SPECTRUM PHARMACEUTICALS INC
Form 10-K/A
May 13, 2003

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D. C. 20549

FORM 10-K/A

Amendment Number Two

**[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2002

[ ] 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 **000-28782**

SPECTRUM PHARMACEUTICALS, INC.

(Exact Name of Registrant as Specified in its Charter)

Delaware	**93-0979187**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
157 Technology Drive Irvine, California (Address of principal executive offices)	**92618** (Zip Code)
Registrant s telephone number, including area code:	**(949) 788-6700**

SECURITIES REGISTERED PURSUANT TO SECTION 12(b) OF THE ACT: None

SECURITIES REGISTERED PURSUANT TO SECTION 12 (g) OF THE ACT:

Common Stock, $.001 par value

Common Stock Purchase Warrants
Rights to Purchase Series B Junior Participating Preferred Stock

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 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 [X] 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. [ ]

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the act).

Yes [ ] No [X]

The aggregate market value of the voting common equity held by non-affiliates of the registrant as of June 28, 2002 was $6,147,364.

As of May 7, 2003, there were 3,108,100 shares of the registrant s common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

None

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EXPLANATORY NOTE

The primary purpose of this Amendment is to update the Company s financial statements to report the subsequent event of the issuance of a 444 shares of Series D 8% Cumulative Convertible Voting Preferred Stock for gross cash proceeds of $4.4 million and the re-issuance of the independent auditors opinion to remove their explanatory paragraph regarding a doubt about our ability to continue as a going concern. The Annual Report on Form 10-K for the year ended December 31, 2002, as filed with the Securities and Exchange Commission on March 28, 2003, and the Amendment Number One to the Annual Report on Form 10-K for the year ended December 31, 2002, as filed with the Securities and Exchange Commission on April 30, 2003, are hereby amended and restated in their entirety as follows.

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Spectrum Pharmaceuticals, Inc. s Annual Report on Form 10-K contains certain words, not limited to, believes, may, will, expects, intends, estimates, anticipates, plans, seeks, or continues, that are forward-looking statements within the meaning of Section 27A of the Securities Ac 1933 and Section 21E of the Securities Exchange Act of 1934. Readers should not put undue reliance on these forward-looking statements. Forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified. Spectrum Pharmaceuticals, Inc. s actual results may differ materially from the results projected in the forward-looking statements. Factors that might cause such a difference include, but are not limited to, those discussed in this Report including the Risk Factors, and in ITEM 7 Management s Discussion and Analysis of Financial Condition and Results of Operations included in this ITEM 1.

PART I

ITEM 1. BUSINESS

General

Spectrum Pharmaceuticals, Inc., was incorporated in Colorado as Americus Funding Corporation (AFC) in December 1987. In August 1996, AFC changed its name to NeoTherapeutics, Inc. and in June 1997, the Company was reincorporated in the State of Delaware. In December 2002, NeoTherapeutics changed its name to Spectrum Pharmaceuticals, Inc. Spectrum Pharmaceuticals had four subsidiaries at December 31, 2002: NeoOncoRx, Inc., 90.48% owned by Spectrum Pharmaceuticals and incorporated in California in November 2000; NeoTherapeutics GmbH, wholly owned by Spectrum Pharmaceuticals and incorporated in Switzerland in April 1997; NeoGene Technologies, Inc., 88.4% owned by Spectrum Pharmaceuticals and incorporated in California in October 1999; and NeoJB LLC, organized in California in April 2002 and 80% owned by Spectrum Pharmaceuticals. NeoTravel, Inc., a previously wholly owned subsidiary of Spectrum Pharmaceuticals was liquidated on December 31, 2002. Advanced ImmunoTherapeutics, Inc., a previously wholly owned subsidiary of Spectrum Pharmaceuticals, was merged into Spectrum Pharmaceuticals in 2001. In addition, NeoOncoRx, Inc. was liquidated during the first quarter of 2003. Unless the context otherwise requires, all references to the Company, we, our, us, Spectrum and Spectrum Pharmaceuticals refer to Spectrum Pharmaceuticals, Inc., NeoTherapeutics GmbH, Advanced ImmunoTherapeutics, NeoTravel, NeoGene, NeoOncoRx and NeoJB LLC as a consolidated entity. We conduct all of our activities as Spectrum Pharmaceuticals.

We were a development stage pharmaceutical company through the second quarter ended June 30, 2002. Beginning in the third quarter ended September 30, 2002, we are no longer a development stage enterprise in that we have commenced our planned principal operations of (1) in-licensing of oncology drug candidates and the further development of and strategic alliances for these drug candidates, (2) the out-licensing of our neurology drug candidates to strategic partners and (3) the development and marketing of generic drugs in the United States and have generated revenue from these operations.

Also during the year, our functional genomics business was engaged in discovering gene functions and validating novel molecular targets for innovative drug development. On July 19, 2002, we adopted a formal plan to discontinue the operations of our functional genomics business. However, as part of a change in management and reassessment of the Company s strategy in August 2002, we altered our plans to discontinue the operations and changed the focus of the business to out-licensing the genomics technology and the administration of two Pfizer collaboration agreements. During the first quarter of 2003, we transferred our rights to the two Pfizer collaboration agreements to The Regents of the University of California, Irvine (UCI) in exchange for the termination of certain obligations due to UCI (For more information see Note 7 to the Consolidated Financial Statements). We have eliminated all further functional genomics research operations and the associated research funding commitments to UCI.

For financial information regarding our business activities, please see Item 8. Financial Statements.

Pharmaceutical Business

Our pharmaceutical business engages in the development of novel drugs to treat significant medical diseases or indications associated with cancer. We currently have three drug candidates in clinical trial development satraplatin, Eoquin (formerly Neoquin) and elsamitrucin. We also plan to continue to pursue in-license additional clinical stage cancer drugs from other pharmaceutical companies. We believe that this method of drug development is a cost effective and expedient business strategy. Some of our drug candidates may prove to be beneficial in additional disease indications

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as our research progresses. Our pharmaceutical business has never produced products or rendered services that generate revenues from sales.

Products in Development

Our drug candidates, target indications and phase of development are summarized in the following table:

ONCOLOGY

Drug Candidate	Target Indication	Phase of Development
satraplatin *	Prostate cancer	Phase 3: Study expected to begin in 2003
Eoquin	Bladder cancer	Phase 1/2: Study in progress
	Radiation sensitization	
elsamitrucin	non-Hodgkin s lymphoma	Phase 2: Study expected to begin in 2004

* On September 30, 2002, we entered into a Co-Development and License Agreement with GPC Biotech AG for the development of satraplatin.

Oncology, Oncology Drug Candidates and Development Strategy, and Cancer and Therapeutic Targets

Oncology

Cancer is the second leading cause of death in the United States, accounting for approximately 25% of all deaths. In the United States, approximately 1.3 million new cancer cases are expected to be diagnosed in 2003 and over 550,000 persons are expected to die from the disease in 2003, which is an average of approximately 1,500 deaths per day. More than three quarters of all cancers are diagnosed after age 50. Statistics show that in the United States men have a 50% probability and women have a 33% probability of developing cancer in their lifetime. Accordingly, social demand for improved and novel cancer treatments is very high. In addition, the National Institute of Health estimates that $60 billion was spent in 2000 for all direct cancer-related health expenditures. Cancers with anticipated cases over 100,000 per year include prostate, colon, breast and lung. Cancers with anticipated cases over 50,000 per year include non-Hodgkin s lymphoma, bladder and skin.

Cancer is usually a malignant tumor or growth caused when cells multiply uncontrollably, destroying healthy tissue. The different forms are:

Sarcomas: a malignant tumor that begins growing in connective tissue such as muscle, bone, fat, or cartilage;

Carcinomas: a malignant tumor that starts in the epithelium (a thin layer of tightly packed cells lining internal cavities, ducts, and organs and covering exposed bodily surfaces) of an organ or body part and may spread to other parts of the body;

Leukemias: a type of cancer in which abnormal white blood cells displace normal blood cells leading to infection, anemia (a blood condition in which there are too few red blood cells or the red blood cells are deficient in hemoglobin, resulting in poor health), bleeding, and other disorders, and often proves fatal; and

Lymphomas: a malignant tumor originating in a lymph node, for example, Hodgkin s lymphoma or any of the range of cancers known as non-Hodgkin s lymphomas.

All cancers involve the malfunction of genes that control cell growth and division. Extensive unrestrained growth of cancerous cells may result in the person s death. Cancer causing agents include both internal and external factors such as chemicals, radiation, viruses, hormones, immune deficiency conditions, and inherited changes in the genes. The production of cancerous cells most likely results from a combination of factors the body experiences over time. At times it is difficult to diagnose cancer in early stages, therefore, many cancers are far advanced when diagnosed. The typical treatment for cancer include surgery, radiation, chemotherapy, hormones, and immunotherapy.

