



AUGUST 4, 2008

INITIATING COVERAGE

MARC ROBINS, CFA
 MROBINS@THEROBINSGROUP.COM
 503-241-1880

SCIVANTA MEDICAL CORP. (OTC BB: SCVM)

INDUSTRY: HEATH SERVICES

DISCLOSURES: 1, 4A, 5, 10

RATING: BUY

RISK: HIGH

CLOSING PRICE 08/01/08	TRAILING P/E (TTM)	SHARES OUT (MILS.)	MARKET CAP (MILS.)	3-5 YEAR REV. GROWTH	PRICE TARGET
\$0.14	NM	25.6	\$3.6	N/A	\$0.87

ANNUAL DATA – OCT YEAR END			
	2008E	2009E	2010E
EPS	\$ (0.07)	\$ (0.03)	\$ 0.11
P/E	N/M	N/M	1.3
REVENUE (MIL.)	N/M	\$0.8	\$15.5
P/S	N/M	4.5	0.2

EARNINGS					
	Q1	Q2	Q3	Q4	ANNUAL
2010E	\$ 0.00	\$ 0.01	\$ 0.04	\$ 0.06	\$ 0.11
2009E	\$ (0.02)	\$ (0.01)	\$ (0.00)	\$ 0.01	\$ (0.03)
2008E	\$ (0.02)	\$ (0.02)	\$ 0.02	\$ (0.02)	\$ (0.07)

Introduction

Veeeeesh, Gaah!.....Veeeeeesh, Gaah!.....Veeeeesh, Gaah!..... Even 35 years later, the memory of white dressed, starch-capped nurses mentioning the name of this particular upcoming procedure brought a combination of dread, expectation and fear for the patient’s life into all of us that worked on the CCU/ICU ward and throughout the North Wing of the hospital.

Veeeeesh, Gaah!.....Veeeeeesh, Gaah!.....Veeeeesh, Gaah!..... While the rhythmic operation of the ventilators kept their critically wounded or decrepit patients oxygenated, not only did the nurses but even the attending Doctors mention the name of the procedure in hushed tones. Quietly, as if the mere mentioning of “Swan-Ganz” might scare-up Lucifer himself or cast a spell to draw-out the very life force of those clinging to the last vestiges of this world, the procedure was ordered. To us Nursing Techs, we knew there was danger. We certainly got to clean-up afterward and if lucky, help-out if things got hairy. But, we always thought it a bit eerie and certainly strange how everyone’s voices dropped in the rooms where the noise level due to the ventilators was such that it was near impossible for patients to actually sleep.

Veeeeesh, Gaah!.....Veeeeeesh, Gaah!.....Veeeeesh, Gaah!..... In the 1970’s, “Swan-Ganz” was enough to stop, or slow, most nursing activity in its tracks. Nearly three and a half decades later, it may not even cause a pause, but to me 1) I was surprised that the procedure was still in use and not replaced by some new advanced technology introduced years ago, and 2) somewhat shocked that the usage of had grown considerably over the years. When earning my way through college by working various jobs through-out the hospital, I noted that the performance of a pulmonary artery catheterization, or a Swan-Ganz catheterization, was a real rarity in what was one of the busier hospitals in the State. More recently, the prevalence of the procedure has become fairly commonplace. By the mid 1990’s, frequency of catheter placements were nearly 6 per 1000 patients and more recently the need for this medical data has given rise to almost a half billion dollars of testing.

The reason for the growth is the growing demographic shifts in the aging U.S. population and of course, the hand-in-hand increase in the number of cardiac and congestive heart failure cases. The real problem is not the increasing number of CHF cases but what organic aspect of heart failure is actually failing and how to best treat the patient. Yes, modern medical science over the years has added an array of new drugs and procedures to the Cardiologists’ armamentarium to fight heart disease, but the real problem is making sure that the clinician

This report was prepared from data and information believed reliable but not guaranteed by us as to its accuracy and does not purport to be complete. It is not to be considered as an offer to sell or a solicitation of an offer to buy the securities of the companies covered by this report. Opinions expressed are subject to change without notice. Catalyst Financial Research LLC, its affiliates and other associates may have positions and may effect transactions in securities of companies mentioned herein. ©Catalyst Financial Research LLC, Suite 201, 3220 SW 1st Ave. Portland, Or. 97239; (503)-241-1880.

knows for sure what the patient is suffering from. Hence, the increased calling for the Swan Ganz catheterization. It is a procedure which definitely provides data on what aspect of the heart's mechanical pumping function is not operating correctly.

INVESTMENT SYOPSIS

Based in Spring Lake, New Jersey, Scivanta Medical Corporation is a medical technology company that in-licenses late-stage, emerging device technologies that need that very last margin of corporate, engineering, financial, regulatory and/or marketing initiative to introduce a new therapeutic or health product device or product to the market. The Company has recently licensed the right to develop, market, and distribute the proprietary technology known as the Hickey Cardiac Monitoring System (HCMS) from its partners based out of the University of Buffalo where this novel system for measuring heart functionality has been under development for nearly 18 years.

The Company's HCMS includes a minimally-invasive, two-balloon esophageal catheter system used to detect cardiac performance and left atrial pressure and is proposed to replace the Swan-Ganz catheter, which is a long-used, far more invasive approach known to have 3% mortality and higher morbidity rates. Now protected with 33 patents, HCMS consists of two parts: an electronic base station monitor, which is about the size of a standard, notebook computer and the above-mentioned disposable catheter, which is used with each patient and will be sold to hospitals, out-patient clinics or doctor offices. It is this disposable that senses the patients' vital data and transmits the analog signal to the base station for conversion, analysis and readout.

Development of the HCMS should be complete by the end of August. FDA trials are scheduled to begin by September and the data and application submission to the Agency is planned to occur by the end of October. The HCMS trial consists of relatively simple cathing procedures and comparing cardiac output readouts, taking not much longer than approximately 15 minutes per patient. These trials are to be held in cardiac procedure units at three major hospitals where a large volume of patients are seen daily. Comparisons of left atrial pressure (LAP) in laboratory studies show a remarkable ability of the HCMS to measure this function without cutting into the circulatory system.

Sales of the base station and multiple-packs of the disposables should commence in the US by early spring of 2009 following FDA clearance. The Company also believes that it should actually receive the EU's CE Mark for product sale before the HCMS reaches the US market, but because of logistics and locations, the European market will not be entered until nearly Fall, 2009.

