

RESVERLOGIX CORP.

ANNUAL INFORMATION FORM

Fiscal Year-Ended April 30, 2011

July 19, 2011

TABLE OF CONTENTS

GLOSSARY	2
NOTE REGARDING FORWARD-LOOKING INFORMATION.....	7
CURRENCY	9
CORPORATE STRUCTURE	9
Name and Incorporation	9
Inter-Corporate Relationships.....	9
GENERAL DEVELOPMENT OF THE BUSINESS	10
Three Year History.....	10
Board of Directors, Scientific Advisory Board, Clinical Advisory Board and Management	14
Financing	15
Recent Developments	16
DESCRIPTION OF BUSINESS	17
General	17
Company's Business Model	17
The Regulatory Process for Drug Development.....	17
Resverlogix's Drug Development Strategy.....	18
Cardiovascular Disease Research Programs.....	18
Cardiovascular Disease and Cholesterol	19
Protective Role of ApoA-I and HDL and RCT Particles.....	20
Percent Atheroma Volume (PAV) as Predictive Factor in CVD	20
NexVas Plaque Regression Program.....	21
PRODUCT CANDIDATE.....	21
RVX-208	21
Summary of RVX-208 Clinical Trials	22
Pre-clinical Programs.....	24
Competitive Environment.....	25
GENERAL	26
Employees	26
Regulatory Matters	26
Intellectual Property	26
Trademarks.....	26
RISK FACTORS.....	27
Risks Relating to Our Business	27
Risks Relating to our Intellectual Property.....	36
Risks Relating to Owning our Common Stock	38
DIVIDENDS.....	39
DESCRIPTION OF CAPITAL STRUCTURE	40
Common Shares.....	40
Preferred Shares	40
MARKET FOR SECURITIES	40
Trading Prices and Volume by Month for Fiscal Year Ended April 30, 2011	40
PRIOR SALES	41
DIRECTORS AND EXECUTIVE OFFICERS.....	41
Name, Occupation and Security Holdings.....	41
Clinical Advisory Board.....	45
Clinical Steering Committee	45
Audit Committee Matters	45
Cease Trade Orders, Bankruptcies, Penalties or Sanctions.....	46
Conflicts of Interest.....	47
INTERESTS OF MANAGEMENT AND OTHERS IN MATERIAL TRANSACTIONS	47
TRANSFER AGENT AND REGISTRAR.....	48
MATERIAL CONTRACTS	48
INTERESTS OF EXPERTS	49
ADDITIONAL INFORMATION	49
SCHEDULE "A" - AUDIT & FINANCE COMMITTEE CHARTER	50

GLOSSARY

In this Annual Information Form, the following terms shall have the following meanings, unless otherwise defined elsewhere in this Annual Information Form:

ABCA	means the <i>Business Corporations Act</i> (Alberta).
ABCA1	ATP-binding cassette sub-family A member 1, is a transmembrane protein that mediates the transport of cholesterol, phospholipids and other lipophilic molecules across cellular membranes to lipid-poor HDL apolipoproteins. This transporter is a major regulator of cellular cholesterol and phospholipid homeostasis.
ABCG1	ATP-binding cassette sub-family G member 1, is a transmembrane protein that mediates macrophage cholesterol and phospholipid transport and may regulate cellular lipid homeostasis in other cell types.
ALTs	Alanine transaminase, also called serum glutamic pyruvic transaminase (SGPT) or alanine aminotransferase (ALAT), is found in serum and most commonly associated with the liver, measurements are used as a part of a diagnostic evaluation of hepatocellular injury.
Alpha1 HDL	mature lipid-rich particles that are involved in reverse cholesterol transport (RCT) whereby cholesterol is removed from cell membranes to the liver for excretion.
Allometric scaling	is the study of the relationship of body size to shape, anatomy, physiology and biology for practical applications to the differential growth rates of the parts of a living organism's body.
Alzheimer's disease (AD)	a disease marked by the loss of cognitive ability, generally over a period of 10 to 15 years, and associated with the development of abnormal tissues and protein deposits in the cerebral cortex.
Amyloid-beta40 (A-beta40)	Amyloid beta 40 is one isoform formed by the cleavage of the amyloid precursor protein (APP). Along with $A\beta_{42}$, $A\beta_{40}$ has been identified in cerebral spinal fluid and plasma and may play a role in the pathology of Alzheimer's disease (AD). Both isoforms are therapeutic targets for AD, and are being studied as experimental biomarkers for the disease.
Angiography	a medical imaging technique used to visualize the inside (lumen) of blood vessels and organs of the body, with particular interest in the arteries, veins and the heart chambers.
Angioplasty	the surgical repair of a blood vessel by inserting a balloon-tipped catheter to dilate the vessel (<i>also known as balloon angioplasty</i>).
Apolipoprotein	the protein combined with a lipid to form a lipoprotein, a component of HDL and LDL.
ApoA-I	is one of the apolipoprotein components of the HDL particle.
ApoA-I _{Milano}	a naturally occurring variant of ApoA-I, discovered in the body of some people from Limone-sul-Garda, Italy.

ApoB	is one of the apolipoprotein components of the LDL particle.
ApoE	apolipoprotein E is a component of very low-density lipoproteins (VLDLs) and plays a role in the removal of excess cholesterol from the body. Apo E also has a role in several biological processes not directly related to lipoprotein transport, including Alzheimer's disease, immune regulation and cognition.
Atherosclerosis	a disease in which the deposition of lipids and plaque in arteries results in the hardening and decrease of arterial lumen size.
Atherosclerotic Plaque	the deposit or accumulation of lipid-containing plaques in the arterial wall (<i>also known as atheroma</i>).
Beta Amyloid Plaque	is an aggregation of Beta Amyloid, a peptide of 39–43 amino acids. Beta Amyloid appears to be the main constituent of amyloid plaques in the brains of Alzheimer's disease patients. These plaques are composed of a tangle of regularly ordered fibrillar aggregates called amyloid fibers, a protein fold shared by other peptides such as the prions associated with protein misfolding diseases.
b.i.d.	“bis in die” (Latin) refers to twice a day dosing.
Bilirubin	the yellow breakdown product of normal heme catabolism, that is excreted in bile and urine; elevated levels may indicate a disease state.
Bioavailability	the degree and rate at which a drug is absorbed into a living system or is made available at the site of activity after administration.
Biomaterial	a natural or synthetic material that is suitable for introduction into living tissue especially as part of a medical device.
Biopharmaceuticals	a medical drug developed by biotechnology to improve human or animal health.
Blood Plasma	the liquid component of blood in which the blood cells are normally suspended; contains dissolved proteins, glucose, clotting factors, mineral ions, hormones and carbon dioxide.
Cancer	a disease characterized by abnormal and uncontrolled cell growth.
Coronary artery disease (CAD)	Coronary artery disease is the most common type of heart disease. It is the leading cause of death in the United States in both men and women. CAD occurs when arteries that supply blood to heart muscle become hardened and narrowed. This is due to the buildup of cholesterol and other material, called plaque, on their inner walls.
Cardiovascular disease (CVD)	is a group of diseases of the heart and blood vessels.
Cholesterol	a fatty molecule essential for normal body functions, including the production of hormones and bile acids; it is also an important component of a cell membrane.
Cholesterol Efflux	the removal of cholesterol from the tissues to the liver for excretion.

Common Shares	means common shares in the capital of Resverlogix Corp.
Company	Resverlogix Corp., a corporation incorporated under the ABCA.
Compound	a chemical substance formed from two or more elements (<i>also see drug</i>).
Contract Research Organization (CRO)	an organization (commercial, academic or other), contracted by the sponsor to conduct research or development activities.
Clinical Trial/Study	a research study in human subjects to evaluate a new drug, medical device, biologic or other intervention under a strictly controlled scientific setting.
Deoxyribonucleic Acid (DNA)	the material inside the nucleus of cells that carries genetic information.
Drug	is any substance that can be used to modify a chemical process or processes in the body to mitigate, treat or prevent a medical condition.
Drug Eluting Stent (DES)	a cylindrical medical device, typically made of bare metal or a polymer, which is inserted into a body duct or tube, such as an artery, to prevent collapse.
Dyslipidemia	a disorder associated with abnormal levels of blood lipids and lipoproteins.
Endogenous	is a process whereby a molecule is produced within the body.
Enzyme	a protein that acts as a catalyst in mediating and accelerating a specific chemical reaction.
Epidemiology	is the study of factors affecting the health and illness of populations, and serves as the foundation and logic of interventions made in the interest of public health and preventive medicine. It is considered a cornerstone methodology of public health research and is highly regarded in evidence-based medicine for identifying risk factors for disease and determining optimal treatment approaches to clinical practice.
Fibrous Tissue	is tissue consisting of fibers or fiber-containing materials, such as scar tissue.
Food and Drug Administration (FDA)	is the United States governmental agency responsible for the approval, manufacture, usage and sale of food, human diagnostics and therapeutic products.
Gene	a sequence of DNA encoding a protein.
Good Clinical Practice (GCP)	is the international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve human subjects.
Good Laboratory Practice (GLP)	is the international regulation which embodies a set of principles which provide a framework for laboratory studies, ensuring high quality experimental standards and reliable data.
Good Manufacturing Practice (GMP)	is the international set of regulations, codes and guidelines for the manufacture of drugs, medical devices, diagnostics and food products.

High-density Lipoprotein (HDL)	a complex of lipids and proteins (ApoA-I) that function in the transport of cholesterol away from the tissues to the liver and is associated with a decreased risk of atherosclerosis and coronary heart disease (<i>also known as "good cholesterol"</i>).
Health Canada	is the governmental agency which regulates the manufacture, use and sale of human diagnostics and therapeutic products in Canada, and oversees safety of foods.
Hepatic Transaminases	are variables analyzed in plasma that describe liver function and liver cell integrity. They include, for example, Alanine Transaminase (ALT) and Aspartate Transaminase (AST).
In vivo	an experimental procedure conducted in a living organism.
Investigational New Drug (IND)	the application submitted to the FDA prior to a drug being tested in humans in clinical trials.
Intravascular Ultrasound (IVUS)	an invasive procedure, performed along with cardiac catheterization; a miniature sound probe (transducer) on the tip of a coronary catheter is threaded through the coronary arteries and, using high-frequency sound waves, produces detailed images of the interior walls of the arteries. Where angiography shows a two-dimensional silhouette of the interior of the coronary arteries, IVUS shows a cross-section of both the interior, and the layers of the artery wall itself.
Life Science Organization(s)	an industry term describing both biotechnology and pharmaceutical organizations.
Low-density Lipoprotein (LDL)	a complex of lipids and proteins (ApoB) that function by transporting cholesterol to the tissues, in particular the arteries, and is associated with an increased risk of atherosclerosis and coronary heart disease (<i>also known as "bad cholesterol"</i>).
Lipids	are fatty substances, including cholesterol and triglycerides, that are present in cell membranes and body tissues.
Lipoproteins	a complex of proteins and lipids that are the principal means by which fat and cholesterol is transported in the blood; major lipoproteins are low-density lipoproteins (LDL) and high-density lipoproteins (HDL).
Macrophage	a type of white blood cell that ingests foreign particles, including cholesterol.
Medical Device	a diagnostic or therapeutic article that does not work by chemical action (<i>see DES</i>).
Metabolism	is the biochemical modification or degradation of a drug, often readily removing the drug from the body.
Monocyte	a white blood cell that circulates in the blood and becomes a macrophage when it enters the body's tissues and organs.
New Drug Application (NDA)	the documentation submitted to the FDA, Health Canada or other local regulatory authorities to obtain approval to market a new drug.

NexVas AD	NexVas™ Alzheimer's Disease is a discovery stage technology for the development of drugs that enhance ApoA-I and RCT markers for stabilization and potential transport of Beta Amyloid Plaque.
NexVas PR	NexVas™ Plaque Reduction is the Company's primary program for the development of drugs that increase the production of ApoA-I to reduce the risk of cardiovascular diseases. ApoA-I is the key building block of HDL, the "good cholesterol".
NexVas AI	NexVas AI Autoimmune is our emerging research program focused on novel small molecules that affect markers of inflammation in autoimmune disorders such as Multiple Sclerosis and Rheumatoid Arthritis.
Patent Cooperation Treaty	a multinational treaty (effective in 1978) that provides a unified procedure (PCT) for filing a patent application, active in approximately 125 countries.
Pharmacological Agent	(see "Drug").
Pharmacodynamics	the study of the biological actions of a drug in the body, specifically the relationship between how much drug is present and its effects.
Pharmacoeconomics	the scientific discipline that compares the value of one pharmaceutical drug or drug therapy to another. It is a sub-discipline of Health economics. A pharmacoeconomic study evaluates the cost (expressed in monetary terms) and effects (expressed in terms of monetary value, efficacy or enhanced quality of life) of a pharmaceutical product.
Pharmacokinetics	the study of how a drug is absorbed, distributed, metabolized and eliminated (ADME) by the body over time.
Pharmacology	the study of pharmacological agents and their origin, nature, properties and effects on living organisms.
Phase 1 Clinical Trial	a smaller scale trial, where a drug is first tested on a small number of healthy human volunteers to evaluate the drug's safety, schedule, dose, pharmacokinetics and pharmacodynamics (an approximate 1-2 year time trial).
Phase 2 Clinical Trial	a study in patients (not healthy volunteers) with the main objective to establish a safe and efficacious dose for phase 3 clinical trials.
Phase 3 Clinical Trial	a study or studies in a defined patient population designed to demonstrate effect to support use for a special indication, for example treatment of patients with previous coronary artery disease to prevent the occurrence of a major adverse coronary.
Pre-beta1 HDL	lipid-poor particles that initiate reverse cholesterol transport (RCT) from cell membranes to the liver for excretion (also known as nascent HDL).
Preclinical Studies	the studies conducted in animals to evaluate the toxic effects, pharmacokinetics and metabolism of a drug to provide evidence for safety, efficacy and bioavailability of the drug prior to its administration to humans in clinical studies.

Restenosis	the re-narrowing of the inside of a vessel, typically a complication after an angioplasty.
ReVas	ReVas™ is the Company's third CVD program, a research stage technology for the development of therapeutics to be used with medical devices for the treatment of cardiovascular diseases.
Reverse Cholesterol Transport (RCT)	the term that signifies the process whereby cholesterol, an insoluble molecule, is packaged and transported by special particles in the plasma called lipoproteins for movement from peripheral tissues through the blood and back to the liver for excretion from the body. Cholesterol that moves from peripheral tissues to the liver is considered to be moving in the reverse direction.
RVX-208	our drug candidate for the treatment of dyslipidemia in patients at high risk for cardiovascular disease.
SR-BI-dependent pathways	Scavenger receptor class B member 1 (SRB1), is an integral membrane protein found in numerous cell types/tissues, and facilitates the uptake of cholesteryl esters, functioning as a receptor for high-density lipoprotein.
Statin	a class of drugs that block cholesterol production in the body by inhibiting an enzyme called HMG-CoA reductase.
Therapeutic	a biopharmaceutical useful for treating a disease.
Toxicology	the study of the harmful effects of substances in the body, including the level of toxicity, the mechanism by which toxicity occurs and how it can be controlled.
Therapeutic Products Directorate (TPD)	the Canadian governmental agency that is responsible for the regulation and approval of the sale of drugs and diagnostics in Canada.
Triglycerides	a type of fat found in the blood and other parts of the body.

NOTE REGARDING FORWARD-LOOKING INFORMATION

All statements, other than statements of historical facts, included in this Annual Information Form regarding our strategy, future operations, financial position, future revenues, projected costs, prospects, plans and objectives of management are forward-looking statements that contain forward looking information within the meaning of Canadian securities legislation. Forward looking statements and forward looking information are referred to collectively herein as "forward looking statements". The words "believe", "anticipate", "estimate", "plan", "expect", "intend", "may", "project", "will", "would" and similar expressions and the negative of such expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we actually will achieve the plans, intentions or expectations disclosed in our forward-looking statements and you should not place undue reliance on our forward-looking statements.

Our statements of "belief" in respect of our drug candidates are based primarily upon our results derived to date from our pre-clinical and clinical research and development and our research and development program. We also use the term "demonstrated" in this Annual Information Form to describe certain findings that we make arising from our research and development including any pre-clinical and clinical studies that we have conducted to date.

We believe that we have a reasonable scientific basis upon which we have made such statements of "belief" or arrived at such findings. It is not possible, however, to predict, based upon in vitro, animal

and/or human studies whether a new therapeutic agent will be proved to be safe and/or effective in humans and no conclusions should be drawn in that regard from what we state has been demonstrated by us to date. We cannot assure you that the particular results expected by us will occur.

There are a number of important factors that could cause our actual results to differ materially from those indicated or implied by forward-looking statements or statements of “belief”, including the factors discussed under “Risk Factors”. These factors and the other cautionary statements made in this Annual Information Form should be read as being applicable to all related forward-looking statements and statements of “belief” wherever they appear in this Annual Information Form.

Any forward-looking statements and statements of “belief” represent our estimates only as of the date of this Annual Information Form and should not be relied upon as representing our estimates as of any subsequent date. Except as required by law, we do not assume any obligation to update any forward-looking statements or statements of “belief”. We disclaim any intention or obligation to update or revise any forward-looking statements or statements of “belief”, whether as a result of new information, future events or otherwise, except as otherwise required by law. The forward-looking statements contained in this Annual Information Form include, but are not limited to, statements regarding our:

- intention to commercialize our products for the treatment of unmet medical needs, including cardiovascular disease, Alzheimer's disease and inflammatory diseases;
- intention to carry out trials on our products for the treatment of cardiovascular disease, Alzheimer's disease and inflammatory diseases;
- intention to obtain regulatory approval for our products;
- expectations with respect to the cost of the testing and commercialization of our products;
- sales and marketing strategy;
- anticipated sources of revenue;
- intentions regarding the protection of our intellectual property;
- business strategy; and
- intention with respect to dividends.

Such forward-looking statements involve known and unknown risks and uncertainties, including those referred to in this Annual Information Form, which may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. These risks include, but are not limited to:

- risks related to the early stage of our products and the Company;
- uncertainties related to clinical trials and product development;
- uncertainties relating to current economic conditions;
- rapid technological change;
- uncertainties relating to forecasts and timing of clinical trials and regulatory approval;
- competition in the market for therapeutic products to treat cardiovascular disease, Alzheimer's disease and inflammatory diseases;
- risks relating to potential product liability claims;
- availability of additional financing and access to capital for research and development, clinical trials and regulatory approval;
- market acceptance and commercialization of our products;
- the availability and supply of raw materials, including supplies of sufficient active pharmaceutical ingredients for larger clinical trials and future commercial production;
- risks relating to the effective management of our growth;
- potential reliance on partnering agreements to provide support for discovery and development efforts, and on corporate sponsors, pharmaceutical companies, universities, research groups and others to successfully develop and commercialize the Company's technology;
- the willingness of health care insurers and other organizations to pay for our products;
- risks relating to our reliance on key personnel;
- risks relating to the regulatory approval process for the manufacture and sale of non-therapeutic and human therapeutic products; and

- the Company's ability to secure and protect its intellectual property, and to operate without infringing on the proprietary rights of others or having third parties circumvent the rights owned or licensed by the Company.

Such forward-looking statements are based on a number of assumptions which may prove to be incorrect, including, but not limited to, assumptions about:

- general business and economic conditions;
- interest rates;
- the timing of the receipt of regulatory and governmental approvals for research and development projects;
- the availability of financing for research and development projects, or the availability of financing on reasonable terms;
- the costs of pre-clinical and clinical trials;
- our ability to attract and retain skilled staff;
- the impact of changes in Canadian dollar-euro, Canadian dollar-US dollar and other foreign exchange rates on our costs and results;
- market competition;
- tax benefits and tax rates; and
- ongoing relations with employees and with business partners.