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Oncology Drug Candidates and Development Strategy

Novel cancer drugs are very exciting; however, we believe that traditional chemotherapeutic agents will remain the primary treatment for cancer for the foreseeable future. Currently, we in-license oncology drug candidates that are in clinical trials from pharmaceutical companies. These drug candidates have the potential to be effective therapeutic agents with less side-effects than drugs currently on the market. We intend to develop and commercialize them in the United States and in world markets. We do not currently have in-house capabilities to perform drug discovery for cancer-related therapies. The drug candidates that we in-license typically have smaller market potential than larger pharmaceutical companies target. Large pharmaceutical companies typically require at minimum annual sales potential of $250 to $300 million; therefore, these companies are typically motivated to out-license drug candidates with expected sales potential below this market level. Late stage drug candidates generally have a higher success rate with respect to obtaining necessary FDA approval and ultimately being distributed commercially. We believe that our in-licensing of late-stage oncology drug candidates will position us to generate product revenues earlier than if we had attempted to develop oncology drug candidates through in-house drug discovery efforts. Although we are required to make milestone payments and royalty payments under the in-licensing agreements, we expect that our anticipated earlier realization of revenues and contribution to overhead and profit should bring a quicker return on investment.

Satraplatin: Currently used in treating a wide range of cancers, platinum derivatives have been available for some time and are one of the most widely used anti-cancer agents. Satraplatin is an oral chemotherapy drug belonging to the class of platinum derivatives such as currently available, cisplatin and carboplatin. Like cisplatin and carboplatin, satraplatin interrupts DNA replication, thus killing the tumor cells. Satraplatin offers the following potential advantages over the currently used platinum-based therapies; 1) patient convenience and acceptance, 2) improved compliance, 3) reduced hospitalization, and 4) cost savings to patient and health care system. In previous clinical studies, satraplatin has demonstrated benefits in the treatment of several cancers particularly prostate cancer. Johnson Matthey PLC developed satraplatin and we in-licensed satraplatin in 2001. On September 30, 2002, we entered into a Co-Development and License agreement with GPC Biotech for the development and commercialization of satraplatin. Under this agreement, GPC Biotech has agreed to fully fund development and commercialization expenses for satraplatin. Spectrum may receive up to $22 million in license fees and milestone payments. GPC Biotech expects to initiate a Phase 3 clinical study in the third quarter of 2003.

Eoquin : Eoquin (EO9, apaziquone) has the potential to improve treatment of bladder cancer and a wide variety of other cancers. The New Drug Development Office (NDDO) Research Foundation in the Netherlands developed Eoquin and 80 related derivatives and we in-licensed these compounds from them in 2001. Eoquin is a prodrug (an inactive drug compound), which is activated by special enzymes present in high amounts in cancer cells. The activated form of Eoquin kills tumor cells, with less risk of harming normal body cells. We are currently conducting a Phase 1/2 clinical trial in Europe of Eoquin for superficial bladder cancer. Results from the first patient in our Phase 1/2 clinical trial showed a complete response (complete disappearance of the tumor as confirmed by biopsy) after receiving six treatments with Eoquin over a period of six weeks. During the fourth quarter of 2002, we agreed to expand this study to four additional sites.

Elsamitrucin: Elsamitrucin is an antitumor antibiotic with dual inhibition of the enzymes topoismerase I and II, two key enzymes involved in the process of DNA replication and cell multiplication. This inhibiting activity results in DNA breaks which prevent the correct replications of DNA, resulting in cell death. Elsamitrucin has demonstrated a marked and broad antitumor activity in experimental models and was well tolerated showing minimal toxicity to bone marrow. Bristol-Myers Squibb developed elsamitrucin and we in-licensed it from them in 2001. We may initiate a Phase 2 clinical study in early 2004.

Cancer and Therapeutic Targets

Prostate Cancer. Prostate cancer is the most commonly diagnosed malignancy and the second leading cause of cancer death among men in the United States. The American Cancer Society estimates that approximately 221,000 new cases of prostate cancer will be diagnosed in the United States in 2003. Furthermore, an estimated 29,000 men die annually from prostate cancer in the United States out of an estimated 165,000 prostate cancer-related deaths worldwide. Currently, the initial treatment of prostate cancer includes surgery along with radiation and hormone-based therapies. Approximately 30% of all newly diagnosed prostate cancer patients will progress to hormone-refractory prostrate cancer. Currently approved therapies are only effective in treating the symptoms of advanced prostate cancer. We plan to initiate a Phase 3 clinical study of satraplatin in hormone-refractory prostrate cancer in the third quarter of 2003.

Non-Hodgkin s Lymphoma. Non-Hodgkin s lymphoma is the fourth most commonly diagnosed malignancy and the fifth leading cause of cancer death among persons in the United States. The American Cancer Society estimates that approximately 53,000 new cases of non-Hodgkin s lymphoma will be diagnosed and an estimated 23,000 persons will die from non-Hodgkin s lymphoma in the United States during 2003. Although chemotherapy and radiation therapy can induce a very high initial response rate, about half of the patients will eventually relapse and die from the disease. There is a large

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unmet medical need for new treatments to help increase survival in these patients. Elsamitrucin may prove to be an important addition in treating this disease. We may initiate a Phase 2 clinical study of elsamitrucin for the treatment of non-Hodgkin s lymphoma in 2004.

Bladder Cancer. Bladder cancer is the sixth most commonly diagnosed malignancy and the tenth leading cause of cancer death among persons in the United States. The American Cancer Society estimates that approximately 57,000 new cases of bladder cancer will be diagnosed and an estimated 13,000 persons will die from bladder cancer in the United States during 2003. Treatment for bladder cancer consists of removal of the tumor by local surgery or electric cauterization. Chemotherapy is used with the aim of delaying and reducing frequency of recurrences in these patients. New therapies for all stages of bladder cancer are in very high demand. We currently have an ongoing Phase 1/2 clinical study of Eoquin for the treatment of superficial bladder cancer.

Radiation Sensitization. Radiotherapy therapy along with chemotherapy have been the primary treatment for a number of cancers. Sometimes the cancer cells can be primed to respond better to radiation therapy by pre-treatment with a radiation sensitization drug. We believe Eoquin may have the potential to act as a radiosensitizer.

Generic Business

Our plan is to generate revenue from our generic business to fund the development of our oncology drug candidates. We plan on partnering with low cost providers and focus on drug products which we believe will generate meaningful revenues and generate profits quickly. In 2002, we formed a joint venture, NeoJB LLC, with J.B. Chemicals & Pharmaceuticals Ltd. (JBCPL). JBCPL has high technology manufacturing facilities that produce first class products at competitive prices. JBCPL has the advantage of scale because they produce large volumes for Asian and European markets. We also intend to expand our generic business with other partners who can provide us low cost, high quality drug products.

Our plan calls for our first Abbreviated New Drug Application (ANDA) for a generic drug candidate to be approved in late 2003 or early 2004, and for Spectrum to begin generating revenues from generic drug sales in 2004. We plan on filing three ANDA s during 2003 and another five during 2004, so that we have multiple avenues for achieving revenues and for growing revenues from the generic business. Success in the execution of our plan would lead to profits from the generic business before the end of 2005.

The climate of today s healthcare industry and the advancement of managed care make it important to bring more economically priced products to the market. The generics industry is facing a period of unprecedented growth, with $100 billion worth of global blockbusters set to face U.S. patent expiration by 2005. Spectrum, with strategic partnerships with several state-of-the-art Indian generic drug-manufacturing companies, hopes to take advantage of the changing dynamics of the generics market.

Our first ANDA was submitted in January 2003 for Ciprofloxacin and plans are well underway for the next series of compounds that will be prepared during 2003.

Joint Venture with J.B. Chemicals & Pharmaceuticals Ltd.

J.B. Chemicals & Pharmaceuticals Ltd operates 12 manufacturing facilities, which produce high quality bulk pharmaceuticals and drug products, intermediates, specialty pharmaceuticals and herbal remedies. JBCPL s products are marketed and well accepted in over 50 countries.

JBCPL has been an innovative and profitable participant in the pharmaceutical industry for more than 25 years, and has maintained its competitive manufacturing position by investing heavily in technology and automation in its plants. Manufacturing scale has also been critical to JBCPL s success. With sales of its products throughout Asia, Europe, Africa and South America, JBCPL is well positioned to be a competitive source of generic drugs in the United States.

Last year, Spectrum and JBCPL formed NeoJB LLC to enable Spectrum to utilize JBCPL s high quality, cost competitive drug manufacturing capabilities through the sale of JBCPL s generic drugs in the United States. NeoJB LLC is an 80% and 20% joint venture of Spectrum and a subsidiary of J. B. Chemicals & Pharmaceuticals Ltd., respectively.

Neurology Products

We also have a portfolio of neurology drug candidates that we are interested in out-licensing for further development. Our drug candidates include; AIT-034 for dementia, SPPI-339 for attention deficit disorders, SPPI-356 for psychosis, schizophrenia and other mood disorders and Neotrofin for neurodegenerative diseases. A summary of each of our drug candidates are as follows:

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AIT-034: AIT-034 has been demonstrated in animal studies to enhance memory and to reverse memory deficits in severely impaired animals. AIT-034 has structural similarities to piracetam, a compound suggested to be both memory enhancing and neuroprotective. However, AIT-034 has been shown to have advantages over piracetam in animal models for learning and memory, with AIT-034 demonstrating a different efficacy profile and higher potency. AIT-034 has been shown to have positive memory enhancing effects in animal models of memory recall and reverse amnesia induced by specific treatments in young, adult and aged mice. The memory enhancing effects of AIT-034 are most pronounced in aged animals (24 month old mice) in which the drug restored learning and memory recall in animals that had no apparent recall capacity, a model in which other memory-enhancing agents were ineffective. Toxicity studies conducted to date indicate that AIT-034 does not induce any systemic toxicity in animals. An IND application for AIT-034 was filed in September 2001. The FDA issued new toxicology and safety testing guidelines just prior to our filing the IND and has requested that these additional studies be completed prior to the start of the first clinical trial.

