ANNUAL INFORMATION FORM

For the fiscal year ended October 31, 2014

January 22, 2015

FORWARD-LOOKING STATEMENTS

This Annual Information Form contains forward-looking statements to provide investors with guidance as to DiagnoCure's expectations, opportunities and future activities or projects. More specifically, paragraphs relating to the Corporation's plans may include forward-looking information. Furthermore, the words "may", "could", "should", "outlook", "believe", "plan", "envisage", "anticipate" and "estimate", and the use of the conditional tense as well as similar expressions denote forward-looking statements. By their very nature, these involve uncertainties and inherent risks, both general and specific, which give rise to the possibility those predictions, will not materialize. We therefore caution investors against placing undue reliance on these statements. The risks and uncertainties related to the business of the Corporation are described in section 3.10 of this Annual Information Form. DiagnoCure undertakes no obligation to publicly update or revise any forward-looking statements contained herein, unless required by the applicable securities laws and regulations.

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SECTION 1 - CORPORATE STRUCTURE OF THE CORPORATION

1.1 NAME, ADDRESS, INCORPORATION AND MATERIAL AMENDMENTS

DiagnoCure Inc. ("**DiagnoCure**" or the "**Corporation**") was incorporated on December 8, 1994 pursuant to a certificate of incorporation issued under Part 1A of the *Companies Act* (Québec) and now exists under the *Business Corporations Act* (Québec). On November 7, 1995, the articles of the Corporation were amended to subdivide the then outstanding 300 common shares of the Corporation into 7,333,332 common shares and to remove the private company restrictions to enable DiagnoCure to proceed with a private placement. DiagnoCure's articles were also amended on January 10, 1996, to restore such private company restrictions. On September 18, 1996, the articles of the Corporation were again amended to: (i) remove the private company restrictions for the purposes of its initial public offering; (ii) cancel the Corporation's Class A preferred shares, Class B preferred shares and Class C preferred shares; and (iii) create an unlimited number of preferred shares issuable in series, non-voting, for which the rights privileges, restrictions and conditions are determined by the directors upon issuance (the "**Preferred Shares**"). As a result of a resolution adopted by the shareholders at the annual meeting of April 29, 2013, the articles of the Corporation were also amended on May 7, 2013 to include provisions to the effect that (i) the Board of Directors may appoint one or more directors to hold office for a term expiring no later than the close of the next annual meeting following their appointment, provided that the number of directors so appointed does not exceed one-third of the number of directors elected at the annual meeting of shareholders preceding their appointment, and (ii) a meeting of shareholders may be held outside of the Province of Québec.

As of the date hereof, the Corporation had 43,040,471 common shares issued and outstanding (the "**Common Shares**") and 4,900,000 Series A Convertible Preferred Shares (see *Description of Share capital*).

DiagnoCure's head and registered office is located at 4535 Wilfrid-Hamel Blvd., Suite 250, Québec (Québec) G1P 2J7. The Corporation's website address is www.diagnocure.com.

1.2 SUBSIDIARIES

As of October 31, 2014, DiagnoCure had three wholly-owned subsidiaries, 9161-6722 Québec Inc., 9184-6766 Québec Inc., and Catalyst Oncology, LP.

9161-6722 Québec Inc. was incorporated on October 19, 2005 under Part 1A of the *Companies Act* (Québec) and now exists under the *Business Corporations Act* (Québec) to hold the license on the molecular biomarker PCA3 granted by the University of Nijmegen to the Corporation. . 9161-6722 Québec Inc. sub-licensed its rights to DiagnoCure.

On July 12, 2007, the Corporation created a wholly-owned subsidiary, 9184-6766 Québec Inc., under Part 1A of the *Companies Act* (Québec) which now exists under the *Business Corporations Act* (Québec).

The Corporation acquired Catalyst Oncology, Inc., in August 2007, a company existing under the laws of Delaware, which held all of the rights to certain prognostic tests for breast, colon and potentially other cancers. On March 20, 2008, DiagnoCure converted Catalyst Oncology, Inc.,

into Catalyst Oncology, LP, of which 9184-6766 Québec Inc. is the general partner, and DiagnoCure is the limited partner.

Unless the context otherwise requires or indicates, “DiagnoCure” or the “Corporation” herein refers to DiagnoCure Inc., 9161-6722 Québec Inc., 9184-6766 Inc., and Catalyst Oncology, LP, on a consolidated basis.

SECTION 2 - GENERAL DEVELOPMENT OF THE BUSINESS

2.1 FOREWORD

DiagnoCure was founded in December 1994 for the purpose of commercializing technologies developed by its research partners relating to the diagnosis and treatment of genito-urinary cancers. Over the years, the Corporation withdrew from therapeutic activities and concentrated its efforts on the detection and management of cancer. DiagnoCure commercialized its first diagnostic test, ImmunoCyt / uCyt+ for bladder cancer in Europe in 1998 and obtained 510(k) clearance from the Food and Drug Administration (FDA) for its commercialization in the United States in 2000. In August 2008, DiagnoCure entered into a product divestment agreement for ImmunoCyt / uCyt+ with Scimedx Corporation, a U.S.-based company.

In May 2000, DiagnoCure obtained an exclusive worldwide license from the University of Nijmegen, the Netherlands, to exploit the PCA3 molecular biomarker in prostate cancer, which had been discovered by Dr. Marion Bussemakers from Dr. Jack Schalken’s laboratory at the University of Nijmegen while performing internship with Dr. William Isaacs working at The Brady Urological Institute at Johns Hopkins University. In 2003, DiagnoCure developed its second diagnostic test, uPM3, based on measuring the expression of the PCA3 molecular biomarker in urine. The uPM3 assay reagents were first sold in 2003 in the United States as analyte specific reagents (ASR). That same year, DiagnoCure entered into a licensing and collaboration agreement with Gen-Probe Incorporated (Gen-Probe), now a subsidiary of Hologic, Inc., for the development and commercialization of a test based on the PCA3 molecular biomarker.

In April 2007, DiagnoCure obtained an exclusive worldwide sublicense from Targeted Diagnostics and Therapeutics, Inc. to exploit the intellectual property of the Thomas Jefferson University related to the biomarker GCC in colorectal cancer and developed a third molecular test, for the staging of colorectal cancer, which was launched in August 2008 by the Corporation’s U.S. service laboratory, DiagnoCure Oncology Laboratories (DOL). The Corporation launched the test under the trade name Previstage® GCC Colorectal Cancer Staging Test. In June 2011, the test was licensed to a subsidiary of Signal Genetics LLC, CC Health LLC, which concurrently acquired the clinical laboratory assets of DiagnoCure Oncology Laboratories. In January 2013, all rights and licenses under the Signal Genetics license agreement reverted back to DiagnoCure. On June 4, 2014, DiagnoCure granted an exclusive license to Shuwen Biotech Co., Ltd. for commercialization of the Previstage® GCC test in the Greater China Region.

2.2 LAST THREE YEARS HISTORY OF THE CORPORATION

2.2.1 Fiscal Year 2012

2.2.1.1 Progress of PCA3 for prostate cancer

In February 2012, Gen-Probe announced that the FDA had approved its PROGENSA® PCA3 assay, the first molecular test for prostate cancer to help determine the need for repeat prostate biopsies in men who have had a previous negative biopsy.

In August 2012, Gen-Probe, DiagnoCure's exclusive licensee for PCA3 (Prostate Cancer Antigen 3) diagnostic applications was acquired and became a wholly-owned subsidiary of Hologic Inc. that from then began operating under the name "Hologic Gen-Probe".

2.2.1.2 Progress of Previstage® GCC Colorectal Cancer Staging Test

In January 2012, a study [1] confirming prognostic capabilities of the Previstage® GCC Colorectal Cancer Staging Test in patients with colon cancer was presented at the 2012 Gastrointestinal Cancer Symposium of the ASCO held in San Francisco, California.

In September 2012, DiagnoCure confirmed that Signal Genetics was no longer offering the Previstage® GCC test, as its laboratory in Pennsylvania had been closed.

2.2.2 Fiscal Year 2013

2.2.2.1 Progress of PCA3 for prostate cancer

In March 2013, DiagnoCure reported that a new research on the PCA3 had been featured at the 28th annual European Association of Urology (EAU) meeting held in Milan. Dr. Harry Rittenhouse spoke about the clinical utility of the urinary marker PCA3 during the International Conference on Prostate Cancer Prevention 2013 with Consensus Conference on Chemoprevention of Prostate Cancer.

2.2.2.2 Progress of Previstage® GCC Colorectal Cancer Staging Test

In January 2013, DiagnoCure announced that the development and license agreements between DiagnoCure and Signal Genetics entered into in June 2011 had been terminated. As a result, DiagnoCure regained all commercial rights and complete control of all intellectual property relating to its GCC biomarker and was released from any and all future obligations to Signal Genetics.

In June 2013, DiagnoCure reported that positive results of a new study for its Previstage® GCC Colorectal Cancer Staging Test had been presented during the 2013 American Society of Clinical Oncology (ASCO) Annual Meeting held in Chicago, Illinois. On a validation set, including 463 stage IIa (T3N0) colon cancer patients from North American and European sites, the study showed that molecular staging based on GCC LNR status was able to predict higher recurrence risk for 195 patients (42%) treated by surgery alone. None of the patients in the study had been treated with adjuvant chemotherapy because their lymph nodes appeared cancer-free by examination under the microscope, yet 10% of them had a disease recurrence or died from

[1] Sargent DJ et al., Evaluation of the prognostic value of guanylyl cyclase C (GCC) lymph node (LN) classification in patients with stage II colon cancer: A pooled analysis. *2012 ASCO Gastrointestinal Cancers Symposium.* Abstract 443

cancer afterwards [2]. These findings complemented those obtained during the first phase of the prospectively specified multi-center VITAR study performed on 241 stage II colorectal cancer patients which were published in 2011 [3].

