developers and suppliers are also required to manufacture the MASCT and Microcatheter Systems in compliance with current Good Manufacturing Practice requirements set forth in the QSR. The QSR requires a quality system for the design, manufacture, packaging, labeling, storage, installation and servicing of marketed devices, and includes extensive requirements with respect to quality management and organization, device design, buildings, equipment, purchase and handling of components, production and process controls, packaging and labeling controls, device evaluation, distribution, installation, complaint handling, servicing and record keeping. The FDA enforces the QSR through periodic announced and unannounced inspections that may include the manufacturing facilities of our subcontractors. If the FDA believes we or any of our contract manufacturers or regulated suppliers is not in compliance with these requirements, it can shut down our manufacturing operations, require recall of the MASCT System, refuse to clear or approve new marketing applications, institute legal proceedings to detain or seize products, enjoin future violations, or assess civil and criminal penalties against us or our officers or other employees. Any such action by the FDA would have a material adverse effect on our business.

We received a Warning Letter (“Letter”) from the FDA on February 21, 2013, regarding our MASCT System and MASCT System Collection Test (together, the “System”). The Letter arose from certain FDA findings during a July 2012 inspection, to which we responded in August 2012, explaining why we believed we are in compliance with applicable regulations and/or were implementing changes responsive to the findings of the FDA inspection. The FDA alleges in the Letter that following 510(k) clearance we changed the System in a manner that requires submission of an additional 510(k) notification to the FDA. Specifically, the FDA observes that the Instructions For Use (IFU) in the original 510(k) submission stated that the user must “Wash the collection membrane with fixative solution into the collection vial...” and the current IFU states “...apply one spray of Saccomanno’s Fixative to the collection membrane...” and that “this change fixes the NAF specimen to the filter paper rather than washing it into a collection vial.” At the time that the changes were made we determined that a new 510(k) was not required in accordance with the FDA’s guidance document entitled “Deciding When to Submit a 510(k) for a Change to an Existing Device.”

The Letter also raises certain issues with respect to our marketing of the System and our compliance with FDA Good Manufacturing Practices (cGMP) regulations, among other matters. If the FDA does not agree with our position concerning clearance of the System, we may be required to submit and receive clearance of a new 510(k) notice for the current form of the System or revert to marketing the System using the prior NAF processing method.

We responded to the Letter on March 13, 2013, indicating the current actions taken and the timing of commitments we have made for future actions. The FDA could direct other compliance-verification activities or take other actions in connection with matters raised in the Letter, related to our response, and in connection with other matters that the FDA could identify in the future. Until these issues are resolved we may be subject to additional regulatory action by the FDA, and any such actions could disrupt our ongoing business and operations. Our business will be adversely affected if we cannot timely resolve the matters raised in the Letter, or other matters raised by the FDA, to the FDA’s satisfaction or if we are not successful in continuing to market our existing System, reverting to marketing the System using the prior NAF processing method or obtaining an additional 510(k) clearance in a timely and cost-effective

manner.

We are reasonably confident in our responses to the FDA. Consequently, no provision or liability has been recorded as of December 31, 2012 as a result of the Letter. However, it is at least reasonably possible that our estimate of related liability may change in the near term. Any payments by reason of an adverse determination in this matter will be charged to earnings in the period of determination.

### **CLIA and State Regulation**

As a provider of cytology and molecular diagnostic services, we are required to hold certain federal, state and local licenses, certifications, and permits. Under CLIA, we are required to hold a certificate applicable to the type of work we perform and to comply with certain CLIA-imposed standards. CLIA regulates all laboratories by requiring they be certified by the federal government and comply with various operational, personnel, facilities administration, quality, and proficiency requirements intended to ensure that laboratory testing services are accurate, reliable, and timely. CLIA does not preempt state laws that are more stringent than federal law.