Neotrofin : The FDA allowed an IND for Neotrofin in June 1997. The first clinical trial of Neotrofin in the United States began in July 1997. Additional Phase 1 clinical trials evaluating safety and pharmacokinetic parameters have been conducted with Neotrofin. The results from the Phase 1 clinical trials indicate that Neotrofin is rapidly absorbed after oral administration and produces no serious side effects, even at high doses.

Five Phase 2 clinical trials of Neotrofin have been completed with a range of doses of Neotrofin for a treatment period of one to three months. The Phase 2 studies completed to date demonstrate non-statistically significant improvements in memory and behavior in patients with mild to moderate Alzheimer s disease. One of these studies was initiated in the United States in the third quarter of 1999 to study the effects of oral Neotrofin in the brain using PET (Positron Emission Tomography) imaging technology. The results of this study indicated that certain doses of Neotrofin (500 and 1000 mg/day) demonstrated positive effects on cognition in psychometric tests and positive effects on PET and EEG (electroencephalogram) parameters. In 2002, we completed a Phase 2 clinical trials of Neotrofin in patients with Alzheimer s disease and Parkinson s disease. The results of these studies indicated there was no statistically significant improvements noted for the primary endpoints under investigation. Studies in spinal cord injury and chemotherapy-induced peripheral neuropathy have been completed. Preliminary results were not positive and therefore we have stopped all further analysis of the data.

SPPI-339: SPPI-339 was designed and selected for the treatment of attention deficit disorders. SPPI-339 appears to produce positive effects on the acquisition of memory in certain models of memory in aged rodents, reverses the memory loss effects of certain pharmacological treatments, and improves attention in models of information processing. Based on research, we believe that SPPI-339 may have greater efficacy and fewer side effects than therapies currently under evaluation for the treatment of mild cognitive impairment and attention deficits associated with aging and dementia.

SPPI-356: SPPI-356 was designed and selected for schizophrenia with minimal side effects by combining structural components that are known to have anti-psychotic activity with structural components that may enhance treatment of the negative symptoms of schizophrenia.

Business Strategy

Marketing and Sales

We do not currently sell any products or services on a recurring basis and therefore have no marketing, sales, or distribution organization. We intend to enter into strategic alliances with other pharmaceutical companies to assist us in the development, marketing and sale of our drug candidates. However, we may retain rights to co-market our products in the United States.

We have developed and we in-licensed several drug candidates and drug technology platforms. As of December 31, 2002 our drug candidate pipeline consisted of seven drugs in various stages of development. We believe that we will continue to in-license additional drug candidates that we will be able to develop in-house, co-develop with other pharmaceutical companies, or out-license in exchange for milestone payments and royalties.

Strategic Alliances

We believe that our patented technology platforms provide a commercial opportunity for developing strategic alliances with other pharmaceutical companies. We believe that any such alliance would enable us to expand and diversify our drug candidate portfolio.

We periodically engage in preliminary licensing discussions with one or more pharmaceutical companies with respect to our drug candidates. We anticipate that the terms of any strategic alliance that we enter into for our drug candidates will include an up-front payment, milestone payments and royalties on product sales.

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We have entered into three strategic alliances to in-license niche market oncology drugs. In June 2001, we entered into a licensing agreement with the New Drug Development Office (or NDDO) Research Foundation whereby we acquired exclusive worldwide rights to Eoquin (EO9) and 80 related derivatives for which we paid NDDO an up-front payment. This agreement is subject to certain additional payments based upon achievement of defined milestones.

In August 2001, we entered into a licensing agreement with Johnson Matthey PLC whereby we acquired exclusive worldwide rights to satraplatin (JM216) for which we paid Johnson Matthey PLC an up-front payment and an additional payment in February 2002. This agreement is subject to certain additional payments based upon achievement of defined milestones.

In October 2001, we entered into a licensing agreement with Bristol-Myers Squibb whereby we acquired exclusive worldwide rights to elsamitrucin for which we paid Bristol-Myers Squibb an up-front payment. This agreement is subject to certain additional payments based upon achievement of defined milestones.

In March 2001, we entered into an agreement whereby Pfizer Inc. acquired rights to one of our G-protein-coupled receptor/ligand systems for evaluation in their DrugPfinder program. This agreement provides for up-front payments and milestone payments based upon reaching certain milestones in the discovery and development of drug candidates in this system. During 2002, Pfizer reached the first milestone under the terms of the agreement for which we received a milestone payment. In December 2001, we entered into a second DrugPfinder agreement with Pfizer Inc. for an additional G-protein-coupled receptor/ligand system under similar conditions as the previous agreement. As a result of the discontinuation of our research activities at our functional genomics subsidiary, NeoGene Technologies, we agreed to assign our rights under these two agreements to the Regents of the University of California, Irvine (UCI), in exchange for the forgiveness of certain current and future payables due to UCI.

On September 30, 2002, we entered into a co-development and license agreement with GPC Biotech AG for the development and commercialization of our lead drug candidate, satraplatin. Under the co-development and licensing agreement, we may receive up to $22 million in license fees and milestone payments. The license fee consists of a total of $4 million; $2 million upon signing (which was received in October of 2002) and $1 million in cash and a $1 million equity investment within 30 days after the first dosing of a patient in a registrational study. The remaining payments totaling up to $18 million upon achieving agreed upon milestones. However, there can be no assurance that any milestone will be achieved. Furthermore, GPC Biotech has agreed to fully fund development and commercialization expenses for satraplatin. Upon commercial sale of satraplatin, if any, we will be entitled to receive royalty payments based upon net sales.

Research Collaborations

We currently have several proprietary compounds in various stages of pre-clinical development. From time to time, we evaluate these compounds for efficacy in specialized assays or test models. We locate expert academic researchers and/or contract research organizations to perform the desired tests and provide them, through their respective academic institutions, with grants and/or contracts to perform the designated tests while we maintain proprietary rights to the compounds. We monitor these studies to ensure that these studies are performed to the highest research standards. As of December 31, 2002, we were not committed to any such research collaborations.

Production

We currently have our compounds manufactured in large scale by third party vendors and have not established plans to build our own manufacturing facilities. In connection with any licensing arrangements we may enter into regarding our drug candidates, we may retain the rights to control the manufacturing and sale of our compounds to our licensees. Preliminary manufacturing proposals have been received for our cancer drug candidates and certain of our neurology compounds and there are no foreseen problems with manufacturing these compounds.

Drug Approval Process and Other Government Regulation

The production and marketing of our products and our research and development activities are subject to regulation for safety, efficacy and quality by numerous governmental authorities in the United States and other countries. In the United States, drugs are subject to rigorous regulation. The Federal Food, Drug and Cosmetics Act, as amended from time to time, and the regulations promulgated thereunder, as well as other federal and state statutes and regulations, govern, among other things, the testing, manufacture, safety, efficacy, labeling, storage, record keeping, approval, advertising and promotion of our proposed products. Product development and approval within this regulatory framework take a number of years and involve the expenditure of substantial resources. In addition to obtaining FDA approval for each product, each drug manufacturing establishment must be registered with, and approved by, the FDA. Domestic manufacturing establishments are subject to regular inspections by the FDA and must comply with Good Manufacturing Practices. To supply products for use in the United States, foreign manufacturing establishments must also comply with Good Manufacturing Practices and are subject to periodic inspection by the FDA or by regulatory authorities in certain of such

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countries under reciprocal agreements with the FDA. Drug product and drug substance manufacturing establishments located in the State of California also must be licensed by the State of California in compliance with local regulatory requirements.

Estimated Cost of New Drug Development and Approval

The United States system of new drug approval is one of the most rigorous in the world. According to a December 2001 report by the Tufts Center for the Study of Drug Development, it costs an average of $802 million and takes between 10 and 15 years to develop a new prescription medicine and bring it to the U.S. market. Approximately one in 1,000 compounds that enter the pre-clinical testing stage eventually makes it to human testing and only one-fifth of those are ultimately approved for commercialization. In recent years, societal and governmental pressures have created the expectation that drug discovery and development costs can be reduced without sacrificing safety, efficacy and innovation. The need to significantly improve or provide alternative strategies for successful pharmaceutical discovery, research and development remains a major health care industry challenge.

Drug Discovery

In the initial stages of drug discovery, before a compound reaches the laboratory, typically thousands of potential compounds are randomly screened for activity in an assay assumed to be predictive of a particular disease process. This drug discovery process can take several years. Once a screening lead or starting point for drug development is found, isolation and structural determination is initiated. Numerous chemical modifications are made to the screening lead in an attempt to improve the drug properties of the lead. After a compound emerges from this process, it is subjected to further studies on the mechanism of action, further in vitro screening against particular disease targets and finally, in vivo animal screening. If the compound passes these evaluation points, animal toxicology studies are performed to begin to analyze the potential toxic effects of the compound, and if the results indicate acceptable toxicity findings, the compound emerges from the basic research mode and moves into the pre-clinical phase.

Pre-clinical Testing

During the pre-clinical testing stage, laboratory and animal studies are conducted to show biological activity of the compound against the targeted disease and the compound is evaluated for safety. These tests can take up to three years or more to complete.