The foregoing list of important factors and assumptions is not exhaustive. Events or circumstances could cause the Company's actual results to differ materially from those estimated or projected and expressed in, or implied by, these forward-looking statements. You should also carefully consider the matters discussed under "Risk Factors" in this Annual Information Form. We undertake no obligation to update publicly or otherwise revise any forward-looking statements or the foregoing list of factors, whether as a result of new information or future events or otherwise, except as required by securities legislation.

CURRENCY

In this Annual Information Form, unless otherwise noted, all dollar amounts are expressed in Canadian dollars.

CORPORATE STRUCTURE

Name and Incorporation

Resverlogix Corp. ("Resverlogix" or the "Company") was incorporated under the ABCA on August 17, 2000 as Apsley Management Group Inc. The Company acquired all of the shares of Resverlogix Inc. on April 25, 2003. The Company amalgamated with Resverlogix Inc. to form Resverlogix Corp. on February 7, 2005.

Our head office is located at Suite 202, 279 Midpark Way S.E., Calgary, Alberta, T2X 1M2. The registered and records office is located at Suite 600, 815 - 8th Avenue S.W., Calgary, Alberta, T2P 3P2.

Inter-Corporate Relationships

The Company owns all of the voting securities of RVX Therapeutics Inc., a corporation incorporated under the ABCA, And Resverlogix Inc., a corporation incorporated under the laws of the state of Delaware on July 18, 2008.

GENERAL DEVELOPMENT OF THE BUSINESS

Three Year History

During the last three years, we have expanded our operations and technology platform, further advanced the NexVas™ Plaque Regression (NexVas™ PR) program and established new research programs such as NexVas™ Alzheimer's Disease (NexVas™ AD) and NexVas™ Autoimmune (NexVas™ AI). These accomplishments have been achieved by executing on our business strategies, establishing a Clinical Advisory Board and Clinical Steering Committee, hiring internationally renowned personnel and collaborating with leading research institutions and contract research organizations.

The following principal events have influenced the general development of our business in the last three fiscal years.

Product Development

In June 2008, we completed the planned exploratory efficacy analysis of the data from the Phase 1a trial for RVX-208, a lead clinical compound. RVX-208 was found to be safe and well tolerated by healthy subjects in doses of 1 mg/kg to 20 mg/kg as a single dose and from 2 mg/kg/day to 8 mg/kg/day in repeated doses for up to 7 days. A mild side effect was the elevation of hepatic transaminases. Analysis from two independent external laboratories of blinded serum samples showed consistent improvements of key biomarkers for the reverse cholesterol transport (RCT) pathway after 7-days. The trial showed early increases in pre-beta HDL in excess of 30%, cholesterol efflux of 10%, serum ApoA-I over 10%, and HDL-c over 10% (not statistically significant) versus placebo. Although the study was not powered for pharmacodynamic markers, these early preliminary findings supported our decision to continue further development of RVX-208.

In June 2008, we announced a collaboration with the Cleveland Clinic Coordinating Center for Clinical Research for a future clinical trial of RVX-208 using Intravascular Ultrasound (IVUS). Dr. Stephen J. Nicholls, M.B.B.S., Ph.D. led a team of atherosclerosis research experts coordinating the development of a protocol for RVX-208 in a Phase 2b IVUS study in patients with coronary heart disease. The study sought to answer important scientific questions surrounding the early potential for regression of atherosclerosis by measuring the rate of regression of coronary disease using IVUS, a technique that directly measures the amount of plaque in the coronary arteries.

In August 2008, we announced the commencement of our Phase 1b/2a clinical trial. This trial was designed to examine safety and tolerance of RVX-208 as well as exploratory pharmacodynamic effects on ApoA-I production and HDL functionality over 28-days. Approximately one-third of the subjects had low levels of HDL cholesterol and the remaining subjects had normal lipid levels.

In October 2008, we announced the formation of the Steering Committee to assess the design for the RVX-208 Phase 2b IVUS trial in ACS patients. The world renowned doctors who comprised the Steering Committee were as follows:

- Chairman: Dr. Steven Nissen, M.D., Chairman of the Department of Cardiovascular Medicine, Cleveland Clinic;
- Principal Investigator: Dr. Stephen Nicholls, MBBS, Ph.D., Medical Director of Intravascular Ultrasound and Angiography Core Laboratories at Cleveland Clinic and Clinical Director of the Cleveland Clinic Center for Cardiovascular Diagnostics and Prevention;
- Dr. Christie M. Ballantyne, M.D., Associate Chief and Professor, Section of Atherosclerosis and Lipoprotein Research, Baylor College of Medicine, Houston, Texas;
- Dr. John J.P. Kastelein, M.D., Ph.D., Professor of Medicine and Chairman of the Department of Vascular Medicine at the Academic Medical Centre (AMC) of the University of Amsterdam, Strategic Chair of Genetics of Cardiovascular Disease and Director Atherosclerosis Research Group; and
- Dr. Allen Taylor, M.D., Chief, Cardiology Service, Professor of Medicine, USUHS Walter Reed Army Medical Center in Washington, D.C.

In October 2008, we also announced that the first arm (Arm A) of the double blind placebo controlled Phase 1b/2a study in subjects with normal and low HDL was completed. The subjects in Arm A received a low dose of RVX-208 for a period of 28 days. The data was reviewed by the clinical safety committee and found that RVX-208 was safe and well tolerated. As a result of these findings, the safety committee made the decision to commence the next cohort (Arm B), in which 24 subjects received treatment doses escalating each week, for a total of 4 weeks.

In November 2008, we announced that key scientific data was presented in an oral presentation highlighting the novel features of RVX-208 at the American Heart Association Scientific Meeting. The presentation entitled "Compound RVX-208 Modulates HDL-c Levels and Function in Non-human Primates and in Early Human Trials" was presented by Dr. Jacques Genest, MD, Director of the Division of Cardiology at McGill University Health Centre/Royal Victoria Hospital. Dr. Genest reported that in an African Green monkey study, treatment with RVX-208 resulted in a highly significant increase in the average of serum ApoA-1 and HDL-c levels (57% and 92%, respectively). It was noted that RVX-208 treatment modified the distribution of HDL particle size, causing a significant increase in prebeta-HDL and the larger alpha-HDL particles. The ability of serum to promote cholesterol efflux via ABCA1, ABCG1 or SR-BI-dependent pathways in a cell culture model was significantly increased by RVX-208.

In November 2008, we also announced that in a post-hoc analysis of our Phase 1a clinical trial, patients treated with RVX-208 resulted in a positive trend on an important marker of cognitive function and Alzheimer's disease, Amyloid-beta40, an important constituent of amyloid plaques in the brains of Alzheimer's patients.

The Company's Phase 1a trial, a double blind, dose escalation, placebo-controlled trial enrolled 24 subjects in three separate dosing cohorts for a period of one week: 6 received placebo, 6 received 2mg/kg per day, 6 received 3mg/kg per day and 6 received 8 mg/kg per day of RVX-208. Plasma levels of Abeta (A-beta40) were measured on day 1 and 7. A 12-14% increase in plasma A-beta40 levels was observed at the highest dose of RVX-208 after 7 days of dosing. These study results trended towards significance versus placebo, even with the minimal number of study subjects.

In January 2009, we completed Arm B of the Phase 1b/2a clinical study of RVX-208 and our Clinical Safety Committee approved Arm C of the study to proceed. Key objectives of the trial included defining the safety, tolerability, dose tolerance to single and multiple dose regimens, effect of food intake, pharmacokinetics and preliminary evaluation of lipid profiles in healthy volunteers. Following the completion of the Phase 1 studies, Phase 2 clinical testing was being planned to establish the RVX-208 dose-response for ApoA-I, HDL-c, HDL sub particles such as Alpha 1 HDL and regression of atherosclerosis in patients with a history of coronary heart disease evaluated by Intravascular Ultrasound ("IVUS").

In April 2009, we announced that we would add a new assessment of a biomarker for Alzheimer's disease to Arm C of the Phase 1b/2a clinical trial.

In May 2009, we announced that we filed two new patent applications for novel compounds and their use in regulating inflammatory markers. Inflammatory markers are proteins generated by the body during periods of inflammation. These patents were filed based on successful results demonstrated in numerous preclinical studies across several disease areas, in particular the collagen induced arthritis ("CIA") rat model, wherein our proprietary molecules markedly reduced inflammation while improving mobility of arthritic animals.

In August 2009, we announced that initial results from our Phase 1b/2a trial had met the study's primary endpoint of increasing plasma ApoA-I in a safe and tolerable manner.

In August 2009, we also announced that we had successfully completed two arms of a Phase 1 BE (bio-equivalency) study for RVX-208. The Phase 1 BE trial was designed to demonstrate that a capsule version of RVX-208 was equivalent to the powder version that had been used in previous RVX-208 trials.

In September 2009, we announced top line results from our Phase 1b/2a study which tested RVX-208 for 28 days in three different dosing arms. The most pronounced results were achieved among trial subjects with low HDL cholesterol levels. Highlights from the study included:

- the primary endpoint, plasma ApoA-I increase compared to placebo, achieved a range in all subjects of 5.1% - 10.4% in all doses at days 8 and 28 respectively;
- at the lowest dose of 1mg/kg b.i.d. in subjects with low levels of HDL-c, plasma ApoA-I increases reached statistical significance of 5.7% ($p < 0.05$) at day 8 and 7.8% ($p < 0.05$) at day 28;
- a critical RCT functionality marker, Alpha-1 HDL particles, illustrated highly-statistical significance with an increase of 46.7% ($p < 0.004$), in all subjects and 57.2% ($p < 0.02$) in the low dose arm over placebo at day 28;
- pharmacokinetic parameters of RVX-208 were dose dependant with oral administration;
- RVX-208 was shown to be compatible with simvastatin (40mg); and
- seventy out of seventy two subjects completed the trial; one subject did not complete the trial due to personal reasons and one other subject did not complete the trial due to a serious adverse event, specifically cholecystitis (gall stones), which was judged not related to the study drug.

In October 2009, we announced that we would undertake two parallel Phase 2 clinical studies. The studies included a Phase 2 Pilot Intravascular Ultrasound (“IVUS”) trial to examine early lipid effects, and atheroma plaque characterization of the coronary vessel wall in 120 acute coronary syndrome patients. In parallel to this, a Phase 2 Dose-Ranging trial was to be conducted in 280 stable cardiovascular patients on standard of care therapy, including statins, examining lipid changes. Both of these clinical trials were to dose patients with coronary disease who were on standard treatment for 13 weeks.

In December 2009, we announced that we had begun dosing patients in our Phase 2 ASSERT (ApoA-I Synthesis Stimulation Evaluation in Patients Requiring Treatment for Coronary Artery Disease) clinical trial led by the Cleveland Clinic. This trial examined RVX-208 in patients with stable Coronary Artery Disease. This randomized, double-blind, placebo-controlled, multi-centered US study was chaired by Dr. Steven Nissen, MD, Chairman of the Cleveland Clinic Department of Cardiovascular Medicine and the principal investigator was Dr. Stephen Nicholls, Medical Director of Intravascular Ultrasound at Cleveland Clinic. A total of 40 investigator sites across the United States were expected to participate in the study. The primary objective of this study was to determine if RVX-208 produced an increase in plasma apolipoprotein A-I (ApoA-I) levels compared to placebo group after three months of dosing. The secondary objectives were to examine the safety and tolerability of RVX-208, to compare the dose and time response relationships for ApoA-I as well as to examine key reverse cholesterol markers involved with HDL functionality.

In February 2010, we announced the completion of patient enrollment in ASSERT five months ahead of the original schedule.

In February 2010, we also announced that we had officially activated the first site for our second Phase 2 clinical trial, ASSURE 1 (ApoA-1 Synthesis Stimulation in Acute Coronary Syndrome patients), led by Cleveland Clinic. The IVUS study was to be conducted at 15-20 sites and was to dose approximately 120 Acute Coronary Syndrome (“ACS”) patients on standard of care therapy and examine lipid effects by RVX-208 compared to placebo. In half of the patients a change in atherosclerosis (ie. change in plaque volume and plaque composition) was to be assessed. The primary objective of the study was to determine the 3 month effect of RVX-208 on change in plasma levels of ApoA-1 in patients with a recent ACS event who required coronary angiography versus placebo. The secondary objectives for this study included assessing the safety and tolerability of the drug through evaluation of adverse events as well as to evaluate the effect of RVX-208 on other lipid parameters.

In May 2010, because the ASSERT trial completed dosing five months ahead of the original schedule, we announced our intention to apply pertinent findings such as optimal dosing regimen from the ASSERT trial to the design of the Phase 2 ASSURE 1 trial. Enrollment in the ASSURE 1 trial was voluntarily halted on a temporary basis in order to potentially learn and target enrollment procedures.

In June 2010, we announced that in our Phase 1b/2a trial, patients treated with RVX-208 showed increased plasma levels of ApoA-1 by 13.25% compared to placebo in subjects with low baseline HDL/ApoA-1.

In September 2010, we announced important design modifications to our Phase 2b ASSURE clinical trial, with the objective of demonstrating more powerfully the efficacy of RVX-208. Key changes to this clinical trial included:

- increasing the number of patients in the trial from 120 to over 230 (subsequently increased to over 300);
- all patients to undergo an IVUS assessment versus the previously planned 60 patients;
- the number of trial sites was increased from 20 to approximately 45;
- the trial to be conducted in multiple countries;
- the trial to include only patients with low HDL; and
- the trial's primary endpoint was changed to plaque regression.

In November 2010, we announced top line results of the Phase 2 ASSERT clinical trial during the American Heart Association Scientific Sessions 2010. The trial demonstrated that the three key biomarkers in the RCT process showed dose dependent and consistent improvement in response to 12 weeks of dosing with RVX-208. The trial showed dose dependent increases, though not statistically significant, in ApoA-I, the trial's primary endpoint. The trial also showed statistically significant increases in HDL cholesterol including alpha1 particles or functional HDL, and highly statistically significant increases in large HDL particles. RCT is a metabolic pathway by which accumulated cholesterol is transported from the arterial wall to the liver for excretion, thus reducing and/or preventing atherosclerosis. In the high dose, ApoA-I increased 5.6% with a statistical value of $p=0.06$ versus placebo. Across all subjects, ApoA-I showed a trend to increase in higher doses with statistical significance of $p=0.035$. ApoA-I and other HDL particles continued to be increasing at the end of the 12 week study. Both the 8.3% HDL cholesterol increase and the 21.1% large particle HDL increase were highly statistically significant, $p<0.01$ and $p<0.001$ respectively. These pronounced HDL related increases via ApoA-I production are important as they take place later in the RCT chain of events and indicate the potential for plaque regression.

In the high risk sub population, patients who had HDL \leq 45mg/dl, the middle dose of 200 mg saw the most pronounced increases of 12% versus baseline in ApoA-I ($p<0.02$), 21% in HDL ($p<0.015$) and large HDL of 32% ($p<0.018$). These findings have helped us better target the patient population as well as dosing of RVX-208 for the upcoming ASSURE Phase 2b trial. Across all patients, incidents of elevated alanine aminotransferase liver enzymes ("ALTs") in excess of 3 times the upper limit of normal ("ULN") were experienced by 18 of 225 treated patients in ASSERT. Increases in bilirubin, which would indicate liver injury, were not experienced in any patient. In target high risk patients, those with HDL below 45 mg/dl who were on newer leading statin agents at non-maximal doses, only one patient of 45 experienced ALTs in excess of 3 times ULN. The one subject who had the ALT in excess of 3 times ULN had a surgery during the trial and was administered an anesthesia agent (Disfluran) during surgery as well as high dose Tylenol post-surgery, two agents known to cause excessive liver ALT signals. When measuring biochemical safety measures, in all doses, ALTs were highest at week 8 and declined at weeks 10 and 12, possibly indicating adaptation by the liver or that elevated ALTs are transient. Incidents of elevated ALTs were significantly less frequent with patients who were on new leading statin agents at non-maximal doses. In these patients, improvement in key RCT markers was intact. We have incorporated these important new findings from the ASSERT trial into the design of the ASSURE trial and continue to make safety and targeted efficacy a primary focus for the future development of the drug.

An additional presentation at the AHA conference was given by Dr. Norman Wong, our Chief Scientific Officer, containing new data detailing the effects of RVX-208 *in vivo*. The presentation was titled "RVX-208: An Orally Administrated Small Molecule Reduces Atherosclerosis in ApoE Null Mouse and Raises ApoA-I/HDL in Humans". In the ApoE null mice model of atherosclerosis, the oral administration of RVX-

208 reduced aortic plaques in both a prevention model as well as a regression model. The presented model showed plaque reductions of up to 41%.

In December 2010, we announced that Cleveland Clinic researchers in combination with the Company and its Clinical Steering Committee unanimously approved the ASSURE trial design. The Phase 2b multi-center, double-blinded, randomized ASSURE trial will test patients using a placebo-control arm for the assessment of coronary plaque changes with RVX-208 over a six month period, as determined by IVUS.

In January 2011, we announced that RVX-208 illustrated positive effects on a potential novel marker of cognitive function and Alzheimer's disease, plasma Amyloid beta 40 ($A\beta_{40}$). The analysis was performed based on an emerging hypothesis in literature that the transport of potentially harmful $A\beta_{40}$ from the brain to the general circulatory system may be beneficial. Several population studies have indicated that high HDL cholesterol is associated with protection from developing Alzheimer's disease. It has also been shown that plasma $A\beta_{40}$ is a risk factor for developing Alzheimer's disease in older patients. Since the Alzheimer's disease biomarker $A\beta_{40}$ bind to ApoA-1, it has been hypothesized that increasing ApoA-I would transport $A\beta_{40}$ out of the brain thereby decreasing the $A\beta_{40}$ load in the brain, in effect having possible disease modifying effect.

To assess potential for treatment effects by RVX-208 on dementia and Alzheimer's disease, plasma $A\beta_{40}$ was analyzed before and after 12 weeks treatment in a stable coronary artery disease population, i.e. the ASSERT population of 299 patients.

In the quartile with the lowest plasma $A\beta_{40}$ at baseline, which is known to be at greater risk for developing Alzheimer's disease, at a dose of 150 mg, b.i.d., a highly significant 34.8 pg/ml change from baseline ($p=0.0013$) and 13.4% change compared to placebo was observed. The data further supports previous Phase I trial data and the hypothesis that RVX-208 treatment can potentially augment $A\beta_{40}$ transport from the brain. We intend to perform more work to understand these findings in relation to the complex biology and metabolism of lipids and neurology function as it relates to cognitive impairment, dementia and Alzheimer's disease.

Board of Directors, Scientific Advisory Board, Clinical Advisory Board and Management

In June 2008, we appointed Dr. F. Allan Gordon, M.D., Ph.D. Senior Vice President of Clinical Development. Dr. Gordon has more than 20 years of experience as a research scientist and clinician in cardiology.

In July 2008, we announced that Jan Gray, CA had joined our Board of Directors. Ms. Gray is a practicing chartered accountant. She is also Executive Vice-President and Treasurer of Cartwright Canada Inc., a legal publishing company and Controller of Felesky Flynn LLP, a regional Alberta law firm.

In April 2009, we announced that NGN BioMed Opportunity Fund had become entitled to one representative on our Board of Directors which initially would be Dr. Peter Johann, Ph.D. Dr. Johann is a Managing General Partner of NGN Capital, a venture capital firm.

In April 2009, we announced that Dr. Roger S. Newton resigned from the Board of Directors to join the Clinical Advisory Board.

In October 2009, Mr. Kelly B. McNeill was appointed to our Board of Directors. Mr. McNeill is a Chartered Accountant with several years of experience and expertise across all areas of corporate finance and operations. He has held leadership positions with companies in both the biotechnology and manufacturing sectors. Most recently, Mr. McNeill served as our Chief Financial Officer.

In October 2009, we announced the appointment of A. Brad Cann as Chief Financial Officer.

In February 2010, we announced that Arthur J. Higgins, former CEO of Bayer HealthCare and Chairman of the Bayer HealthCare Executive Committee, was appointed to our Board of Directors..