2.2.2.3 Other highlights

In November 2012, following the departure of 3 board members, DiagnoCure's Board of Directors appointed Dr. Jacques Simoneau, President and Chief Executive Officer of Gestion Univalor L.P. and Mr. Andrew J. Sheldon, President and Chief Executive Officer of Medicago Inc. as directors.

Since April 2013, the Common Shares of the Corporation are traded on OTCQX International under the symbol "DGCRF".

In August 2013, DiagnoCure appointed Mr. Richard Bordeleau as Senior Advisor to the Board effective September 1, 2013. As an executive in residence reporting directly to DiagnoCure's Board of directors, and in collaboration with the Corporation's management, Mr. Bordeleau's initial mandate was to identify and implement short-term actions aimed at increasing shareholder value, and to evaluate mid- to long-term scenarios optimizing corporate value.

In October 2013, Mr. Frédéric Boivin, Senior Director, Finances and Administration, was appointed as interim Chief Financial Officer following the departure of Ms. Chantal Miklosi.

2.2.3 Fiscal Year 2014

2.2.3.1 Progress of PCA3 for prostate cancer

In 2014, DiagnoCure's flagship prostate cancer marker, PCA3, continued to be highly regarded by the medical community as a useful tool for the diagnosis and management of prostate cancer patients. The U.S. National Comprehensive Cancer Network (NCCN) recognized the utility and specificity of PCA3 in predicting biopsy outcomes, through recommendations of the test in its Clinical Practice Guidelines in Oncology (NCCN Guidelines) updated in March 2014 for Prostate Cancer Early Detection.

PCA3's attributes were featured during a panel discussing tests that distinguish aggressive from non-aggressive prostate cancer before biopsy during the annual meeting of the American Urological Association (AUA) held in May 2014 in Orlando. Dr. Yves Fradet discussed the value of PCA3 in selecting men for biopsy, and Dr. John T. Wei, Professor of Urology at the University of Michigan, discussed the advantages of integrating PCA3 and other biomarkers into clinical practice. In December 2014, Dr John T. Wei and colleagues published the results of the National Cancer Institute (NCI) Early Detection Research Network (EDRN) validation of PCA3 trial in the Journal of Clinical Oncology [4]. In the study, 859 men scheduled for diagnostic prostate biopsy were evaluated between 2009 and 2011. The researchers evaluated the positive predictive

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[2] Sargent DJ et al., Guanylyl cyclase C (GCC) expression in lymph nodes (LNs) as a determinant of recurrence in stage II colon cancer (CC) patients (pts). 2013 ASCO Annual Meeting. Abstract 3639

[3] Sargent DJ et al., Evaluation of guanylyl cyclase C lymph node status for colon cancer staging and prognosis. *Ann Surg Oncol* 2011;18:3261-70

[4] Wei JT et al., Can urinary PCA3 supplement PSA in the early detection of prostate cancer? *J Clin Oncol* 2014 Nov 10 [Epub ahead of print]

value of the PCA3 urine test at initial biopsy and the negative predictive value at repeat biopsy. When they looked at men with a PCA3 score of less than 20, 46% would have avoided a biopsy; however, of those men, 12% would have had an undiagnosed cancer and 3% would have had an undiagnosed high-grade cancer.

Notwithstanding the important clinical utility of the PCA3 test, the product is still not penetrating the market at levels commensurate with DiagnoCure's expectations. The Corporation believes that this could have been the result of a lack of marketing investment by the Corporation's exclusive PCA3 licensee, even though over the year 2014 DiagnoCure's management team has exerted a multi-faceted effort aimed at galvanizing a stronger commitment of its licensee to market the PCA3 test. However, DiagnoCure's initiative to purchase the entire Prostate Oncology Business Unit from its licensee in order to regain all PCA3 commercial rights and fully exploit its potential has not been adequately heeded by the licensee. Continual and insistent communications with the licensee were principally instigated by DiagnoCure's Board and management expecting that a beneficial outcome to the current situation might emerge, favorably impacting the Corporation's revenue stream and shareholder value.

2.2.3.2 Progress of Previstage® GCC Colorectal Cancer Staging Test

In June 2014, as part of its business development efforts, DiagnoCure reported the granting of an exclusive license to Shuwen Biotech Co., Ltd. for commercialization of the Previstage® GCC Colorectal Cancer Staging Test in the Greater China Region (China, Hong Kong, and Taiwan). This agreement included a commercial development plan where both corporations committed to a close collaboration that is expected to lead to expansion of the clinical use of the test. Discussions with other interested parties are continuing for other territories.

In August 2014, the results of the VITAR II retrospective clinical study of the Previstage® GCC test were published in the Clinical Cancer Research journal. This multicenter study led by Dr. Dan Sargent of the Mayo Clinic confirmed that the GCC status in lymph nodes of 366 stage II colon cancer patients can classify up to 60% of them as having a very low (8%) risk of recurrence at five years suggesting, that these patients may gain little benefit from toxic adjuvant chemotherapy.

2.2.3.3 Introduction of a new multimarker prostate cancer test

Building on its proprietary sample stabilizer and extraction method to conduct gene expression profiling in post-DRE urines, DiagnoCure's R&D team developed the Prostate Cancer Panel Risk Score (PCP Risk Score), a novel prostate cancer screening tool relying on the gene expression levels of several markers involved in the development and progression of prostate cancer to predict the presence of prostate cancer and likelihood of finding high grade cancer at biopsy using urine samples. The association of these markers within a multigene signature was achieved through a leading approach using the latest advances in bioinformatics. Change in the expression pattern of these markers is associated with a high probability of detecting cancer before the first biopsy.

At the end of 2013, DiagnoCure obtained a grant from the National Research Council of Canada supporting a clinical trial to validate its new multi-marker prostate cancer test. Study enrollment

was closed in August 2014 with a total of 503 men and study results have been submitted for presentation in upcoming international meetings.

Broadening of the Corporation's portfolio in the prostate cancer market segment was also supported by the filing of new patent applications which resulted in the PCT application published at the end of January 2014. Based upon the positive results of this clinical trial, DiagnoCure is pursuing out-licensing efforts of its new multimarker prostate cancer test.

2.2.3.4 Other highlights

During fiscal year 2014, DiagnoCure continued to strengthen its overall intellectual property portfolio. One more patent was obtained supporting the PCA3 biomarker in the United States. The Corporation was also granted patents from the European Patent Office (EPO), the Chinese Patent Office, and the Hong Kong Patent Office, all providing exclusive rights through February 2030 regarding use of the GCC marker to gain prognostic information based on the tumor burden measured at the molecular level in lymph nodes.

Effective October 31, 2014, a number of DiagnoCure's employees were temporarily laid off and the few remaining accepted a significant reduction of their working time and related compensation. Moreover, the President and Chief Medical Officer as well as all Board members have also elected to significantly reduce their compensation while maintaining their responsibilities.

SECTION 3 - THE BUSINESS OF DIAGNOCURE

3.1 CANCER OVERVIEW

"Cancer" is a general term used to describe a group of perhaps over 100 related diseases that are characterized by uncontrolled growth and spread of abnormal cells. The uncontrolled growth leads to the development of a mass of cells commonly known as a tumour, followed by invasion of the surrounding tissues and subsequent spread (metastasis) to other parts of the body.

After heart disease, cancer is the second leading cause of mortality and accounts for nearly one out of every four deaths in the United States. The American [5] and Canadian [6] Cancer Societies estimate that in 2014 approximately 1.86 million Americans and Canadians would be diagnosed with cancer and more than 662,000 would die from it. The U.S. National Cancer Institute estimated that there were nearly 14 million people in the United States with a cancer history as of January 2012. Slightly less than one out of two men and a little more than one out of three women will develop cancer in their lifetime. About 77% of all cancers are diagnosed in people aged 55 and older. According to the U.S. Centers for Disease Control and Prevention, cancer is poised to become the leading cause of death in the United States over the next decade, overtaking the current top killer, heart disease, and substantially adding to cancer's financial burden. Globally, the World Health Organization estimates that deaths from cancer will exceed 11 million in 2030.

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[5] American Cancer Society. Cancer Facts & Figures 2014. Atlanta: American Cancer Society; 2014

[6] Canadian Cancer Society's Advisory Committee on Cancer Statistics. Canadian Cancer Statistics 2014. Toronto, ON: Canadian Cancer Society; 2014

3.2 CANCER DIAGNOSTICS OVERVIEW

There is a growing focus on cancer diagnosis and management by healthcare providers and payers, because timely and accurate detection and ongoing management of disease means a better chance for patient survival and lower treatment costs. Diagnostics that provide more timely and accurate information about the presence, staging and prognosis of the cancer or likelihood of therapy response of a particular patient should result in a decrease in the number of cancer deaths, improved treatment of the disease, improved length and quality of life and reduced cost.