To obtain and renew our CLIA certificates, which we are required to renew every two years, we will be regularly subject to survey and inspection to assess compliance with program standards and may be subject to additional random inspections. Standards for testing under CLIA are based on the level of complexity of the tests performed by the laboratory. Laboratories performing high complexity testing are required to meet more stringent requirements than laboratories performing less complex tests where a CLIA certificate is required. Both NAF cytology and molecular diagnostic testing are high complexity tests. CLIA certification is a prerequisite to be eligible for reimbursement under Medicare and Medicaid.

In addition to CLIA requirements, we are subject to various state laws. CLIA provides that a state may adopt laboratory regulations that are more stringent than those under federal law, and a number of states, including Washington, where the Company is located, have done so. The Washington State Medical Test Site, or MTS, Licensure law was passed in May 1989 to allow the state to regulate clinical laboratory testing. In October 1993, Washington became the first state to have its clinical laboratory licensure program judged by the CMS as equivalent to CLIA and was granted an exemption. In addition, New York, Maryland, Pennsylvania, Rhode Island, and California have implemented their own laboratory regulatory schemes. State laws may require that laboratory personnel meet certain qualifications, specify certain quality controls, or prescribe record maintenance requirements.

## **Privacy and Security of Health Information and Personal Information; Standard Transactions**

We are subject to state and federal laws and implementing regulations relating to the privacy and security of the medical information of the patients it treats. The principal federal legislation is part of HIPAA. Pursuant to HIPAA, the Secretary of the Department of Health and Human Services, or HHS, has issued final regulations designed to improve the efficiency and effectiveness of the healthcare system by facilitating the electronic exchange of information in certain financial and administrative transactions, while protecting the privacy and security of the patient information exchanged. These regulations also confer certain rights on patients regarding their access to and control of their medical records in the hands of healthcare providers such as us.

Four principal regulations have been issued in final form: privacy regulations, security regulations, standards for electronic transactions, and the National Provider Identifier regulations. The HIPAA privacy regulations, which fully came into effect in April 2003, establish comprehensive federal standards with respect to the uses and disclosures of an individual's personal health information, referred to in the privacy regulations as "protected health information," by health plans, healthcare providers, and healthcare clearinghouses. We are a healthcare provider within the meaning of HIPAA. The regulations establish a complex regulatory framework on a variety of subjects, including:

- the circumstances under which uses and disclosures of protected health information are permitted or required without a specific authorization by the patient, including but not limited to treatment purposes, activities to obtain payment for services, and healthcare operations activities;
- a patient's rights to access, amend, and receive an accounting of certain disclosures of protected health information;
- the content of notices of privacy practices for protected health information; and
- administrative, technical and physical safeguards required of entities that use or receive protected health information.

The federal privacy regulations, among other things, restrict our ability to use or disclose protected health information in the form of patient-identifiable laboratory data, without written patient authorization, for purposes other than payment, treatment, or healthcare operations (as defined by HIPAA) except for disclosures for various public policy purposes and other permitted purposes outlined in the privacy regulations. The privacy regulations provide for significant fines and other penalties for wrongful use or disclosure of protected health information, including potential civil and criminal fines and penalties. Although the HIPAA statute and regulations do not expressly provide for a private right of damages, we could incur damages under state laws to private parties for the wrongful use or disclosure of confidential health information or other private personal information.

We have implemented policies and practices that we believe brings us into compliance with the privacy regulations. However, the documentation and process requirements of the privacy regulations are complex and subject to interpretation. Failure to comply with the privacy regulations could subject us to sanctions or penalties, loss of business, and negative publicity.

The HIPAA privacy regulations establish a “floor” of minimum protection for patients as to their medical information and do not supersede state laws that are more stringent. Therefore, we are required to comply with both HIPAA privacy regulations and various state privacy laws. The failure to do so could subject us to regulatory actions, including significant fines or penalties, and to private actions by patients, as well as to adverse publicity and possible loss of business. In addition, federal and state laws and judicial decisions provide individuals with various rights for violation of the privacy of their medical information by healthcare providers such as us.

The final HIPAA security regulations, which establish detailed requirements for physical, administrative, and technical measures for safeguarding protected health information in electronic form, became effective on April 21, 2005. We have employed what we consider to be a reasonable and appropriate level of physical, administrative and technical safeguards for patient information. Failure to comply with the security regulations could subject us to sanctions or penalties and negative publicity.