INVESTMENT CONCLUSION

The shares of Scivanta Medical Corporation present investors a very interesting risk/reward investment opportunity. As we noted in our introduction, the growing opportunity in the cardiac and congestive heart failure diagnosis arena is already sizable and growing and the occasion to actually find a viable and exciting device to crack into this market is rare. The HCMS presents the near perfect investment solution to the diagnosis and patient monitoring conundrum that has been presented to physicians for decades: it is simple, safe, seemingly accurate (we will know more by September's end), provides the attending doctor information on the heart that has been heretofore far more difficult to attain, and nearly benign to the patient. The HCMS also comes in the perfect "investment" wrapper, ala the "razor and razor blade" sales package. Yes, adoption is always the critical question. But unlike other test or therapy devices we've seen stumble, this one offers the fewest hurdles when it comes to ease of doctors trying it, cost, medical data output, CMS payment, etc.

Our thoughts are that the shares represent an investment opportunity with as much as two to four-fold appreciation potential with an above normal, "businessman's" element of risk. We developed a point price

projection of \$0.87 per share. Our discounted cash flow analysis of the Company's 2010 projected earnings took into consideration the following risk elements:

- The approval by the FDA of a new device;
- Market introduction of the device into new medical fields of use;
- Technology hang-ups that might slow the Company's progress;
- The need for capital;
- The operation of a "virtual" Company and therefore the lack of operating bench depth; and
- Potential competitive pressures.

To develop our valuation, we used only a 20X PE multiple, which seems reasonable given that fast-growing medical device/diagnostic companies can sell at 25X to 30X multiples, as well as a 50% discount rate for the 2½ years the model covers. This is considerably higher than our normal, 35% discount rate which has been a fairly appropriate figure for device companies.

Despite our cautious stance on the valuation, we think that the HCMS has a very probable opportunity of cracking the Swan-Ganz dominant role of measuring LAP. It has the ability of penetrating markets in a far more pervasive manner, expanding the medical application and most importantly, helping to save the lives of patients with congestive heart failure.

We are initiating our coverage of Scivanta Medical Corporation with a "BUY" rating noting the heightened risk element of this pre-revenue operation.

BACKGROUND

History

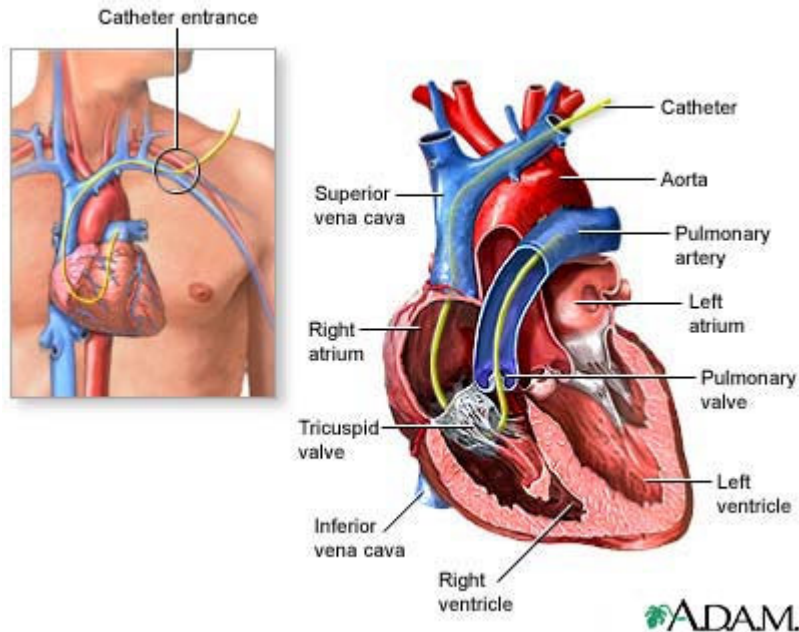
In 1929, Werner Forssmann was the first to demonstrate that a catheter could be advanced safely into the human heart. By using his own heart as the test subject, his primary purpose was to develop a technique for direct delivery of drugs into the heart. With the advent of the pulmonary artery catheterization (PAC), pressure measurements and blood sampling from the cardiac chambers and pulmonary artery became possible outside of the cardiac catheterization laboratory. This transformed the procedure from one that was labor and resource intensive to one that could be performed rapidly at the bedside of a critically ill patient.

Although the concept of using a balloon-assisted catheter had been published 15 years earlier, an opportune observation by a noted cardiologist led to its further development. During a day at the beach, Dr. H. J. Swan noticed a sailboat moving quickly despite the calm weather. This led to the initial idea of devising a catheter with sail-like device attached for pulling the catheter through the blood stream. Because balloon-tipped catheters were easier to fabricate, initial testing was conducted with the catheters we are familiar with today: it proved so successful that the original parachute idea was abandoned.

At the same time, the work of William Ganz on the thermodilution method of measuring cardiac output (CO) was incorporated into the catheter's use. This basic design remains in use today. Interestingly, despite the widespread use of their names for the flow-directed balloon-tipped pulmonary artery catheter, neither of the physicians nor the original manufacturer could obtain a patent.

Procedure

The catheter is inserted through a large vein—often the internal jugular, subclavian, or femoral veins. With the aid of fluoroscopy, it is then threaded through the right atrium of the heart, the right ventricle, and subsequently into the pulmonary artery.



The standard pulmonary artery catheter has two tubes (Swan-Ganz) and is equipped with an inflatable balloon at the tip, which facilitates its placement into the pulmonary artery by essentially allowing the catheter to float with the blood through the main vessels of the heart. The inflated balloon causes the catheter to "wedge" itself in a small pulmonary blood vessel damming itself between the two halves of the heart. So wedged, the catheter can provide a measurement of the pressure in the left atrium of the heart. Hence, this is termed Left Ventricular End Diastolic Pressure or LVEDP.