Purposes of diagnostic tests. The cancer diagnostics market is comprised of several overlapping categories, each corresponding to a stage in the identification and management of the disease. These categories include risk assessment, screening, differential diagnosis, staging, prognosis, therapy selection, therapeutic monitoring and surveillance. Screening tests and procedures, such as mammograms and Pap smears, are performed regularly on individuals who may have no evidence of illness because the tests are effective in revealing hidden, asymptomatic disease. Screening tests do not provide a diagnosis. The actual diagnosis of cancer is usually made after microscopic examination of a tissue obtained from a biopsy. Following the diagnosis, additional tests can be used to establish the stage of the disease, and to monitor its progression and the patient's response to a treatment. Monitoring tests may be repeated at regular intervals and may be continued over the life of an individual in order to detect any recurrence of cancer. Other diagnostic tests are used to evaluate a patient's prognosis in order to help the physician and patient select appropriate therapies. Patients identified as having a high risk of recurrence or a more aggressive form of disease are monitored more closely and may receive more aggressive treatment.

Ideally, a cancer diagnostic test should be both sensitive and specific in order to accurately detect the presence of disease. Clinical sensitivity refers to the percentage of positive cases in which a test correctly identifies the presence of disease. For example, a highly sensitive test is used to detect cancer in its early stages or to exclude a certain disease from a list of possible afflictions. In contrast, clinical specificity refers to the percentage of negative cases in which a test correctly identifies the absence of disease and so a highly specific test is used to confirm the presence of cancer when it is thought to be present or to confirm a diagnosis. Physicians rely on a combination of tests to identify the presence or absence of a disease. For example, in the case of prostate cancer, a positive PSA test, which has relatively good sensitivity but poor specificity can be complemented with a molecular test with much better specificity such as the PCA3 test.

In vitro diagnostics. *In vitro* diagnostics (IVD) generally refers to the laboratory tests used for detection of various substances found in tissues or body fluids such as whole blood, plasma, serum, urine, or saliva. *In vitro* refers to the fact that these tests are performed outside of the body, as distinguished from *in vivo*, which are tests performed within the body. Diagnostic imaging procedures, such as X-rays or angiography, are examples of *in vivo* testing. *In vitro* diagnostic tests are performed in a number of different clinical settings including hospital laboratories, commercial laboratories, physicians' offices, ambulatory care centers and at consumers' homes.

DiagnoCure believes that *in vitro* diagnostics allow healthcare providers to deliver more appropriate and timely care to the patient. Moreover, accurate *in vitro* diagnostic tests can

reduce the need for more invasive and often expensive procedures, such as surgery, biopsy, colonoscopy, bone scans and *in vivo* imaging for diagnosing and managing cancer. *In vitro* diagnostics are also becoming increasingly valuable for selecting, optimizing and monitoring the progress of new pharmaceutical treatments. Due to their important role in the diagnosis and treatment of patients, *in vitro* diagnostics are an integral part of cost efficient, high-quality patient care.

Molecular diagnostics. Molecular diagnostics are well-established in clinical medicine and continue to be a growing segment of the global *in vitro* diagnostics market. Despite representing a small percentage of overall healthcare costs today, the use of molecular diagnostics for cancer management will continue to capture an increasing share, backed by factors such as aging population, rising awareness among cancer patients and proper adoption by treating physicians. Molecular diagnostics, which focuses on how genes and proteins are interacting in a cell, allows the identification of expression patterns characteristic of a set of changes that can be used to identify cancer. Molecular diagnostics categorizes diseases using technologies such as polymerase chain reaction (PCR)-based methods, non-PCR methods, gene chips and microfluidic microarrays, nanodiagnostics, toxicogenomics, single nucleotide polymorphism genotyping, DNA methylation studies, gene expression based tests, DNA sequencing, cytogenetics, proteomic-based methods or molecular imaging Molecular diagnostics in oncology has had its greatest impact in the diagnosis and treatment of breast cancer, with multiple tests widely incorporated in clinical guidelines. Other oncology molecular diagnostics, including those for colorectal cancer, lung cancer and prostate cancer, represent significant opportunities to reduce the mortality due to cancer. In the fight against cancer, molecular diagnostics is not just an early detection tool; it is a disease management tool. Molecular diagnostics, in combination with targeted therapeutics and as a component of personalized medicine, will play an important role in integrated healthcare solutions based on its ability to help clinicians choose the most appropriate therapy for an individual patient at a specific point of his/her disease process.

The markets for molecular diagnostic technologies are difficult to accurately estimate, mainly due to the unpredictable nature of the technologies themselves and the adoption rates by healthcare practitioners. Global molecular diagnostics market is estimated to reach US$8.0 billion by 2018 at a Compound Annual Growth Rate of 9.7% during the forecast period 2013-2018 [7]. Regionally, North America accounts for the largest global molecular diagnostics market share. The driving forces of the molecular diagnostics market include the rising incidences of infectious diseases, genetic disorders, cancer, and technological developments like portability of equipment. The cancer segment of molecular diagnostics, which includes diagnostic products used for cancer screening, diagnosis, staging, therapeutic and relapse monitoring, while not the largest, is growing the fastest partly due to its ability to facilitate better outcomes and reduce healthcare expenditures. Molecular tests for oncology enable targeted cancer diagnosis as well as early detection through screening programs. In the prostate cancer market, the PSA test already generates US$1.25 billion in worldwide revenues annually [8] despite the ongoing controversy over its level of specificity.

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[7] Markets and Markets, Molecular Diagnostics Market by Application, Technology, End User, Product – Global Forecasts to 2018, June 2014

[8] PriceWaterhouseCoopers, Diagnostics 2011 : M&A Surges, Companion Diagnostics Accelerate, and Early Detection Offers New Prospects, Second Edition, December 2011

3.3 DIAGNOCURE PRODUCTS AND PROJECTS

3.3.1 Prostate Cancer

Prostate cancer is the most frequently occurring cancer in men, with an estimate of 256,546 new cases diagnosed in 2014 in North America. Furthermore, with an estimated 33,480 deaths in 2014, prostate cancer is the second-leading cause of cancer deaths in men, surpassed only by lung cancer. According to the U.S. National Cancer Institute, 97% of all patients diagnosed with prostate cancer are 55 years and older.

The standard screening method includes the measurement of PSA levels in blood combined with a digital rectal exam. PSA is produced by the prostate and is a type of enzyme known as a serine protease. It is secreted by prostatic epithelium and becomes a component of the seminal fluid. In normal men, small amounts of PSA leak into the blood and level can increase due to many conditions such as inflammation of the prostate, urinary retention, prostatic infection, benign prostatic hyperplasia, prostate cancer and prostatic manipulation. This is the reason why the value of the PSA test, which has traditionally been used for screening prostate cancer, to determine, in combination with a digital rectal exam whether a biopsy is necessary or for monitoring the recurrence of prostate cancer, is now increasingly questioned. Problems associated with PSA's lack of specificity, leading to unneeded biopsies and inability to detect aggressive cancers, have led companies such as Beckman Coulter and Opko Health to attempt to develop more suitable alternatives. The Beckman Coulter Prostate Health Index (phi), approved by the FDA in June 2012, and which integrates the serum concentrations of tPSA, fPSA and [-2]proPSA into a complex formula is one recent example of such attempts. The test specificity which is 2.5 times that of the PSA specificity in patients with PSA values in the 4-10 ng/mL range, is still lower than that of the PCA3 test.

A prostate biopsy is an invasive procedure consisting of the removal of cells or tissues for subsequent examination under a microscope. It is done by inserting an ultrasound probe in the rectum to guide collection of the needle biopsies (on average 8 to 12) in various prostate zones. Biopsies performed following an elevated PSA result in positive findings approximately one third of the time. The other two thirds of the time, the "false positive" PSA, could be due to one of the above mentioned factors.

Prostate cancer can be treated in a highly effective manner when localized in the prostate. Statistically, more than 90% of prostate cancers are discovered in local and regional stages. With the current focus on prostate cancer screening through PSA testing, the incidence of the disease has increased. The average age of diagnosis is also decreasing due to better diagnosis at an earlier stage.

While routine PSA testing has resulted in earlier and better detection of prostate cancer, recent studies [9] have shown that as many as 25% of patients with a negative PSA (<4.0 ng/ml) may have cancer and that a significant portion of these have an aggressive form of the disease. This lack of specificity and sensitivity of PSA has created a demand for a new test that would more

[9] Crawford ED, Ventii K, Shore ND. New biomarkers in prostate cancer. Oncology 2014 Feb; 28(2):135-42

accurately reflect whether the patient does, in fact, have cancer. It is estimated [10] that approximately 25 million serum PSA tests are performed each year in United States alone.

Moreover, in May 2012, the U.S. Preventive Services Task Force (USPSTF) issued a controversial recommendation against PSA-based screening for prostate cancer for men of all ages. The recommendation was based on a determination that the use of serum PSA to screen for prostate cancer lead to too many false positives, or overdiagnosis, leading to over-treatment which in turn can lead to important, often lasting harms such as erectile dysfunction, urinary incontinence, problems with bowel control and a small risk of death and serious complications.

3.3.1.1 Hologic's PROGENSA® PCA3 Test

The first version of a urine-based PCA3 test for prostate cancer developed by the Corporation was commercialized from 2003 until 2006 in an ASR format under the tradename uPM3. In November 2003, DiagnoCure executed a license and collaboration agreement with Gen-Probe for the development of an innovative, urine-based, nucleic acid test to detect the PCA3 biomarker for use as an aid in the diagnosis of prostate cancer. Under the terms of the agreement, Gen-Probe pays DiagnoCure royalties on cumulative end-user net product sales.