Investigational New Drug Application

After pre-clinical testing, an IND is submitted to the FDA to begin human testing of the drug. The IND becomes effective if the FDA does not reject it within 30 days. The IND must indicate the results of previous experiments, how, where and by whom the studies were conducted, how the chemical compound is manufactured, the method by which it is believed to work in the human body and any toxic effects of the compound found in the animal studies. In addition, the IND clinical protocol must be reviewed and approved by an Institutional Review Board comprised of physicians and lay people at the hospital or clinic where the proposed studies will be conducted. Progress reports detailing the results of both animal studies and human clinical trials must be submitted at least annually to the FDA.

Phase 1 Clinical Trials

After an IND becomes effective, Phase 1 human clinical trials can begin. These studies, involving small numbers of healthy volunteers or patients, can take up to one year or more to complete. The studies determine a drug s safety profile, including the safe dosage range. The Phase 1 clinical studies also determine how a drug is absorbed, distributed, metabolized and excreted by the body. Additional Phase 1 clinical trials, which may be conducted at any time during the clinical development of a new drug, evaluate interactions between the test drug and drugs commonly used in the target population and safety in patients with compromised organ systems.

Phase 2 Clinical Trials

In Phase 2 clinical trials, controlled studies of volunteer human patients with the targeted disease assess the drug s effectiveness. These studies are designed primarily to determine the appropriate dose levels and to evaluate the effectiveness of the drug on humans as well as to determine if there are any side effects on humans. These studies can take up to two years or more.

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Phase 3 Clinical Trials

This phase can last up to three years or more and usually involves large numbers of human patients with the targeted disease. During the Phase 3 clinical trials, physicians monitor the human patients to determine drug candidate efficacy and to observe and report any adverse reactions that may result from long-term use of the drug on a large, more widespread, human patient population.

New Drug Application (NDA)

After completion of all three clinical trial phases, if the data indicates that the drug is safe and effective, an NDA is filed with the FDA. The NDA must contain all of the information on the drug that has been gathered to date, including data from the clinical trials. NDAs are often over 100,000 pages in length. After passage of the Prescription Drug User Fee Act, average review times for new medicine applications dropped from nearly 30 months in 1992 to less than 12 months.

Fast Track Review

In September 1998, the FDA clarified procedures for accelerating the approval of drugs to be marketed for serious diseases for which the manufacturer can demonstrate the potential to address unmet medical needs. We do not know whether any of our drug candidates will fulfill this requirement because there are drugs currently approved and available for related therapies. However, our drug candidates might qualify for fast track classification if the disease indication for which we are seeking approval has no other current therapies available in the market. At this time, we have not requested fast track designation for any of our drug candidates.

The FDA also made provisions for priority review of drugs. A drug will qualify for priority review if it provides a significant improvement compared to marketed products in the treatment, diagnosis or prevention of a disease regardless of whether the indication is serious or life-threatening. We believe that some of our drug candidates may qualify for priority review.

Approval

If the FDA approves the NDA, the drug becomes available for physicians to prescribe to patients for treatment. We must continue to submit periodic reports to the FDA, including descriptions of any adverse reactions reported by doctors prescribing the drug. For certain drugs which are administered on a long-term basis, the FDA may request additional clinical studies (Phase 4) after the drug has begun to be marketed to evaluate long-term effects. The marketing of a drug after FDA approval is subject to substantial continuing regulation by the FDA, including regulation of manufacturing practices and the advertising and promotion of the drug. Certain drugs are removed from the market after receiving FDA approval for a variety of issues ranging, for example, from reports of side effects to unexplained patient death. Some drugs return to the market only after the FDA agrees that issues identified have been adequately addressed or eliminated.

In addition to regulations enforced by the FDA, we are also subject to regulation under the Occupational Safety and Health Act, the Environmental Protection Act, the Toxic Substances Control Act, the Resource Conservation and Recovery Act and other present and future federal, state or local regulations, all of which are amended from time to time. Our research and development activities involve the controlled use of hazardous materials, chemicals, biological materials and various radioactive compounds. We must comply with safety procedures for handling and disposing of such materials according to the standards prescribed by state and federal regulations, however, no matter how good compliance is with safety procedures, the risk of accidental contamination or injury from these materials cannot be completely eliminated. In addition, under certain circumstances, we may become liable due to violations by our vendors and other partners that are subject to the same standards prescribed by state and federal regulations.

For marketing outside the United States, we and our prospective licensees are subject to foreign regulatory requirements governing human clinical trials and marketing approval for drugs in the respective countries. The requirements governing the conduct of clinical trials, product licensing, pricing and reimbursement vary widely from country to country.

Abbreviated New Drug Application (ANDA)

An ANDA is the process created for the accelerated approval of generic drugs. An ANDA must certify that the generic drug does not infringe on existing patent(s) or certify that the patent(s) for the brand-name product is invalid. The ANDA must also demonstrate that the generic drug is bioequivalent to the brand-name product.

Research and Development

Since our inception, we have devoted substantially all of our resources and efforts to research and development. Research and development expenditures are expensed at the time we incur them and were approximately $38.8 million in 2000, $20.6 million in 2001 and $12.7 million in 2002.

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Patents and Proprietary Rights

Patents and other proprietary rights are vital to our business. Our policy is to seek patent protection for our proprietary compounds and technology, and we intend to protect our technology, inventions and improvements to inventions that are commercially important to the development of our businesses. We also intend to rely on trade secrets, know-how, continuing technology innovations and licensing arrangements to develop and maintain our competitive position. In addition, we have applied for registration of several trademarks, including certain of our product candidates.

We currently hold rights to thirteen U.S. patents and currently have seventeen U.S. patent applications pending, however, we have determined that we will not be maintaining eight of the U.S. patents and thirteen of the U.S. patent applications relating to Neotrofin. In addition, we have a number of foreign patents and foreign patent applications pending, which have been granted corresponding to issued U.S. patents. Our U.S. issued patents expire beginning 2003 through 2020. It is possible that the scope of the coverage claimed in our patent applications could be significantly reduced prior to a patent being issued.

All issued, allowed and pending patents were assigned, by the inventors, to us. In connection with these assignments, we granted to one of the inventors, Dr. Alvin Glasky, a royalty of two percent of all revenues derived by us from the use and sale of any products that are covered by any of the aforementioned patents or any subsequent derivative patents, in each case for the life of the patent. However, Dr. Glasky will not receive any royalties with respect to sales of products which utilize patent rights licensed to us by McMaster University as described below. In the event Dr. Glasky dies, his estate or family shall be entitled to continue to receive royalties at the rate of two percent.

With respect to five issued U.S. patents, we entered into a license agreement whereby McMaster University has licensed to us all patent rights belonging to McMaster University contained in such patents. These patents contain a subset of claims to which McMaster University claims patent rights. This agreement calls for annual minimum royalty payments of $25,000 per year to McMaster University, until expiration of the related patent rights, and for us to pay to McMaster University a royalty of five percent of the net sales of all products sold by us that incorporate the patent rights licensed to us by McMaster University.

The patent positions related to our drug candidates are generally uncertain and involve complex legal and factual issues. Third parties may assert patent or other intellectual property infringement claims against us with respect to our products or technology or other matters. There may be third-party patents and other intellectual property relevant to our products and technology of which we are not aware.

Patent litigation is becoming more common in the pharmaceutical industry. Litigation is sometimes necessary to defend against or assert claims of infringement, to enforce our patents, to protect trade secrets we own or to determine the scope and validity of proprietary rights of third parties. No third party has asserted that we are infringing upon their patent rights or other intellectual property, nor are we aware that we are infringing upon any third party s patent rights or other intellectual property. We may, however, be infringing upon a third party s patent rights or other intellectual property, and litigation asserting such claims might be initiated in which we would not prevail or we would not be able to obtain the necessary licenses on reasonable terms, if at all. All such litigation, whether meritorious or not, as well as litigation initiated by us against third parties, is time consuming and very expensive to defend or prosecute and to resolve.

If our competitors prepare and file patent applications in the United States that claim technology we also claim, we may have to participate in interference proceedings required by the Patent and Trademark Office to determine priority of invention, which could result in substantial costs, even if we ultimately prevail. Results of interference proceedings are highly unpredictable and may result in us having to try to obtain licenses in order to continue to conduct clinical trials, manufacture or subsequently market certain of our drug candidates.

We rely on unpatented trade secrets and improvements, unpatented know-how, and continuing technological innovation to develop and maintain our competitiveness. We protect such information with employee, consultant, and corporate partner and/or collaborator confidentiality agreements as such relationships are formed. Confidentiality agreements provide that all confidential information developed or made known to an individual during the course of the employment or consulting relationship shall be kept confidential and shall not be disclosed to third parties except in specified circumstances. Agreements with employees provide that all inventions conceived by the individual while employed by us are our exclusive property. Confidentiality agreements are sometimes not honored, and if breached, we might not have adequate remedies and our trade secrets and improvements, unpatented know-how, and continuing technological innovation might become known. Additionally, our competitors may independently discover our trade secrets and improvements, unpatented know-how, and continuing technological innovation.

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Competition

The pharmaceutical industry is characterized by rapidly evolving technology and intense competition. Many companies of all sizes, including a number of large pharmaceutical companies as well as several specialized pharmaceutical companies, engage in drug research and development activities similar to ours.