The final HIPAA regulations for electronic transactions, referred to as the transaction standards, establish uniform standards for certain specific electronic transactions and code sets and mandatory requirements as to data form and data content to be used in connection with common electronic transactions, such as billing claims, remittance advices, enrollment, and eligibility. We have outsourced to a third-party vendor the handling of our billing and collection transactions, to which the transaction standards apply. Failure of the vendor to properly conform to the requirements of the transaction standards could, in addition to possible sanctions and penalties, result in payors not processing transactions submitted on our behalf, including claims for payment.

The HIPAA regulations on adoption of national provider identifiers, or NPI, required healthcare providers to adopt new, unique identifiers for reporting on claims transactions submitted after May 23, 2007. We intend to obtain NPIs for our laboratory facilities and pathologists so that we can report NPIs to Medicare, Medicaid, and other health plans.

The healthcare information of our patients includes social security numbers and other personal information that are not of an exclusively medical nature. The consumer protection laws of a majority of states now require organizations that maintain such personal information to notify each individual if their personal information is accessed by unauthorized persons or organizations, so that the individuals can, among other things, take steps to protect themselves from identity theft. The costs of notification and the adverse publicity can both be significant. Failure to comply with these state consumer protection laws can subject a company to penalties that vary from state to state, but may include significant civil monetary penalties, as well as to private litigation and adverse publicity. California recently enacted legislation that expanded its version of a notification law to cover improper access to medical information generally, and other states may follow suit.

## **Federal and State Fraud and Abuse Laws**

The federal healthcare Anti-Kickback Statute prohibits, among other things, knowingly and willfully offering, paying, soliciting, or receiving remuneration to induce referrals or in return for purchasing, leasing, ordering, or arranging for the purchase, lease, or order of any healthcare item or service reimbursable under a governmental payor program. The definition of “remuneration” has been broadly interpreted to include anything of value, including gifts, discounts, the furnishing of supplies or equipment, credit arrangements, payments of cash, waivers of payments, ownership interests, opportunity to earn income, and providing anything at less than its fair market value. The Anti-Kickback Statute is broad, and it prohibits many arrangements and practices that are lawful in businesses outside of the healthcare industry. Recognizing that the Anti-Kickback Statute is broad and may technically prohibit many innocuous or beneficial arrangements within the healthcare industry, HHS has issued a series of regulatory “safe harbors.” These safe harbor regulations set forth certain provisions that, if met, will provide healthcare providers and other parties with an affirmative defense against prosecution under the federal Anti-Kickback Statute. Although full compliance with these provisions ensures against prosecution under the federal Anti-Kickback Statute, the failure of a transaction or arrangement to fit within a specific safe harbor does not necessarily mean that the transaction or arrangement is illegal or that prosecution under the federal Anti-Kickback Statute will be pursued.

From time to time, the Office of Inspector General, or OIG, issues alerts and other guidance on certain practices in the healthcare industry. In October 1994, the OIG issued a Special Fraud Alert on arrangements for the provision of clinical laboratory services. The Fraud Alert set forth a number of practices allegedly engaged in by some clinical laboratories and healthcare providers that raise issues under the “fraud and abuse” laws, including the Anti-Kickback Statute. These practices include: (i) laboratories providing employees to furnish valuable services for physicians (other than collecting patient specimens for testing for the laboratory) that are typically the responsibility of the physicians’ staff; (ii) providing free testing to a physician’s managed care patients in situations where the referring physicians benefit from such reduced laboratory utilization; (iii) providing free pick-up and disposal of bio-hazardous waste for physicians for items unrelated to a laboratory’s testing services; (iv) providing general-use facsimile machines or computers to physicians that are not exclusively used in connection with the laboratory services; and (v) providing free testing for healthcare providers, their families, and their employees (professional courtesy testing).