In December 2005, Gen-Probe made the ASR format of its first generation of a PCA3 test on its APTIMA® platform available to selected reference laboratories in the U.S. market. When two of these laboratories, namely Bostwick Laboratories and AmeriPath, announced the commercial availability of a PCA3 prostate cancer test based on Gen-Probe's analyte specific reagents in 2006, DiagnoCure received its first royalty revenues from Gen-Probe and withdrew its uPM3 reagents from the market in accordance with the license and collaboration agreement.

The PROGENSA® PCA3 test was approved by the FDA in February 2012, therefore allowing Gen-Probe (now Hologic Gen-Probe) to market and sell it in the United States for use in conjunction with other patient information, to help guide biopsy decisions for men who have had one or more prior negative biopsies. Hologic Gen-Probe's PROGENSA® PCA3 prostate cancer received CE-mark and has been marketed in Europe since November 2006 while Health Canada's approval for marketing in Canada was obtained in August 2011. Hologic Gen-Probe supports a dedicated multi-language website for PCA3 (www.pca3.org) where physicians and patients can find comprehensive information about the test.

As the field of prostate cancer is moving toward more integrated risk assessment to decide whether a prostate biopsy is necessary, many studies continue to examine the role of the urinary PCA3 score in conjunction with other urinary markers to enhance the specificity of screening and reduce unnecessary biopsies. In 2014 alone, more than 40 new clinical publications describing PCA3 were monitored, bringing the total of papers on PCA3 to more than 230.

The focus of these publications on PCA3 is varied: some confirm the utility of this biomarker in predicting the outcome of a biopsy in men who have had a prior negative biopsy, others demonstrate that PCA3 could be useful in allowing discrimination between indolent and aggressive prostate cancer, some others demonstrate that urinary PCA3 scores could predict the

[10] Constantinou J, Feneley MR. PSA testing: an evolving relationship with prostate cancer screening. Prostate Cancer Prostatic Dis. 2006; 9(1):6-13

presence of prostate cancer prior to an initial prostate biopsy. The relationship of PCA3 to disease volume and grade is also currently the object of studies in men enrolled in prospective active surveillance programs, providing preliminary evidence that PCA3 could allow discrimination between men at risk of aggressive cancer and those who could be placed on less intensive surveillance protocols with fewer repeated prostate biopsies, reducing the risks and costs of invasive procedures.

Although the results of most of these studies strongly advocate in favor of PCA3's utility in improving clinical decision making, the product is still not penetrating the market at levels commensurate with DiagnoCure's expectations. The PCA3 royalty revenues for FY2013 amounted to $671,228 while they were $531,266 for FY2014. The Corporation believes that this could have been the result of a lack of marketing investment by the Corporation's exclusive PCA3 licensee, even though over the year 2014 DiagnoCure's management team has exerted a multi-faceted effort aimed at galvanizing a stronger commitment of its licensee to market the PCA3 test. However, DiagnoCure's initiative to purchase the entire Prostate Oncology Business Unit from its licensee in order to regain all PCA3 commercial rights and fully exploit its potential has not been adequately heeded by the licensee. Continual and insistent communications with the licensee were principally instigated by DiagnoCure's Board and management expecting that a beneficial outcome to the current situation might emerge, favorably impacting the Corporation's revenue stream and shareholder value.

3.3.1.2 New multimarker prostate cancer test

The Corporation's mission is to develop and provide molecular and genomic tests to support effective clinical decisions enabling personalized medicine in oncology. Recent research activities have led DiagnoCure to identify genes involved in the development and progression of prostate cancer. Change in the expression pattern of these markers is associated with a high probability of detecting cancer before the first biopsy. The association of these markers within a multigene signature was achieved through a leading approach using the latest advances in bioinformatics. The mathematical score derived from this computation, the PCP Risk Score, is used to predict the probability of detecting prostate cancer and to identify high grade cancers from a urine sample, even before the first series of biopsies.

In October 2013, DiagnoCure undertook a validation study of the biomarkers of this signature to be used as an *in vitro* test for the early detection of prostate cancer. This prospective multicenter validation study allowed the enrollment of 503 men, which added to the 261 men of the discovery study, brought the number of men studied to a total of 764. In the prospective multicenter validation study, all assay procedures, gene panel and statistical algorithm were predefined. The predictive value of the PCP Risk Score was evaluated using non-parametric receiver operating characteristic (ROC) curve analysis and multivariate logistic regression analysis. In the discovery study, of the 109 men with PCa, 52 (48%) had Gleason ≥7 (HGPCa). Using ROC curves analysis, the PCP Risk Score had a greater accuracy than PSA in predicting prostate cancer. On multivariate logistic regression, the PCP Risk Score was independently and significantly associated with HGPCa detection at biopsy after controlling for established clinical factors such as age, abnormal DRE and prior biopsy history. Further standardization and validation studies are required before this approach can be translated into a hospital setting.

3.3.2 Colorectal Cancer

According to the American [5] and Canadian [6] Cancer Societies, colorectal cancer is the third most common cancer in both men and women respectively, and the second leading cause of death from cancer in North America. In 2014, it is estimated that approximately 161,200 people will be diagnosed with colorectal cancer and close to 60,000 will die from it in North America.

The overwhelming majority of colorectal tumours arise from polyps in the colon and rectum. Polyps are abnormal growth of tissue that protrudes inside the bowel. They are most frequently found by diagnostic/screening procedures; sigmoidoscopy for the rectum and the lower part of the colon, or colonoscopy for the entire large intestine. If polyps are found during these procedures, they are removed and sent to a pathology laboratory for sectioning and microscopic examination. If the pathology report confirms the presence of cancerous cells, surgery is scheduled to remove the tumour and surrounding area of the colon. At the same time, lymph nodes from the surrounding area are also routinely removed for microscopic examination to determine if the cancer has spread (metastasized) into the lymphatic system.

Traditionally, physicians have relied on the results from the histopathology examination of the lymph nodes to detect the spread of colon cancer, and the use of carcinoembryonic antigen (CEA) blood tests to determine colon cancer recurrence. However, these conventional methods are known to have serious deficiencies. Both testing methods can be inaccurate, reflecting errors in sampling, or limited specificity and sensitivity. Studies generally suggest that up to 20% of patients with no pathologically-positive lymph nodes (stage I and II cancers) later develop recurrent disease, presumably through occult metastases that have escaped detection. Similarly, current CEA-based blood tests detect less than 60% [11] of recurrent cancers.

3.3.2.1 Guanylyl Cyclase C

Dr. Scott Waldman, of Thomas Jefferson University, first identified the guanylyl cyclase C (GCC or GUCY2C) gene and protein as uniquely identifying colorectal cells in the early 1990's. The molecule is only found in normal and cancer colorectal cells but not on any normal cells outside the intestine. By using a sensitive messenger RNA-based amplification technology rather than other less sensitive and variable detection systems, such as histopathology (microscopic examination), Dr. Waldman found that GCC could provide a superior method for detecting the presence of colorectal cancer cells outside of the intestinal tract. He proposed that, if GCC was found in the lymph nodes of a colorectal cancer patient, it would be an early indication that the colorectal cancer has spread and thus would represent a significant improvement over current histopathology methods.

The U.S. National Institutes of Health (NIH) funded two GCC five-year multicenter prospective clinical studies led by Dr. Waldman on a total of 2,500 colorectal cancer patients. The first study aimed to demonstrate the usefulness of GCC in staging colorectal cancer patients by identifying the presence of GCC in the lymph nodes surrounding the colorectal tumour; the second study aimed to show the usefulness of identifying GCC in the blood to better monitor patients after their surgery and treatment.

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[11] Mc Call JL et al., The value of serum carcinoembryonic antigen in predicting recurrent disease following curative resection for colorectal cancer. DIS COLON RECTUM 1994; 39: 875-881

The results of the GCC lymph node study for staging colorectal cancer, which started in 2003, were published in February 2009[12]. The study was conducted by investigators from Thomas Jefferson University, with contributions from McGill University, the Fox Chase Cancer Center and others. Including 425 enrolled patients, the study demonstrated that guanylyl cyclase C is the strongest independent predictor of colorectal cancer recurrence in patients considered low risk by current assessment methods. In a group of 257 colorectal cancer patients who were thought to have a lower risk of recurrence according to histopathology (stage I and II patients), when GCC was considered with other factors, patients whose nodes were GCC positive were 4.7 times more likely to develop disease recurrence than those whose nodes were GCC negative, and 3.3 times more likely to die within three years. In fact, patients with GCC positive nodes had a risk of recurrence and survival rate comparable to that of patients considered of a higher risk by histopathology (stage III).

In April 2007, DiagnoCure secured exclusive worldwide diagnostic rights to the GCC biomarker from Targeted Diagnostics & Therapeutics, Inc.

3.3.2.2 Previstage® GCC Colorectal Cancer Staging Test

As a laboratory-developed test, the Previstage® GCC Colorectal Cancer Staging Test was initially developed and its technical characteristics validated by DiagnoCure Oncology Laboratories, a high-complexity laboratory certified under U.S. CLIA regulation from August 2008. In June 2011, the laboratory operations of the U.S. CLIA laboratory were acquired by a subsidiary of Signal Genetics, CC Health LLC, and a worldwide license on the Previstage® GCC test granted to the same company. Signal Genetics ceased to offer the test at the end of July 2012. Under the terms of a settlement and mutual release agreement, the development and license agreements between Signal Genetics and DiagnoCure were terminated at the beginning of 2013 and DiagnoCure regained all commercial rights and complete control of all intellectual property relating to its GCC biomarker.