Our pharmaceutical business competitors that have products on the market or in research and development that are in the same clinical focus as us include Amgen, Inc., Bayer AG, Eli Lilly and Co., Novartis AG, Bristol-Meyers Squibb Company, Glaxo SmithKline, IDEC Pharmaceuticals, Vertex Pharmaceuticals, Inc., Guilford Pharmaceuticals, Inc., Cephalon, Inc., Aventis, Elan Corporation, Pfizer, Inc., Janssen Pharmaceutica, Inc. and Shire Pharmaceuticals Group plc, among others. Competitors that have a strategic and clinical focus similar to ours include AVI Biopharma, Inc., Chiron Corp., Corixa Corp., Dendreon Corp., Genta Inc., Imclone Systems Incorporated, MGI Pharma, Inc. and SuperGen, Inc., among others. Many of our competitors are large-cap companies such as Eli Lilly and Company, Shire Pharmaceuticals, and Bristol-Myers Squibb focusing on a wide range of diseases and drug indications, and many are small to medium-cap, public and private companies, often with niche focuses. Companies that have a similar generic strategy include American Pharmaceuticals, Barr Laboratories, Sicor, Inc., Teva Pharmaceuticals and Watson Pharmaceuticals. Although we have broadened our focus during the past two years, we remain very niched-focused. Companies focused on similar niche-markets are numerous, making the market landscape very diversified and competitive.

Technologies under development by other pharmaceutical companies could result in treatments for diseases and disorders for which we are developing our own treatments. Several other companies are engaged in research and development of compounds that are similar to our research. In the event that one or more of these programs is successful, the market for some of our drug candidates could be reduced or eliminated.

In addition, colleges, universities, governmental agencies and other public and private research institutions conduct research and are becoming more active in seeking patent protection and licensing arrangements to collect license fees, milestone payments and royalties in exchange for license rights to technologies that they have developed, some of which may directly compete with our technologies. These companies and institutions also compete with us in recruiting highly qualified scientific personnel. Many of our competitors have substantially greater financial, research and development, human and other resources than we do. Furthermore, large pharmaceutical companies have significantly more experience than we do in pre-clinical testing, human clinical trials and regulatory approval procedures, among other things.

Although we have conducted clinical trials with respect to Neotrofin and Eoquin and begun preparation for a clinical trial with respect to satraplatin, we have not conducted clinical trials or sought the approval of the FDA with respect to any of our other drug candidates. Furthermore, if we are permitted to commence commercial sales of any of our drug candidates and decide to manufacture and sell such products ourselves, we will also be competing with respect to manufacturing efficiency and marketing capabilities, which are business activities and processes in which we have no prior experience.

Any product for which we obtain FDA approval must also compete for market acceptance and market share. For example, cisplatin and carboplatin are the most prevalent platinum-based derivatives used in chemotherapy and are the primary treatment for many of the cancer types we are pursuing. Our drug candidate, satraplatin, if the FDA ever approves it, would likely compete against these drugs directly. Unless satraplatin is shown to have better efficacy and is as cost effective if not more cost effective than cisplatin and carboplatin, it may not gain acceptance by the medical field and therefore never be successful commercially.

We expect technological developments and improvements in the fields of our business to continue to occur at a rapid rate and, as a result, expect competition to remain intense. Although we think, based on the preliminary pre-clinical and clinical test results involving certain of our drug candidates, that we will be able to continue to compete in the clinical development of drug candidates in our market niche, we may be wrong. Additionally, we do not have sufficient resources to compete with major pharmaceutical companies in the areas of later-stage clinical testing, manufacturing and marketing.

Website Access to Current and Periodic Reports

Additional information, including current and periodic reports filed with the SEC, on the Company can be obtained, free of charge, from our website at www.spectrumpharm.com.

Employees

As of December 31, 2002, we had eighteen (18) full-time employees; of which four hold M.D. degrees and two hold Ph.D. degrees, and two (2) part-time employees. We cannot assure you that we will be able to attract and retain qualified personnel in sufficient numbers to meet our needs. Our employees are not subject to any collective bargaining agreements, and we regard our relations with our employees to be good.

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RISK FACTORS

Our business, financial condition, operating results and prospects can be impacted by a number of factors, including but not limited to those set forth below and elsewhere in this report, any one of which could cause our actual results to differ materially from recent results or from our anticipated future results. Factors that may affect our business, financial condition, operating results, include:

Our losses will continue to increase as we expand our development efforts, and our efforts may never result in profitability.

Our cumulative losses during the period from our inception in 1987 through December 31, 2002 were approximately $141.7 million, almost all of which consisted of research and development and general and administrative expenses. We lost approximately $46.4 million in 2000, $27.8 million in 2001, and $17.6 million in 2002. We expect our losses to continue in the future as we expand our clinical trials and increase our research and development activities. We currently do not sell any products or services and we may never achieve significant revenues or become profitable. Even if we eventually generate revenues from sales, we nevertheless expect to incur operating losses over the next several years.

Our business does not generate the cash needed to finance our current and anticipated operations.

During the three-month period ended December 31, 2002, our expenses were approximately $3.8 million. We anticipate that our expenses will be reduced to approximately $1.5 million, or lower, per quarter starting with the first quarter in 2003.

At the present time, our business does not generate cash from operations needed to finance our short-term operations. We will rely primarily on raising funds through the sale of our securities, and/or out-licensing our drug candidates and technology, to meet all of our short-term cash needs. We have generated operating losses since our inception and our existing cash and investment securities, are not sufficient to fund our current planned pharmaceutical operations beyond June 2004. Therefore, we will need to seek additional funding by June 2004, or sooner, through public or private financings, including equity financings, and through other arrangements to continue operating our businesses and meet our short-term and long-term cash needs. Additionally, our long-term business plans require that we enter into collaborative partnership agreements and strategic alliance agreements with larger pharmaceutical companies to co-develop, manufacture and market our product candidates.

We may not be able to raise additional funds on favorable terms, if at all. Accordingly, we would be forced to significantly change our business plans and restructure our operations to conserve cash, which would likely involve some, combination, or all of the following:

- Out-license or sell some or all of our intellectual, technological, and/or tangible property not presently contemplated and at terms that we believe would not be favorable to us;
- Further reduce the size of our workforce, including the number of our scientific personnel;
- Reduce the scope and nature of our research and drug development activities; and
- Terminate operating leases and other contractual arrangements.

We will need substantial additional funds to support the continued research and development of our potential products. Since we currently have no products available for commercial sale and minimal revenues from licensing in our oncology business, we must use capital to fund our operating expenses. Our operating expenses, and consequently our capital requirements, will depend on many factors, including:

- continued scientific progress in research and development to identify and develop or obtain additional drug candidates; the costs and progress of preclinical and clinical testing of our anti-cancer drugs and additional drug candidates;

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cost involved in filing, prosecuting and enforcing patent claims;

effect of competing technological developments;

cost of manufacturing scale-up;

cost of commercialization activities;

time and cost involved in obtaining regulatory approvals; and

our ability to establish collaborative and other arrangements with third parties, such as licensing and manufacturing agreements.

Our efforts to in-license and develop new drug development targets may fail.

In 2002 we shifted our strategic focus from discovery and development of neurology drugs to the in-licensing of oncology drug candidates and the further development of and forming strategic alliances for these drug candidates, and the out-licensing of our neurology drug candidates to strategic partners. In the fourth quarter of 2002 we announced plans to pursue regulatory approval in the United States of generic drugs manufactured by J.B. Chemicals & Pharmaceuticals Ltd. or JBCL, an Indian company, through our existing joint venture, NeoJB LLC. We may not in-license, discover or validate any more new drug development targets based on our efforts.

Our potential drug candidates are in various stages of clinical and pre-clinical development and may not prove safe or effective enough to obtain regulatory approval to sell any of them.

We have acquired rights to three anti-cancer drugs and we have commenced a clinical trial of our Eoquin drug candidate for superficial urinary bladder cancer. We expect that we will need to complete additional trials before we will be able to apply for regulatory approval to sell any of our potential drug candidates. Our other proposed drug candidates are in various stages of development. We cannot be certain that any of our proposed drug candidates will prove to be safe or effective in treating cancer, disorders of the nervous system, or any other diseases or indications. Our former lead drug candidate, Neotrofin, failed to demonstrate efficacy in previous trials for Alzheimer s disease and Parkinson s disease. All of our proposed drugs will require additional research and development, testing and regulatory clearance before we can sell them. We cannot be certain that we will receive regulatory approval to sell any of our proposed drugs. We do not expect to have any oncology products commercially available for at least five years, if at all.

On September 30, 2002, we entered into a co-development and license agreement with GPC Biotech AG for the development and commercialization of our lead drug candidate, satraplatin. GPC Biotech has agreed to fully fund development and commercialization expenses for satraplatin. We will not have control over the drug development process and therefore, the success of our lead drug candidate will depend upon the efforts of a third party. There is no assurance that GPC Biotech will be successful in the clinical development of the drug, the achievement of any milestones such as the acceptance of an NDA (New Drug Application) filing by the United States Food and Drug Administration or the eventual commercialization of satraplatin.

Our efforts to enter the generic drug market may fail.

We plan to use our management s experience with the regulatory approval process in the United States to seek the introduction of generic drug products into the United States, which may include generic drugs produced by other pharmaceutical companies or developed internally by us. While some members of our management have experience with obtaining regulatory approval of drug candidates in the United States, we have limited experience with generic drug products, and, as a company, we have not successfully obtained regulatory approval of any of our drug candidates.

On January 15, 2003, we announced the filing of our first Abbreviated New Drug Application, or ANDA, with the United States Food and Drug Administration. The filing was made by our NeoJB LLC subsidiary on behalf of JBCPL, and relates to a generic drug product manufactured by JBCPL. We cannot be certain that the FDA will approve this ANDA, or if approved, that we will be able to complete a transfer pricing agreement with JBCPL to allow NeoJB to market the drug product in the United States on terms favorable to us or at all.