In September 2010, at our Annual General Meeting, Stella Thompson and Jan Gray did not stand for reelection to the Board.

In September 2010, we announced that Mr. Kenneth Zuerblis had joined our Board of Directors. Mr. Zuerblis previously served as the Chief Financial Officer and Senior Vice President of ImClone Systems Inc., prior to its acquisition by Eli Lilly. Subsequently, Mr. Wayne Chiu stepped down from his position on the Board in an effort to maintain a Board comprised of six people.

In December 2010, we announced that Dr. Eldon R. Smith OC, MD, FRCPC, FCAHS, FAHA, FIACS had been appointed to our Board of Directors. From 1992 to 1997, Dr. Smith was Dean of the Faculty of Medicine at the University of Calgary. From 1997 until 2010, he was Editor-in-Chief of the *Canadian Journal of Cardiology*. Dr. Smith was chair of the Advisory Board of the Libin Cardiovascular Institute of Alberta, and from 2006 to 2010 he was appointed by the Federal Government to chair the development of a National Strategy for Cardiovascular Health and Disease.

In an effort to maintain a six member Board of Directors, Dr. William Cochrane stepped down from the Board. Dr. Peter Johann, was appointed as Dr. Cochrane's replacement as Chairman of the Board.

Financing

In October 2008, we announced that we amended our convertible debentures and redeemed US\$10 million of the remaining US\$17.3 million of January and June 2007 debentures. The US\$10 million of debentures were redeemed by way of the issuance of 2.4 million Common Shares with a value of US\$5.5 million and a cash payment of US\$4.5 million. Under the terms of the amendment, the conversion price was amended to \$2.61 per share in exchange for debenture holders agreeing to restrict any put options until March 31, 2009. In addition to the removal of certain future dilution factors, the Company also gained the option to redeem any remaining debenture at a 25% premium.

The following were key terms of the restructured convertible debenture:

- in addition to the March 31, 2009 restriction on the put option, the ability to put to us in Common Shares was waived by the holders of the debentures;
- the remaining principal balance of \$278,000 carrying a 15% interest rate from the January 2007 convertible debenture was reduced to 12% and rolled into the remaining convertible debenture;
- mandatory conversion of the remaining debt at our option at \$5.22 per share, subject to certain trading conditions being met;
- the exercise price of 1,467,349 outstanding warrants was re-priced to \$3.07 per share; and
- all future put obligations could only be settled with cash.

In April 2009, a further amendment was made to defer further put obligations from March 31, 2009 to October 9, 2009. In consideration for the amendment, the coupon rate of the remaining convertible debentures was changed from 12% to 18%. We also agreed to defer our call option to redeem the debentures until October 9, 2009.

In April 2009, we also announced that we closed a private placement equity financing for a total of \$24.25 million. We issued 8,916,845 units, representing 8,916,845 Common Shares and 4,175,229 warrants, to a group of investors led by NGN BioMed Opportunity II, L.P., with each unit comprising of one Common Share and 0.40 of a purchase warrant at a price of \$2.72 per unit. Each whole warrant entitled the holder to acquire for a period of five years an additional Common Share at a price of \$2.72 per share.

In November 2009, we announced our Board of Directors had approved a plan authorizing us to repurchase outstanding convertible debentures of up to US\$6.728 million.

In December 2009, we announced that we had signed a non-binding term sheet for a standby equity distribution agreement ("SEDA") with YA Global Master SPV, Ltd ("YA Global"), a fund managed by Yorkville Advisors, LLC ("YA"), whereby we would have the option, at our sole discretion, to issue and sell up to \$25 million of our Common Shares to YA. Under the SEDA, we would be able to sell, and YA would be obligated to buy, up to \$500,000 of our Common Shares in any ten-day period. The Common Shares sold under the SEDA would be purchased at a discount to the market price.

In December 2009, we also announced that we had closed a \$5 million equity private placement. Under the terms and conditions of the agreement, we issued units, with each unit comprising of one Common Share at a price of \$2.50 and one quarter (25%) of a warrant per unit. Each full warrant had an exercise price of \$2.50 representing the 5 day volume weighted average price and an expiry date of December 18, 2011.

In January 2010, we confirmed that we had completed our previously announced redemption of a total of US\$6.7 million of convertible debt.

In January 2010, we also announced that we had completed an \$8 million second tranche of our equity private placement. Under the terms and conditions of the private placement, we issued units at a price of \$2.50 per unit, with each unit comprising of one Common Share and one quarter of a warrant. Each full warrant had an exercise price of \$2.50 and an expiry date of December 18, 2011. The second tranche, together with the first tranche that closed on December 18, 2009, brought the total proceeds of the private placement to \$13 million.

In March 2010, we announced that we had activated the SEDA with YA Global whereby we had the option, at our sole discretion, to issue and sell, and YA Global was committed to purchase, up to \$25 million of Common Shares from treasury.

In June 2010, we announced the closing of a public offering of 2.8 million units at a price of \$3.30 per unit for gross proceeds of \$9.2 million. Each unit was comprised of one Common Share and 0.4 of one Common Share purchase warrant. Each warrant was exercisable at a price of \$4.00 per share for a period of four years from the closing date.

In June 2010, we also announced the issuance of 51,290 Common Shares at a price of \$3.90 per share for the settlement of \$200,010 in connection with a draw down under the SEDA.

In June 2010, we also announced the closing of a second public offering of 3.1 million units at a price of \$3.23 per unit for gross proceeds of \$10.0 million. Each unit was comprised of one Common Share and 0.4 of one Common Share purchase warrant. Each warrant was exercisable at a price of \$4.00 per share for a period of four years from the closing date.

Recent Developments

In June 2011, we announced the closing of a public offering of 7 million units at a price of \$1.80 per unit for gross proceeds of \$12.6 million. Each unit was comprised of one Common Share and 0.5 of one Common Share purchase warrant. Each warrant was exercisable at a price of \$2.25 per share for a period of five years from the closing date.

In June 2011, we also announced that we had completed chronic repeated-dose toxicology studies on our lead compound, RVX-208. RVX-208 underwent six and twelve month testing in rodents and non-rodents, respectively, and the analysis, results and reporting of these studies to the appropriate regulatory authorities, had been completed.

The chronic toxicology studies supported the initiation of the longer duration, Phase 2b ASSURE clinical trial. With the safety studies complete, RVX-208 could advance into trials of more than three months duration. The Phase 2b ASSURE trial, in which IVUS technology is to be used to determine coronary

arterial plaque regression, will have a treatment duration of six months. The IVUS measurement will be used as the trial's primary endpoint.

Results from the ASSERT trial demonstrated that RVX-208 is effective, although not statistically significant, in elevating new production of ApoA-1, the key protein in 'good cholesterol', HDL cholesterol and HDL Alpha1 sub particles. None of these reverse cholesterol transport biomarkers appear to have reached their plateaus at the completion of the 12 week trial. As a result, FDA rules required that we complete the safety studies in order to progress to a six month human clinical study.

We have identified approximately 60 clinical sites in eight countries to participate in ASSURE. The Cleveland Clinic will serve as the trial co-manager and coordinate all data management and readouts of the primary endpoint. Countries with secured trial sites were located in both Europe and South America. With the completion of these chronic repeated-dose toxicology studies, we commenced the required national approval filings. Upon completion of regulatory filings in each specific country, Resverlogix will then commence enrollment and dosing procedures.

The ASSURE trial will be a placebo-controlled, double-blind intervention trial. The trial patient population will be selected from patients referred for coronary angiography who meet the inclusion criteria. Approximately 310 patients are to participate, of which 77 are to receive placebo and 233 are to receive RVX-208 treatment.

DESCRIPTION OF BUSINESS

General

We are a biotechnology company engaged in the development of novel therapies for important global medical markets with significant unmet medical needs. Our primary focus is the NexVas™ PR program is our primary focus which is to develop novel small molecules that enhance ApoA-I production and reverse cholesterol transport. These vital therapies are focused to address the burden of atherosclerosis and other important diseases such as ACS, Alzheimer's disease, Peripheral Artery Disease and other vascular disorders. Our secondary research focus is on inflammatory and autoimmune diseases.

Company's Business Model

Our business model is to be a leading biomedical company focused on the development of novel therapeutics for medical markets with unmet needs. We seek strategic opportunities through alliance partnerships that are best suited to bring our technology platforms to successful commercialization. Alongside this approach we will seek opportunities to maximize shareholder return. We are committed to good corporate governance and protection of shareholder value.

The Regulatory Process for Drug Development

In the United States, it takes approximately 12 to 15 years for a typical experimental drug to go from concept to approval. The production, manufacture, research and development activities are subject to regulation for safety and efficacy by various governmental authorities around the world. In the United States, drugs and biological products are subject to regulation by the Food and Drug Administration (FDA). There are other comparable agencies in Canada, Europe and other parts of the world. Applicable legislation requires licensing of manufacturing and contract research facilities, carefully controlled research and testing of products, governmental review and approval of results prior to marketing therapeutic products. Additionally, adherence to good laboratory practices, good clinical practices during clinical testing and good manufacturing practices during production is required. The system of new drug approval in the United States is generally considered to be the most rigorous in the world. In Canada, these activities are regulated by the *Food and Drug Act and Regulations* and the rules and regulations promulgated thereunder, which are enforced by the Therapeutics Product Directorate of Health Canada.

Briefly, the steps required for drug approval in the United States and Canada are as follows:

Discovery: Prior to preclinical studies, a discovery phase involves validation of target and function, design, screening, synthesis and formulation of therapeutic agents.

Preclinical Studies: This involves the evaluation of toxic effects and pharmacokinetics and metabolism of a drug in animals to provide evidence of the safety, efficacy and bioavailability of the drug prior to its administration to humans in clinical studies. The results of the preclinical studies as well as the comprehensive descriptions of proposed human clinical studies are then submitted as part of the Investigational New Drug (IND) application to the FDA and TPD.

Phase 1 Clinical Trials: Phase 1 clinical trials are usually *first-in-man* trials, take approximately one to two years to complete and are generally conducted on a small number of healthy human subjects to evaluate the drug's safety, schedule and dose, pharmacokinetics and pharmacodynamics. However, in the case of a life threatening disease, such as cancer, the initial Phase 1 testing may be done in patients with the disease. This latter trial typically takes longer to complete.

Phase 2 Clinical Trials: Phase 2 clinical trials have the main objective to establish optimal treatment regimen for phase 3 studies. They take approximately one to three years to complete and are carried out on a relatively small to moderate number of patients (compared to Phase 3) suffering from the targeted condition or disease to determine the drug's efficacy, optimal doses, treatment regimens, pharmacokinetics, pharmacodynamics and dose response relationships. This phase also provides additional safety data and serves to identify possible common short-term side effects and risks in a larger group of patients. These trials often include randomization of patients as well as a placebo arm.

Phase 3 Clinical Trials: Phase 3 clinical trials, if successful, provide the supporting clinical evidence to register a drug and making a drug available to patients. Phase 3 clinical trials in CVD typically take two to five years to complete and involve tests on a much larger population of patients (several hundred to several thousand patients) suffering from the targeted condition or disease. This type of study is usually double-blind using the dose and treatment regimen arrived upon in phase 2.

New Drug Application: Upon completion of Phase 3 Clinical Trials, the company sponsoring the new drug then assembles all the preclinical and clinical data and submits it to the TPD and/or the FDA as part of a New Drug Application (NDA) (in the United States), or a New Drug Submission (NDS) (in Canada). The NDA or NDS is then reviewed by the regulatory body for approval to market the product. This process usually takes between six months and two years to complete.

Resverlogix's Drug Development Strategy

Given the high costs, long development times and high attrition rates associated with drug development, many biotechnology companies seek the assistance of a pharmaceutical partner to advance their products through clinical trials. Resverlogix will seek to license its pharmaceutical drug candidates at the stage that will provide shareholders with the optimal value for their investment. Should such licensing be successful, the pharmaceutical company will provide the funding and expertise to complete the latter stages of drug development and commercialization. As such, our business strategy remains to generate drug candidates and technologies that will attract pharmaceutical company partners.

Cardiovascular Disease Research Programs

NexVas™ Plaque Regression (NexVas PR) is our primary program for the development of drugs that increase the production of ApoA-I to reduce the risk of cardiovascular diseases. ApoA-I is the key building block of HDL, the "good cholesterol". Our lead drug candidate, RVX-208, is currently in the Phase 2b ASSURE clinical trial led by the Cleveland Clinic.

NexVas™ Alzheimer's Disease (NexVas AD) is a clinical program focused on development of drugs that enhance ApoA-I and RCT markers for stabilization and the potential transport of Beta Amyloid Plaque found in patients with dementia and Alzheimer's disease. The program will also seek to research

new novel biomarkers and diagnostics that may emerge and provide greater targeting for patients who could benefit the most from our novel agents.

NexVas™ Autoimmune (NexVas AI) is a discovery stage effort focused on the development of drugs that target molecular markers of inflammation specifically targeted at important diseases such as Multiple Sclerosis (MS) and Rheumatoid Arthritis (RA).

ReVas™ is a research stage program focused on the development of therapeutics to be used with medical devices for the treatment of cardiovascular diseases.

Cardiovascular Disease and Cholesterol

Atherosclerosis is the major cause of heart attacks and strokes which remain a major cause of mortality and morbidity in North America. According to the American Heart Association, more than 80.7 million Americans have one or more vascular diseases with estimated direct and indirect costs of US \$448.5 billion annually (2008). These conditions include angina, heart attack, stroke, aortic aneurysms, kidney failure and severe limb ischemia; all are contributed to by the increasing prevalence of obesity, hypertension, diabetes and dyslipidemia.

Atherosclerosis, the narrowing and hardening of the arteries caused by the deposition of cholesterol and lipids in the inner arterial walls, is typically the result of high fat diets. When ingested, cholesterol and lipids are transported to and from tissues by special carriers called lipoproteins. There are several types of lipoproteins, but in the context of cardiovascular disease, the medical community focuses on the roles of low-density lipoprotein (LDL) cholesterol and high-density lipoprotein (HDL) cholesterol.

LDL is a major cholesterol carrier in the blood. This carrier is mainly responsible for taking newly produced or absorbed cholesterol from the gut to the other organs of the body. LDL's major lipoprotein is ApoB. High amounts of LDL cholesterol circulating in the blood can result in the slow build-up of cholesterol within the arterial walls forming atherosclerotic plaque. HDL carries cholesterol away from the arteries and back to the liver for excretion from the body, through a process called Reverse Cholesterol Transport (RCT). HDL's major lipoprotein is ApoA-I which accounts for 70% of the total protein content of the HDL particle. By itself or as part of HDL, ApoA-I has anti-atherogenic properties. There is a growing body of evidence that ApoA-I/HDL removes excess cholesterol from atherosclerotic plaques and thus not only prevents plaque growth but promotes plaque regression.

Atherosclerosis is the key underlying cause of coronary and cardiovascular disease. Atherosclerosis develops when there is too much cholesterol being deposited in the arteries and organs by LDL and/or too little being cleared by HDL and RCT. One of the most successful strategies for preventing cardiovascular diseases is the management of reducing LDL cholesterol levels by agents such as statins. Although the statins have been the most successful therapeutic market segment in the world reducing overall CVD risk by approximately 25-30% there still remains a large unmet medical need in further reduction of CAD and CVD risk. The regression of atherosclerosis burden in coronary arteries via the production of ApoA-I and RCT is a strategy that we are actively pursuing.

Therapies aimed at managing cholesterol and reducing LDL levels comprise the single largest class of prescription pharmaceuticals by revenue, with global sales in 2004 exceeding US\$30 billion (IMS Health, 2005). The use of statins, widely prescribed LDL-lowering agents, has been shown to lower the risk of developing heart disease by 25%. A number of statins are facing near term patent expiration; the patent for Pfizer's Lipitor®, with sales of US\$13.3 billion in 2006, will expire in 2011. A strategic imperative for pharmaceutical firms whose revenue will be impacted by patent expirations is to potentially introduce a new category of drugs that will provide additional CAD and CVD risk reduction over standard of care products such as statins.

Protective Role of ApoA-I and HDL and RCT Particles

Numerous epidemiological and interventional studies have demonstrated that high or increased levels of ApoA-I and RCT particles such as HDL and larger HDL are cardio-protective against the development of atherosclerosis.

The Framingham Heart Study illustrated the importance of HDL enhancement for CVD risk reduction. For every mg/dL increase in HDL, the 10-year risk of a heart attack fell by 2-3%. The Veterans' Affairs Cooperative Studies Program showed that men who took a lipid regulating drug for five years had a 6% increase in HDL levels, resulting in a 22% risk reduction in death due to coronary artery disease, heart attack, or stroke.

The Framingham Offspring Study (FOS), [Asztalos et al ATVB 2004], illustrated that certain types of HDL particles, specifically large HDL or Alpha 1 HDL particles were even more predictive in calculating future CAD events in CVD patients. For every mg/dl increase in Alpha1 HDL, patients in the FOS cohort had a reduction of future coronary events by 26%. Asztalos and others, suggested Alpha 1 particles were significantly better predictors of risk than HDL-C values.

Recent landmark trials such as INTERHEART (2004) and AMORIS (2005) clinically validate ApoA-I as an important target for the reduction of CVD risk. The INTERHEART trial, a landmark study of 30,000 patients, demonstrated that the ratio of ApoB to ApoA-I was the strongest risk predictor of acute myocardial infarction (heart attack).

In the AMORIS trial, more than 175,000 patients with cardiovascular risk factors were studied for the incidence of cardiac and stroke events. AMORIS clearly illustrated that reducing the ratio of ApoB to ApoA-I was associated with a dramatic reduction of stroke in this population. The key findings of this study indicate that improvement of 'cholesterol balance', or the ApoB to ApoA-I ratio, is a robust and specific marker of virtually all ischemic events.

In a six week Phase 2 clinical trial involving 47 patients, Esperion Therapeutics Inc.'s drug candidate reported the proprietary ApoA-I_{Milano} formulation, reduce absolute atheroma (plaque) volume by 4.2%; a level of atherosclerotic regression unattainable with current drug therapies.

Based on the findings from these studies, there has been considerable interest and effort within the pharmaceutical industry to identify, develop and acquire therapies that raise the level of ApoA-I and/or HDL. With a number of pending patent applications, we believe we have broad intellectual property in the area. If shown efficacious in clinical trials, we believe that our novel small molecule, RVX-208, will be well-positioned to participate in critically important global atherosclerosis management market.

Percent Atheroma Volume (PAV) as Predictive Factor in CVD

The hypothesis that increasing ApoA-I production reduces CVD risk is supported by intervention trials such as the Veterans Affairs High Density Lipoprotein Cholesterol Intervention Trial (VA-HIT) *N Engl J Med.* 1999. In intervention trials it is critical to gather data to assess the effects of a therapeutic on atheroma, also known as atheromatous plaque. Imaging technology is used to make such visual assessments. Data from early imaging studies using coronary angiography and carotid ultrasound established a strong link between atheroma burden, its progression and CVD outcome. Therapies that slow the progression of atheroma burden have repeatedly been shown to reduce CVD events in randomized clinical trials. Thus, many medical institutions have set stabilization or slowing of atheroma burden progression as a goal of medical therapy.

IVUS is an invasive procedure, performed along with cardiac catheterization; a miniature sound probe (transducer) on the tip of a coronary catheter is threaded through the coronary arteries and, using high-frequency sound waves, produces detailed images of the wall of the artery. Where angiography shows a two-dimensional silhouette of the interior of the coronary arteries, IVUS shows a cross-section of both the interior, and the layers of the artery wall itself. It is expected that data gathered using IVUS will provide

further support for the relationship between atherosclerosis and CVD events. Percent atheroma volume (PAV) at baseline and subsequent serial increases are greater in patients who experience a cardiovascular event. Analysis of combined data from the treatment groups in the ILLUSTRATE IVUS trial showed that: (1) patients who had an event during the trial had a higher PAV at baseline followed by greater progression, and (2) the difference in change in PAV between those who had an event and those who were event-free ranged from 0.5-0.6%. This difference in the PAV was subsequently confirmed in pooled analysis of seven IVUS clinical trials performed at the Cleveland Clinic involving more than 4,500 patients.