Staging is a method of evaluating the progress of the cancer in a patient. It is based on how far the cancer has grown into the wall of the intestine, whether or not it has reached nearby structures, and whether or not it has spread to the lymph nodes or distant organs. The stage of colorectal cancer is one of the most important factors in determining prognosis and treatment options.

Current standards of practice require that pathologists microscopically examine a thin slice section (5 µm) of tissue from each of the lymph nodes harvested during the patient's surgery to see if cancer has spread. When looking at each section microscopically, at least 1 cancer cell must be present in every 200 normal cells to be detected. Currently, up to 20% of patients with no pathologically-positive lymph nodes (stage I and II cancers) later develop recurrent disease, presumably through occult metastases that have escaped detection. Most of these patients do not receive additional therapies such as chemotherapy.

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[12] Waldman SA, Hyslop T, Schulz S, Barkun A, Nielsen K, Haaf J, Bonaccorso C, Li Y, Weinberg DS., Association of GUCY2C expression in lymph nodes with time to recurrence and disease-free survival in pN0 colorectal cancer. *JAMA* 2009; 301:745-52

In contrast, the technology employed in Previstage® GCC can detect 1 cancer cell among up to 10 million normal cells. Moreover, the method examines an average of 375 times more nodal tissue compared to traditional pathologic examination using light microscopy. In the test, minute quantities of GCC messenger RNA are amplified to magnify the presence of cancer cells. For patients with colorectal cancer, lymph node metastases represent a prevailing prognostic indicator for both risk or disease recurrence and survival. Recurrence risk is determined primarily by disease stage and studies have demonstrated that Previstage® GCC could be a leap forward which would provide physicians with a significantly more sensitive tool for staging patients with colorectal cancer. More accurately determining the disease stage can assist physicians in making the appropriate treatment decisions such as adjuvant chemotherapy. Early treatment may reduce the possibility of recurrence and associated mortality rate.

The Previstage® GCC test uses an analytical cut-off to discriminate between the positive and negative results. The cut-off value is defined as the test's limit of detection (LOD). A value exceeding the LOD is comparable to values found in histopathology positive lymph nodes from Stage III colon cancer patients. A value less than the LOD is comparable to values found in lymph nodes from patients with other diseases. The studies performed in 2008 by DiagnoCure showed a diagnostic sensitivity of 92% and diagnostic specificity of 98% for Previstage® GCC.

Clinical validation

A retrospective study, called VITAR (standing for Validating Indicators To Associate Recurrence), started in 2009, involved 241 patients in a first phase and allowed to establish an optimal cut-off for GCC. In January 2011, the results of the VITAR study were presented at the ASCO Gastrointestinal Cancers Symposium by the study Principal Investigator, Daniel Sargent, PhD, Professor of Biostatistics and Oncology at Mayo Clinic [13]. The study included 241 stage II colon cancer patients from six North American clinical sites and aimed at further classifying the risk of recurrence of these patients. Stage II colon cancer patients considered as low risk by traditional methods have an average recurrence rate of 20%. In this population, the study demonstrated that Previstage® GCC can stratify patients into high and low recurrence risk groups, thereby providing relevant and more accurate clinical information for physicians to make more personalized treatment decisions. In May 2011, the results of the same study [14] were published in the peer-reviewed journal Annals of Surgical Oncology, with Dr. Daniel J. Sargent as lead author. In order to establish a risk of recurrence (prognosis) for these patients, the study focused on the positive lymph node (LN) ratio, defined as the number of nodes in which cancer cells were identified with the Previstage® GCC test, divided by the total number of nodes examined. This LN ratio approach was able to significantly predict higher recurrence risk for 84 patients (35%). In fact, the estimated recurrence rates at five years after surgery were 27% for patients with a LN ratio equal to or higher than 1/10 (high-risk group), and 10% for patients with a LN ratio under 1/10 (low-risk group).

[13] Sargent DJ et al., GCC expression in lymph nodes (LNs) as a significant determinant of recurrence in stage II colon cancer (CC) patients (pts). 2011 ASCO Gastrointestinal Cancers Symposium. Abstract 369

[14] Sargent DJ et al., Evaluation of guanylyl cyclase C lymph node status for colon cancer staging and prognosis. *Ann Surg Oncol* 2011;18:3261-70

The second phase of this study was called VITAR II. Its results were first presented at the 2013 ASCO meeting [15] and then published in 2014 in the Clinical Cancer Research [16] journal. The study focused on a validation set including 463 stage IIa (T3N0) colon cancer patients from North American and European sites showed that molecular staging based on GCC LNR status was able to predict higher recurrence risk for 195 patients (42%) treated by surgery alone. All patients had not been treated with adjuvant chemotherapy mainly because their lymph nodes appeared cancer-free by examination under the microscope, yet 10% of them had a disease recurrence or died from cancer afterwards. In the final study cohort (n=366), the Previstage® GCC test classified 21.8% of patients as having a high risk of recurrence following surgery, 17.5% at intermediate risk and 60.7% of patients at low risk of recurrence. In this subset analysis, the 5-year recurrence risk was estimated at 8% and 22% for the low and high risk groups respectively, with a hazard ratio of 2.7 (p=0.006) supporting the prognostic capabilities of the GCC nodal status as an independent risk factor.

A new study published online in December 2014 in the Clinical Colorectal Cancer journal showed that the Previstage® GCC colorectal cancer staging test is predictive of disease recurrence in low-risk patients who have had curative resection of colon cancer. This study demonstrated that quantitative assessment of GCC mRNA levels in lymph nodes can be used to detect the presence of occult metastases and that patients considered at high risk based on their GCC LNR status have significantly inferior outcomes compared to those with low GCC LNR values, particularly among those traditionally considered to be at low risk for recurrence.

Sales and Marketing

In August 2008, DiagnoCure Oncology Laboratories had received U.S. CLIA certification for performing high-complexity clinical tests, and commercialized the Previstage® GCC Colorectal Cancer Staging Test. Between 2008 and June 2011, commercialization efforts were deployed to offer Previstage® GCC to targeted physicians until DiagnoCure U.S. operations were acquired by CC Health LLC, a subsidiary of Signal Genetics. At the time of its transfer to Signal Genetics in June 2011, the laboratory had obtained licenses for processing patient samples in all states, including the states of Pennsylvania (home state), California, Florida, Maryland, Rhode Island and New York. CC Health LLC (Signal Genetics) was also granted an exclusive worldwide license to the Previstage® GCC test by DiagnoCure.

Throughout the operation by DiagnoCure of its CLIA-certified laboratory, the Previstage® GCC Colorectal Cancer Staging test was exhibited at key medical conferences in the U.S. The Gastrointestinal Cancers Symposium of the ASCO and the American Society of Colon and Rectal Surgeons (ASCRS) meeting were preferred forums to reach a key interested audience.

Out-licensing

In January 2013, DiagnoCure entered into a settlement and mutual release with Signal Genetics under which the development and license agreements entered into in June 2011 were terminated. DiagnoCure regained all commercial rights and complete control of all intellectual

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[15] Sargent DJ et al., Guanylyl cyclase C (GCC) expression in lymph nodes (LNs) as a determinant of recurrence in stage II colon cancer (CC) patients (pts). 2013 ASCO Annual Meeting. Abstract 3639

[16] Sargent DJ et al., Molecular testing for lymph node metastases as a determinant of colon cancer recurrence: results from a retrospective multicenter study. *Clin Cancer Res.* 20(16):4361-9

property relating to its GCC biomarker. The Corporation undertook discussions during the fall of 2013 to have multiple partners market the test, both in North America and Europe. In June 2014, an exclusive license was granted to Shuwen Biotech Co., Ltd. for commercialization of the Previstage® GCC colorectal cancer staging test in the Greater China Region (China, Hong Kong, and Taiwan). Discussions with other interested parties are continuing for other territories.

3.3.3 Bladder Cancer Test

In July 2008, DiagnoCure entered into a product divestment agreement for its bladder cancer test, ImmunoCyt™/uCyt+™, with Scimedx Corporation, a U.S.-based company. As a result, the test for monitoring superficial bladder cancer is now commercialized by Scimedx.

3.3.4 Services

Since its foundation 20 years ago, DiagnoCure's Québec-based R&D laboratory has been actively involved into the development and validation of several IVD products focused on fulfilling unmet clinical needs. Any product development performed by DiagnoCure's R&D team had been conducted using processes compliant with requirements of the ISO 13485 standard and of the FDA Quality System Registration (QSR). Based upon the recommendation from the *Laboratoire de santé publique du Québec* (LSPQ), DiagnoCure's laboratory also holds a license from the *Ministère de la Santé et des services sociaux du Québec* (MSSS) for the operation of a medical laboratory anatomopathology and the biochemistry fields.

DiagnoCure also has access to a large repository of well annotated biospecimens acquired through the years for many cancers enables the realization of new projects for multiple applications with unparalleled efficiency and rigor.

3.4 INTELLECTUAL PROPERTY

DiagnoCure's products are developed in-house through research done internally or through the acquisition of rights on third parties technologies. The time and substantial investments required to develop these technologies and products as well as the efforts required to obtain regulatory approvals, warrant that the Corporation timely seeks sound patent protection.

The Corporation is overseeing patent prosecution for many technologies, whether proprietary or obtained through exclusive licenses. Typically, applications would first be filed under the Patent Cooperation Treaty (PCT) and national phase would be entered in the United States, Canada, Europe, Japan and other countries as may be deemed appropriate, in accordance with the Corporation's development and commercialization plans. Furthermore, the filing of provisional applications to ensure the earliest possible protection of new and inventive solutions considered of interest is a prudent safeguarding of the intellectual property assets of the Corporation.