Modern catheters have been changed to include multiple tubes (five or six are common) and have openings along the length to allow administration of drugs along the length of the catheter and directly into the atrium itself. The other major change is the addition of a small temperature sensor, or thermistor probe, which lies about 3 cms behind the tip of the catheter. Cold fluid--typically 10 ml of saline (0.9% NaCL), which is normally under 10°C or room temperature (which does not give as accurate reading) is injected into an opening in the Right Atrium. As this cooler fluid passes the tip temperature sensor, a very brief drop in the blood temperature is recorded. By attaching both the injector site and the ventricular thermistor to a small computer, the curve that illustrates the drop in temperature can be plotted. If details about the patient's body mass; core temp, systolic, diastolic, central venous pressure (CVP) (which is found by measuring the blood pressure from the atrium by the third tube simultaneously) and pulmonary artery pressure are inputted, a comprehensive flow vs. pressure map can be plotted. In crude terms, this measurement compares right and left cardiac activity and calculates pre-load and after-load flow and pressures. All this relays to the physician the volume that the heart is pumping, the "strength" in which the flow of blood is pushed from the heart, an indication of muscle problems, myocardial infarction and how medications may be affecting each of the factors just described.

Modern medicine has become really very good at detecting several heart ailments. And these diseases can be broken down into some major groups: nutrient and oxygen flow problems, electrical problems and pump

problems. The first two are pretty well understood and approaches for treatment well known. For the third aspect of heart disease, congestive heart disease, the range of problems is vast and the remedies equally complicated. Without a better understanding of what is at the root of the patient's problem, sometimes the treatments are not as targeted as they should be. Given the data that is available from the basic Swan-Ganz pulmonary cardio artery catheterization and the more sophisticated devices now employed, here is a list of indications or complications that may affect the patient:

- Myocardial infarction;
- Muscle infiltration;
- Viral problems;
- Metabolic arterial sclerosis;
- Assessment Valvular heart disease.

The biggest problem with this wonderful and helpful test is that the procedure's invasive nature, the required use of certain, specialized equipment (which also means it needs to be performed in an ICU/CCU environment) and the high risk factors associated with the procedure thereby limits its use to the most ill patients. It is also costly.

Other less invasive and dangerous approaches have been forwarded by science into medical practice but with limited success. Their advantages over the PAC have been restricted, unfortunately, by their accuracy.

Now, the Hickey Cardiac Monitoring System (HCMS) seems to obviate the major risks of the far more invasive PAC catheters while producing clinical data (e.g. left atrial pressure (LAP)) that is so medically valuable to cardiologists much like that provided by the Swan-Ganz. Developed over the last 20 years at the University of Buffalo by Dr. Donald D. Hickey, MD, the Hickey Catheter is a system that consists of a monitor and a disposable, two-balloon esophageal catheter. It is minimally invasive in that the catheter is passed down the patient's nasogastric passage rather than being threaded through one of the major veins and is situated directly behind the left atrium and aortic arch.

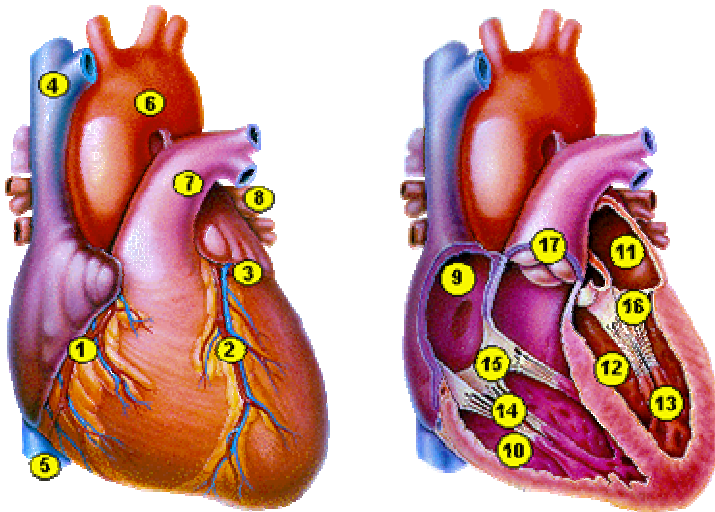
Dr. Hickey realized that the use of the Swan-Ganz in patients posed various risks to critically ill subjects running the gamut from introducing infection via the catheter site to actually creating puncture wounds within the circulatory system (including right ventricular perforations, pulmonary artery ruptures, etc.), and he believed that there had to be a way to measure LAP without invasively entering the circulatory system itself. The benefits of such a sensitive measurement device would be enumerable to the patient as well as also allow the possibility of expanding the availability of this truly valuable data to a much broader patient population. Now developed and under testing, the HCMS appears to have features and capabilities that should allow for the application of the device well beyond the Intensive Care/Coronary Care Units where the Swan-Ganz Catheterization normally takes place. Because placing the Hickey Catheter is a minimally invasive procedure, the HCMS provides the health system cost benefits while providing a higher level of medical care.

How It Works

The Hickey Cardiac Monitoring Catheter, by itself, is a relatively simple device. By looking at what appears to be an "everyday medical," polyurethane strand of coiled plastic, there is no telling how the benign elegance of this disposable device transforms the various signals received by the balloons and other lead inputs into such meaningful and critical information about the patient's heart. As mentioned, the disposable is an injection molded, two-balloon esophageal catheter. Because it is inserted through the nasogastric passage, it is considered minimally invasive and does not require a sterile environment or special procedures to place the monitoring device into position. It should be pointed out that these characteristics also imply a less complicated manufacturing process and simplified placement procedure, which signals another benefit to the HCMS over the Swan-Ganz...lower device and procedure costs. In addition, because of its convenient placement the HCMS is

compatible with continuous, long-term cardiac performance monitoring. So, for patients that are under long-term cardiac care or require constant monitoring as to how their therapies are progressing, the HCMS could be placed for long-term in-patient monitoring; or, because of ease of placement, it could be actually deployed as a “office call” procedure.