NexVas Plaque Regression Program

We are developing small molecules that increase the endogenous production of ApoA-I that enhance RCT. These compounds have been generated from a proprietary combination of technologies, know-how and expertise. To date, we have identified several classes of small molecules and have generated in vivo proof-of-concept data demonstrating a significant increase in ApoA-I, HDL and functional HDL in a number of animal models. We have further validated these results in human clinical trials discussed below.

We believe our approach is therapeutically and commercially attractive for the following reasons:

- ApoA-I is a well validated clinical target, as demonstrated in studies such as INTERHEART and AMORIS.
- RVX-208 and other compounds from our NexVas PR program are highly differentiated from other therapies that focus only on increasing HDL in plasma. The Company's small molecules have been shown to enhance the functionality of ApoA-I particles resulting in cholesterol efflux from macrophage foam cells, a critical step in RCT. We believe that functional HDL plays a role in reducing atheroma in the vessel wall. We also believe that RVX-208 works by activating ApoA-I production, impacting markers of RCT such as pre-beta HDL and cholesterol efflux in order to enhance RCT and reduce CVD risk.
- Our compounds work via a physiological approach of activating the body's own health-promoting genes (such as ApoA-1) to fight diseases. We have developed small molecules that increase the endogenous production of ApoA-1 as a means to impact cardiovascular disease. This approach minimizes the likelihood of immunologic complications associated with peptide or recombinant ApoA-I therapies currently in development, and more importantly facilitates continual enhancement of ApoA-I levels at physiological levels.

For the above reasons, we believe that compounds from our NexVas PR program, specifically RVX-208, have the potential to become important, differentiated therapeutics for high risk patients with CAD and CVD. ApoA-I production and RCT enhancement treatments are positioned to provide the most efficient impact on atherosclerosis and potentially become an important new tool in fighting this leading killer worldwide.

PRODUCT CANDIDATE

RVX-208

RVX-208 is a small molecule drug candidate for the treatment of atherosclerosis. Its primary mode of action appears to be through the transcriptional up-regulation of ApolipoproteinA-I (ApoA-I), producing an increase in plasma ApoA-I protein and high-density lipoprotein cholesterol (HDL-c). ApoA-I is the major protein component of the HDL particle, the "good cholesterol", and has a well established role in atherosclerosis and CVD protection.

In-vivo studies have shown RVX-208 to produce significant increases in plasma ApoA-I and HDL-c in mice and monkeys. RVX-208 displays good oral bioavailability, high metabolic stability and low plasma

clearance. RVX-208 was well tolerated in rats and monkeys when orally administered daily for thirteen weeks and in our chronic toxicology studies over 52 weeks at doses several fold above those which are pharmacologically effective. RVX-208 has been tested in over 130 preclinical studies.

RVX-208 is currently being tested in human clinical studies in cardiovascular disease which are detailed below.

Summary of RVX-208 Clinical Trials

Trial	Summary	Patients	Status	Initiated	Data Release
Phase 2b ASSURE	26 weeks risk-stratified IVUS study in patients with HDL under 45	310	Being initiated	TBD	TBD
Phase 2 ASSERT	12 week dose-ranging safety, tolerability and efficacy in stable CVD patients	299	Completed	Q4 2009	Q4 2010
Phase 1b/2a	28 day multiple dosing safety, tolerability and efficacy in healthy volunteers with low HDL	72	Completed	Q3 2008	Q3 2009
Phase 1 BE	Single dose bio-equivalency comparing capsule and tablet drug form	9	Completed	Q3 2009	N/A
Phase 1 BE	Single dose bio-equivalency	7	Completed	Q3 2009	Q4 2009
Phase 1a	First-in-man single ascending dose and 7-day multiple dosing	80	Completed	Q4 2007	Q1 2008

Phase 1a Clinical Trial - Completed

The primary objectives of the Phase 1a trial were to examine the safety, tolerability and pharmacokinetics of RVX-208. This study successfully met those objectives. In addition, analysis from 24 healthy volunteers in Arm C of the 7 day trial showed statistically significant improvements over placebo in key variables assessed. Highlights of the study include increases in the healthy volunteers' serum levels of pre-beta HDL of in excess of 30%, cholesterol efflux above 10%, serum ApoA1 production above 10%, and HDL-c above 10% (not statistically significant) versus placebo.

These results, when applying allometric scaling, are similar to results generated in previously reported African Green Monkey studies.

Phase 1b/2a Clinical Trial - Completed

The Phase 1b/2a study tested RVX-208 for 28 days in three different dosing arms: a low dose arm with 24 subjects, a dose-escalation arm with 24 subjects, and a high dose arm with 24 subjects. The trial was a double-blind safety and tolerance study that investigated the pharmacokinetics and early pharmacodynamics effects of RVX-208. This trial also examined early markers for RCT such as ApoA-I, HDL-c, pre-beta HDL and alpha HDL subparticles. Approximately half of the subjects had low levels of baseline HDL cholesterol.

Results of the Phase 1b/2a study showed that RVX-208 was safe and tolerable. Importantly, RVX-208 met its primary endpoint to increase the production of plasma ApoA-I, the key cardioprotective protein in HDL.

Highlights from the study are as follows:

- the primary endpoint, plasma ApoA-I increase compared to placebo, achieved a range in all subjects of 5.1% - 10.4% in all doses at days 8 and 28 respectively.
- at the lowest dose of 1mg/kg b.i.d. in subjects with low levels of HDL-c, plasma ApoA-I increases reached statistical significance of 5.7% ($p < 0.05$) at day 8 and 7.8% ($p < 0.05$) at day 28.
- a critical RCT marker, Alpha-1 HDL particles, illustrated highly-statistical significance with an increase of 46.7% ($p < 0.004$), in all subjects and 57.2% ($p < 0.02$) in the low dose arm over placebo at day 28.
- pharmacokinetic parameters of RVX-208 were dose dependant with oral administration.
- RVX-208 was shown to be compatible with simvastatin (40mg).
- seventy out of seventy-two subjects completed the trial. One subject did not complete the trial due to personal reasons and one other subject did not complete the trial due to a serious adverse event, cholecystitis (gall stones), which was judged not related to the study drug.

Phase 1: BE Comparing Suspension and Capsule Dosage Form - Completed

The Phase 1 bioequivalence study was designed to investigate the pharmacokinetics of a capsule form of RVX-208 after single-dose administration to healthy male volunteers. Pharmacokinetic analysis of healthy volunteers following 200 mg single dose administrations of RVX-208, indicate the systemic exposure (AUC) and C_{max} are similar between powder-in-bottle suspension and capsule on a fed stomach and lower on a fasted stomach.

Phase 1 BE: Comparing Suspension and Tablet Dosage Form - Completed

The Phase 1 bioequivalence study was designed to investigate the pharmacokinetics of a tablet form of RVX-208 after single-dose administration to healthy male volunteers. Preliminary pharmacokinetic analysis of healthy volunteers following 200 mg single dose administrations of RVX-208, indicate the systemic exposure (AUC) and C_{max} are similar between powder-in-bottle suspension and tablet on a fed stomach.

Phase 2 ASSERT Clinical Trial - Completed

ASSERT was a 13-week randomized, double-blind, placebo-controlled, multi-center US study with 299 patients enrolled with stable coronary artery disease. The primary endpoint of the study was increased plasma ApoA-I levels compared to placebo group after three months of dosing of RVX-208. Other objectives are to examine the safety and tolerability of RVX-208 and to compare the dose and time response relationship for ApoA-I as well as to examine key reverse cholesterol markers involved with HDL functionality.

In November 2010, we announced top line results of the ASSERT Phase 2 clinical trial during the American Heart Association Scientific Sessions 2010. The ASSERT trial data demonstrated that the three key biomarkers in the reverse cholesterol transport ("RCT") process showed dose dependant and consistent improvement. The trial showed dose dependent increases, though not statistically significant, in ApoA-I, the trial's primary endpoint. The trial also showed statistically significant increases in HDL cholesterol including alpha1 particles or functional HDL, and highly statistically significant increases in large HDL particles. RCT is a pathway by which accumulated cholesterol is transported from the arterial wall to the liver for excretion, thus reducing and/or preventing atherosclerosis. In the high dose, ApoA-I achieved a 5.6% increase with a statistical value of $p = 0.06$ versus placebo. Across all subjects, ApoA-I showed a trend to increase in higher doses with statistical significance of $p = 0.035$. ApoA-I and other HDL particles continued to be increasing at the end of the 12 week study. Both the 8.3% HDL cholesterol increase and the 21.1% large particle HDL increase were highly statistically significant, $p < 0.01$ and

$p < 0.001$ respectively. These pronounced HDL related increases via ApoA-I production are important as they take place later in the reverse cholesterol transport chain of events and strongly indicate the potential for plaque regression.

In the high risk sub population, patients who had low HDL ≤ 45 mg/dl, the middle dose of 200 mg saw the most pronounced increases of 12% in ApoA-I ($p < 0.02$), 21% in HDL ($p < 0.015$) and large HDL of 32% ($p < 0.018$) versus baseline. These findings have helped us better target the patient population as well as dosing of RVX-208 for the upcoming ASSURE Phase 2b trial. Across all patients, incidents of elevated alanine aminotransferase liver enzymes (“ALTs”) in excess of 3 times the upper limit of normal (“ULN”) were experienced by 18 of 225 treated patients in ASSERT. It is important to note that elevated ALTs alone are not considered indicative of liver injury. Increases in bilirubin, which would indicate liver injury, were not experienced in any patient. In high risk patients, HDL below 45 mg/dl who were on newer leading statin agents at select doses, 1 patient of 45 experienced ALTs in excess of 3 times ULN. The one subject who had the ALT in excess of 3 times ULN had a surgery during the trial and was administered an agent during as well as high dose Tylenol post-surgery, two agents known to cause excessive liver ALT signals. When measuring biochemical safety measures, in all doses, ALTs were highest at week 8 and declined at weeks 10 and 12, possibly indicating adaptation by the liver or that elevated ALTs are transient. Incidents of elevated ALTs were significantly less frequent with patients who were on new leading statin agents at low and medium doses. Target levels for key RCT markers in these patients maintained or improved on these dosing combinations over co-administration with high doses of statins. We consider these findings important, novel and understandable given RVX-208 site of action to induce the production of de-novo ApoA-I particles is in the liver; we have incorporated these important new findings from the ASSERT trial into the design of the ASSURE trial and continue to make safety and targeted efficacy a primary focus for the future development of the drug.

Phase 2b ASSURE 1 Clinical Trial - enrollment anticipated to commence in Q3 2011

ASSURE is a 26-week randomized double-blind placebo-controlled multi-center study. As previously discussed, we voluntarily halted the trial on a temporary basis in order to modify the trial design based on information learned from the ASSERT trial. We have completed the redesign of ASSURE and are expecting enrollment of the first patient dosing in Q3 2011. Approximately 310 patients will be enrolled at more than 60 clinical sites in eight countries. The patient population will be selected from patients referred for coronary angiography who meet angiographic criteria. Intravascular Ultrasound technology will be used to determine coronary arterial plaque regression. The trial’s primary endpoint is plaque regression, with secondary endpoints being measurements of ApoA-I, HDL-c and HDL subclasses. Plaque composition as determined by IVUS will be an exploratory endpoint.

Pre-clinical Programs

In addition to our NexVas PR Program, we continue to conduct research through our NexVas AD, NexVas AI and ReVas programs.

NexVas AD, NexVas AI and ReVas Programs

NexVas AD: Small molecules for Alzheimer’s disease and cognitive disorders – clinical development stage

Epidemiological and mechanistic evidence indicate a link between low ApoA-I/HDL and neurodegenerative diseases such as dementia and Alzheimer’s disease. Our lead molecule RVX-208 has illustrated potent and selective effects in raising plasma ApoA-I/HDL by ApoA-I production which has the potential to beneficially impact mild cognitive impairment (MCI) and Alzheimer’s disease (AD). We announced from an early analysis of our Phase 1a trial that RVX-208 also illustrated positive transport effects on Amyloid Beta 40, another marker thought to play a role in cognitive function. We are currently examining these markers in our Phase 2 ASSERT trial for the potential of RVX-208 in MCI and AD. Preliminary data show that RVX-208 treatment in the population with the lowest Amyloid Beta 40 cause a transient 13% increase in plasma Amyloid Beta 40. Based on the prespecified hypothesis, this plasma

concentration increase would be generated by exit of harmful Amyloid Beta 40 from the brain. Discussions are ongoing with potential clinical investigators about how to best assess RVX-208's effect in a mild cognitive impaired, dementia or Alzheimer's Disease population.

According to statistics, every 72 seconds someone will develop Alzheimer's disease (AD). Neurodegenerative diseases such as Alzheimer's are among the most debilitating in the developed world. There are now more than 5 million people in the United States who are living with AD. It is estimated that in the United States the prevalence of the disease may grow to 15 million people by 2050. In a report commissioned by the Alzheimer's Association, caregiver costs in the United States are estimated at US\$36.5 billion which include loss of productivity, absenteeism and worker replacement. The indirect costs of AD are also considerable; it is estimated that one-half to two-thirds of the cost of AD care stems from unpaid caregivers (often family members), who spend 16-35 hours per week looking after a person with AD. These figures underscore the importance of developing new therapies to address the socioeconomic burden of AD.

NexVas AI: Novel small molecules for Autoimmune disorders – preclinical stage

We have continued to discover novel small molecules with a unique and highly differentiated molecular target that have significant effects on tested autoimmune animal models. We have illustrated positive effects in animal models for arthritis and multiple sclerosis (EAE) with a test compound RVX-297. We have learned a significant amount that will help drive additional research and the development of potential novel compounds that will affect important inflammation markers such as IL-6 and IL-17.

ReVas Program: Small molecules for acute local therapy via drug eluting devices – pre clinical research stage

Our ReVas program is focused on developing therapeutic compounds with anti-inflammatory properties that can be used with medical devices and biomaterials for the local non-systemic treatment of CVD, in particular restenosis. Worldwide, there are over 1.2 million angioplasty procedures performed annually with a substantial percentage of patients subsequently developing restenosis. The US \$2 billion restenosis market has been subject to cost pressures. New product entrants in the market will have to provide significant value over current reimbursed products.

One method of preventing or treating restenosis is to use a drug-eluting stent (DES), which is a scaffold (metal or polymer) that has been coated with a pharmacologic agent known to interfere with the process of restenosis. We are currently developing compounds that target multiple markers of inflammation and cellular proliferation that would aid in the current unmet medical need for treating late stage restenosis. This opportunity presents a significant commercial prospect for us.

Competitive Environment

ApoA-I/HDL Target(s)

Competition in the pharmaceutical industry generally revolves around overall product performance, including efficacy and safety, patient adaptability and compliance, cost, physician's willingness to prescribe to patients, manufacturing, marketing, and distribution. Barriers to entry into the market include patent protection and governmental approval at all stages of drug development.

Due to the size of the market for cardiovascular drugs and the large unmet medical need, a number of pharmaceutical companies and biotechnology companies are developing products to treat cardiovascular diseases. However, there are a limited number of companies pursuing programs that focus on ApoA-I enhancement. The Medicines Company and Roche are developing recombinant protein or peptides that exogenously increase ApoA-1. However, these types of therapies are costly to manufacture and may cause immunological responses for patients when used for longer durations. Therefore, these therapies are likely to have utility only as acute or induction based therapies. There are a number of product candidates in development to increase HDL levels, however, we believe that our approach to developing

small molecules that enhance the body's own ability to elevate ApoA-I and HDL levels has several advantages for the acute and chronic management of CVD.

GENERAL

Employees

As at April 30, 2011, we employed 28 full-time management, scientific and administration employees, many of whom participate in the research and development activities.

Regulatory Matters

RVX-208 is being investigated for the treatment of patients with dyslipidemia and atherosclerosis at high risk for cardiovascular disease. An IND was filed and accepted by the FDA in 2007 to commence clinical testing. We have submitted information to the FDA regarding clinical studies (protocols, safety, and reports), manufacturing and labeling and nonclinical reports. In the past, we have provided an annual report to the FDA regarding data collected over a 12 month period.

Product development activities related to RVX-208 or related products will be subject to extensive regulation by various government authorities, including the FDA and comparable regulatory authorities in other countries, which regulate the design, research, clinical and non-clinical development, testing, manufacturing, storage, distribution, import, export, labeling, advertising and marketing of pharmaceutical products and devices.

Intellectual Property

We devote significant resources to ensure protection of the ideas and inventions related to core areas of our business. Our intellectual property portfolio covers compositions for cardiovascular and inflammatory disease, cancers and fibrotic indications.

As of July 19, 2011, we own a license to one issued US patent and numerous pending patent applications including non-provisional US and Patent Cooperation Treaty applications. The pending patent applications are interrelated and assert rights to substantially similar inventions in different jurisdictions.

Our intellectual property strategy is to build a strong patent portfolio around core technology that is important to development of leading edge medicines. Our offensive and defensive strategies are to be the first to identify, isolate, and patent therapeutic agents with commercial importance, to seek out and license intellectual property believed to be useful in connection with potential products, and to control public disclosures.

We also believe that our know-how will provide a significant competitive advantage, and intend to continue to develop and protect our proprietary tools, methods and trade secrets. Our policy is to require employees, consultants, members of our Scientific and Clinical Advisory Board and other third parties in collaborative agreements to execute confidentiality agreements. Employee, consultant and contract research organization agreements specify that all inventions resulting from work performed utilizing our property, business strategies, and work completed during employment/services performed are our exclusive property to the extent permitted by law.

Trademarks

"NexVas", "TGF- β Shield", "Resverlogix" and "Clearing the Path to Better Health" are trademarks of Resverlogix Corp. in Canada and the United States.

RISK FACTORS

The biotechnology industry generally may be regarded as uncertain given the nature of the industry. Accordingly, investments in biotechnology companies should be regarded as speculative. Biotechnology research and development involves a significant degree of risk. An investor should carefully consider the risks and uncertainties described below, as well as other information contained in this Management's Discussion and Analysis. The risks and uncertainties described below is not an exhaustive list. Additional risks and uncertainties not presently known to us or that we believe to be immaterial may also adversely affect our business. If any one or more of the following risks occur, our business, financial condition and results of operations could be seriously harmed. Further, if we fail to meet the expectations of the public market in any given period, the market price of our common shares could decline.

Risks Relating to Our Business

We are a development stage company. If we do not develop commercially successful products, we may be forced to cease operations.

We are in an early stage of development, which may require significant additional investment for research and development, manufacturing, clinical testing, and regulatory submissions prior to commercialization. Investors must evaluate our business in light of the uncertainties and complexities affecting a development stage pharmaceutical company. We have not completed clinical development for any of our products and there can be no assurance that any such products will actually be developed. Each of our products will be unsuccessful if it:

- does not demonstrate acceptable safety and efficacy in preclinical studies and clinical trials or otherwise does not meet applicable regulatory standards for approval;
- does not offer therapeutic or other improvements over existing drugs used to treat the same or similar conditions;
- is not capable of being produced in commercial quantities at an acceptable cost, or at all; or
- is not accepted by patients, the medical community or third party payors.

A commitment of substantial time and resources is required to conduct research and clinical trials if we are to complete the development of any product. We have not proven our ability to develop and commercialize products. It is not known whether any of these products will meet applicable health regulatory standards and obtain required regulatory approvals, or (i) whether such products can be produced in commercial quantities at reasonable costs and be successfully marketed, (ii) whether our products will achieve market acceptance, or (iii) if our investment in any such products will be recovered through sales or royalties. Problems frequently encountered in connection with the development and utilization of new and unproven technologies and the competitive environment in which we operate might limit our ability to develop commercially successful products.