The OIG emphasized in the Special Fraud Alert that when one purpose of an arrangement is to induce referrals of program-reimbursed laboratory testing, both the clinical laboratory and the healthcare provider, or physician, may be liable under the Anti-Kickback Statute, and may be subject to criminal prosecution and exclusion from participation in the Medicare and Medicaid programs.

Another issue about which the OIG has expressed concern involves the provision of discounts on laboratory services billed to customers in return for the referral of more lucrative federal healthcare program business. In a 1999 Advisory Opinion, the OIG concluded that a proposed arrangement whereby a laboratory would offer physicians significant discounts on non-federal healthcare program laboratory tests might violate the Anti-Kickback Statute. The OIG reasoned that the laboratory could be viewed as providing such discounts to the physician in exchange for referrals by the physician of business to be billed by the laboratory to Medicare at non-discounted rates. The OIG indicated that

the arrangement would not qualify for protection under the discount safe harbor because Medicare and Medicaid would not get the benefit of the discount. Subsequently, in a year 2000 correspondence, the OIG stated that the Anti-Kickback Statute may be violated if there were linkage between the discount offered to the physician and the physician's referrals of tests covered under a federal healthcare program that would be billed by the laboratory directly. Where there was evidence of such linkage, the arrangement would be considered "suspect" if the charge to the physician was below the laboratory's "average fully loaded costs" of the test.

Generally, arrangements that would be considered suspect, and possible violations under the Anti-Kickback Statute, include arrangements between a clinical laboratory and a physician (or related organizations or individuals) in which the laboratory would (1) provide items or services to the physician or other referral source without charge, or for amounts that are less than their fair market value; (2) pay the physician or other referral source amounts that are in excess of the fair market value of items or services that were provided; or (3) enter into an arrangement with a physician or other entity because it is a current or potential referral source. HIPAA also applies to fraud and false statements. HIPAA created two new federal crimes: healthcare fraud and false statements relating to healthcare matters. The healthcare fraud statute prohibits knowingly and willfully executing a scheme to defraud any healthcare benefit program, including private payors. A violation of this statute is a felony and may result in fines, imprisonment, or exclusion from governmental payor programs such as the Medicare and Medicaid programs. The false statements statute prohibits knowingly and willfully falsifying, concealing, or covering up a material fact or making any materially false, fictitious, or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items, or services, as well as the retention of any overpayment. A violation of this statute is a felony and may result in fines or imprisonment or exclusion from governmental payor programs.

### **Physician Referral Prohibitions**

Under a federal law directed at "self-referral," commonly known as the Stark Law, prohibitions exist, with certain exceptions, on Medicare and Medicaid payments for laboratory tests referred by physicians who personally, or through a family member, have an investment interest in, or a compensation arrangement with, the laboratory performing the tests. A person who engages in a scheme to circumvent the Stark Law's referral prohibition may be fined up to \$100,000 for each such arrangement or scheme. In addition, any person who presents or causes to be presented a claim to the Medicare or Medicaid programs in violation of the Stark Law is subject to civil monetary penalties of up to \$15,000 per bill submission, an assessment of up to three times the amount claimed, and possible exclusion from participation in federal governmental payor programs. Bills submitted in violation of the Stark Law may not be paid by Medicare or Medicaid, and any person collecting any amounts with respect to any such prohibited bill is obligated to refund such amounts.

Any arrangement between a laboratory and a physician or physicians' practice that involves remuneration will prohibit the laboratory from obtaining payment for services resulting from the physicians' referrals, unless the arrangement is protected by an exception to the self-referral prohibition or a provision stating that the particular arrangement would not result in remuneration. Among other things, a laboratory's provision of any item, device, or supply to a physician would result in a Stark Law violation unless it was used only to collect, transport, process, or store specimens for the laboratory, or was used only to order tests or procedures or communicate related results. This may preclude a laboratory's provision of fax machines and computers that may be used for unrelated purposes. Most arrangements involving physicians that would violate the Anti-Kickback Statute would also violate the Stark Law. Many states also have "self-referral" and other laws that are not limited to Medicare and Medicaid referrals. These laws may prohibit arrangements which are not prohibited by the Stark Law, such as a laboratory's placement of a phlebotomist in a physician's office to collect specimens for the laboratory. Finally, recent amendments to these laws require self-disclosure of violations by providers.