Since the Hickey Monitoring Catheter is positioned in the esophagus, it capitalizes on the unique anatomic relationship of the left atrium and the aortic arch. It so happens that humans have a physiological architecture whereby the “backside” of the heart itself is positioned right up against the esophagus. Two of the closest components of the pumping muscle are the left atrium and the aortic arch. The left atrium is the upper right chamber of the heart which receives freshly oxygenated blood from the lungs and pumps it down into the left ventricle which then pumps this blood to the body. It is designated in the illustration below by the number #11. The aorta is the main blood vessel that carries oxygen-rich blood away from the heart to the organs of the body. After it leaves the heart, the aorta ascends to give off blood vessels to the arms and head, then arches and turns downward towards the lower half of the body. The aortic arch—used by the HCMS algorithm for measuring heart function—is the second section of the aorta after it first ascends out of the heart itself, then bends (the arch), and then descends down in to the trunk. The bend—as I understand the anatomy, is actually depicted by the number #6—is the aortic arch itself. Fortuitously, both of these anatomical features are lodged up against the esophagus so that the balloons of the Hickey catheter can “feel” the pulsing



- | | |
|-----------------------------|-----------------------------|
| 1. Right Coronary | 9. Right Atrium |
| 2. Left Anterior Descending | 10. Right Ventricle |
| 3. Left Circumflex | 11. Left Atrium |
| 4. Superior Vena Cava | 12. Left Ventricle |
| 5. Inferior Vena Cava | 13. Papillary Muscles |
| 6. Aorta | 14. Chordae Tendineae |
| 7. Pulmonary Artery | 15. Tricuspid Valve |
| 8. Pulmonary Vein | 16. Mitral Valve |
| | 17. Pulmonary Valve |
| | Aortic Valve (Not pictured) |

pressure of the individual heartbeats. This cardiac wall motion generates measurable pressure changes in the balloons, transferred by the catheters and eventually measured and monitored by the actual electronic system within the device. These two pulse/pressure signals combined with data from an electrocardiogram, phonocardiogram and automated blood pressure manometer are all transmitted to the electronic circuitry in the monitoring system. Combined and deciphered, the various data feeds are converted into real-time clinical information for the physician.

Although the HCMS that is planned to be initially introduced to the medical profession will be a version that provides the most fundamental read-outs, and is also most readily acceptable (and easily acceptable) to the FDA, there is a vast array of clinical information that is also available from the device for clinicians. A growing list currently includes: Mean left atrial pressure; Left ventricular contractility; Resting esophageal pressure (intrapleural pressure); Mean left atrial transmural pressure; Systolic time intervals; Two measures of diastolic dysfunction; Cardiac output by pulse contour method; Arterial pulse wave velocity; Continuous phonocardiography with audio output and visual display; Electrocardiogram; and Blood pressure.

Although the creation and engineering involved was extraordinarily time-consuming, labored and sophisticated, the finished design is incredibly elegant and the operation of the HCMS marvelously basic. Given some of the engineering work that was witnessed while preparing for this report, the advantages provided by this medical device over current practices seem to place the Hickey Catheter in a position where it can not only expand the market at a time where the need seems to be prevalent but also begin to displace the Swan-Ganz when management believes that the time is appropriate to move toward that goal. The HCMS certainly appears to provide numerous market advantages whether compared to the Swan-Ganz in the ICU or not.

From the medical personnel and institution side of the “benefit” equation, the HCMS catheter should be rapidly inserted and positioned into a patient without trouble. Using the nasogastric passage, placement of similar tubes (e.g. feeding tubes) is “old hat” to most professional medical personnel. Training a doctor, nurse or other specialized technician to position a HCMS so that the Hickey balloons correctly measure the two pressure points would require some work, but not undue effort. As we said this is a minimally-invasive procedure that provides numerous benefits from an ease of use standpoint. Lastly, the real benefit to the institution and staff is that the HCMS allows for the monitoring of the heart patient from just about anywhere. It is not restricted to the ICU/CCU or surgical arena. As we pointed out, it could easily be deployed in an emergency room, with proper training in “STAT” situations and even on-board an ambulance, and certainly included as part of a cardiologist’s office diagnostic armamentarium. In addition, because the Hickey Catheter disposable has no metal components itself, it can be left in place during a MRI.

A separate aspect of the “positioning” procedure is the fact that proper catheter placement is built into the electronics, which helps the physician or technician appropriately locate the right site for the two balloons. Not only is the process built in and tested to exactly locate the right spot for the measurement, but the way in which it’s done is proprietary. This is part of the way the Company is creating barriers for competitors.

From the patient’s standpoint, the HCMS really provides three major benefits. First of all, the Hickey Cardiac Monitoring System can be used for procedures earlier in their cardiac diagnostic and therapeutic course (think about the use of Swan-Ganz catheters now - a patient has to be on death’s doorstep, or nearly so, to warrant consideration of the procedure by the attending physician). Secondly, patients may be monitored continuously over longer intervals, say during a hospital stay, allowing time-period reviews of treatment. Finally, the minimal risk of systemic infection that compares very favorably to the enumerable infections and nearly 90,000 annual catheterization-caused deaths...this provides a real, eye-popping advantage.

The following table compares the different clinical outputs of the Hickey Cardiac Monitoring System and the Swan-Ganz Catheter System.

Features	HCMS	Swan-Ganz
Cardiac Output	X	X
Left Atrial Pressure	X	X
Left Ventricular Contractility	X	
Left Atrial Transmural Pressure	X	
Pleural Pressure	X	

The Market Opportunity

Heart disease is one of the fastest growing and most rampant causes of death among the elderly in the United States. The affliction is really three diseases, and due to our growing understanding of the nature of heart disease, the medical community is becoming much better at defining what the root causes of mortality are. That said, 4.9 million patients in the US experience Congestive Heart Failure (CHF) of one form or another annually, and the number is growing with 700,000 new cases diagnosed with each passing year. Indeed, it is the one heart condition that is actually on the increase, with nearly 20% of all those Americans 65 or older as patients.

From a medical-economic standpoint, Congestive Heart Failure is a real factor as it affects the healthcare system. In the year 2000, nearly \$32.5 billion in direct and indirect costs were associated with cardiovascular disease. CHF and related diseases were and continue to be the leading reason for emergency department admissions and nearly 13% of all hospital visits. To better express the economic significance of this malady on healthcare, Medicare spends more on the treatment of Congestive Heart Failure than it does on treating all the various forms of cancer in the US, and yet, the societal concern and heartbreak of cancer has far greater emotional impact.

As we have implied, the Swan-Ganz pulmonary artery catheter is still the standard of care for monitoring the cardiac performance of patients with CHF, sepsis, congenital heart failure, or burns. Despite the somewhat controversial clinical use of this invasive monitoring device, it has not stopped, or even slowed, Edwards Life Science (NYSE: EW – Not Rated) from marketing and capitalizing its sales.

In fact, the whole hemodynamic monitoring arena has experienced sales in 2006 of nearly half-a-billion-dollars, and the segment of monitoring devices experienced compounded annual growth from 2003 to 2006 of nearly 5.5%. In particular, the pulmonary artery catheter segment of the market, dominated by Edwards' Critical Care Segment (including their new FloTrac catheter system, as well as Venous oximetry catheters, Swan-Ganz catheters, etc.) has shown relatively stable top-line performance during that same period...from 2003 through 2007. This episode of relatively flat growth is overshadowed by the introduction of the above-mentioned FloTrac System, a new technology, which has specifically buoyed Edwards' overall catheter business and, fortunately for Edwards, masked a difficult decline that Swan-Ganz catheter sales was experiencing from 2003 through 2006.