Results of early research may not be indicative of the results that will be obtained in later stages of research. If regulatory authorities do not approve the products or if regulatory compliance is not maintained, we would have limited ability to commercialize our products, and our business and results of operations would be harmed. We may fail to develop any products, to obtain regulatory approvals, to enter clinical trials, or to commercialize any products. If we are unable to make our product candidates commercially available, we will not generate product revenues, and we may be forced to cease operations.

We have a history of net losses. We expect to continue to incur substantial net losses for the foreseeable future, and we may never achieve or maintain profitability.

To date, we have not recorded any revenues from the sale of biopharmaceutical products, and have incurred significant net losses in each year since our inception, including a net loss of \$20.9 million for the year ended April 30, 2011 (2010 - \$27.6 million). As of April 30, 2011 we had a deficit of \$150.3 million.

We expect to incur substantial net losses and negative cash flow for the foreseeable future. Such losses have had, and will continue to have, an adverse effect on our stockholders' equity and working capital.

The process of developing and commercializing our products requires significant pre-clinical testing and clinical trials as well as regulatory approvals for commercialization and marketing before we could begin product sales. In addition, commercialization of our products would require us to establish a sales and marketing organization or contractual relationships to enable product manufacturing and other related activities. Because of the numerous risks and uncertainties associated with pharmaceutical product development and commercialization, we are unable to accurately predict the timing or amount of future expenses or when, or if, we will be able to achieve or maintain profitability. Currently, we have no products approved for commercial sale, and to date we have not generated any product revenue. We have financed our operations primarily through the sale of equity securities. The size of our future net losses will depend, in part, on the rate of growth or contraction of our expenses and the level and rate of growth, if any, of our revenues. We expect to incur losses unless and until such time as payments, if any, from corporate collaborations, product sales and/or royalty payments generate sufficient revenues to fund our continuing operations. Quarter to quarter fluctuations in revenues, expenses and losses are also expected. Even if we do achieve profitability, it may not be able to sustain or increase profitability on an ongoing basis.

We will need to raise additional capital in the future to fund our operations. If we cannot raise additional capital, we will have to delay, reduce or cease operations.

We will need to raise additional capital to fund our operations and to develop our products. We expect to attempt to raise additional funds through public or private equity or debt financing and/or from other sources. Our future capital requirements will be substantial and will depend on many factors, such as the following:

- the scope, rate of progress, results and costs of our preclinical studies and clinical programs;
- timing, costs and outcomes of regulatory proceedings;
- the cost and timing of developing sales and marketing operations or partnerships;
- payments received under any future partnerships;
- prosecution or defense of patent claims;
- the cost and timing of developing manufacturing capacity;
- the rate of progress in our research, drug discovery and developmental programs;
- costs associated with commercialization of our products; and
- competing technological and market developments, including the introduction by others of new therapies in our market.

We believe that with current cash and cash equivalents, together with funds available from our SEDA, we will be able to maintain our currently planned operations over the next year. We may also raise additional capital other than through the SEDA. If we do not draw on the SEDA, and if we are not able to raise additional capital, we will not have sufficient capital to fund our currently planned operations over the next year. We would have to reduce our cash requirements by eliminating or deferring discretionary spending on research, development and corporate activities.

Further, changing circumstances may cause us to consume capital significantly faster or slower than we currently anticipate. We have based these estimates on assumptions that may prove to be wrong, and we could utilize our available financial resources sooner than we currently expect.

There can be no guarantee that we will be able to access capital markets in the future to fund our ongoing operations. If we cannot access capital markets in the future we may be forced to cease operations. Any financing transaction may contain unfavorable terms. If we raise additional funds by issuing equity securities, our stockholders' equity will be diluted. If we raise additional funds through strategic partnerships, we may be required to relinquish rights to our products, or to grant licenses on terms that are not favorable to us.

Unstable market conditions may have serious adverse consequences on our business.

The recent economic downturn and market instability has made the business climate more volatile and more costly. Our business strategy may be adversely affected by unpredictable and unstable market conditions. If the current equity and credit markets deteriorate it may make any necessary equity or debt financing more difficult, more costly, and more dilutive. Failure to secure any necessary financing in a timely manner and on favorable terms could have a material adverse effect on our growth strategy, financial performance and stock price and could require us to delay or abandon clinical development plans. There is a risk that one or more of our current or future strategic partners may encounter difficulties during challenging economic times, which would directly affect our ability to attain our operating goals on schedule and on budget.

If our clinical trials fail to establish the safety and efficacy of our products, including RVX-208, we will not be able to commercialize our products.

Drug discovery and development has inherent risk and the historical failure rate is high. Failures in the HDL cholesterol market by some pharmaceutical companies have highlighted the risk of these types of therapies. To obtain regulatory approval to market and sell any of our products, we must satisfy the United States Federal Drug Administration (“FDA”), Health Canada’s Therapeutic Products Directorate (the “TPD”), and other regulatory authorities, through extensive clinical trials and preclinical studies, that our products are safe. If we cannot demonstrate that our drugs, including RVX-208, are safe and effective for human use, we may need to abandon one or more of its drug development programs.

We may not have conducted or may not conduct in the future the types of testing ultimately required by regulatory authorities, or future tests may indicate that our products are not safe for use in humans. Preclinical testing and clinical trials are expensive, can take many years and have an uncertain outcome. In addition, success in initial preclinical testing does not ensure that later preclinical testing or clinical trials will be successful. There are a number of factors that could cause a clinical trial to fail or be delayed including:

- the clinical trials may produce negative or inconclusive results, which may require us to conduct additional preclinical testing or to abandon product candidates that we believed to be promising;
- the regulators may require that we hold, suspend or terminate clinical research for noncompliance with regulatory requirements;
- we, our potential partners, the FDA, the TPD or foreign regulatory authorities could suspend or terminate a clinical trial due to adverse side effect of a drug on subjects or patients in the trial;
- we may decide, or regulators may require us, to conduct additional preclinical testing or clinical trials;
- enrollment in our clinical trials may be slower than anticipated;
- the cost of our clinical trials may be greater than anticipated;
- our products may have unfavorable pharmacology, toxicology or carcinogenicity;
- our product candidates may cause undesirable side effects; and
- the supply or quality of our drugs or other materials necessary to conduct clinical trials may be insufficient, inadequate or delayed.

If any of our drugs in clinical studies, including RVX-208, do not show sufficient efficacy in patients with the targeted indication, it could negatively impact our development and commercialization or goals for this and other drugs and, as result, materially adversely affect our business, financial condition and results of operations.

We may be required to conduct broad, long-term clinical trials to address concerns that the long-term use of our leading product, RVX-208, in broader chronic indications might increase the risk of liver damage. This may materially adversely affect our business, financial condition and results of operations.

In our recent Phase 2 clinical trial, results showed some patients had increased liver enzymes, which may signal potential liver toxicity resulting from use of RVX-208. While such increase may not indicate liver toxicity, if further tests were to determine such risk did exist the FDA may require us to conduct broad, long-term clinical trials to address these concerns prior to receiving FDA or foreign regulatory approval for RVX-208. These clinical trials would be expensive and could delay any commercialization of RVX-208. Adverse results in these trials could prevent commercialization of RVX-208 for chronic indications or could jeopardize existing development in other indications.

If our testing assumptions are incorrect our products may not be approved for marketing.

The design of our clinical trials is based on many assumptions about the expected effect of our product candidates. If those assumptions prove incorrect, the clinical trials may not produce statistically significant results. We cannot assure you that the design of, or data collected from, the clinical trials of our product candidates will be sufficient to support the FDA and foreign regulatory approvals.

We are dependent on third parties to conduct our clinical trials and to provide services for certain important aspects of our business. If these third parties do not perform as contractually required or expected, we may not be able to obtain regulatory approval for our products, or we may be delayed in doing so.

We rely on third parties, such as contract research organizations, medical institutions, academic institutions, independent clinical investigators and contract laboratories, to conduct our preclinical studies and clinical trials, and we expect to continue to do so in the future. We rely heavily on these parties for successful execution of our clinical trials, but do not control many aspects of their activities. As a result, many important aspects of our product development are outside our direct control. We are responsible for confirming that our preclinical studies are conducted in accordance with applicable regulations and that each of our clinical trials is conducted in accordance with its general investigational plan and protocol. The FDA requires us to comply with regulations and standards, commonly referred to as good laboratory practices, or GLP, for conducting and recording the results of our preclinical studies and good clinical practices for conducting, monitoring, recording and reporting the results of clinical trials, to assure that data and reported results are accurate and that the clinical trial participants are adequately protected. Our reliance on third parties does not relieve us of these responsibilities. If the third parties conducting our clinical trials do not perform their contractual duties or obligations, do not meet expected recruitment or other deadlines, fail to comply with the FDA's good clinical practice regulations, do not adhere to our clinical trial protocols or otherwise fail to generate reliable clinical data, development, approval and commercialization of our products, including RVX-208, may be extended, delayed or terminated or may need to be repeated, and we may not be able to obtain regulatory approval.

We do not currently own or operate manufacturing facilities for clinical or commercial production of the active pharmaceutical ingredient, or API, used in RVX-208. As a result, we rely on third parties to supply the API. We expect to continue to depend on third parties to supply the API for our lead product candidates and any additional product candidates we develop in the foreseeable future. An API manufacturer must meet high precision and quality standards for that API to meet regulatory specifications and comply with regulatory requirements. A contract manufacturer's failure to comply with applicable regulations and requirements could result in refusal to approve or a delay in approval of RVX-208 or other product candidate. We are ultimately responsible for confirming that the APIs used in our product candidates are manufactured in accordance with applicable regulations. Furthermore, if our third party drug suppliers fail to achieve and maintain high manufacturing standards in compliance with applicable regulations, we could be subject to certain product liability claims in the event such failure to comply resulted in defective products that caused injury or harm.

We rely on partnerships and strategic relationships for our success. The failure to successfully collaborate with third parties may delay, prevent or otherwise impair the development or commercialization of our products or revenue expectations.

As a result of the costs and risks associated with commercializing a product candidate we seek strategic partnerships with corporate and academic collaborators, licensors, licensees and others for the research, development, clinical testing, manufacturing, marketing and commercialization of our products, and we intend to attract corporate partners and enter into additional research collaborations. There can be no assurance, however, that such collaborations will be established on favourable terms, if at all, or that future collaborations will be successful. In particular, recent failures in HDL cholesterol therapies may negatively impact our potential partners' willingness to enter into partnering agreements due to the potential risks in the cholesterol market and the high clinical costs to bring such drugs to market. Failure to attract commercial partners for our products may result in our incurring substantial clinical testing, manufacturing and commercialization costs prior to realizing any revenue from product sales or result in delays or program discontinuance if funds are not available in sufficient quantities, and this may materially adversely affect our business, financial condition and results of operations.

Should a collaborative partner fail to develop, manufacture, or commercialize successfully any product to which it has rights, or any partner's product to which we have rights, the business may be adversely affected. Failure of a collaborative partner to continue to participate in any particular program could delay or halt the development or commercialization of products generated from such program. In addition, there can be no assurance that the collaborative partners will not pursue other technologies or develop alternative products either alone or in collaboration with others, including our competitors, as a means for developing treatments for the diseases targeted by our programs.

Furthermore, we will hold licenses for certain technologies and there can be no assurance that these licenses will not be terminated, or that they will be renewed on conditions acceptable to us. We may negotiate additional licenses in respect of technologies developed by other companies and academic institutions. Terms of license agreements to be negotiated may include, inter alia, a requirement to make milestone payments, which may be substantial. We may also be obligated to make royalty payments on the sales, if any, of products resulting from licensed technology and, in some instances, are responsible for the costs of filing and prosecuting patent applications.

We face significant competition in seeking appropriate strategic partners, and these strategic partnerships can be intricate and time consuming to negotiate and document. We may not be able to negotiate additional strategic partnerships on acceptable terms, or at all. We are unable to predict when or if we will enter into any additional strategic partnerships because of the numerous risks and uncertainties associated with establishing strategic partnerships. If we are unable to negotiate additional strategic partnerships for our products we may be forced to delay or terminate development or commercialization of one or more of our products. If we elect to increase our expenditures to fund development or commercialization activities on our own, we may need to obtain additional capital, which may not be available to us.

If we enter into partnerships or other strategic relationships, we may lose important rights to and control over the development of our products.

As a result of the costs and risks associated with commercializing a product we will seek strategic partnerships in order to continue to develop and, if approved, market our products. Such strategic partnerships may require us to relinquish control over the timing and manner of clinical trials and commercialization of our products. Strategic partners may experience financial difficulties or choose to terminate the arrangement or independently work on a competing product resulting in the delay or discontinuation of development or commercialization of our product candidates. Furthermore, disputes may arise between us and our strategic partners that result in the delay or termination of the research, development or commercialization of our product candidates or that result in costly litigation or arbitration that diverts management's attention and consumes resources. Strategic partners may not properly

maintain or defend our intellectual property rights or may use our proprietary information in a manner that could jeopardize or invalidate our proprietary information or expose us to potential litigation.

If our products fail to achieve market acceptance for any reason, such failure may materially adversely affect our business, financial condition and results of operations.

There can be no assurance that any of our products, if approved for marketing, will achieve market acceptance. If our products, once approved, do not receive market acceptance for any reason, it will adversely affect our business, financial condition and results of operations. The degree of market acceptance of any products we develop will depend on a number of factors, including:

- the clinical efficacy and safety of our products;
- our products' potential advantages over existing and future treatment methods;
- the price of our products; and
- reimbursement policies of government and third-party payers, including hospitals and insurance companies.

If after we obtain regulatory approval to sell our products, physicians, and healthcare payors fail to adopt our products or conclude that our products are not safe and effective, physicians could choose not to use them to treat patients. Our competitors may also develop new technologies or products which are more effective or less costly, or that seem more cost-effective than our products.

In addition, regulations affecting the pricing of pharmaceutical products may change in ways adverse to us. While we cannot predict the likelihood of any regulatory proposals, if a government agency were to adopt proposals limiting market or third-party payor pricing for pharmaceutical products, it could materially adversely affect our business, financial condition and results of operations.

We cannot be certain that we will ever obtain regulatory approvals in Canada, the United States, or other countries. The failure to obtain such approvals may materially adversely affect our business, financial condition and results of operations.

Biotechnology, medical device and pharmaceutical companies operate in a high-risk regulatory environment. The study, manufacture and sale of products are governed by numerous statutes and regulations in the United States, Canada and other countries. We are required to obtain various regulatory approvals prior to being able to study, commercialize and distribute our products. The regulatory review and approval process required to perform a clinical study in Canada, the United States and other countries includes evaluation of preclinical studies and clinical studies, as well as the evaluation of our manufacturing process. This process is complex, lengthy, expensive, resource intensive and uncertain. Securing regulatory approval to market our products also requires the submission of extensive preclinical and clinical data, manufacturing information regarding the process and facility, scientific data characterizing our product and other supporting data to the regulatory authorities in order to establish its safety and effectiveness. We, or our collaborators, may fail to obtain the necessary approvals to commence or continue preclinical or clinical testing including RVX-208 or to manufacture or market our products in reasonable time frames, if at all.

Governmental authorities in Canada, the United States, or other countries may enact regulatory reforms or restrictions on the development of new therapies that could adversely affect our ability to develop our products. Many of the products and processes that are being currently developed by us require significant development, testing and the investment of significant funds prior to their commercialization. There can be no assurance that RVX-208 or any other drugs we attempt to develop will actually be developed to a commercial level. Completing clinical testing through late stage trials and obtaining required approvals is expected to take several years and to require the expenditure of substantial resources. There can be no assurance that clinical trials will be completed successfully within any specified period of time, if at all. Furthermore, clinical trials may be delayed or suspended at any time by us or by the FDA, the TPD or foreign regulatory authorities if it is determined that the subjects or patients are being exposed to unacceptable risks. We may encounter delays or rejections based on varying

regulatory interpretations or changes in regulatory agency policies, during the period in which we develop a product.

No assurance can be given that RVX-208 or any of the other product candidates will prove to be safe and effective in clinical trials or that we will receive the requisite regulatory approval. Moreover, any regulatory approval of a drug which is eventually obtained may be granted with specific limitations on the indicated uses for which that drug may be marketed or may be withdrawn if problems occur following initial marketing or if compliance with regulatory standards is not maintained. We have limited experience in filing and pursuing applications necessary to gain these regulatory approvals.

The approval procedures vary among countries and can involve additional product testing and administrative review periods. The time required to obtain approval in various countries vary from one another. Approval in one country does not ensure approval by the regulatory authorities of other countries. The failure to obtain such approvals may materially adversely affect our business, financial condition and results of operations.

Regulatory authorities may not approve our products even if they meet safety and efficacy endpoints in clinical trials.

The FDA, the TPD and other foreign regulatory agencies can delay, limit or deny marketing approval for many reasons, including finding a product may not be considered safe and effective; the manufacturing processes or facilities may not meet applicable requirements; or changes in approval policies or regulations. Our product candidates may not be approved even if they achieve their endpoints in clinical trials. Regulatory agencies, including the FDA, or their advisors may disagree with our trial design and our interpretations of data from preclinical studies and clinical trials. Regulatory agencies may change requirements for approval even after a clinical trial design has been approved. Regulatory agencies also may approve a product candidate for fewer or more limited indications than requested or may grant approval subject to the performance of post-marketing studies. In addition, regulatory agencies may not approve the labeling claims that are necessary or desirable for the successful commercialization of our product candidates.

Our products will remain subject to ongoing regulatory review even if they receive marketing approval. If we fail to comply with continuing regulations, we could lose these approvals, and the sale of any future products could be suspended.

In the event we receive regulatory approval to market a particular product candidate, United States, Canadian or other foreign regulatory authority could condition approval on conducting additional costly post-approval studies or could limit the scope of approved uses. In addition, the product may later cause adverse effects that limit or prevent its widespread use, force us to withdraw it from the market or prevent or delay our ability to obtain regulatory approvals in additional countries. In addition, we will continue to be subject to regulatory review and periodic inspections to ensure adherence to applicable regulations. After receiving marketing approval, the FDA imposes extensive regulatory requirements on the manufacturing, labeling, packaging, adverse event reporting, storage, advertising, promotion and record keeping related to the product. Failure to comply with the regulatory requirements could result in:

- civil or criminal penalties or fines;
- injunctions;
- product seizures, detentions or import bans;
- voluntary or mandatory product recalls and publicity requirements;
- suspension or withdrawal of regulatory approvals; and
- refusal to approve pending applications for marketing approval of new drugs or supplements to approved applications.

We may be subject to product liability claims if our products harm people, and we do not have product liability insurance.

The manufacture and sale of pharmaceutical products involve an inherent risk of product liability claims and associated adverse publicity. We have entered into human clinical trials that involve inherent risks in the testing of unproven products. We currently have only clinical trial liability insurance for our products; we do not have product liability insurance. We do not know if we will be able to maintain existing or obtain additional clinical trial liability insurance or obtain product liability insurance on acceptable terms or with adequate coverage against potential liabilities. This type of insurance is expensive and may not be available on acceptable terms. If we are unable to obtain or maintain sufficient insurance coverage on reasonable terms or to otherwise protect against potential clinical trial and product liability claims, we may be unable to commercialize our products. A successful clinical trial liability or product liability claim brought against us in excess of our insurance coverage, if any, may require us to pay substantial amounts. This could have a material adverse effect on our business, financial condition and results of operations.

The pharmaceutical industry is extremely competitive. If our competitors develop and market products that are more effective, safer or less costly than any future products that we may develop, our commercial opportunity will be reduced or eliminated.