### **Discriminatory Billing Prohibition**

In response to competitive pressures, we will be increasingly required to offer discounted pricing arrangements to managed care payors and physicians and other referral services. Discounts to referral sources raise issues under the Anti-Kickback Statute. Any discounted charge below the amount that Medicare or Medicaid would pay for a service also raises issues under Medicare's discriminatory billing prohibition. The Medicare statute permits the government to exclude a laboratory from participation in federal healthcare programs if it charges Medicare or Medicaid "substantially in excess" of its usual charges in the absence of "good cause." In 2000, the OIG stated in informal correspondence that the prohibition was violated only if the laboratory's charge to Medicare was substantially more than the "median non-Medicare/ — Medicaid charge." On September 15, 2003, the OIG issued a notice of proposed rulemaking addressing the statutory prohibition. Under the proposed rule, a provider's charge to Medicare or Medicaid would be considered "substantially in excess of [its] usual charges" if it was more than 120% of the provider's mean or median charge for the service. The proposed rule was withdrawn in June 2007. At that time, the OIG stated that it would continue to evaluate billing patterns of individuals and entities on a case-by-case basis.

### **Corporate Practice of Medicine**

Our contractual relationships with the licensed healthcare providers are subject to regulatory oversight, mainly by state licensing authorities. In certain states, for example, limitations may apply to the relationship with the pathologists that we intend to employ or engage, particularly in terms of the degree of control that we exercise or have the power to exercise over the practice of medicine by those pathologists. A number of states, including New York, Texas, and California, have enacted laws prohibiting business corporations, such as us, from practicing medicine and employing or engaging physicians to practice medicine. These requirements are generally imposed by state law in the states in which we operate, vary from state to state, and are not always consistent among states. In addition, these requirements are subject to broad powers of interpretation and enforcement by state regulators. Some of these requirements may apply to us even if we do not have a physical presence in the state, based solely on the employment of a healthcare provider licensed in the state or the provision of services to a resident of the state. We believe that we operate in



material compliance with these requirements. However, failure to comply can lead to action against us and the licensed healthcare professionals that we employ, fines or penalties, receipt of cease and desist orders from state regulators, loss of healthcare professionals' licenses or permits, the need to make changes to the terms of engagement of those professionals that interfere with our business, and other material adverse consequences.

### **State Laboratory Licensure**

We are certified by CLIA and have been licensed in the states of California, Florida, Maryland, Rhode Island, and Washington. We are in the process of obtaining a license to accept testing samples from New York, which requires out-of-state laboratories to hold a state license, and are currently processing samples from New York under recognized exemption provisions. All other states do not have specific state licensing requirements and/or recognize our Federal CLIA certification as an out-of-state laboratory. Similarly, many of the states from which we will solicit specimens require that a physician interpreting specimens from that state be licensed by that particular state, irrespective of where the services are to be provided. In the absence of such a state license, the physician may be considered to be engaged in the unlicensed practice of medicine.

We may become aware from time to time of other states that require out-of-state laboratories or physicians to obtain licensure in order to accept specimens from the state, and it is possible that other states do have such requirements or will have such requirements in the future. We intend to follow instructions from the state regulators as how to comply with such requirements.

### **Referrals after Becoming a Public Company**

Now that our stock is publicly traded, we are not able to accept referrals from physicians who own, directly or indirectly, shares of our stock unless we comply with the Stark Law exception for publicly traded securities. This requires, among other things, \$75 million in stockholders' equity (total assets minus total liabilities). The parallel safe harbor requires, among other things, \$50 million in undepreciated net tangible assets, in order for any distributions to such stockholders to be protected under the Anti-Kickback Statute.