Conversely, the non-invasive hemodynamic monitors and pressure monitoring/blood sampling device segments of the market have both been showing 30% and 3.5% relative growth, respectively. The point here is that minimally invasive procedures have grown far more rapidly than those that place the patient at greater risk. That said, the Hickey Cardiac Monitoring System—certainly a part of the latter group of less invasive tests—has real opportunity for adoption if it can prove its effectiveness and safety to those clinicians (which we believe it can) that can use it effectively.

The Marketing Attack: One would think that the primary focus for the introduction of the Hickey Cardiac Monitoring System, since it is as an ideal alternative to the Swan-Ganz catheter, would be to attack the market where its competitor is the strongest. Wrong!!! Scivanta management believes that the best way to introduce the HCMS and sell the device into the market is to attack those areas where the Swan-Ganz is not. Why provoke the “800 pound Gorilla”—Edwards Scientific—when the ultimate result would only upset the sleeping beast and cause it to become incredibly defensive?!! As in the case of other, major healthcare alternatives, EW would defend its turf vigorously by trying to crush adoption, no matter how powerful the benefits and positive, by comparison, the safety advantages are. (I can think of the best example, Curon Medical, Inc. and its battle in the GERD marketplace: a thirty-minute procedure curing nearly 80% of the patients versus a lifetime of little purple pills.)

What we know is that the Hickey Catheter does not need to be placed by a specialist; it does not need to be placed in the patient who is situated in a specially outfitted and expensive ICU or CCU facility; and the Hickey Cardiac Monitoring System can be used in a greater variety of everyday medical environments and less serious conditions meaning that the device is not limited to just the most critical of cardiac patients. But instead of going head-to-head with cardiologists and the place where they employ the Swan-Ganz catheter directly, the hospital’s ICU or CCU, the Company plans to employ a distributor team and start approaching the specialists at their offices in hopes to convince the physicians to deploy the HCMS during CHF patient office visits.

Just think, out-patient monitoring of CHF and other cardiac patients is a perfect opportunity for the HCMS. The out-patient market has been pursued by other companies, such as CardioDynamics International Corp. (NASDAQ: CDIC – Not Rated), and medical device sales through that channel are already running at projected \$190 million pace. The problem with existing technologies is that their measurement of heart function is not particularly accurate. The really good news is that the competing technologies should be able to be displaced economically and with much greater specificity and accuracy by the HCMS. The best news is that as adoption broadens, as physicians understand how the HCMS can help them perform their patient diagnostic and treatment, there is a very good chance that use of the HCMS could expand from just occasional office visit use to entire hospital stay monitoring.

The approach of broaching the hospital is with a less direct, “Trojan Horse” tactic. Scivanta management has concluded that its sales effort should promote and detail the HCMS and try to expand utilization to anesthesiologists for assisting in surgery where patients have a high risk of a cardiac event (for example, surgeries involving the elderly and/or procedures involving significant fluid shifts such as open abdominal or thoracic surgery procedures). As it stands, the anesthesiologists are tasked with the responsibility of monitoring and maintaining the patients’ health while undergoing the operating procedures and having a device like the HCMS would certainly help improve monitoring cardiac health and function. Although many devices and instruments are used during a surgical procedure to monitor a variety of vital signs, the HCMS would actually replicate and render a raft of existing devices as duplicative while actually providing the anesthesiologist new, and truly quantifiably additive, heart function information. The point here is that by entering the surgery theater, Scivanta again penetrates the hospital environment, and not via the ICU, therefore once again not challenging the Edwards’ Swan-Ganz stronghold. On the other hand, it does introduce its HCMS to the hospital’s medical team, administration and buying staff.

One last, but not so minor point. Because the HCMS provides the same information as the Swan-Ganz, there is no need to secure a new code for medical insurance reimbursement for in-hospital use. This is a very important point as it affects Scivanta’s operating future. It is a leg up in the payment process to have a reimbursement code and an easing of the insurance and payment process. Unfortunately, the Company will have to hold a small, secondary research study to generate sufficient data when seeking a reimbursement code for insurance coverage regarding office visits, etc.

Another obvious non-confrontational market opportunity would be hospital Emergency Departments. With nearly 120 million Emergency Department visits expected this year and roughly 13% of those involving CHF, it is a perfect prospective arena to use the HCMS. Since the job of Emergency Department doctor is to stabilize the patient and then refer them on to the specialist/hospitalist, it is very likely that a duo sale between ER doctor and cardiologist might occur where the hospitalist sees the need for the HCMS and requests patient “pull-through” with the device already placed as he is moved up onto the cardiac floor. The ER doctor might really appreciate a simple, undemanding measure of heart functionality, and a hospitalist physician would welcome the HCMS for daily monitoring of the patient’s condition. Lastly, of the patients that are being brought in with CHF history or complaints, it is not hard to imagine where the patient could actually arrive on the ER doorstep with the HCMS already positioned and either feeding live data to the base station at the hospital or ready to deliver data upon arrival.

The really exciting aspect that the HCMS opportunity creates is that it should augment the market development for cardiac monitoring by almost two to three times, increasing its size to a billion to a billion-and-a-half dollars. This is accomplished while providing a much higher degree of medical analysis and performance as well as better cost/benefit returns to the medical system, in that physicians and their patients will receive better diagnostic and progress information at a lower cost to the medical system.

Product Development and Regulatory Plan

What we have described just above is Scivanta’s operating plan from the very end of March, 2009 through the end of the second calendar quarter in 2010. Of course, this depends on the Company receiving FDA 510k clearance for the HCMS (and it will be just a clearance for Left Atrial Pressure at that time). Therefore, this is a perfect opportunity to discuss the Company’s development and regulatory plans since they follow parallel tracks and also go hand-in-hand with how Scivanta plans to expand the market.

At the time of this Publication, the Company reports that progress on all development fronts—software, hardware, as well as manufacturing set-up and QC—is proceeding on schedule. Juxtaposed to the internal efforts, working arrangements with three major, nationally recognized coronary centers are underway to provide patients and study data for the FDA trials. Scivanta, given its discussions with the Agency to date, believes that it will only have to provide solid comparative data on 50 to 60 patients as well as proper documentation to show benefit and safety of the new device.