The technological competition we face from new and established pharmaceutical companies, biopharmaceutical companies and universities is intense and is expected to increase, in particular in the market for therapeutic products to treat, mitigate or prevent cardiovascular disease. Competitors may develop products more quickly and obtain regulatory approval for such products more rapidly, or develop products which are more effective than those which we intend to develop. Our commercial opportunity will be reduced or eliminated if our competitors develop and commercialize products that are safer, more effective, have fewer side effects or are less expensive than any future products that we may develop and commercialize. In addition, significant delays in the development of our product candidates could allow our competitors to bring products to market before us and impair our ability to commercialize our product candidates. Research and development by others may render our technology or products obsolete or noncompetitive or produce treatments or cures superior to any therapy developed or to be developed by us.

We anticipate that, if approved for cardiovascular / atherosclerotic disease, RVX-208 would potentially compete with Niacin, Niaspan, cholesteryl ester transfer protein (“CETP”) inhibitors such as anacetrapib and dalcetrapib, and PPAR agents such as pioglitazone.

We anticipate that, if approved for vascular inflammation, RVX-208 would potentially compete with novel anti-inflammatory agents currently in preclinical development.

We anticipate that, if approved for mild cognitive impairment / Alzheimer’s disease, RVX-208 would potentially compete with other agents and novel approaches to this disease such as small molecules, Namenda and PBT2, and monoclonal antibody technologies (“MOABs”) such as Bapineuzumab.

Many of our competitors have significantly greater financial resources and expertise in research and development, manufacturing, preclinical testing, conducting clinical trials, obtaining regulatory approvals and marketing approved products than we do. Established pharmaceutical companies may invest heavily to discover quickly and develop novel compounds or drug delivery technology that could make our product candidates obsolete. Smaller or early stage companies may also prove to be significant competitors, particularly through strategic partnerships with large and established companies. In addition, these third parties compete with us in recruiting and retaining qualified scientific and management personnel, establishing clinical trial sites and patient registration for clinical trials, as well as in acquiring technologies and technology licenses complementary to our programs or advantageous to our business. Accordingly, our competitors may succeed in obtaining patent protection, receiving FDA approval or discovering, developing and commercializing products before we do. If we are not able to compete

effectively against our current and future competitors, our business will not grow and our financial condition will suffer.

We are dependent upon retaining and attracting key personnel and others, the loss of which could materially adversely affect our business, financial condition and results of operations.

We depend on certain members of our management and scientific staff, the loss of whose services might significantly delay or prevent the achievement of research, development or business objectives and would materially adversely affect our business, financial condition and results of operations. We do not have employment agreements with any of our senior management that would prevent them from leaving Resverlogix. In addition, our success depends, in large part, on our ability to improve our management systems and attract and retain qualified management, scientific and medical personnel, and on our ability to develop and maintain important relationships with commercial partners, leading research institutions and key distributors. We face intense competition for such personnel and relationships. We cannot assure that we will attract and retain such persons or maintain such relationships. In addition, failure to succeed in clinical trials may make it more challenging for us to recruit and retain qualified scientific personnel.

We may not be able to attract, train and retain a sufficient number of qualified employees to maintain and grow our business.

We expect that our potential expansion into areas and activities requiring additional expertise, such as further clinical trials, governmental approvals, manufacturing, sales, marketing and distribution will place additional requirements on our management, operational and financial resources. We expect these demands will require an increase in management and scientific personnel and the development of additional expertise by existing management personnel. There is currently aggressive competition for employees who have experience in technology and engineering. The failure to attract and retain such personnel or to develop such expertise could materially adversely affect our business, financial condition and results of operations.

Confidentiality agreements with employees and others may not adequately prevent disclosure of trade secrets and other proprietary information. Disclosure of this information may materially adversely affect our business, financial condition and results of operations.

We rely on trade secrets, which we seek to protect, in part, through confidentiality and non-disclosure agreements with our employees, collaborators, suppliers, and other parties. There can be no assurance that these agreements will not be breached, that we would have adequate remedies for any such breach or that our trade secrets will not otherwise become known to or independently developed by our competitors. We might be involved from time to time in litigation to determine the enforceability, scope and validity of our proprietary rights. Any such litigation could result in substantial cost and divert management's attention from our operations.

We may need to implement additional finance and accounting systems, procedures and controls in the future as we grow and to satisfy new reporting requirements.

As we grow we may access capital markets more broadly which could require us to implement additional finance and accounting systems along with enhanced internal control systems. This will result in increased costs to us as we continue to undertake efforts to comply with best practices and applicable rules and requirements applicable to public companies. These rules may make it more difficult and costly for us to obtain certain types of insurance, including director and officer liability insurance, and we may be forced to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage as compared to the policies previously available to public companies. The impact of these events could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors or our board committees or as executive officers. In addition, we may need to hire additional legal and accounting staff with appropriate experience and technical knowledge, and we cannot assure that if additional staffing is necessary that we will be able to do so in a timely fashion.

Our products may not be eligible for reimbursement from government or private third-party payors, or may be eligible for reimbursement at lower prices than we currently anticipate, which could materially adversely affect our business, financial condition and results of operations.

Our ability to successfully market therapeutic products depends in part on the extent to which reimbursement for the cost of such products and related treatments will be available from government health administration authorities, private health insurers and other healthcare organizations. Significant uncertainty exists as to whether newly-approved pharmaceutical products will qualify for reimbursement from these organizations. Furthermore, challenges to the price of medical products continue to grow in frequency due to increased focus on cost containment and pharmacoeconomic issues. These recent changes will become more pronounced as leading therapeutics in the atherosclerosis market such as statins are set to come off patent over the next few years. Health authorities will continue to increase their scrutiny and pharmacoeconomic diligence on new products in all disease areas including those for the cardiovascular market. These rapid changes in the healthcare reimbursement marketplace will potentially have a significant impact on the future marketability of new drugs in development and could materially adversely affect our business, financial condition and results of operations. It is expected that new drug entrants will not only have to be effective and safe but also have to provide a clear value proposal to health systems, such as risk reduction in major adverse cardiovascular events, over the current standard of care therapy, statin therapy.

In light of these market changes in drug development, pricing of drug therapies has come under significant pressure with government authorities and private health insurers around the world. The top current leading reimbursed markets; USA, Japan, Germany, UK, France, Spain, Italy, and Canada, have implemented healthcare reforms that focus specifically on value and reimbursement. Reforms such as reference based pricing, pharmacoeconomics, and numbers needed to treat are a few of the many instruments that healthcare organizations utilize to ensure maximum value for reimbursed therapeutics. Healthcare reform is underway in these top global markets and there is additional uncertainty about the viability of current pricing methodologies for reimbursement. There can be no assurance that adequate third-party coverage will be available to establish price levels which would allow us to realize an acceptable return on its investment in product development. If we cannot realize an acceptable return on our investment in product development we may need to delay or cease our product development.

It may be difficult or impossible for U.S. investors to enforce judgments against us, our directors or our officers in Canada.

We were formed under the laws of the Province of Alberta. Some of the members of our board of directors and our officers are residents of countries other than the United States. As a result, it may be impossible for U.S. investors to affect service of process within the U.S. upon us or these persons or to enforce against us or these persons any judgments in civil and commercial matters, including judgments under U.S. federal or state securities laws. In addition, a Canadian court may not permit U.S. investors to bring an original action in Canada or to enforce in Canada a judgment of a state or federal court in the United States.

Risks Relating to our Intellectual Property

We may not accurately predict the protection afforded by our patents and proprietary technology and if our predictions are wrong, this may materially adversely affect our business, financial condition and results of operations.

Our success will depend in part on our ability to obtain, maintain, and enforce patent rights, maintain trade secret protection and operate without infringing the proprietary rights of third parties, both domestically and internationally.

Our patent positions are highly uncertain, and any future patents we receive for our potential products will be subject to this uncertainty, which may adversely affect our business, financial condition and results of

operations. There can be no assurance that pending patent applications will be allowed and that we will develop additional proprietary products that are patentable, that issued patents will provide any competitive advantage or will not be challenged by any third parties, or that patents of others will not have an adverse effect on the ability to do business. Furthermore, there can be no assurance that others will not independently develop similar products, duplicate any of the products, or design around the products patented by us. In addition, we may be required to obtain licenses under patents or other proprietary rights of third parties. No assurance can be given that any licenses required under such patents or proprietary rights will be available on terms acceptable to us. If such licenses are not obtained we could encounter delays in introducing one or more of our products to the market, while we attempt to design around such patents, or could find that the development, manufacturing or sale of products requiring such licenses could be foreclosed. In addition, we could incur substantial costs in defending suits brought against us on such patents or in suits in which we attempt to enforce our own patents against other parties. Such disputes could involve arbitration, litigation or proceedings declared by the United States Patent and Trademark Office or International Trade Commission or other foreign patent authorities. Intellectual property litigation can be extremely expensive, and this expense, as well as other consequences should we not prevail, could seriously harm our business. With respect to any infringement claim asserted by a third party, we can give no assurances that we will be successful in the litigation or that such litigation would not have a material adverse effect on our business, financial condition and results of operation.

Until such time, if ever, that patent applications are filed and or approved, our ability to maintain the confidentiality of the described technology may be crucial to our ultimate possible commercial success. While procedures have been adopted to protect the confidentiality of our technology through signed invention and service agreements, no assurance can be given that such arrangements will be effective, that third parties will not gain access to trade secrets or disclose the technology, or that we can meaningfully protect our rights to our trade secrets.

Even if valid and enforceable patents cover our products and technologies, such patents will provide protection only for a limited amount of time.

Even if patents are issued regarding our product candidates or methods of using them, those patents can be challenged by our competitors who can argue that our patents are invalid and/or unenforceable. Third parties may challenge our rights to, or the scope or validity of, our patents. Patents also may not protect our products if competitors devise ways of making these or similar product candidates without legally infringing our patents. The Federal Food, Drug and Cosmetic Act and the FDA regulations and policies provide incentives to manufacturers to challenge patent validity or create modified, non-infringing versions of a drug or device in order to facilitate the approval of generic substitutes. These same types of incentives encourage manufacturers to submit new drug applications that rely on literature and clinical data not prepared for or by the drug sponsor.

We also rely on trade secrets to protect our technology, especially where we do not believe that patent protection is appropriate or obtainable. However, trade secrets are difficult to protect. The employees, consultants, contractors, outside scientific collaborators and other advisors of our company and our strategic partners may unintentionally or willfully disclose our confidential information to competitors. Enforcing a claim that a third party illegally obtained and is using our trade secrets is expensive and time consuming and the outcome is unpredictable. Failure to protect or maintain trade secret protection could adversely affect our competitive business position.

Our research and development collaborators may have rights to publish data and other information in which we have rights. In addition, we sometimes engage individuals or entities to conduct research that may be relevant to our business. The ability of these individuals or entities to publish or otherwise publicly disclose data and other information generated during the course of their research is subject to certain contractual limitations. These contractual provisions may be insufficient or inadequate to protect our trade secrets and may impair our patent rights. If we do not apply for patent protection prior to such publication or if we cannot otherwise maintain the confidentiality of our technology and other confidential information, then our ability to receive patent protection or protect our proprietary information may be jeopardized.

Litigation or other proceedings or third party claims of intellectual property infringement could require us to spend time and money and could shut down some of our operations.

Our commercial success depends in part on not infringing patents and proprietary rights of third parties. Others have filed, and in the future are likely to file, patent applications covering products that are similar to our product candidates, as well as methods of making or using similar or identical products. If these patent applications result in issued patents and we wish to use the claimed technology, we would need to obtain a license from the third party. We may not be able to obtain these licenses at a reasonable cost, if at all.

In addition, administrative proceedings, such as interferences and reexaminations before the U.S. Patent and Trademark Office, could limit the scope of our patent rights. We may incur substantial costs and diversion of management and technical personnel as a result of our involvement in such proceedings. In particular, our patents and patent applications may be subject to interferences in which the priority of invention may be awarded to a third party. We do not know whether our patents and patent applications would be entitled to priority over patents or patent applications held by such a third party. Our issued patents may also be subject to reexamination proceedings. We do not know whether our patents would survive reexamination in light of new questions of patentability that may be raised following their issuance.

We may be subject to claims for intellectual property infringement from former employers of our key employees, which could result in loss of intellectual property, our key employees or both.

Many of our employees were previously employed at universities or other biotechnology or pharmaceutical companies, including competitors or potential competitors. We could be subject to claims that these employees or we have inadvertently or otherwise used or disclosed trade secrets or other proprietary information of their former employers. In many cases, litigation may be necessary to defend against these claims.

Even if we are successful in defending against these claims, litigation could result in substantial costs and be a distraction to management. If we fail in defending such claims, in addition to paying money claims, we may lose valuable intellectual property rights or personnel. A loss of key research personnel or their work product could hamper or prevent the ability to commercialize certain product candidates, which could severely harm our business, financial condition and results of operations.

Risks Relating to Owning our Common Stock

Our stock price has been and may continue to be extremely volatile. It may be difficult to resell our common stock.

The market price of our common stock has fluctuated substantially in the past and could fluctuate substantially in the future. During the twelve months preceding April 30, 2011, the closing market price of our common shares ranged from \$1.72 to \$6.39 per share. In addition, the trading prices of life science and biotechnology company stocks in general have experienced extreme price fluctuations in recent years. The valuations of many life science companies without consistent product revenues and earnings are high based on conventional valuation standards, such as price to revenue ratios. These trading prices and valuations may not be sustained. Any negative change in the public's perception of the prospects of life science or biotechnology companies could depress our stock price regardless of our results of operations. In addition our stock may fluctuate based on a variety of factors, including actual or anticipated regulatory approvals or disapprovals of our products or competing products, actual or anticipated results and timing of our clinical trials, changes in the expected or actual timing of our development programs, changes in our operating results, conditions or trends in the life science and biotechnology industries, announcements by us or our competitors of significant acquisitions, strategic partnerships, joint ventures or capital commitments, additions or departures of key personnel, sales and distributions of our common stock by us or our shareholders, changes in general conditions in the

economy or other developments affecting us, our clients, or our competitors, some of which may be unrelated to our performance.

Among other things, volatility in our stock price could mean that investors will not be able to sell their shares at or above prices at which they were acquired. The volatility also could impair our ability in the future to offer common stock as a source of additional capital. In addition, in the past, stockholders have often instituted securities class action litigation after periods of volatility in the market price of a company's securities. If a stockholder files a securities class action suit against us, we would incur substantial legal fees, and our management's attention and resources would be diverted from operating our business in order to respond to the litigation.

If we sell common stock in the future, existing common shareholders will experience immediate dilution and our stock price may decrease.

We will need to raise additional capital to fund our operations and to develop our products. We will likely raise such additional capital through the sale of our common shares from time to time. As a result, our existing common stockholders will experience immediate dilution upon any such issuance. We are currently a party to a SEDA pursuant to which we may issue up to \$25 million worth of common shares until the SEDA's expiration on March 26, 2012. We expect to enter into additional financing transactions involving the issuance of our common stock. Any such financing transaction or draw down on our SEDA will result in our existing common stockholders experiencing immediate dilution.

If our estimates regarding timing of milestones are incorrect our stock price may decrease.

For planning purposes, we estimate and may disclose timing of a variety of clinical, regulatory and other milestones. We base our estimates on present facts and a variety of assumptions. Many underlying assumptions are outside our control such as the ability to recruit patients, obtain access to clinical sites as expected or obtain approval from regulatory bodies such as the Food and Drug Administration to enter into trials. If we do not achieve milestones consistent with investors' expectations, the price of our shares would likely decline.

We do not currently intend to pay dividends on our common stock and, consequently, investors' ability to achieve a return on investment will depend on appreciation in the price of our common stock.

We have not to date paid any dividends on our common stock. We currently intend to invest our future earnings, if any, to fund the development and growth of our business. The payment of dividends will be at the discretion of our board of directors and will depend on our results of operations, capital requirements, financial condition, future prospects, contractual arrangements, restrictions imposed by applicable law, any limitations on payments of dividends present in any debt agreements we may enter into and other factors our board of directors may deem relevant. If we do not pay dividends, your ability to achieve a return on your investment in our company will depend on any future appreciation in the market price of our common stock. There is no guarantee that our common stock will appreciate in value or even maintain the price at which our holders have purchased their common stock.

DIVIDENDS

We have not declared or paid any dividends on our Common Shares in our past fiscal years or current financial year.

The ABCA does not permit a corporation to pay dividends if the corporation is, or would after the payment, be unable to pay its liabilities as they become due or the realizable value of the corporation's assets would thereby be less than the aggregate of its liabilities and stated capital of all classes. Our directors may issue preferred shares that have preference over the Common Shares with respect to the payment of dividends, in which case such preference may prevent us from paying dividends on the Common

Shares. There are no preferred shares outstanding as at the date hereof. There are no other restrictions on our ability to pay dividends.

We intend to retain any earnings to finance growth and do not expect to pay dividends on our Common Shares in the near future. The Board will review this policy from time to time having regard for our financial condition, financing requirements and other factors considered relevant.

DESCRIPTION OF CAPITAL STRUCTURE

We are authorized to issue an unlimited number of Common Shares and an unlimited number of Preferred Shares issueable in series. As at April 30, 2011, we had 52,277,907 Common Shares issued and outstanding, and no preferred shares are outstanding.

The following is a summary of the rights, privileges, restrictions and conditions attaching to the Common Shares and the preferred shares.

Common Shares

The holders of Common Shares are entitled, subject to the rights of holders of preferred shares, to dividends declared by the Board, to one vote per share at meetings of the shareholders and, upon liquidation, dissolution or winding up, to receive pro rata the remaining assets of Resverlogix, subject to the rights of the preferred shares.

Preferred Shares

The preferred shares may be issued from time to time in one or more series. The terms of each series of preferred shares, including the number of shares, the designation, rights, preferences, privileges, priorities, restrictions and conditions, will be determined at the time of creation of each such series by the Board. The preferred shares shall rank senior to the Common Shares and the shares of any other class ranking junior to the preferred shares with respect to the payment of dividends or distribution of capital of Resverlogix in the event of a dissolution, liquidation or winding up of Resverlogix.

MARKET FOR SECURITIES

Our Common Shares are listed and posted for trading on the TSX under the symbol "RVX". Our securities are not listed on any stock exchange in the United States and there is no established trading market for our securities in the United States.

Trading Prices and Volume by Month for Fiscal Year Ended April 30, 2011

Date	High (\$)	Low (\$)	Close (\$)	Volume
4/29/2011	2.23	1.90	1.94	989,400
3/31/2011	2.83	1.70	2.18	3,273,700
2/28/2011	2.15	1.82	1.88	2,319,300
1/30/2011	2.47	2.02	2.11	4,603,400
12/31/2010	3.78	2.12	2.36	9,883,200
11/30/2010	6.98	1.80	3.43	27,934,000
10/29/2010	5.84	3.94	5.40	4,395,200
9/30/2010	4.98	2.64	4.02	8,789,800
8/31/2010	3.14	2.60	2.64	2,395,500
7/30/2010	2.90	2.62	2.72	921,300
6/30/2010	3.92	2.60	2.68	7,545,600
5/30/2010	6.48	3.28	3.99	2,966,800

PRIOR SALES

We issued the following securities at the prices set out below during the fiscal year ended April 30, 2011:

	Type of Security	Issue Price of Securities	Number of Securities	Type of Issuance
March 2011	Stock Options	\$2.30	60,000	Pursuant to stock option plan
December 2010	Stock Options	\$2.30	75,000	Pursuant to stock option plan
November 2010	Common Shares	\$2.72	137,986	Exercise of warrants
October 2010	Stock Options	\$4.37	150,000	Pursuant to stock option plan
October 2010	Common Shares	\$2.72	175,530	Exercise of warrants
September 2010	Common Shares	\$2.72	40,040	Exercise of warrants
August 2010	Stock Options	\$2.68	215,000	Pursuant to stock option plan
June 2010	Units ⁽¹⁾	\$3.23	3,095,975	Prospectus offering
June 2010	Common Shares	\$3.90	51,290	SEDA ⁽²⁾
June 2010	Units ⁽¹⁾	\$3.30	2,800,000	Prospectus offering
May 2010	Common Shares	\$2.72	103,012	Exercise of warrants
April 2010	Common Shares	\$2.72	68,240	Exercise of warrants
April 2010	Common Shares	\$2.72	10,000	Exercise of stock options

Notes:

1. Each unit was comprised of one common share and 0.4 common share purchase warrant, with each whole warrant exercisable at \$4.00 for a period of four years.
2. Refers to the draw down pursuant to the SEDA based on a draw down notice issued on May 26, 2010 and having a settlement date of June 11, 2010.