3.4.1 Current Patent Portfolio

DiagnoCure owns or has obtained worldwide exclusive rights to the technologies covered by the following patents and patent applications:

Patents and/or Patent Applications	Status	Patent Number / Expiration Date
PCA3, PCA3 Genes and Methods of Use PCT/CA98/00346 (WO98/045420) Assignees: Radboud University Nijmegen Medical Centre and Johns Hopkins University Inventors: M. Bussemakers (Nijmegen) et W. Isaacs (JHU) Priority Date: 1997-04-10	PCT National Phase Entries	
Canada	Issued (2007-08-07)	**2,286,304** (2018-04-09)
Europe (Validated in Austria, Belgium, France, Germany, Italy, Netherlands, Spain, Sweden, Switzerland, United Kingdom)	Issued (2009-03-18)	**1007650** (2019-10-27)
Europe (Validated in Austria, Belgium, France, Germany, Italy, Netherlands, Spain, Sweden, Switzerland and United Kingdom)	Issued (2012-10-24)	**2060630** (2018-04-09)
Japan	Issued (2007-07-06)	**3981416** (2018-04-09)
United States	Issued (2006-03-07)	**7,008,765** (2018-04-09)
United States	Issued (2009-12-15)	**7,632,643** (2018-04-09)
United States	Issued (2013-10-08)	**8,551,699** (2018-04-09)
United States (divisional)	Pending	
PCA3 messenger RNA species in benign and malignant prostate tissues PCT/CA00/01154 (WO 2001/023550) Assignee: DiagnoCure Inc. Inventors: U. Busse & *al.* Priority Date: 1999-09-29	PCT National Phase Entries	
Canada	Issued (2009-11-03)	**2,385,477** (2020-09-29)
Europe (Validated in Austria, Belgium, France, Germany, Italy, Netherlands, Spain, Sweden, Switzerland, United Kingdom)	Issued (2006-03-29)	**1222266** (2020-09-29)
Japan	Issued (2008-04-18)	**4113228** (2020-09-29)
Japan	Issued (2010-07-16)	**4550873** (2020-09-29)
United States	Issued (2008-05-06)	**7,368,545** (2020-09-29)
United States	Issued (2010-02-02)	**7,655,408** (2020-09-29)
United States	Issued (2011-04-19)	**7,927,806** (2020-09-29)
United States	Issued (2012-08-14)	**8,241,848** (2020-09-29)
United States	Issued (2013-12-31))	**8,618,276** (2020-09-29)
United States (divisional)	Pending	

Patents and/or Patent Applications	Status	Patent Number / Expiration Date
Nucleic acid molecules comprising the promoter for PCA3, a new prostate antigen, and uses thereof Assignee: Radboud University Nijmegen Medical Centre Inventors: M. Bussemakers & *al.* Priority Date: 2001-05-31		
Canada	Issued (2008-07-08)	**2,357,073** (2021-09-07)
United States	Issued (2005-05-24)	**6,897,024** (2021-11-30)
United States	Issued (2006-11-21)	**7,138,235** (2021-11-30)
Method to Detect Prostate Cancer in a Urine Sample PCT/CA2004/000170 (WO 2004/070056) Assignee: DiagnoCure Inc. Inventors: Y. Fradet & *al.* Priority Date: 2003-02-07	PCT National Phase Entries	
Australia	Issued (2013-04-26)	**2010201155** (2024-02-09)
Canada	Issued (2014-12-30)	**2,513,780** (2024-02-09)
Europe (Validated in Austria, Belgium, France, Germany, Italy, Netherlands, Spain, Sweden, Switzerland, United Kingdom)	Issued (2013-04-10)	**1592809** (2024-02-09)
Japan	Issued (2011-09-16)	**4824540** (2024-02-09)
United States	Issued (2012-06-05)	**8,192,931** (2024-02-09)
United States	Issued (2013-10-01)	**8,546,551** (2024-02-09)
United States (divisional)	Pending	
Specific Method of Prostate Cancer Detection based on PCA3 Gene and Kits Therefor PCT/EP2004/007124 Assignee: Radboud University Nijmegen Medical Centre Inventors: J. A. Schalken & *al.* Priority Date: 2003-06-30	PCT National Phase Entries	
Australia	Issued (2013-04-26)	**2010201771** (2024-06-30)
Canada	Pending	
Europe (Validated in Austria, Belgium, France, Germany, Italy, Netherlands, Spain, Sweden, Switzerland, United Kingdom)	Issued (2011-11-30)	**1639138** (2024-06-30)
Japan	Issued (2011-05-13)	**4741481** (2024-06-30)
mRNA Ratios in Urinary Sediments and/or Urine as a Prognostic and Theranostic Marker for Prostate Cancer PCT/EP2005/014021 Assignee: Radboud University Nijmegen Medical Centre Inventors: J. A. Schalken & *al.* Priority Date: 2004-12-24	PCT National Phase Entries	
Australia	Issued (2012-05-24)	**2005318369** (2025-12-23)
Canada	Pending	

Patents and/or Patent Applications	Status	Patent Number / Expiration Date
Europe (validated in Austria, Belgium, Denmark, France, Germany, Ireland, Italy, Netherlands, Spain, Sweden, Switzerland and United Kingdom)	Issued (2010-02-10)	**1761651** (2025-12-23)
Europe (divisional)	Pending	
Hong Kong	Pending	
Japan	Issued (2012-03-09)	**4944041** (2025-12-23)
United States	Issued (2011-06-14)	**7,960,109** (2027-08-17)
United States	Issued (2012-09-04)	**8,257,924** (2025-12-23)
United States (divisional)	Pending	
Compositions that specifically bind to colorectal cancer cells and methods of using the same PCT/US94/012232 Assignee: Thomas Jefferson University Inventor: S. A. Waldman Priority Date : 1993-10-26		
United States	Issued (2000-05-09)	**6,060,037** (2016-04-26)
Methods of and kits and compositions for diagnosing colorectal tumors and metastasis thereof Assignee: Thomas Jefferson University Inventor: S. A. Waldman Priority Date: 1994-09-13		
United States	Issued (2005-09-13)	**6,942,985** (2015-10-30)
United States	Issued (2008-07-22)	**7,402,401** (2015-03-31)
Methods of and kits and compositions for diagnosing colorectal tumors and metastasis thereof Assignee: Thomas Jefferson University Inventors: S. A. Waldman & *al.* Priority Date: 1996-05-03		
United States	Issued (2003-08-05)	**6,602,659** (2017-05-02)
Compositions that specifically bind to colorectal cancer cells and methods of using the same Assignee: Thomas Jefferson University Inventors: S. A. Waldman & *al.* Priority Date: 1997-08-07		
Australia	Issued (2003-01-03)	**738,504** (2018-08-07)
Canada	Issued (2013-01-08)	**2,299,630** (2018-08-07)
Europe	Pending	
Japan	Issued (2010-02-12)	**4456266** (2017-08-07)
United States	Issued (2000-09-19)	**6,120,995** (2017-08-07)
United States	Issued (2006-11-14)	**7,135,333** (2019-05-08)
United States	Issued (2008-01-08)	**7,316,902** (2018-06-11)

Patents and/or Patent Applications	Status	Patent Number / Expiration Date
Method for detecting metastasis of GI cancer Assignee: DiagnoCure Inc. Inventors: J,-F. Haince & *al.* Priority Date: 2009-02-25	PCT National Phase Entries	
Australia	Pending	
Canada	Pending	
China	Issued (2014-04-02)	**102333887** (2030-02-24)
Europe	Issued (2013-11-27)	**2401394** (2030-02-24)
Europe	Pending	
Hong Kong	Issued (2014-04-17)	**1165836** (2030-02-24)
Japan	Pending	
United States	Pending	
Shc protein-related methods and compositions for the prognosis of breast, prostate and ovarian cancer Assignee: Roger Williams Hospital Inventors: A. R. Frackelton Jr. & al. Priority Date: 2002-03-01		
Australia	Issued (2010-08-13)	**2003228225** (2022-03-01)
Japan	Issued (2011-03-04)	**4694786** (2023-02-28)
United States	Issued (2011-03-22)	**7,910,314** (2025-09-25)
Methods for prognosing the recurrence of gastrointestinal and other cancers using the Shc proteins Assignee: Catalyst Oncology LP Inventors: A. R. Frackelton Jr. & al. Priority Date: 2006-01-20		
United States	Issued (2013-11-19)	**8,586,320** (2027-05-05)
Methods, kits and compositions for providing a clinical assessment of prostate cancer Assignee: DiagnoCure inc. Inventors: J.-F. Haince. & al. Priority Date: 2012-07-20		
PCT	Pending	

In addition to the intellectual property rights listed above, DiagnoCure relies upon and will continue to rely upon trade secrets, exclusive non-patented know-how and continuous technological innovation in order to increase and maintain the Corporation's competitive position. To protect legal rights in the Corporation's technologies and know-how, whether or not patent protection has been sought, the Corporation has a policy of entering into confidentiality agreements with employees, consultants, licensees and collaborators.