Because of the size and patient flow-through of the medical center hospitals, it is believed that the trial data should be collected relatively quickly compared to most studies. I was surprised that it could be collected within a month’s time and essentially sent off to the FDA by the end of another month. Also, the cost of the tests is incredibly reasonable. To place a ribbon around this aspect of the development process, it appears that SCVM should be able to submit the research package to the FDA by the end of October and well within the financial limits of its current balance sheet.

Given the normal processing time and tribulations of the FDA, one could generally expect that the Agency would respond by the end of January or early February with approval. Likewise, the Company should be running a nearly parallel approval track for CE Mark in Europe with the hope of receiving the Mark in the second quarter.

As the HCMS file wends its way through the approval process, management should be working to hire and train the appropriate distribution team to introduce, demo and dispense both the HCMS and the disposable catheters throughout hospitals. The current plan is to not have an in-house team but actually have an outside established firm act as the representative sales reps to sell-through the System. As introduced above, this first leg of the marketing process is supported by the ready access of reimbursement payments for hospitals.

To expand the use for the HCMS into other markets, Scivanta must take steps to further expand reimbursement codes for non-hospital settings. For instance, to broach the cardiology office market it must both establish new CMS codes as well expand the HCMS' clinical information provided, specifically left ventricular contractility, which is particularly helpful to Cardiologists when diagnosing and monitoring patients with CHF. That said, the Company will probably initiate two follow-on studies almost immediately after the launch of the HCMS into the hospital market. First, there will be a small follow-on trial for the FDA to expand the scope of the device's cardiac measurements. Remember in an effort to gain 510K approval, the most basic Hickey Base Station design and system was forwarded by the Company. This second trial would not only allow the Company to expand the market by providing specialists additional medical cardiac data but also give Scivanta a chance to incorporate a number of technical upgrades bridled-back for the original approval process. Also, from a marketing standpoint, it makes sense to provide a chance for "Upgrades" to the market. Guessing at the FDA requirements, this most likely implies a 50 to 100 patient trial of similar complexity to the one planned for the Fall, 2008. So, the cost or time should not be extravagant or lengthy.

Separately, there will be the need for a clinical trial to gather the data needed for the CMS code and convincing the Medicare agency types for reimbursement amounts. This is always an arduous process and one that is vexed with grief regarding amounts that seem too small, on-going negotiations, etc. Despite this sobering prospect, because the HCMS presents a relatively inexpensive alternative for a heart monitoring/assessing disposable, we think investors should not discount too heavily the opportunity. We would imagine that both trials would be completed and results approved for calendar 2010.

Income Projection, Balance Sheet Thoughts and Valuation

The included projection for the Company's income statement forecasts that sales in the United States start in late March or early April of 2009. This is based on receiving FDA approval as well as successful initial sales into the hospital arena. We are not taking too aggressive a stance regarding the ramp of system sales even though the price of a new HCMS is expected to be priced at less than \$10,000 per unit. This compares really quite favorable versus system "buys" that hospitals often face that range in the six digits. On the other hand, we are using a more aggressive ramp in catheter sales, not at the initial sale, but after the unit has been used for four to six months. The usage for roughly two to three patients per day might be considered common per installed base station.

The situation in Europe actually ramps at a slower pace. We are projecting that the first sales of the base unit start will start in September 2009...just after the well-known, summer doldrums. Sales grow in the fall but never really catch up to the rate that is experienced in the US. Disposable sell-through runs about parallel to that experienced in the US.

One comment on gross margin. As you would expect, disposable sales are the real crux of the operating model. With increasing catheter sales, gross margin expands with time. We see it start at about 8% when the sales first start and then rise to 38% of sales by October of 2010. It should continue to ramp as the mix continues to move toward disposables (and this is what should be expected).

As of this writing, Scivanta intends to raise about \$3 million to support the launch of products into the US and Europe. They have been running a very tight ship financially and should do so going forward. In addition, grant development money from NY secured by the University of Buffalo has helped to offset R&D costs and has really worked to expand the budget dollars.

One might be a little worried about the situation given how close to the finish line that Scivanta is except for the fact that many of Dr. Hickey's and Dr. Lundgren's colleagues, who have been very closely tied to the HCMS

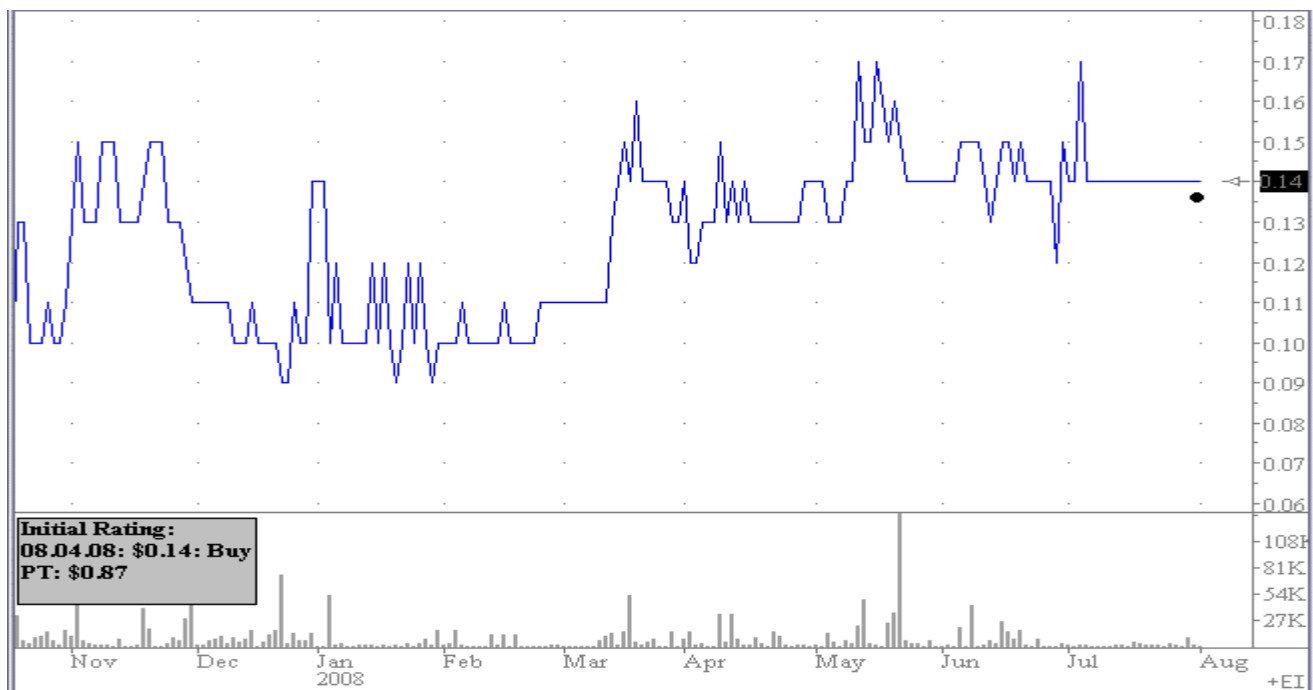
development and successes, are very interested in helping out. They, in particular, should understand the science and the progress of the technology. Also as we have worked with the Company, we have seen real interest by professional investors in the model and opportunity. That said, we have added nearly 25.7 million shares via an equity financing to help finance the remainder of the development process and the launch. Also beware of the added share dilution caused by the addition of shares as more employees are hired and option grants are made.