DIRECTORS AND EXECUTIVE OFFICERS**Name, Occupation and Security Holdings**

The following table sets forth the name, municipality of residence, year of appointment as a director or executive officer of the Company, and position held with us and principal occupation of each of the directors or executive officers of the Company.

The Board is composed of six directors. The directors are elected annually by the shareholders and serve until the next annual meeting of shareholders unless their successors are duly elected or appointed prior thereto.

Name and Municipality of Residence	Position	Principal Occupation	Director Since
Dr. Peter Johann ^{(1),(2),(3)} Heidelberg, Germany	Director and Chairman	Dr. Peter Johann, Ph.D. is a Managing General Partner of NGN Capital, a venture capital firm. He joined from Boehringer Ingelheim where he was the Division Head of Corporate Development. His responsibilities at Boehringer Ingelheim included strategic planning, strategic projects, M&A, business development and licensing. Prior to this Dr. Johann served at F. Hoffmann-La Roche as Global Business Leader where he led global business teams and was responsible for global marketing of oncology products as well as evaluation of pipeline products from internal and external sources. In addition to Resverlogix, Dr. Johann serves on the board of Micromet.	2009
Donald J. McCaffrey Calgary, Alberta, Canada	Director, President, CEO and Secretary	President, Chief Executive Officer and Secretary of Resverlogix since inception. Don has almost 30 years of experience in drug discovery and development, and international conference and tradeshow management across multiple industries, including biotechnology.	2003
Kenneth Zuerblis ⁽¹⁾ Sarasota, Florida, U.S.A.	Director and Chair of the Audit and Finance Committee	Mr. Zuerblis previously served as Chief Financial Officer and Senior Vice President of ImClone Systems, a biopharmaceutical company developing biologic medicines in the area of oncology, from 2008 through 2009 at which time he helped lead the sale of the company to Eli Lilly for US\$6.6 billion. Prior to joining ImClone, Mr. Zuerblis served as Chief Financial Officer of Enzon Pharmaceuticals Inc. from 1994 through 2005 and Corporate Controller from 1991 through 1994. He began his career at KPMG, LLP, in 1982, ultimately serving as Senior Manager prior to his departure in 1991. Mr. Zuerblis previously served as a member of the Board of Directors of XTL Biopharmaceuticals, Ltd., and is a member of the Board of Directors of Immunomedics and the New Jersey Technology Council. He received a BS in Accounting from Seton Hall University and is a certified public accountant in the State of New Jersey.	2010
Dr. Eldon Smith ⁽¹⁾ Calgary, Alberta, Canada	Director	From 1997 until 2010, Dr. Smith has been Editor-in-Chief of the <i>Canadian Journal of Cardiology</i> and from 1992 to 1997, Dr. Smith was Dean of the Faculty of Medicine at the University of Calgary. Dr. Smith is a director of Canadian Natural Resources Limited, Aston Hill Financial Inc. and IntelliPharmaceuticals International Inc. In 2005, Dr. Smith was made an Officer of the Order of Canada.	2010

Name and Municipality of Residence	Position	Principal Occupation	Director Since
Kelly McNeill, CA ^{(2),(3)} Winnipeg, Manitoba, Canada	Director	Kelly McNeill is the Executive Vice President, Finance and Administration, Chief Financial Officer and Secretary of IMRIS Inc., a provider of fully integrated image guided therapy solutions. From 2006 to 2009, Mr. McNeill was Resverlogix's Chief Financial Officer. Prior thereto, Mr. McNeill was General Manager at Haworth Ltd., a global office interiors manufacturer located in Calgary, Alberta. Mr. McNeill was previously Vice President, Finance at SMED International, a global office interiors manufacturer. Mr. McNeill is a Chartered Accountant and earned a B.Comm (Hons), and M.Acc from the University of Manitoba.	2009
Arthur J. Higgins ^{(2),(3)} Libertyville, Illinois, U.S.A.	Director, Chair of the Corporate Governance and Nominating Committee, and Chair of the Compensation and HR Committee	Arthur J. Higgins, is the former Chief Executive Officer of Bayer HealthCare and Chairman of the Bayer HealthCare Executive Committee. Mr. Higgins joined Bayer in 2004 as Chairman of the Bayer HealthCare Executive Committee and in 2006 was named Chairman of the Board of Management of Bayer HealthCare. Mr. Higgins has played a key role in driving the success of Bayer HealthCare through a combination of strong organic growth and key acquisitions, including the (euro)17 billion acquisition of the German pharmaceutical company, Schering AG, in 2006. Mr. Higgins is currently a director of Zimmer, Inc. (since February 2007), a manufacturer of orthopedic products and instruments, listed on the New York Stock Exchange and Ecolab (since May 2010), a company that develops and markets cleaning, sanitizing, food safety and infection prevention products and services, listed on the New York Stock Exchange.	2010
A. Brad Cann, CA, CBV Calgary, Alberta, Canada	Chief Financial Officer	Chief Financial Officer of Resverlogix since 2009. Prior to joining Resverlogix, Brad was Executive Vice President and Chief Financial Officer of Royal Host Real Estate Investment Trust, a diversified hospitality trust engaged in hotel ownership, investment, management and franchising, and Canada's second largest hotel REIT. Brad joined Royal Host in 2004 and held a number of senior positions and was appointed Chief Financial Officer in 2007 and Executive Vice President in 2008. Brad is a Chartered Accountant and a Chartered Business Valuator, and holds a Bachelor of Commerce from the University of Saskatchewan.	N/A
Kenneth Lebioda, BA Calgary, Alberta, Canada	Senior VP Business & Corporate Development	Senior Vice President Business and Corporate Development of Resverlogix since 2005; Senior Manager Market Access and Health Policy, Bristol-Myers Squibb from 1999 to 2004	N/A

Name and Municipality of Residence	Position	Principal Occupation	Director Since
Dr. Norman Wong, BSc, MSc, MD, FRCP(C) Calgary, Alberta, Canada	Co-Founder, Chief Scientific Officer and Chairman of the Scientific Advisory Board	Chief Scientific Officer of Resverlogix since inception; Professor, Departments of Medicine and Biochemistry and Molecular Biology within the Faculty of Medicine the University of Calgary since 1987; Associate Dean, Research. Dr. Wong received his Bachelor of Science degree, Master of Science degree and Doctor of Medicine degree from the University of Calgary. Dr. Wong has presented at national and international medical conferences and has been the author and co-author of more than 220 articles and abstracts and has been invited to sit on more than 35 panels and committees. Dr. Wong has also acted as a consultant to several multinational pharmaceutical companies.	N/A
Dr. Jan Johansson, MD, PhD San Ramon, California, U.S.A.	Senior Vice President Medical Affairs	Senior Vice President Medical Affairs of Resverlogix since 2004; Chief Medical Officer at Nuvelo, Inc. from 2003 to 2004; Vice President, Clinical Research and Development, Lipid Sciences Inc. from 2001 to 2003; Co-Founder, Vice President, Clinical Affairs and Senior Clinical Research Fellow of Esperion Therapeutics, Inc. from 1998 to 2001. Dr. Johansson earned his MD and Ph.D. at the Karolinska Institute in Sweden and has published more than 50 peer-review medical articles.	N/A
Dr. Gregory Wagner, PhD, DABT Foster City, California, U.S.A	Senior Vice President Research and Development	Senior Vice President Research and Development of Resverlogix since 2006; Vice President, Preclinical Development of Galileo Pharmaceuticals, Inc. from 2005 to 2006. Dr. Wagner earned a Bachelor of Science, Biochemistry with Distinction from the University of Illinois, and a MS, Pharmacology and Toxicology and a PhD in Pharmacology and Toxicology from the University of Iowa.	N/A
Dr. Allan Gordon, MD, PhD Piedmont, California, U.S.A.	Senior Vice President Clinical Development	Senior Vice President Clinical Development of Resverlogix since 2008; Chief Executive Officer of Nile Therapeutics Inc., as early-stage bio-pharmaceutical in cardiovascular in 2007; Senior Director Clinical Research of Scios Inc. (a Johnson & Johnson company) from 2004 to 2007. Dr. Gordon has worked with several multinational pharmaceutical companies in leading positions on the clinical development programs for cardiovascular disease. Dr. Gordon received his MD and PhD from the Karolinska Institute in Sweden. He has published approximately 50 articles and abstracts.	N/A

Notes:

- (1) Member of the Audit and Finance Committee
- (2) Member of the Corporate Governance and Nominating Committee
- (3) Member of the Compensation and HR Committee

The directors and executive officers, in the aggregate, beneficially own, directly or indirectly, or exercise control or direction over 11,705,993, or 19.7%, of issued and outstanding Common Shares as of July 19, 2011.

The Company is required to have an Audit and Finance Committee. The Audit and Finance Committee consists of Mr. Zuerblis (Chair of the Committee), Dr. Johann and Dr. Smith. We also have a Corporate Governance and Nominating Committee whose members consist of Mr. Higgins (Chair of the Committee), Dr. Johann and Mr. McNeill. We also have a Compensation and HR Committee whose members consist of Mr. Higgins (Chair of the Committee), Dr. Johann and Mr. McNeill.

Clinical Advisory Board

In November 2006, we created a Clinical Advisory Board (CAB), consisting of internationally renowned cardiovascular researchers. This committee purpose is to provide guidance during the clinical development of our lead cardiovascular drug.

Clinical Steering Committee

The role of the Steering Committee is to provide overall supervision of the clinical trials and ensure that they are being conducted in accordance with the principles of Good Clinical Practice and FDA regulations. The Steering Committee will agree on the trial protocols, any protocol amendments and provide advice to the investigators on all aspects of the trials.

Audit Committee Matters

Audit and Finance Committee Charter

The Audit and Finance Committee Charter is attached hereto as Schedule "A".

Composition of the Audit and Finance Committee

The Audit and Finance Committee is composed of three independent, unrelated directors – Mr. Zuerblis as Chair, Dr. Johann and Dr. Smith. All three members of the Committee are considered financially literate. Each of the members have held board and executive positions on behalf of several companies, and have a wealth of experience in leading and managing companies.

Relevant Education & Experience

Kenneth Zuerblis

Mr. Zuerblis received a BS in Accounting and is a Certified Public Accountant with nearly 30 years of experience, has held senior financial positions with two publicly-traded companies and has held directorships with numerous organizations.

Dr. Peter Johann

Dr. Johann is a Managing Director of NGN Capital, a venture capital firm dedicated to healthcare investing. Previously, Dr. Johann was Division Head of Corporate Development with Boehringer Ingelheim with responsibility for strategic planning, strategic projects, mergers and acquisitions, business development and licensing. Prior thereto, Dr. Johann was Global Business Leader with F. Hoffman-La Roche where he led global business teams. Dr. Johann has held directorships with numerous organizations.

Dr. Eldon Smith

Dr. Smith has held directorships, and been a member of the audit committees, of several publicly-traded companies and held directorships with numerous organizations.

Pre-approval of Audit Fees

We will not engage external auditors to carry out any Prohibited Service as defined in the CICA revised Rules of Professional Conduct.

The Board, upon recommendation from the Audit and Finance Committee, will consider the pre-approval of permitted services to be performed by the external auditors in each of the following broad categories:

- Audit Services
- Audit Related Services
- Tax Services

Engagements of external auditors will only commence subsequent to Board pre-approval of audit services, and only a member of the Audit and Finance Committee, or the President and CEO or Chief Financial Officer shall be authorized to request services of external auditors.

External Auditor Service Fees

The following table sets out the aggregate fees billed by our external auditor in each of the last two financial years for services provided to the Company:

Year	Audit Fees (1)	Audit-Related Fees	Tax Fees (2)	Other Fees
2011	\$379,500	\$Nil	\$63,900	\$Nil
2010	\$149,600	\$Nil	\$5,750	\$Nil

Notes:

(1) Audit fees were for professional services for the audit of our annual financial statements, for reviews of our unaudited interim financial statements, our short form base shelf prospectus and prospectus supplements, IFRS-related review as well as services provided in connection with statutory and regulatory filings or engagements paid to KPMG LLP.

(2) Tax Fees were for professional services for corporate reorganization advise, tax planning and compliance services paid to KPMG LLP.

Cease Trade Orders, Bankruptcies, Penalties or Sanctions

Other than as set out below, no director or executive officer is as at the date hereof, or has been within ten years before the date hereof, a director or chief executive officer or chief financial officer of any company (including the Company) that, while he was acting in such capacity: (i) was the subject of a cease trade or similar order, or an order that denied the relevant company access to any exemption under securities legislation for a period of more than 30 consecutive days; (ii) was subject to an event that resulted, after the director or executive officer ceased to be a director or chief executive officer or chief financial officer, in the company being the subject of a cease trade or similar order or an order that denied the relevant company access to any exemption under securities legislation, for a period of more than 30 consecutive days.

In addition, other than set out below, no director or executive officer or shareholder holding a sufficient number of securities of the Company to affect materially the control of the Company is as at the date hereof, or has been within ten years before the date hereof, a director or executive officer of any company (including the Company) that, while that person was acting in that capacity or within a year of that person ceasing to act in that capacity, became bankrupt, made a proposal under any legislation relating to bankruptcy or insolvency or was subject to or instituted any proceedings, arrangement or compromise

with creditors or had a receiver, receiver manager, or trustee appointed to hold its assets. In addition, no director or executive officer or shareholder holding a sufficient number of securities of the Company to affect materially the control of the Company has, within ten years before the date hereof, become bankrupt, made a proposal under any legislation relating to bankruptcy or insolvency, or become subject to or instituted any proceedings, arrangement or compromise with creditors, or had a receiver, receiver manager or trustee appointed to hold the assets of the director, executive officer or shareholder.

Dr. Smith was a director of BioMax Technologies Inc. which was subject to a cease trade order in 2002 from the Alberta and British Columbia Securities Commissions for failure to file financial statements. Subsequent to the resignation of Dr. Smith from the Board of Directors, the company was delisted but continues as a solvent private company.

Mr. Cann was a director of Banff Rocky Mountain Resort Ltd., General Partner for the Banff Rocky Mountain Resort Limited Partnership, which was subject to cease trade orders between May and November 2008 from the Alberta and Ontario Securities Commissions for a delay in filing audited annual financial statements of the Partnership.

No director, executive officer or shareholder holding a sufficient number of our securities to affect materially the control of the Company has, within the past ten years, become bankrupt, made a proposal under any legislation relating to bankruptcy or insolvency, or became subject to or instituted any proceedings, arrangement or compromise with creditors, or had a receiver, receiver manager or trustee appointed to hold the assets of such person.

No director, executive officer or shareholder holding a sufficient number of our securities to affect materially the control of the Company has since December 31, 2000, been subject to any penalties or sanctions imposed by a court relating to Canadian securities legislation or by a Canadian securities regulatory authority or has entered into a settlement agreement with a Canadian securities regulatory authority or been subject to any other penalties or sanctions imposed by a court or regulatory body that would likely be considered important to a reasonable investor in making an investment decision.

Conflicts of Interest

Certain directors and officers of the Company and our subsidiary are associated with other reporting issuers or other corporations which may give rise to conflicts of interest. In accordance with the ABCA directors who have a material interest or any person who is a party to a material contract or a proposed material contract with us are required, subject to certain exceptions, to disclose that interest and generally abstain from voting on any resolution to approve the contract.

INTERESTS OF MANAGEMENT AND OTHERS IN MATERIAL TRANSACTIONS

Other than as described below, there are no material interests, direct or indirect of directors, executive officers, any shareholders that beneficially own, directly or indirectly, more than 10% of our outstanding Common Shares, or any known associates or affiliates of such persons, in any transaction within the last three years or in any proposed transaction which has materially affected or would materially affect us.

In March 2004 Dr. Jan Johansson, currently our Senior Vice President, Medical Affairs, commenced working for us under a consulting agreement for his services through a private Delaware corporation he controls. As part of that agreement Dr. Johansson had permission to continue his existing work relating to peptide development for acute CVD treatment as Resverlogix did not and has never had any peptide program involvement. Due to some development progress in Dr. Johansson's peptide program, we obtained a right of first refusal on a peptide technology for the treatment of acute coronary syndrome late in 2006. The technology was owned by the private Delaware corporation. During the year ended April 30, 2010, the Company made payments to maintain the right of first refusal for this technology from the Delaware corporation in the amount of US\$77,740. Two former directors, Mr. Whitney Ward and Mr. Wayne Chiu had separately and independently chosen to obtain minority interests in the Delaware corporation. During the year ended April 30, 2010, the company that Dr. Johansson controls entered into

a collaboration agreement with a pharmaceutical company; Resverlogix did not exercise its right of first refusal.

TRANSFER AGENT AND REGISTRAR

The transfer agent and registrar for our Common Shares is Valiant Trust Company at its transfer offices in Calgary and Toronto.

MATERIAL CONTRACTS

In April 2009, we entered into a Share Purchase Agreement (“SPA”) with NGN Biomed Opportunity II L.P. (“NGN”) as well as a syndicate of other investors. The terms of the SPA provided for a first tranche equity financing of \$24.3 million which closed on April 15, 2009 and an optional US\$15 million second tranche within six months of the first tranche closing date. The detail of the terms is described in “GENERAL DEVELOPMENT OF THE BUSINESS” under the “Financing” section and the SPA has been filed on SEDAR. In addition to the financial terms noted above, the SPA provided NGN the right to appoint an NGN nominee to the Board of Directors and provided that NGN be entitled to nominate a second director to the Board upon resignation or replacement of any other current Board member.

The SPA also required an Investor Rights Agreement (“IRA”) to be entered into among us, the investors and each of Donald McCaffrey, Wayne Chiu and Norman Wong (the “Management Shareholders”). The IRA provided for certain restrictions on transfers of securities by a party who is subject to the IRA (an “IRA Shareholder”) and grants the investors preferential rights on the issuance of new securities by us. The IRA restricts any IRA Shareholder, to transfer Common Shares without first offering such securities to other IRA Shareholders. If an IRA Shareholder is permitted to sell securities to a third party, the IRA Shareholder must allow other IRA Shareholders the right to participate in such an offering for its proportionate share of securities (referenced as “Tag-Along Rights”). If a third-party purchaser proposes to acquire not less than 66 2/3% of our issued and outstanding voting securities or substantially all of its assets, then any IRA Shareholder shall have the right to require every other shareholder to sell their proportionate percentage of securities, or in the case of an asset sale, vote in favour of a recommended transaction (referenced as “Drag-Along Rights”). In addition, we shall not issue any new securities, exclusive of the second tranche noted above, without offering a proportionate share to NGN and the other investors. The IRA also provides NGN with certain approval rights including, any offering of securities that rank senior to the Common Shares, any increase or decreases from the intended composition of seven Board members, any amendment to our constating documents, any related party transactions, the exercise of our redemption rights of the convertible debentures and any sale, lease or disposal of all or substantially all of our assets or any change of control transaction that does not provide cumulative proceeds that equal or exceed five (5) times NGN’s aggregate invested capital. The approval rights related to the sale of assets or change of control expire the latter of (i) three (3) years from the closing of the second tranche noted above and (ii) the date the Phase 2b proof of concept data on RVX222 is made available. The complete IRA document has been filed on SEDAR.