## **Other Regulatory Requirements**

Our laboratory is subject to federal, state, and local regulations relating to the handling and disposal of regulated medical waste, hazardous waste, and biohazardous waste, including chemical, biological agents and compounds, and human tissue. We use outside vendors who are contractually obligated to comply with applicable laws and regulations to dispose of such waste. These vendors are licensed or otherwise qualified to handle and dispose of such waste.

The Occupational Safety and Health Administration, or OSHA, has established extensive requirements relating to workplace safety for healthcare employers, including requirements mandating work practice controls, protective clothing and equipment, training, medical follow-up, vaccinations, and other measures designed to minimize exposure to, and transmission of, blood-borne pathogens. Pursuant to its authority under the FDCA, the FDA has regulatory responsibility over instruments, test kits, reagents, and other devices used to perform diagnostic testing by laboratories such as ours. Specifically, the manufacturers and suppliers of analyte specific reagents, or ASRs, which we will obtain for use in diagnostic tests, are subject to regulation by the FDA and are required to register their establishments with the FDA, to conform manufacturing operations to the FDA's Quality System Regulation and to comply with certain reporting and other record keeping requirements. The FDA also regulates the sale or distribution, in interstate commerce, of products classified as medical devices under the FDCA, including *in vitro* diagnostic test kits. Such devices must undergo premarket review by the FDA prior to commercialization unless the device is of a type exempted from such review by statute or pursuant to the FDA's exercise of enforcement discretion.

The FDA maintains that it has authority to regulate the development and use of LDTs or "home brews" as medical devices, but to date has not exercised its authority with respect to "home brew" tests as a matter of enforcement discretion. The FDA regularly considers the application of additional regulatory controls over the sale of ASRs and the development and use of "home brews" by laboratories such as ours.

The FDA has conducted public hearings to discuss oversight of LDTs. While the outcome of those hearings is unknown, it is probable that some form of pre-market notification or approval process will become a requirement for certain LDTs. Pre-market notification or approval of our future LDTs would be costly and delay our ability to commercialize such tests.

## **Compliance Program**

Compliance with government rules and regulations is a significant concern throughout the industry, in part due to evolving interpretations of these rules and regulations. We seek to conduct our business in compliance with all statutes and regulations applicable to our operations. To this end, we have established a compliance program that reviews for regulatory compliance procedures, policies, and facilities throughout our business.

## Legal Proceedings

On June 30, 2011, Robert Kelly, our former President, filed a counterclaim against the us in an arbitration proceeding, alleging breach of contract in connection with the termination of a consulting agreement between Mr. Kelly (dba Pitslayer LLC) and us that was entered into in July 2010 in connection with his resignation as President and a director. The consulting agreement was terminated by us in September 2010. Mr. Kelly seeks \$450,000 in compensatory damages, which is the amount he claims would have been earned had the consulting agreement been fulfilled to completion.

On December 11, 2012, Mr. Kelly filed a complaint in the United States District Court, Western Division of Washington seeking compensatory damages, interest and attorneys' fees related to the termination of Mr. Kelly's consulting contract and the rescission of shares issued to him in July 2010 in connection with his resignation as President and a director. The specific amount of damages sought is to be proven at trial and is not specified.

On February 26, 2013, Mr. Victor Cononi filed a complaint in the United States District Court, Western Division of Washington seeking compensatory damages, interest and attorneys' fees related to the rescission of shares issued to him in July 2010 in connection with Mr. Kelly's resignation as President and a director. Mr. Cononi is the father of Mr. Kelly's paramour. The specific amount of damages sought is to be proven at trial and is not specified.

A hearing in the arbitration has been postponed pending certain procedures in the above Western Division action and may be delayed further to accommodate other third party civil and federal criminal proceedings alleging securities and wire fraud that have been brought against Mr. Kelly with respect to his prior employment and predating his service with us.

We are reasonably confident in our defenses to Mr. Kelly's and Mr. Cononi's claims. Consequently, no provision or liability has been recorded for these claims as of December 31, 2012. However, it is at least reasonably possible that the our estimate of liability may change in the near term. Any payments by reason of an adverse determination in this matter will be charged to earnings in the period of determination.