Given this projection, we have projected that the Scivanta loses \$1.4 million on just over \$9.7 million in revenues in Fiscal, 2009 (ending October). For the next year, the results are much better. Remember, we do believe that the Company is able to get approval for using the HCMS in physicians' offices and an additional code for the majority of 2010. We show sales buoyed to \$51.3 million in sales and \$6.1 million in Net Income. This represents \$0.11 per share in earnings for their October, 2010 year. Remember the company has almost \$16 million of NOL. So, we incorporate that that NOL to offset the gain in the fourth quarter in 2009 and in all of the quarters in 2010.

Based on the following assumptions:

- FDA approval in First Calendar Quarter 2009;
- Income Statement ramp as shown;
- Requirement of \$3 million to fund on-going ops until launch in March/April in 2009;
- 50% discount rate for 2 ½ years and a 20-time multiple on fully-taxed earnings for fiscal 2010 of \$0.11.

We place a current valuation of Scivanta shares at \$0.87.



This report was prepared from data and information believed reliable but not guaranteed by us as to its accuracy and does not purport to be complete. It is not to be considered as an offer to sell or a solicitation of an offer to buy the securities of the companies covered by this report. Opinions expressed are subject to change without notice. Catalyst Financial Resources LLC, its affiliates and other associates may have positions and may effect transactions in securities of companies mentioned herein. ©Catalyst Financial Resources LLC. Suite 201, 3220 SW 1st Ave. Portland, Or. 97239; (503) 241-1880.

Scivanta	1Q08A	2Q08A	3Q08E	4Q08E	2008E	1Q09E	2Q09E	3Q09E	4Q09E	2009E	2010E
Revenues Model											
Number of Base Stations Sold in Europe	0	0	0	0	0	0	0	5	90	95	1,185
Gross Revenue to Company @ \$8,000	0	0	0	0	0	0	0	37,500	675,000	712,500	8,887,500
Number of Catheters sold in Europe	0	0	0	0	0	0	0	10	1,480	1,490	70,071
Gross Revenue to Company @ \$85	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$850	\$125,800	\$ 126,650	\$ 6,656,745
Total Gross Revenue in Europe	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 38,350	\$ 800,800	\$ 839,150	\$ 15,544,245
Number of Base Stations Sold in the USA	0	0	0	0	0	5	100	265	280	\$ 650	\$ 2,115
Gross Revenue to Company @ \$8,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 37,500	\$ 750,000	\$ 1,987,500	\$ 2,100,000	\$ 4,875,000	\$ 15,862,500
Number of Catheters sold in the USA	0	0	0	0	0	20	1,700	13,060	32,120	46,900	208,898
Gross Revenue @ \$85	\$0	\$0	\$0	\$0	\$0	\$1,700	\$144,500	\$1,110,100	\$2,730,200	\$ 3,986,500	\$ 19,845,310
Total Gross Revenue in the USA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 39,200	\$ 894,500	\$ 3,097,600	\$ 4,830,200	\$ 8,861,500	\$ 35,707,810
Total Revenues	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 39,200	\$ 894,500	\$ 3,135,950	\$ 5,631,000	\$ 9,700,650	\$ 51,252,055
Cost of Goods Sold											
Base Stations	\$0	\$0	\$0	\$0	\$0	\$35,000	\$600,000	\$1,620,000	\$2,220,000	\$ 4,475,000	\$19,800,000
Catheters	\$0	\$0	\$0	\$0	\$0	\$1,000	\$85,000	\$653,500	\$1,680,000	\$ 2,419,500	\$ 13,948,450
Total	\$0	\$0	\$0	\$0	\$0	\$36,000	\$685,000	\$2,273,500	\$3,900,000	\$6,894,500	\$ 33,748,450
Gross Profit	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,200	\$ 209,500	\$ 862,450	\$ 1,731,000	\$ 2,806,150	\$ 17,503,605
Gross Margin	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>8.16%</i>	<i>23.42%</i>	<i>27.50%</i>	<i>30.74%</i>	<i>28.93%</i>	<i>34.15%</i>
Operating Costs											
Selling, General & Administration	\$393,000	\$327,000	\$370,000	\$425,000	\$1,515,000	\$550,000	\$575,000	\$600,000	\$650,000	\$2,375,000	\$8,778,700
R&D	\$33,000	\$65,000	\$100,000	\$350,000	\$548,000	\$450,000	\$300,000	\$300,000	\$300,000	\$1,350,000	\$1,700,000
Added Compliance, Trials and Marketing	\$0	\$0	\$0	\$50,000	\$50,000	\$100,000	\$100,000	\$100,000	\$150,000	\$450,000	\$950,000
Operating Profit	(\$426,000)	(\$392,000)	(\$470,000)	(\$825,000)	(\$2,113,000)	(\$1,096,800)	(\$765,500)	(\$137,550)	\$631,000	-\$1,368,850	\$6,074,905
Oper. Margin	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>-2797.96%</i>	<i>-85.58%</i>	<i>-4.39%</i>	<i>11.21%</i>	<i>-14.11%</i>	<i>11.85%</i>
Other Income (Expense), Net	\$21,000	\$11,000	\$10,000	\$10,000	\$52,000	\$15,000	\$15,000	\$15,000	\$15,000	\$60,000	\$60,000
Earnings before Interest and Taxes	(\$405,000)	(\$381,000)	(\$460,000)	(\$815,000)	-\$2,061,000	(\$1,081,800)	(\$750,500)	(\$122,550)	\$646,000	-\$1,308,850	\$6,134,905
Interest Expense	\$8,000	\$8,000	\$10,000	\$10,000	\$36,000	\$10,000	\$10,000	\$10,000	\$10,000	\$40,000	\$45,000
Income from Continuing Operations	(\$413,000)	(\$389,000)	(\$470,000)	(\$825,000)	-\$2,097,000	(\$1,091,800)	(\$760,500)	(\$132,550)	\$636,000	-\$1,348,850	\$6,089,905
Pre-Tax Income	(\$413,000)	(\$389,000)	(\$470,000)	(\$825,000)	-\$2,097,000	(\$1,091,800)	(\$760,500)	(\$132,550)	\$636,000	-\$1,348,850	\$6,089,905
Pre-Tax Income	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>nm</i>	<i>-2785.20%</i>	<i>-85.02%</i>	<i>-4.23%</i>	<i>11.29%</i>	<i>-13.90%</i>	<i>11.88%</i>
Taxes						\$0	\$0	\$0	NOL \$254K	NOL \$254K	NOL \$6089K
(Tax Rate)											
Net Income Applicable to Shareholders	(\$413,000)	(\$389,000)	(\$470,000)	(\$825,000)	-\$2,097,000	(\$1,091,800)	(\$760,500)	(\$132,550)	\$636,000	-\$1,348,850	\$6,089,905
Shares Outstanding	25,850,000	25,850,000	25,850,000	51,450,000	32,250,000	52,500,000	52,900,000	53,250,000	53,850,000	\$53,125,000	\$54,765,750
Earnings per Share	(\$0.02)	(\$0.02)	(\$0.02)	(\$0.02)	(\$0.07)	(\$0.02)	(\$0.01)	(\$0.00)	\$0.01	(\$0.03)	\$0.11