On March 26, 2010, we entered into a Standby Equity Distribution Agreement with YA Global SPV Ltd. (the “Purchaser”), a fund managed by Yorkville Advisors, LLC, pursuant to which the Purchaser has irrevocably agreed to purchase and we irrevocably committed to issue and sell, from time to time, for a period of 24 months from the date of the SEDA (the “Commitment Period”) and in connection with a Draw Date Notice (as defined herein), up to \$25,000,000 (the “Commitment Amount”) of its Common Shares. Each right to sell Common Shares is called a “draw down”. In order to request a draw down, Resverlogix submits a written notice (a “Draw Down Notice”) to the Purchaser. The Draw Down Notice will specify, among other things, the amount of the draw down and the minimum price per Common Share for such draw down. The date the Draw Down Notice is delivered to the Purchaser is called a “Draw Down Notice Date”. Each draw down will be in an amount determined by us, but will not exceed the lesser of (a) \$500,000; or (b) the remaining portion of the aggregate Commitment Amount. In addition, the number of Common Shares distributed by us under one or more equity line of credits, including under the SEDA, will not exceed (i) in any 12-month period, 10% of the aggregate number of Common Shares outstanding as at the start of such period, and (ii) during the term of the SEDA 19.9% of the aggregate number of our

Common Shares outstanding at the date of the SEDA. The Common Shares will be issued at a purchase price equal to 95% of the daily volume-weighted average price per Common Share on the TSX for each of the ten consecutive trading days following a Draw Down Notice ("Draw Down Pricing Period"). Each draw down will be reduced by up to 10% of the draw down amount for each trading day during the Draw Down Pricing Period for which the daily volume-weighted average price is below a minimum price equal to either (i) 90% of the daily volume-weighted average price of the Common Shares on the trading day immediately preceding the Draw Down Notice Date; or (ii) the price determined by us in the Draw Down Notice, provided that such price is equal to or lower than 90% of the daily volume weighted trading price for the trading day immediately preceding the Draw Down Notice. In addition, the draw down will be reduced by such amount necessary to ensure that the draw down amount does not equal or exceed 5% or more of our market capitalization as of the settlement date. Each draw down will also be reduced such that in no event shall the number of Common Shares issuable to the Purchaser pursuant to a draw down cause the Purchaser, its affiliates, associates, partners and insiders, at any time, directly or indirectly, together with any member of its group, to own in excess of 9.9% of Resverlogix's then issued and outstanding Common Shares. Under the terms of the SEDA, we paid the Purchaser a commitment fee of \$250,000 by issuing Common Shares at a price of \$5.70 per share. We may terminate the SEDA at any time upon prior notice to the Purchaser, without the payment of any fee or penalty, except for the settlement of any outstanding draw down. We obtained from the appropriate Canadian securities regulatory authorities exemptive relief from certain securities regulatory requirements. A copy of such exemptive relief decision may be obtained by accessing the disclosure documents available through the Alberta Securities Commission website at www.albertasecurities.com. The Purchaser's obligation to accept a Draw Down Notice and purchase such Common Shares specified therein shall be subject to certain customary terms and conditions, including, but not limited to, obtaining all applicable regulatory, corporate and shareholder approvals required by the TSX.

INTERESTS OF EXPERTS

Our auditors are KPMG LLP, Chartered Accountants of Calgary, Alberta, Canada. KPMG LLP has confirmed that it is independent with respect to us in accordance with the rules of professional conduct of the Institute of Chartered Accountants of Alberta.

ADDITIONAL INFORMATION

Additional information, including directors' and executive officers' remuneration and indebtedness, principal holders of our securities and securities authorized for issuance under equity compensation plans is contained in the Management Information Circular with respect to the most recent annual meeting of shareholders. Additional financial information is provided in our audited financial statements and MD&A for the year ended April 30, 2011.

Additional information relating to us may be found on SEDAR at www.sedar.com. In addition, we maintain updated information on our website at www.resverlogix.com.

SCHEDULE "A"**RESVERLOGIX CORP.
AUDIT & FINANCE COMMITTEE CHARTER****PART I
ESTABLISHMENT OF COMMITTEE****1. Committee Purpose**

The Audit and Finance Committee (the "**Committee**") is established by the board of directors (the "**Board of Directors**") of Resverlogix Corp. ("**Resverlogix**") primarily for the purpose of overseeing the accounting and financial reporting processes of Resverlogix and the reviews and audits of the financial statements of Resverlogix.

The Committee shall assist the Board of Directors in fulfilling its oversight responsibilities by monitoring, among other things:

- (a) the quality and integrity of the financial statements and related disclosure of Resverlogix;
- (b) compliance by Resverlogix with legal and regulatory requirements that could have a material effect upon the financial position of Resverlogix which are not subject to the oversight of another committee of the Board of Directors or the Board of Directors as a whole;
- (c) the independent auditor's qualifications and independence; and
- (d) performance of Resverlogix's independent auditor.

2. Composition of Committee

The Committee shall consist of as many members as the Board shall determine, but in any event not fewer than three directors, provided that all member of the Committee shall satisfy the independence, financial literacy and experience requirements of applicable securities laws and rules, and applicable stock exchange requirements and any other applicable regulatory rules and in particular shall be determined by the Board to be independent within the meaning of National Instrument 52-110 (Audit Committees), Rule 10A-3(b)(1) under the United States Securities Exchange Act of 1934 and the rules of any stock exchange or market on which Resverlogix's shares are listed or posted for trading (collectively, "**Applicable Governance Rules**"). In this Charter, the term "independent" includes the meanings given to similar terms by Applicable Governance Rules, including the terms "non-executive", "outside" and "unrelated" to the extent such terms are applicable under Applicable Governance Rules. No member of the Audit Committee shall have participated in the preparation of the financial statements of the Corporation or any current subsidiary of the Corporation at any time during the past three (3) years.

All members of the Audit Committee must be able to read and understand fundamental financial statements (including a balance sheet, income statement and cash flow statement) and read and understand a set of financial statements that present a breadth and level of complexity of accounting issues that are generally comparable to the breadth and level of complexity of the issues that can reasonably be expected to be raised by the Corporation's financial statements. In addition: (i) at least one member of the Audit Committee must have past employment experience in finance or accounting, requisite professional certification in accounting or any other comparable experience or background that results in the individual's financial sophistication, including service as a chief executive officer, chief financial officer, or other senior officer with financial oversight responsibilities or otherwise satisfy standards for financial expertise required for audit committees of companies listed on the NASDAQ Stock Market, and (ii) at least one member of the Audit Committee must be an "audit committee financial expert"

as defined by the applicable rules set out by the United States Securities and Exchange Commission or any other applicable regulatory authority.

3. Appointment of Committee Members

The members of the Committee shall be appointed by the Board of Directors on the recommendation of the Corporate Governance and Human Resources Committee. The members of the Committee shall be appointed at the time of each annual meeting of shareholders and shall hold office until the next annual meeting, until they are removed by the Board of Directors or until their successors are earlier appointed, or until they cease to be directors of Resverlogix.

PART II COMMITTEE PROCEDURE

4. Vacancies

Where a vacancy occurs at any time in the membership of the Committee, it may be filled by the Board of Directors on the recommendation of the Corporate Governance and Human Resources Committee and shall be filled by the Board of Directors if the membership of the Committee is fewer than three directors. The Board of Directors may remove and replace any member of the Committee.

5. Committee Chair

The Board of Directors shall appoint a chair (the "**Chair**") for the Committee. The Chair may be removed and replaced by the Board of Directors.

6. Absence of Chair

If the Chair is not present at any meeting of the Committee, one of the other members of the Committee present at the meeting shall be chosen by the Committee to preside at the meeting.

7. Secretary of Committee

The Committee shall appoint a Secretary who need not be a director of Resverlogix.

8. Regular Meetings

The Chair, in consultation with the Committee members, shall determine the schedule and frequency of the Committee meetings, provided that the Committee shall meet at least quarterly. The Committee at any time may, and at each regularly scheduled Committee meeting shall, meet without management present and shall meet periodically with management and the independent auditor. The Committee shall also meet separately with the independent auditor at every regularly scheduled meeting of the Committee at which the independent auditor is present. The Committee shall record and maintain minutes of meetings.

9. Special Meetings

The Chair, any two members of the Committee, the independent auditor or the Chief Executive Officer of Resverlogix may call a special meeting of the Committee.

10. Quorum

A majority of the members of the Committee, present in person or by telephone or other telecommunication device that permits all persons participating in the meeting to speak to each other, shall constitute a quorum.

11. Notice of Meetings

Notice of the time and place of every meeting shall be given in writing or by e-mail or facsimile communication to each member of the Committee at least 48 hours prior to the time fixed for such meeting; provided, however, that a member may, in any manner, waive notice of a meeting and attendance of a member at a meeting is a waiver of notice of the meeting, except where a member attends a meeting for the express purpose of objecting to the transaction of any business on the grounds that the meeting is not lawfully called.

12. Agenda

The Chair shall develop and set the Committee's agenda, in consultation with other members of the Committee, the Board of Directors and management of Resverlogix. The agenda and information concerning the business to be conducted at each Committee meeting shall, to the extent practicable, be communicated to the members of the Committee sufficiently in advance of each meeting to permit meaningful review.

13. Delegation

Subject to subsection PART III19(e), the Committee shall have the power to delegate its authority and duties to subcommittees or individual members of the Committee as it deems appropriate.

14. Access

In discharging its oversight role, the Committee shall have full access to all books, records, facilities and personnel of Resverlogix.

15. Attendance of Others at a Meeting

At the invitation of the Chair, one or more officers, directors or employees of Resverlogix may, and if required by the Committee shall, attend a meeting of the Committee.

16. Procedure, Records and Reporting

The Committee shall fix its own procedure at meetings, keep records of its proceedings and report to the Board of Directors when the Committee may deem appropriate (but not later than the next meeting of the Board of Directors).

17. Outside Consultants or Advisors

The Committee, when it considers it necessary or advisable, may retain, at Resverlogix's expense, outside consultants or advisors (including independent counsel) to assist or advise the Committee independently on any matter within its mandate. The Committee shall have the sole authority to retain or terminate such consultants or advisors, including the sole authority to approve the fees and other retention terms for such persons.

**PART III
MANDATE OF COMMITTEE**

18. Appointment of Resverlogix's Independent Auditor

Subject to confirmation by the independent auditor of its compliance with Canadian regulatory registration requirements, the Committee shall recommend to the Board of Directors the appointment of the independent auditor for the purpose of preparing or issuing any audit report or performing other audit, review or attest services for Resverlogix, such appointment to be confirmed by Resverlogix's

shareholders at each annual meeting. The Committee shall also recommend to the Board of Directors the engagement letter with the independent auditor, the approval of fees to be paid to the independent auditor for audit services and shall pre-approve the retention of the independent auditor for any permitted non-audit service. The Committee shall also be directly responsible for overseeing the work of the independent auditor (including resolution of disagreements between management of Resverlogix and the independent auditor regarding financial reporting) for the purpose of preparing or issuing an audit report or performing other audit, review or attest services for Resverlogix. The Committee shall communicate directly with the independent auditor. The independent auditor shall report directly to the Committee.

The Committee shall review the independence of the independent auditor including a written report from the independent auditor delineating all relationships between the auditor and Resverlogix, considering whether the advisory services performed by the independent auditor during the course of the year have affected its independence, and ensuring that no relationship or service between the independent auditor and Resverlogix is in existence that may affect the objectivity and independence of the auditor, or recommending appropriate action to ensure the independence of the independent auditor.

19. Specific Mandates

The Committee, to the extent required by applicable laws or rules, or otherwise considered by the Committee to be necessary or appropriate, shall:

(a) Oversight in Respect of Financial Disclosure

- (i) review, discuss with management of Resverlogix and the independent auditor, and recommend to the Board of Directors for approval:
 - A. the annual and interim financial statements;
 - B. the annual information form;
 - C. the annual and interim management's discussion and analysis;
 - D. the portions of the management proxy circular, for any annual or special meeting of shareholders, containing significant financial information respecting Resverlogix;
 - E. all financial statements included in prospectuses or other offering documents;
 - F. any significant financial information contained in all prospectuses and all documents which may be incorporated by reference in a prospectus;
 - G. any significant financial information respecting Resverlogix contained in a material change report or a business acquisition report;
- (ii) review and discuss with management of Resverlogix:
 - A. each press release which contains significant financial information respecting Resverlogix (including, without limitation, annual and interim earnings press releases) or contains earnings guidance, prior to public dissemination thereof;
 - B. the use of "pro forma" or "adjusted" non-GAAP information;

- C. financial information and earnings guidance provided to analysts and rating agencies; provided, however, that such discussion may be done generally (consisting of discussing the types of information to be disclosed and the types of presentations to be made), and the Committee need not discuss in advance each instance in which Resverlogix may provide earnings guidance or presentations to rating agencies;
- (iii) review with management and the independent auditor the scope of the audit, in particular the independent auditor's view of Resverlogix's accounting principles as applied in the financial statements in terms of disclosure quality and evaluation methods, inclusive of the clarity of Resverlogix's financial disclosure and reporting, degree of conservatism or aggressiveness of Resverlogix's accounting principles and underlying estimates, and other significant decisions made by management in preparing the financial disclosure and reviewed by the independent auditor;
 - (iv) review with management of Resverlogix and the independent auditor major issues regarding accounting and auditing principles and practices as well as the adequacy of internal controls and procedures for financial reporting and management information systems and inquire of management and the independent auditor about significant risks and exposures to Resverlogix that could significantly affect Resverlogix's financial statements;
 - (v) review with management of Resverlogix and the independent auditor, and satisfy itself as to the adequacy of the procedures that are in place for the review of Resverlogix's disclosure of financial information extracted or derived from Resverlogix's financial statements, and periodically assess the adequacy of those procedures;
 - (vi) review with management of Resverlogix and the independent auditor (including those of the following that are contained in any report of the independent auditor): (a) all critical accounting policies and practices to be used by Resverlogix in preparing its financial statements; (b) all alternative treatments of financial information within GAAP that have been discussed with management, ramifications of the use of these alternative treatments, and the independent auditor's assessment of the alternatives; and (c) other material communications between the independent auditor and management of Resverlogix, such as any management letter or schedule of unadjusted differences;
 - (vii) review with management of Resverlogix and the independent auditor the effect of regulatory and accounting initiatives as well as off-balance sheet transactions on Resverlogix's financial statements;
 - (viii) review the plans of management of Resverlogix and the independent auditor regarding any significant changes in accounting practices or policies and the financial and accounting impact thereof;
 - (ix) review with management of Resverlogix, the independent auditor and, if necessary, legal counsel, any litigation, claim or contingency, including tax assessments, that could have a material effect upon the financial position of Resverlogix, and the manner in which these matters have been disclosed in the financial statements;

- (x) review disclosures by Resverlogix's Chief Executive Officer and Chief Financial Officer with respect to any required certification for Resverlogix's financial statements by such individuals; and
 - (xi) discuss with management Resverlogix's material financial risk exposures and the steps management of Resverlogix has taken to monitor and control such exposures, including Resverlogix's financial risk assessment and financial risk management policies.
- (b) **Oversight in Respect of Legal and Regulatory Matters**
- (i) review, if necessary, with legal counsel, Resverlogix's compliance policies, legal matters and any material reports or inquiries received from regulators or governmental agencies that could have a material effect upon the financial position of Resverlogix and which are not subject to the oversight of another committee of the Board of Directors or the Board of Directors as a whole.
- (c) **Oversight in Respect of the Chief Financial Officer**
- (i) consult with management on management's appointment, replacement, reassignment or dismissal of the Chief Financial Officer of Resverlogix; and
 - (ii) ensure the Chief Financial Officer of Resverlogix has access to the Chair, the Chairman of the Board of Directors and the Chief Executive Officer of Resverlogix, and shall meet separately with the Chief Financial Officer of Resverlogix to review any problems or difficulties he or she may have encountered in the performance of his or her responsibilities and report to the Board of Directors on such meetings.
- (d) **Oversight in Respect of the Independent Auditor**
- (i) meet with the independent auditor prior to the annual audit to review the planning and staffing of the audit;
 - (ii) review annually the independent auditor's formal written statement of independence delineating all relationships between itself and Resverlogix and review all such relationships;
 - (iii) receive confirmation from the independent auditor as to its standing as a "participating audit firm" and its compliance with any restrictions or sanctions imposed by the Canadian Public Accountability Board as those concepts are set forth in National Instrument 52-108 of the Canadian Securities Administrators;
 - (iv) review and evaluate the independent auditor, including the lead partner of the independent auditor team and shall confirm compliance by the independent auditors with laws and regulations relating to audit partner rotation;
 - (v) meet separately with the independent auditor to review with them any problems or difficulties they may have encountered and specifically:
 - A. any difficulties which were encountered in the course of the audit work, including any restrictions on the scope of activities or access to required information, and any disagreements with management of Resverlogix; and

- B. any changes required in the planned scope of the audit;
- and report to the Board of Directors on such meetings;
- (vi) review the engagement reports of the independent auditor on unaudited financial statements of Resverlogix; and
 - (vii) review and approve Resverlogix's hiring policies regarding partners, employees, former partners and former employees of Resverlogix's present and former independent auditor.
- (e) **Oversight in Respect of Audit and Non-Audit Services**
- (i) have the sole authority to pre-approve all audit services (which may entail providing comfort letters in connection with securities underwritings) and all permitted non-audit services, other than non-audit services where:
 - A. the aggregate amount of all such non-audit services provided to Resverlogix or its subsidiaries constitutes not more than 5% of the total amount of fees paid by Resverlogix (and its subsidiaries) to the independent auditor during the fiscal year in which the non-audit services are provided;
 - B. such services were not recognized by Resverlogix (or any subsidiary) at the time of the engagement to be non-audit services; and
 - C. such services are promptly brought to the attention of the Committee and approved, prior to the completion of the audit, by the Committee or by one or more members of the Committee to whom authority to grant such approvals has been delegated by the Committee; and
 - (ii) delegate to one or more designated members of the Committee the authority to grant pre-approvals required by this section; provided that the decision of any member to whom authority is delegated to pre-approve an activity shall be presented to the Committee at the first scheduled meeting following such decision, and provided further that, if the Committee approves an audit service within the scope of the engagement of the independent auditor, such audit service shall be deemed to have been pre-approved for purposes of this section
- (f) **Oversight in Respect of Certain Policies**
- (i) establish procedures for: (a) the receipt, retention and treatment of complaints received by Resverlogix regarding accounting, internal accounting controls or auditing matters; and (b) the confidential, anonymous submission by employees of Resverlogix of concerns regarding questionable accounting or auditing matters; and
 - (ii) periodically review Resverlogix's public disclosure policy.

20. Self-Evaluation

The Committee shall conduct an annual performance self-evaluation and shall report to the Board the results of the self-evaluation. In addition, the Committee shall conduct an annual assessment of management's adherence to Resverlogix's Code of Business Conduct and Ethics.

21. Non-Exhaustive List

The foregoing list of duties is not exhaustive, and the Committee may, in addition, perform such other functions as may be necessary or appropriate for the performance of its oversight responsibilities.

22. Review of Committee's Charter

The Committee shall assess the adequacy of this Charter on an annual basis and recommend any changes to the Board of Directors. The Committee will also, annually, make a critical review of its past performance to ensure that it has assumed its responsibilities and executed all required tasks and will suggest changes if it failed to do so. This review will also cover individual members' performance. This review forms part of the review process undertaken by the Governance and HR Committee, which reports its findings to the Board.

23. Oversight Function

While the Committee has the responsibilities and powers set forth in this Charter, it is not the duty of the Committee to plan or conduct audits or to determine that Resverlogix's financial statements are complete and accurate or are in accordance with GAAP. These are the responsibilities of management of Resverlogix and the independent auditor. The Committee and its Chair are members of the Board of Directors, appointed to the Committee to provide broad oversight of the financial risk and control related activities of Resverlogix, and are specifically not accountable nor responsible for the day to day operation or performance of such activities. The role of all Committee members is to oversee the process, not to certify or guarantee the accuracy or completeness of the external audit of Resverlogix's financial information or public disclosure.