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Even if we obtain regulatory approval to market one or more generic drug products in the United States, we may face opposition from the producers of the branded versions of these drugs. Branded pharmaceutical companies have historically been aggressive in seeking to prevent generic competition, including the extensive use of litigation.

In addition, many branded pharmaceutical companies increasingly have used state and federal legislative and regulatory means to delay generic competition. These efforts have included:

- pursuing new patents for existing products which may be granted just before the expiration of one patent which could extend patent protection for a number of more years or otherwise delay the launch of generics;
- using the Citizen Petition process to request amendments to FDA standards;
- seeking changes to the United States Pharmacopeia, an organization which publishes industry recognized compendia of drug standards; and
- attaching patent extension amendments to non-related federal legislation.

In addition, some branded pharmaceutical companies have engaged in state-by-state initiatives to enact legislation that restricts the substitution of some generic drugs. Some of these initiatives could have an impact on products that we will seek to introduce to the United States. We have limited resources, and may not be able to effectively respond to these or other measures that may be taken by pharmaceutical companies that produce the branded version of our generic products.

We must comply with the listing requirements of the Nasdaq SmallCap Market or we could be delisted and the liquidity of our common stock would decline.

Our common stock was transferred from the Nasdaq National Market to the Nasdaq SmallCap Market where it began trading on October 16, 2002. On December 11, 2002, we changed our name to Spectrum Pharmaceuticals, Inc., and began trading under the ticker symbol SPPI. To remain listed on this market, we must meet Nasdaq s continued listing requirements. Among other requirements, Nasdaq rules require that a SmallCap Market company maintain a minimum stockholders equity of $2.5 million or a minimum market value of listed securities of $35 million or a net income from continuing operations (in latest fiscal year or 2 of the last 3 fiscal years) of at least $500,000. As of December 31, 2002, we were not in compliance with this standard and we have received a notice indicating that our securities are subject to delisting. The Company has requested and been granted a hearing before a Nasdaq Listing Qualifications Panel to review the delisting notice. As a result of the issuance of the shares of our convertible preferred stock, we believe we have regained compliance with this standard. However, there is no assurance that the Panel will grant the Company s request for continued listing or that we will be able to maintain compliance with any of the continued listing requirements. If we fail to do so, our common stock could be delisted from the Nasdaq SmallCap Market.

If our common stock is delisted from the Nasdaq SmallCap Market, we would likely seek quotation on the American Stock Exchange or a regional stock exchange, if available. However, quotation on such a market or exchange could reduce the market liquidity for our common stock. If our common stock is not quoted on another market or exchange, trading of our common stock could be conducted in the over-the-counter market on an electronic bulletin board established for unlisted securities such as the Pink Sheets or the OTC Bulletin Board. As a result, an investor would find it more difficult to dispose of, or obtain accurate quotations for the price of, our common stock.

If our common stock is delisted from the Nasdaq SmallCap Market, we fail to obtain quotation on another market or exchange, and the trading price remains below $5.00 per share, trading in our common stock might also become subject to the requirements of certain rules promulgated under the Securities Exchange Act of 1934, which require additional disclosure by broker-dealers in connection with any trades involving a stock defined as a penny stock (generally, any equity security not listed on a national securities exchange or quoted on Nasdaq that has a market price of less than $5.00 per share, subject to certain exceptions). Many brokerage firms are reluctant to recommend low-priced stocks to their clients. Moreover, various regulations and policies restrict the ability of stockholders to borrow against or margin low-priced stocks and declines in the stock price below certain levels may trigger unexpected margin calls. Additionally, because brokers commissions on low-priced stocks generally represent a higher percentage of the stock price than commissions on higher priced stocks, the current price of the common stock can result in an individual stockholder paying transaction costs that represent a higher percentage of total share value than would be the case if our share price were higher. This factor may also limit the willingness of institutions to purchase our common stock. Finally, the additional burdens imposed upon broker-dealers by these requirements could discourage broker-dealers from facilitating trades in our common stock, which could severely limit the market liquidity of the stock and the ability of investors to trade our common stock.

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Nasdaq corporate governance rules prohibit an issuer of listed securities from issuing 20% or more of its outstanding voting stock in one transaction or a series of related transactions other than a public offering at less than the greater of book value or the then current market value, without obtaining prior stockholder consent. While we have obtained stockholder approval of this type of financing in the past, we do not currently have stockholder approval to do similar financings in the future. We do not generate sufficient revenues to fund operations, and we do not currently have sufficient cash on hand to fund our operations beyond June 2004. While we are exploring all financing and strategic alternatives, we will need to raise additional funds through the sale of securities by June 2004, or sooner, to continue operating our business. Based on our recent experience and our current financial position, we believe that we might need to offer our securities at a discount to market price in order to attract investors to provide these funds. Therefore Nasdaq s 20% share limitation rule may hinder or prevent financing transactions from occurring.

Nasdaq corporate governance standards also require us to notify Nasdaq no later than fifteen (15) days prior to entering into a transaction that may result in the potential issuance of common stock greater than ten percent (10%) of the total shares of common stock outstanding. Several of our recent financings have been very sensitive to market conditions, and consequently have only had a short time period in which they could be completed. Therefore this 15 day notification rule may hinder or prevent similar financing transactions from occurring.

Competition for patients in conducting clinical trials may prevent or delay approval of a drug candidate and strain our limited financial resources.

Many pharmaceutical companies are conducting clinical trials in patients with the cancer types that Spectrum s drug candidates target. As a result, we must compete with them for clinical sites, physicians and the limited number of patients who fulfill the stringent requirements for participation in clinical trials. Also, due to the confidential nature of clinical trials, we cannot be certain how many of the eligible cancer patients may be enrolled in competing studies and consequently not available to us. This competition may increase costs of our clinical trials and delay the introduction of our potential products.

Any failure to comply with extensive governmental regulation could prevent or delay product approval or cause governmental authorities to disallow our products after approval and subject us to criminal or civil liabilities.

The FDA and comparable agencies in foreign countries impose many requirements on the introduction of new drugs through lengthy and detailed clinical testing and data collection procedures, and other costly and time consuming compliance procedures. These requirements apply to every stage of the clinical trial process and make it difficult to estimate when any of our drug candidates will be available commercially, if at all. Our proprietary compounds will require substantial clinical trials and FDA review as new drugs. Even if we successfully enroll patients in our clinical trials, patients may not respond to our potential drug candidates. We think it is prudent to expect setbacks. While we believe that we are currently in compliance with applicable FDA regulations, if we fail to comply with the regulations applicable to our clinical testing, the FDA may delay, suspend or cancel our clinical trials, or the FDA might not accept the test results. The FDA, or any comparable regulatory agency in another country, may suspend clinical trials at any time if it concludes that the trials expose subjects participating in such trials to unacceptable health risks. Further, human clinical testing may not show any current or future product candidate to be safe and effective to the satisfaction of the FDA or comparable regulatory agencies or the data derived from the clinical tests may be unsuitable for submission to the FDA or other regulatory agencies.

We cannot predict with certainty when we might submit any of our drug candidates currently under development for the regulatory approval required in order to commercially sell the products. Once we submit a drug candidate for commercial sale approval, the FDA or other regulatory agencies may not issue their approvals on a timely basis, if at all. If we are delayed or fail to obtain these approvals, our business and prospects may be significantly damaged. If we fail to comply with regulatory requirements, either prior to seeking approval or in marketing our products after approval, we could be subject to regulatory or judicial enforcement actions. These actions could result in:

product recalls or seizures;

injunctions;

civil penalties;

criminal prosecution;

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refusals to approve new products and withdrawal of existing approvals; and

enhanced exposure to product liabilities.

The loss of key researchers or managers could significantly hinder our drug development process and might cause our business to fail.

Our success depends upon the contributions of our key management and scientific personnel. The loss of Dr. Luigi Lenaz, our President Oncology Division, would damage the development of our anti-cancer business substantially. Dr. Lenaz has an employment agreement with us that will expire on July 1, 2003, with automatic one year renewals thereafter unless Dr. Lenaz or we gives notice of intent not to renew at least 90 days in advance of the renewal date. We also may need substantial additional expertise in marketing and other areas in order to achieve our business objectives. Competition for qualified personnel among pharmaceutical companies is intense, and the loss of key personnel, or the inability to attract and retain the additional skilled personnel required for the expansion of our business, could significantly damage our business.

If we cannot protect or enforce our intellectual property rights adequately, the value of our research could decline as our competitors appropriate portions of our research.

We actively pursue patent protection for our proprietary products and technologies. We hold rights to thirteen U.S. patents and currently have seventeen U.S. patent applications pending. The Company has determined it will not be maintaining eight of the U.S. patents and thirteen of the U.S. patent applications relating to Neotrofin. Our issued patents expire between 2003 and 2020. In addition, we have numerous foreign patents issued and patent applications pending corresponding to our U.S. patents. However, our patents may not protect us against our competitors. We may have to file suit to protect our patents or to defend our use of our patents against infringement claims brought by others. Because we have limited cash resources, we may not be able to afford to pursue or defend against litigation in order to protect our patent rights.

We also rely on trade secret protection for our unpatented proprietary technology. Trade secrets are difficult to protect. While we enter into proprietary information agreements with our employees, consultants and others, these agreements may not successfully protect our trade secrets or other proprietary information.