This report was prepared from data and information believed reliable but not guaranteed by us as to its accuracy and does not purport to be complete. It is not to be considered as an offer to sell or a solicitation of an offer to buy the securities of the companies covered by this report. Opinions expressed are subject to change without notice. Catalyst Financial Resources LLC, its affiliates and other associates may have positions and may effect transactions in securities of companies mentioned herein. ©Catalyst Financial Resources LLC, Suite 201, 3220 SW 1st Ave. Portland, Or. 97239; (503) 241-1880.

DISCLOSURES:

This report has been commissioned by Scivanta Medical Corporation (the Company) as part of an on-going research and awareness program contracted between Catalyst Financial Resources, LLC (CFR), and the Company. CFR has been paid or promised payment for the production and editorial content of this report. The Company is paying CFR \$6,000 per month for 12 months for services rendered. However, the opinions, forecasts and price targets are based on our examination of company fundamentals, conversations with management, independent analysis of markets, economic conditions, and other publicly available information.

This report has been written in accordance with current SEC regulations and the Standards of Practice developed by the Association of Investment Management & Research (AIMR). Our research has been conducted by employing analytical practices generally accepted as standard within the analytical industry. Our conclusions are, by the very nature of forecasting, speculative, but are also reasonable, supportable and consistent. Key to disclosures:

- (1) Catalyst Financial Resources LLC (CFR) does not make markets in any securities and has not managed or co-managed a public offering of securities for the subject company within the past 12 months.
- (2) CFR received compensation for investment banking services from the Subject Company within the past 12 months.
- (3) CFR expects to receive or intends to seek compensation for investment banking services from the Subject Company within the next 3 months.
- (4) The research analyst or a member of the research analyst's household has a financial interest in the securities of the Subject Company in the form of a (a) long position (b) short position (c) right (d) warrant (e) future or (f) call option in such securities.
- (5) CFR and/or its officers or affiliates may either hold a position in this company's share or own options, rights or warrants to purchase any of the securities of the subject company.
- (6) The research analyst principally responsible for preparing this research report received compensation based upon various factors, including CFR total revenue, a portion of which was generated by CFR's investment banking services.
- (7) The research analyst or a member of the analyst's household serves as an officer, director, or advisory board member of the subject company;
- (8) An affiliate of CFR may have a different view from the views expressed herein.
- (9) CFR and/or its affiliates beneficially own 1% or more of the subject company.
- (10) The Subject Company is a client of CFR or one of its affiliates.
- (11) CFR is a client of the Subject Company or one of its affiliates.

The analyst hereby certifies that the research conclusions and recommendation contained herein accurately reflects his/her personal views about the industry, company and shares and also hereby certifies that no part of his/her research compensation was or will be directly or indirectly related to the earnings estimates, target price or recommendation about the security.

The research provided herein should not be considered a complete analysis of every material fact regarding the companies, industries or securities named above. The opinions expressed herein reflect the analysis and judgment of the author on the date of publication and are subject to change without notice. Facts have been obtained from sources considered reliable but should not be construed as complete and are not guaranteed to be accurate. Catalyst Financial Research LLC; its members; employees and their families may have positions in the securities covered within the research material above and may make purchases or sales while this report is in circulation. Additional information on the subject companies is available upon request.

EQUITY RECOMMENDATION SYSTEM:

Buy	Immediate purchase is recommended. The security expected to outperform the market over the next 12 to 18 months.
Accumulate	Purchase of the stock is recommended for above average appreciation over the next 12 to 18 months, but the buyer may have an opportunity to acquire the stock within a 10% trading range.
Hold	Holding the stock is recommended because the share price has moved above the specific "Buy" range and, therefore, appreciation potential is less than or equal to the market.
Sell	The stock has reached the target price objective and/or conditions have changed sufficiently to alter the outlook for the stock.

EQUITY RISK SYSTEM:

High	The security is more volatile than the market and/or the company is more leveraged than its peer group.
Moderate	The security has about the same volatility as the market and/or the company carries a level of leverage in line with its peer group.
Low	The security is less volatile than the market and/or the company is less leveraged than its peer group.

DISTRIBUTION OF RECOMMENDATIONS:

At this time, there are an insufficient number of companies under coverage to generate usable distribution information or draw any conclusions regarding bias about the research methodology. Prospective companies are screened and evaluated by sales personnel and research analysts with the investment thesis and overall research recommendation developed before the commission is established.