3.4.2 Current In-License Agreements

Radboud University Nijmegen Medical Center and Johns Hopkins University – The discovery of the PCA3 biomarker, which is located on chromosome 9, was performed by Marion J. Bussemakers of the Radboud University Nijmegen Medical Center (RUNMC), while she was performing post-doctoral studies in the laboratory of Dr. William B. Isaacs of the Johns Hopkins University, in Baltimore. DiagnoCure holds exclusive worldwide licenses from both academic

institutions to which the two inventors had assigned their respective rights. The license with the RUNMC also covers other inventions related to the PCA3 biomarker, which formed the basis of the Corporation's first generation of a PCA3 test for prostate cancer, uPM3™, and Gen-Probe's PCA3 test (see *DiagnoCure Products and Projects – PCA3 Prostate Cancer Test*).

Targeted Diagnostics & Therapeutics, Inc. – Through a licensing agreement executed in April 2007, DiagnoCure obtained the worldwide exclusive rights for the development of *in vitro* diagnostic tests for humans based on guanylyl cyclase C (GCC), a biomarker belonging to Thomas Jefferson University. GCC, which is normally expressed in cells lining the intestinal tract, is only detected outside the intestine when colorectal cancer has metastasized. A GCC-based test can be useful for detecting the presence of metastatic colorectal cancer.

Roger Williams Medical Center – Through its acquisition of Catalyst Oncology, Inc., in August 2007, DiagnoCure became a worldwide exclusive licensee of the Roger Williams Medical Center of Providence, Rhode Island, as it pertains to intellectual property related to the Shc proteins for prognosticating breast cancer. The p66 Shc protein and the activated tyrosine phosphorylated Shc protein are involved in well documented cellular pathways that are correlated with tumor aggressiveness across many types of cancers, offering a broad opportunity for clinical testing.

3.4.3 Trademarks

As a result of applications filed in 2009, the Corporation's trademark "Previstage" is currently registered in Canada, in Europe and in the United States. The trademark "uPM3" that had been used to market the first PCA3 product is still registered in Canada.

3.5 REGULATORY AFFAIRS AND GOVERNMENT REGULATIONS

In most industrialized countries, *in vitro* diagnostic products are considered as medical devices. As a result, their marketing, production and sale are regulated by government agencies in order to ensure that only safe and effective products are advertised and distributed. The following provides an overview of the current regulatory environment in the United States, Canada and the European Union, the primary markets for DiagnoCure's products. Other markets may have different requirements. The requirements described below are subject to change by regulatory agencies.

3.5.1 United States

In the United States, the Food and Drug Administration (FDA) regulates the advertising, production and sale of *in vitro* diagnostic devices. Devices fall into three classes, I, II or III. Class I devices, the lowest risk, requires the least stringent controls and the highest risk Class III devices requires the most stringent controls. All three classes are subject to general controls, which include facilities (production site) registration of compliance with the Good Manufacturing Practices (GMP) and Quality System Regulation requirements (QSR) 21 CFR 820. The lowest risk Class I devices are only subject to general controls with no submission process. Intermediate risk Class II devices are subject to general controls and Premarket Notification (often called "510(k)"), in order to establish substantial equivalence to a legally marketed product under Class II. High-risk Class III devices are subject to general controls and Premarket Approval (PMA), in order to establish the safety and effectiveness of the device. Most *in vitro* diagnostic products, which are based upon novel biomarkers or assay technology, or products intended for

screening asymptomatic individuals or diagnosing symptomatic patients, are subject to a PMA submission. In certain cases, novel biomarkers can be classified in class II and be subject to a *de novo* 510(k). The review process, together with requests for additional information, usually takes between 12 and 24 months after completion of all clinical trials and submission of the application for approval.

It is possible for manufacturers to market, in the United States, reagents to be used in the development of diagnostic tests. These reagents, regulated under the Analyte Specific Reagents (ASR) guidelines, are meant to be used by *in vitro* diagnostic manufacturers, clinical laboratories (which bear the responsibilities associated with the development of tests made with ASRs) or organizations that use the reagents to make tests for purposes other than providing diagnostic information to patients and practitioners. ASRs are divided into three classes: Class III for reagents used in tests on high risk contagious diseases, Class II when reagents are used in tests for blood banks and Class I for other tests. Class III ASRs require a PMA, Class II a 510(k) while Class I, contrary to the diagnostic kit that must be submitted to regulatory authorities before commercialization, does not require a FDA filing. Even if regulatory requirements are less stringent for ASRs of Class I, manufacturers must comply with certain rules.

3.5.1.1 Laboratory Developed Tests

The Centers for Medicare & Medicaid Services (CMS) oversee laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). The objective of the CLIA program is to ensure quality laboratory testing.

CLIA-certified laboratories can develop, validate and commercialize their own tests, called "Laboratory-Developed Tests" or LDTs, without having to file an FDA submission. The CLIA regulations however require that all LDTs be rigorously documented by the laboratories. Therefore, before the laboratory begins testing and reporting patient results, the LDT must be analytically validated for reproducibility, performance, precision and accuracy. Licensing of the laboratory will occur only if the test has been shown to be robust, safe and performed using valid quality control measures. In all, the laboratory not only accepts samples, performs testing and reports results, but also conducts quality control and assurance reviews, performs proficiency testing, competency reviews and maintains records of all customer complaints or issues. Periodic inspections of the laboratory by state and federal agencies are conducted to ensure continuing patient safety and compliance with CLIA regulations.

In addition, some states require specific licensing to allow out-of-state clinical laboratories to receive and perform testing of their residents' samples.

3.5.2 Canada

Health Canada, under the authority of the *Food and Drugs Act*, regulates the sale of medical devices and drugs in Canada. *In vitro* diagnostic devices are classified into one of four risk classes based on how the device is represented for use by the manufacturer. The Canadian classes generally correspond to the European four classes. Manufacturers must hold a license for Class II, III and IV medical devices imported, sold or advertised for sale in Canada, which license is delivered by Health Canada upon satisfactory evidence that the device meets the applicable safety and effectiveness requirements. A device license is subject to annual renewal. Any filing with Health Canada must strictly be accompanied with a proof that the corporation holds a

quality system certification conforming to the CAN/CSA ISO 13485:2003 standard, which certification can only be obtained through an organization recognized through the Canadian Medical Devices Conformity Assessment System (CMDCAS).

3.5.2.1 Laboratory Developed Tests

A license issued by the *Ministère de la santé et des services sociaux du Québec*, upon recommendation from the LSPQ, is required to operate a medical laboratory in the province of Québec. Accreditation to the ISO 15189:2012 standard may be required as additional proof of quality and competence of a laboratory. Periodic inspections of a laboratory by LSPQ, and, if applicable, of a recognized accrediting-body to the ISO 15189 standard, would be conducted to ensure continuing patient safety and compliance with standards. LSPQ and/or ISO 15189 accredited laboratories in Canada can develop, validate and commercialize their own tests, called "Laboratory-Developed Tests" or LDTs.

3.5.3 European Union

In Europe, the Medical Device Directive of 1993 (MDD) and the *In Vitro* Diagnostic Medical Device Directive of 1998 (IVD MDD or IVD Directive) describe essential requirements for medical devices, which are classified into four categories. Compliance with the essential requirements of these directives is mandatory before the CE marking can be legally placed on a product or associated labeling. In addition, to be proven fit for the CE marking, a European-based notified body, or alternatively a Canadian-based affiliated registrar, must have certified that the quality system of the device manufacturer is compliant with the requirements of the EN ISO 13485:2012 standard. For both MDD and IVD MDD, the manufacturer is required to be proactive in monitoring post-production performance of its product and in establishing and maintaining a system for reporting and acting upon incidents affecting the health and/or safety of the patient or user or others.

3.5.4 HIPAA and Other Privacy Laws

In the United States, the *Health Insurance Portability and Accountability Act of 1996*, or HIPAA, established for the first time comprehensive protection for the privacy and security of health information. Healthcare providers conducting certain healthcare transactions electronically are considered as Covered Entities and are subject to the provisions of the HIPAA regulations regarding the privacy and the security of health data, the standardization of identifying numbers used in the healthcare systems and the standardization of data content, codes and formats used in healthcare transactions. An active program designed to address regulatory compliance issues is maintained and administrative, physical, and technical standards put in place to guard against the abuse of individually identifiable health information. Penalties for non-compliance with HIPAA include both civil and criminal penalties. In addition to the federal privacy regulations, there are a number of state laws regarding the confidentiality of health information that are applicable to clinical laboratories.

In Canada, the applicable privacy laws include, but are not limited to the Personal Information Protection and Electronic Documents Act (Canada) (PIPEDA), the Personal Information Protection Act, 2003, S.B.C., c. 63 (PIPA), the Freedom of Information and Protection of Privacy Act, R.S.B.C. 1996 c. 165 (FOIPPA) and the *Loi québécoise sur la Protection des renseignements personnels dans le secteur privé* (L.R.Q., chapitre P-39.1). Companies doing business with

countries of the European Union have to comply with the Directive 95/46/EC of October 24, 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data.

3.6 COMPETITION

The development and commercialization of cancer diagnostics is a highly competitive market, characterized by rapid technological changes. There are many pharmaceutical companies, biotechnology companies, public and private universities and research organizations actively engaged in the research and development of cancer diagnostic products and some of them have financial and human resources greater than those of the Corporation.

3.6.1 Products Competing with the Hologic Gen-Probe's PCA3 Test

The Corporation believes that there is currently no gene expression profiling test on the market that has characteristics or features resembling the Hologic Gen-Probe's PROGENSA® PCA3 urine-based assay, which is indicated for use in conjunction with other patient information to aid in the decision for repeat biopsy in men 50 years of older who have had one or more previous negative prostate biopsies and for whom a repeat biopsy would be recommended by a urologist based on current standard of care, before consideration of the results of the assay.