We are a small company relative to our principal competitors and our limited financial and research resources may limit our ability to develop and market new products.

Many companies, both public and private, including well-known pharmaceutical companies such as Amgen, Inc., Bayer AG, Eli Lilly and Company, Novartis AG, Bristol-Meyers Squibb Company, Glaxo SmithKline, IDEC Pharmaceuticals, Vertex Pharmaceuticals, Inc., Guilford Pharmaceuticals, Inc., Cephalon, Inc., Aventis, Elan Corporation, Pfizer, Inc., Janssen Pharmaceutica, Inc. and Shire Pharmaceuticals Group plc, are developing products to treat certain of the diseases we are pursuing. Competitors that have a strategic and clinical focus similar to ours include AVI Biopharma, Inc., Chiron Corp., Corixa Corp., Dendreon Corp., Genta Inc., Imclone Systems Incorporated, MGI Pharma, Inc. and SuperGen, Inc. among others. Companies that have a similar generic strategy include American Pharmaceuticals, Barr Laboratories, Sicor, Inc., Teva Pharmaceuticals and Watson Pharmaceuticals. Many of these companies have substantially greater financial, research and development, manufacturing, marketing and sales experience and resources than us. As a result, our competitors may be more successful than us in developing their products, obtaining regulatory approvals and marketing their products to consumers.

Numerous oncology drugs are on the market for each cancer type we are pursuing. For example, cisplatin and carboplatin are the most prevalent platinum-based derivatives used in chemotherapy. Our product candidate, satraplatin, if the FDA ever approves it, would likely compete against these drugs directly. Unless satraplatin is shown to have better efficacy and is as cost effective if not more cost effective than cisplatin and carboplatin, it may not gain acceptance by the medical field and therefore never be successful commercially.

Our limited experience at managing and conducting clinical trials ourselves may delay the trials and increase our costs.

We may manage and conduct some future clinical trials ourselves rather than hiring outside clinical trial contractors. We believe managing and conducting clinical trials ourselves has reduced and could continue to reduce the

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costs associated with our clinical trials and gives us more control over the clinical trial process. However, while some of our management has had experience at conducting clinical trials, we have limited experience in doing so as a company. While we have not experienced significant delays or increased costs to date by conducting clinical trials ourselves, as we move forward with our self-conducted clinical trials, our limited experience may delay the completion of our clinical trials and increase our costs.

We may be dependant on third parties for clinical testing, manufacturing and/or marketing.

We may not conduct some clinical trials ourselves, and we will not manufacture any of our proposed products for commercial sale nor do we have the resources necessary to do so. Our current management does not have any experience marketing pharmaceutical products. We intend to contract with larger pharmaceutical companies or contract research organizations to conduct such activities. In connection with our efforts to secure corporate partners, we may seek to retain certain co-marketing rights to certain of our drug candidates, so that we may promote our products to selected medical specialists while our corporate partner promotes these products to the medical market generally. We cannot be certain that we will be able to enter into any partnering arrangements on this or any other basis. If we are not able to secure adequate partnering arrangements, we will have to hire additional employees or consultants with expertise in marketing, since our current employees have no experience in these areas. We cannot be certain that sufficient employees with relevant skills will be available to us. Any increase in the number of our employees would increase our expense level, and could make it harder for us to make a profit.

In addition, we cannot be certain that we or our potential corporate partners can successfully introduce our proposed products or that such proposed products will achieve acceptance by patients, health care providers and insurance companies. Further, it is possible that we may not be able to secure arrangements to manufacture and market our proposed products at prices that would permit us to make a profit. To the extent that clinical trials are conducted by corporate partners, we may not be able to control the design and conduct of these clinical trials.

We may be subject to product liability claims, and may not have sufficient product liability insurance to cover any claims, which may expose us to substantial liabilities.

We may be exposed to product liability claims from patients who participate in our clinical trials, or, if we are able to obtain FDA approval for one or more of our potential products, from consumers of our products. Although we currently carry product liability insurance in the amount of $5 million per occurrence, it is possible that the amounts of this coverage will be insufficient to protect us from future claims. Further, we cannot be certain that we will be able to maintain our existing insurance or obtain or maintain additional insurance on acceptable terms for our clinical and commercial activities or that such additional insurance would be sufficient to cover any potential product liability claim or recall. Failure to maintain sufficient insurance coverage could have a material adverse effect on our business, prospects and results of operations if claims are made that exceed our coverage.

The use of hazardous materials in our research and development efforts imposes certain compliance costs on us and may subject us to liability for claims arising from the use or misuse of these materials.

Our research and development efforts involve the use of hazardous materials, including biological materials, chemicals and radioactive materials. We are subject to federal, state and local laws and regulations governing the storage, use and disposal of these materials and some waste products. We believe that our safety procedures for the storage, use and disposal of these materials comply with the standards prescribed by federal, state and local regulations. However, we cannot completely eliminate the risk of accidental contamination or injury from these materials. If there were to be an accident, we could be held liable for any damages that result, which could exceed our financial resources. We currently maintain insurance coverage of up to $1,000,000 per occurrence for injuries resulting from the hazardous materials we use, and up to $25,000 per occurrence for pollution clean up and removal, however, future claims may exceed these amounts. Currently the costs of complying with federal, state and local regulations are not significant, and consist primarily of waste disposal expenses.

There are a substantial number of shares of our common stock eligible for future sale in the public market. The sale of these shares could cause the market price of our common stock to fall. Any future equity issuances by us may have dilutive and other effects on our existing stockholders.

There were 2,726,019 shares of our common stock outstanding as of December 31, 2002. In addition, security holders held options, warrants and other rights as of December 31, 2002 which, if exercised, would obligate us to issue up to an additional 1,091,859 shares of common stock at a weighted average exercise price of $50.09 per share, of which

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671,233 shares are subject to options or warrants which are currently exercisable at a weighted average exercise price of $71.58 per share. In addition, on May 7, 2003, we completed a financing resulting in the issuance of 444 shares of our Series D 8% Cumulative Convertible Voting Preferred Stock, which are convertible into a total of 1,889,361 shares of our common stock at a conversion price of $2.35 per share. In addition, the investors received 944,681 warrants to purchase our common stock at an exercise price of $3.00 per share and 944,681 warrants to purchase our common stock at an exercise price of $3.50 per share. A substantial number of those shares, when we issue them upon exercise, will be available for immediate resale in the public market. The market price of our common stock could fall as a result of such resales due to the increased number of shares available for sale in the market.

We have financed our operations, and we expect to continue to finance our operations, primarily by issuing and selling our common stock or securities convertible into or exercisable for shares of our common stock. Any issuances by us of equity securities may be at or below the prevailing market price of our common stock and may have a dilutive impact on our other stockholders. These issuances would also cause our net income, if any, or loss per share to decrease in future periods. As a result, the market price of our common stock could drop.

The market price and volume of our common stock fluctuate significantly and could result in substantial losses for individual investors.

The stock market from time to time experiences significant price and volume fluctuations that are unrelated to the operating performance of particular companies. These broad market fluctuations may cause the market price and volume of our common stock to decrease. In addition, the market price and volume of our common stock is highly volatile. Factors that may cause the market price and volume of our common stock to decrease include fluctuations in our results of operations, timing and announcements of our technological innovations or new products or those of our competitors, FDA and foreign regulatory actions, developments with respect to patents and proprietary rights, public concern as to the safety of products developed by us or others, changes in health care policy in the United States and in foreign countries, changes in stock market analyst recommendations regarding our common stock, the pharmaceutical industry generally and general market conditions. In addition, the market price and volume of our common stock may decrease if our results of operations fail to meet the expectations of stock market analysts and investors. While a decrease in market price could result in direct economic loss for an individual investor, low trading volume could limit an individual investor s ability to sell our common stock, which could result in substantial economic loss as well. During 2002, the price of our common stock ranged between $101.25 and $0.80, as adjusted to reflect a 25-for-1 reverse split of our outstanding common stock that we effected on September 6, 2002, and the daily trading volume, adjusted to reflect the reverse split has been as high as 777,764 shares and as low as 940 shares, with a recent average from January 2, 2003 up to and including May 7, 2003 of approximately 53,000 shares.

Certain provisions of our preferred stock may prevent or make it more difficult for us to raise funds or take certain other actions.

Certain provisions of the Preferred Stock and Warrant Purchase Agreement and Certificate of Designation, Rights and Preferences of the Series D 8% Cumulative Convertible Voting Preferred Stock (Preferred Stock) may require us to obtain the approval of the preferred stockholders to (i) amend, alter or repeal any provision of the Charter or Bylaws which may be deemed to adversely affect the terms of the Preferred Stock (ii) offer, sell or designate a security senior to or equal with the Preferred Stock, (iii) sell or issue common stock or securities convertible into or exercisable for shares of our common stock below $2.35 per share, (iv) incur any bank or non-trade indebtedness, (v) grant or make any mortgage or pledge of our property, (vi) merge or consolidate with another entity or sell or dispose of substantially all of our assets or businesses or (vii) take certain other actions which may be deemed to adversely affect the terms of the Preferred Stock. These provisions may make it more difficult for management, the board of directors or stockholders of the Company to take certain corporate actions and could delay, discourage or prevent future financings. These provisions could also limit the price that certain investors might be willing to pay for shares of our common stock.

Certain charter and bylaws provisions and our stockholder rights plan may make it more difficult for someone to acquire control of us or replace current management.

The accompanying notes are an integral part of these condensed consolidated financial statements.

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HEALTHCARE TRUST OF AMERICA, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except for per share data)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Revenues:				
Rental income	$139,525	$113,144	$263,518	$220,394
Interest and other operating income	354	90	708	155
Total revenues	139,879	113,234	264,226	220,549
Expenses:				
Rental	43,523	35,061	82,543	68,414
General and administrative	8,472	6,813	16,895	13,586
Transaction	5,073	2,062	5,357	3,875
Depreciation and amortization	55,353	44,738	102,409	82,566
Impairment	5,093	—	5,093	—
Total expenses	117,514	88,674	212,297	168,441
Income before other income (expense)	22,365	24,560	51,929	52,108
Interest expense:				
Interest related to derivative financial instruments	(239)	(659)	(563)	(1,304)
Gain (loss) on change in fair value of derivative financial instruments, net	45	(658)	884	(3,450)
Total interest related to derivative financial instruments, including net change in fair value of derivative financial instruments	(194)	(1,317)	321	(4,754)
Interest related to debt	(17,706)	(13,989)	(33,764)	(28,117)
Gain on sale of real estate, net	—	4,212	3	4,212
Loss on extinguishment of debt, net	(10,386)	(22)	(10,418)	(22)
Income from unconsolidated joint venture	63	—	63	—
Other income	6	72	14	125
Net (loss) income	$(5,852)	$13,516	$8,148	$23,552
Net income attributable to noncontrolling interests [1]	(66)	(442)	(521)	(618)
Net (loss) income attributable to common stockholders	$(5,918)	$13,074	$7,627	$22,934
Earnings per common share - basic:				
Net (loss) income attributable to common stockholders	$(0.03)	$0.10	$0.05	$0.17
Earnings per common share - diluted:				
Net (loss) income attributable to common stockholders	$(0.03)	$0.09	$0.05	$0.17
Weighted average common shares outstanding:				
Basic	176,464	136,528	159,218	132,932
Diluted	176,464	140,512	163,490	135,876
Dividends declared per common share	$0.300	$0.295	$0.600	$0.590

(1) Includes amounts attributable to redeemable noncontrolling interests.
The accompanying notes are an integral part of these condensed consolidated financial statements.

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HEALTHCARE TRUST OF AMERICA, INC.
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(In thousands)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Net (loss) income	$(5,852)	$13,516	$8,148	$23,552
Other comprehensive loss				
Change in unrealized losses on cash flow hedges	(748)	—	(836)	—
Total other comprehensive loss	(748)	—	(836)	—
Total comprehensive (loss) income	(6,600)	13,516	7,312	23,552
Comprehensive income attributable to noncontrolling interests	(27)	(446)	(449)	(591)
Total comprehensive (loss) income attributable to common stockholders	$(6,627)	$13,070	$6,863	$22,961

The accompanying notes are an integral part of these condensed consolidated financial statements.

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HEALTHCARE TRUST OF AMERICA, INC.
CONDENSED CONSOLIDATED STATEMENTS OF EQUITY
(In thousands)
(Unaudited)

	Class A Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Cumulative Dividends in Excess of Earnings	Total Stockholders' Equity	Noncontrolling Interests	Total Equity
	Shares	Amount						
Balance as of December 31, 2015	127,027	$1,270	$2,328,806	$ —	$(950,652)	$1,379,424	$ 27,534	$1,406,958
Issuance of common stock	10,399	105	291,580	—	—	291,685	—	291,685
Issuance of operating partnership units in connection with an acquisition	—	—	—	—	—	—	70,754	70,754
Share-based award transactions, net	203	2	3,031	—	—	3,033	—	3,033
Repurchase and cancellation of common stock	(83)	(1)	(2,286)	—	—	(2,287)	—	(2,287)
Redemption of noncontrolling interest and other	207	2	4,138	—	—	4,140	(4,598)	(458)
Dividends declared	—	—	—	—	(79,170)	(79,170)	(1,838)	(81,008)
Net income	—	—	—	—	22,934	22,934	591	23,525
Balance as of June 30, 2016	137,753	$1,378	$2,625,269	$ —	$(1,006,888)	$1,619,759	$ 92,443	$1,712,202
Balance as of December 31, 2016	141,719	$1,417	$2,754,818	$ —	$(1,068,961)	$1,687,274	$ 93,143	$1,780,417
Issuance of common stock	58,623	586	1,623,636	—	—	1,624,222	—	1,624,222
Issuance of operating partnership units in connection with an acquisition	—	—	—	—	—	—	610	610
Share-based award transactions, net	198	2	3,837	—	—	3,839	—	3,839
Repurchase and cancellation of common stock	(114)	(1)	(3,338)	—	—	(3,339)	—	(3,339)
Redemption of noncontrolling interest and other	221	2	5,530	—	—	5,532	(5,532)	—
Dividends declared	—	—	—	—	(103,273)	(103,273)	(2,651)	(105,924)
Net income	—	—	—	—	7,627	7,627	469	8,096

Other comprehensive loss	—	—	—	(816)	—	(816)	(20)	(836)
Balance as of June 30, 2017	200,647	$2,006	$4,384,483	$ (816)	$(1,164,607)	$3,221,066	$ 86,019	$3,307,085

The accompanying notes are an integral part of these condensed consolidated financial statements.

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HEALTHCARE TRUST OF AMERICA, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)
(Unaudited)

	Six Months Ended June 30,	
	2017	2016
Cash flows from operating activities:		
Net income	$8,148	$23,552
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation, amortization and other	100,536	81,362
Share-based compensation expense	3,839	3,033
Bad debt expense	227	386
Impairment	5,093	—
Income from unconsolidated joint venture	(63)	—
Gain on sale of real estate, net	(3)	(4,212)
Loss on extinguishment of debt, net	10,418	22
Change in fair value of derivative financial instruments	(884)	3,450
Changes in operating assets and liabilities:		
Receivables and other assets, net	(2,969)	(667)
Accounts payable and accrued liabilities	14,272	(5,983)
Security deposits, prepaid rent and other liabilities	1,907	(4,543)
Net cash provided by operating activities	140,521	96,400
Cash flows from investing activities:		
Investments in real estate	(2,202,815)	(336,760)
Investment in unconsolidated joint venture	(68,839)	—
Development of real estate	(348)	—
Proceeds from the sale of real estate	4,746	23,368
Capital expenditures	(26,022)	(21,826)
Restricted cash, escrow deposits and other assets	(19,362)	(426)
Net cash used in investing activities	(2,312,640)	(335,644)
Cash flows from financing activities:		
Borrowings on unsecured revolving credit facility	305,000	336,000
Payments on unsecured revolving credit facility	(393,000)	(293,000)
Proceeds from unsecured senior notes	900,000	—
Payments on secured mortgage loans	(74,319)	(22,791)
Deferred financing costs	(9,400)	—
Debt extinguishment costs	(10,391)	—
Security deposits	1,964	765
Proceeds from issuance of common stock	1,624,222	292,984
Repurchase and cancellation of common stock	(3,339)	(2,287)
Dividends paid	(85,683)	(76,018)
Distributions paid to noncontrolling interest of limited partners	(2,722)	(1,331)
Net cash provided by financing activities	2,252,332	234,322
Net change in cash and cash equivalents	80,213	(4,922)
Cash and cash equivalents - beginning of period	11,231	13,070
Cash and cash equivalents - end of period	$91,444	$8,148

The accompanying notes are an integral part of these condensed consolidated financial statements.

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HEALTHCARE TRUST OF AMERICA HOLDINGS, LP
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands, except unit data)
(Unaudited)

	June 30, 2017	December 31, 2016
ASSETS		
Real estate investments:		
Land	$461,340	$386,526
Building and improvements	5,699,968	3,466,516
Lease intangibles	635,330	467,571
Construction in progress	251	—
	6,796,889	4,320,613
Accumulated depreciation and amortization	(907,728)	(817,593)
Real estate investments, net	5,889,161	3,503,020
Investment in unconsolidated joint venture	68,901	—
Cash and cash equivalents	91,444	11,231
Restricted cash and escrow deposits	33,176	13,814
Receivables and other assets, net	175,340	173,461
Other intangibles, net	108,736	46,318
Total assets	$6,366,758	$3,747,844
LIABILITIES AND PARTNERS' CAPITAL		
Liabilities:		
Debt	$2,784,162	$1,768,905
Accounts payable and accrued liabilities	135,214	105,034
Derivative financial instruments - interest rate swaps	1,569	1,920
Security deposits, prepaid rent and other liabilities	55,286	49,859
Intangible liabilities, net	78,779	37,056
Total liabilities	3,055,010	1,962,774
Commitments and contingencies		
Redeemable noncontrolling interests	4,663	4,653
Partners' Capital:		
Limited partners' capital, 4,122,846 and 4,323,095 units issued and outstanding as of June 30, 2017 and December 31, 2016, respectively	85,749	92,873
General partners' capital, 200,646,523 and 141,719,134 units issued and outstanding as of June 30, 2017 and December 31, 2016, respectively	3,221,336	1,687,544
Total partners' capital	3,307,085	1,780,417
Total liabilities and partners' capital	$6,366,758	$3,747,844

The accompanying notes are an integral part of these condensed consolidated financial statements.

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HEALTHCARE TRUST OF AMERICA HOLDINGS, LP
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except per unit data)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
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Revenues:				
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Transaction	5,073	2,062		