The other products discussed thereafter are applicable only for patients who have already had a biopsy. Tests, such as the MDxHealth's ConfirmMDx genetic test that relies on tissue samples collected during a prostate biopsy require preparations by a pathologist and shipping of the material for analysis. All these multiple costly steps, combined with the lack of predictive value for men who have not undergone a biopsy, cannot approach the pharmacoeconomic benefits of the PROGENSA® PCA3 assay. Tests which are based on the biopsy itself, unlike PROGENSA®PCA3, cannot be repeated based on the same biopsy specimen.

MDxHealth is currently offering a genetic test that detects an epigenetic field effect to identify genetic DNA modification associated with prostate cancer. This prostate cancer test known as ConfirmMDx is aimed at helping urologists distinguish patients who have a true-negative biopsy from those at high risk for occult cancer. Earlier in 2014, MDxHealth reported results of a blinded multicenter clinical validation of the ConfirmMDx suggesting that 25% of unnecessary biopsies could be avoided. The multicenter trial enrolled 350 PSA-screened men with negative prostate biopsies and compared assay results to cancer detection in subsequent repeat biopsies within 24 months.

Mitomics' Prostate Core Mitomic Test is being offered as a laboratory-developed test (LDT) for detection of missed cancer in previously negative biopsies. This test uses mitochondrial DNA (mtDNA) detection in negative biopsy material to determine the presence of malignant cells via a cancerization field effect designed to detect underlying molecular alterations in tissues that appear normal.

3.6.2 Products Competing with the Previstage® GCC Colorectal Cancer Staging Test

The following analysis is based upon the position that the Previstage® GCC Colorectal Cancer Staging test would have into the market should it be, directly or indirectly, commercialized by the Corporation. DiagnoCure's Previstage® GCC test, the first commercial assay that can be used to stage colorectal cancer patients at the molecular level, was launched in August 2008.

There is currently no commercial assay used to stage colorectal cancer patients at the molecular level. Companies such as Genomic Health, Agendia and Almac Diagnostics rely on gene expression profile of the primary tumor to predict the probability of recurrence in colon cancer patients. These companies rely on complex "gene signatures", involving mathematical algorithms, to determine if the pattern of expression of the genes may be associated with a higher risk of recurrence in a population of colon cancer patients. Genomic Health's Oncotype Dx Colon Cancer was commercially launched as a colon cancer prognosis test. Agendia's Coloprint test provides stratification to predict the risk of relapse for all stage II colon cancer patients but needs to be performed on fresh, unfixed tumor specimen placed into RNA Retain solution within one hour of surgery. Almac Diagnostics has published the results a 634-gene transcriptome-based microarray assay to stratify colorectal cancer patients by high or low risk of relapse. Helomics' GeneFx Colon gene signature, currently marketed in the U.S. as a laboratory-developed test, relies on Almac's technology.

Other molecular tests such as those detecting what is known as "microsatellite instability" or "chromosome 18q LOH" have been reported as useful in determining a patient's probability of colorectal cancer recurrence. Neither these nor the Genomic Health and the Helomics tests performed on formalin-fixed paraffin-embedded (FFPE) tissues can be compared with Previstage® GCC Colorectal Cancer Staging test, which associates the presence of GCC in lymph nodes with previously undetected colorectal cancer metastases.

3.7 FACILITIES AND LABORATORIES

DiagnoCure moved its research and development activities in March 2011 into premises of 9,627 square feet in Québec, Province of Québec. The lease has a term of five years and 2 months, expiring in April 2016. At expiry, the lease is renewable for an additional period of five years.

3.8 HUMAN RESOURCES

As of October 31, 2014, DiagnoCure employed a total of ten (10) people in Québec City. About half of them were scientists or technical support employees directly engaged in research and development activities while the others oversaw quality assurance, business development, intellectual property, finance and administration. Four scientists and lab technicians held a Ph.D., an M.D. or an MSc. All employees have entered into confidentiality agreements with DiagnoCure as a condition of employment. The Corporation believes that its relationships with its employees are good.

3.9 RISK FACTORS

The following list of factors may not be exhaustive, as the Corporation operates in a rapidly changing business, and new risk factors emerge from time to time. The Corporation cannot predict such risk factors, nor can the Corporation assess the impact, if any, of such risk factors on its business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those projected in any forward-looking statements. Accordingly, the Corporation does not, and nor should shareholders of the Corporation or purchasers of Common Shares, rely on forward-looking statements as a prediction of actual results. If any of these risks actually occur, the Corporation's business, results of operations and financial

condition could be adversely affected. In any such case, the market price of the Common Shares could decline, and investors may lose all or part of their investment.

Limited Revenue History

Founded in 1994, DiagnoCure has yet to generate significant revenues from the sale of its products. For the fiscal year ended October 31, 2014, the Corporation has recorded a net loss and comprehensive loss of $2,032,151. In addition, it is unknown whether any of DiagnoCure's future developed products would meet applicable health regulatory standards and obtain the required regulatory approvals. It is not certain whether commercial quantities of its products or services can be produced or delivered at a reasonable cost and be successfully marketed, nor is it known whether investments in any such product candidates will be recovered through sales revenues or royalties. Some of the products or processes developed to date or to be developed may not be commercially available for some years to come or may be discontinued altogether, for reasons not within the control of the Corporation, and the Corporation may encounter difficulties or delays in operations or commercialization efforts as well as potential difficulties in realizing manufacturing and purchasing efficiencies.

Uncertainty Concerning Revenues

To date, DiagnoCure has placed three products on the market: the Previstage® GCC Colorectal Cancer Staging Test, the uPM3 reagents (ASR) for prostate cancer detection and ImmunoCyt / uCyt+, a test for monitoring superficial bladder cancer.

In June 2014, an exclusive license was granted to Shuwen Biotech Co., Ltd. for commercialization of the Previstage® GCC colorectal cancer staging test in the Greater China Region (China, Hong Kong, and Taiwan). Discussions with other interested parties are continuing for other territories.

With regards to the PCA3 test for prostate cancer, the Corporation has granted an exclusive license to Hologic Gen-Probe. PROGENSA® PCA3 is now available across the European Union, sold and marketed in the United States and in Canada. DiagnoCure receives an 8% royalty on the first aggregate amount of US$62.5 million of end-user net sales of the PCA3 test or reagents by Hologic Gen-Probe and a 16% royalty on all subsequent sales.

Regarding the bladder cancer test ImmunoCyt / uCyt+, DiagnoCure entered into a product divestment agreement in 2008 with Scimedx Corporation, a U.S.-based company.

Even if DiagnoCure were to use all means at its disposal to ensure the commercialization of its products, revenues would depend on one or more factors such as DiagnoCure's ability to promote these tests, on the performance of its distribution channels, on the competition, on the acceptance of the products by the medical community, on the rules governing reimbursements by governments and health insurers in the countries where the products are available and on the impact of the intervention of regulatory authorities such as the FDA.

At the moment, DiagnoCure's revenues are mainly generated from its current relationship with Hologic Gen-Probe through royalty payments. DiagnoCure also earns interest income on its invested surplus funds. The Corporation expects that its future revenues will include royalties from the sale of the PCA3 test and from sales of its other proprietary products as they are

commercialized. There can be no assurance that any of the Corporation's products will continue to be utilized by current partners or by customers at their current levels or at all.

Uncertainty of Healthcare Reimbursement

Healthcare is an area of continuing national attention and a priority of many governments. Certain reform proposals, if adopted, could impose limitations on the prices DiagnoCure and its partners would be able to charge for their products or the amount of reimbursement available from governmental agencies or third-party payers. In the case of private insurance, the reimbursement of any diagnostic device is at the sole discretion of the patient's individual insurance carrier. The decision to reimburse can be made on a case-by-case basis or on a system-wide basis. Historically, the decision to reimburse for a new medical procedure is made by the insurance carrier's technical review committee. This group will base its reimbursement decision on published clinical data and information received by treating physicians. Even if a procedure has been approved for reimbursement, there is no assurance that the insurance carrier will continue to reimburse the procedure.

The ability of DiagnoCure and its partners to successfully commercialize their products will depend in part on the extent to which reimbursement for the cost of products will be available from government health administration authorities, private medical insurance carriers and other third-party payers. Reimbursement issues and decisions vary country by country as to procedure and time for review and/or reimbursement approval.

Dependence on Collaborative Partners

DiagnoCure's strategy, in addition to self-reliance for commercialization of certain of its products, is to enter into various arrangements with corporate and academic collaborators, licensors, licensees and others for the research, development, clinical testing, manufacturing, marketing and commercialization of the Corporation's products. To date, DiagnoCure has entered into different types of collaborations whether for research and development, manufacturing or marketing. The Corporation intends to enter into additional corporate partnering agreements to develop and commercialize products and testing services. There can be no assurance, however, that the Corporation will be able to establish such additional collaborations on favourable terms, if at all, or that current or future collaborative arrangements will be successful.

Should any collaborative partner fail to develop or commercialize successfully any product to which DiagnoCure has rights, or any of the partners' products to which the Corporation has rights, DiagnoCure's business may be adversely affected.

In addition, there can be no assurance that the collaborative partners will not pursue alternative technologies or develop alternative products either on their own or in collaboration with others, including competitors, as a mean for developing diagnostic products targeted by the Corporation's programs.

Marketing and Distribution Challenges

To the extent that the Corporation relies on third parties, such as licensees, to market and distribute its products, the commercial success of such products may be beyond DiagnoCure's control. Moreover, there can be no assurance that any agreement with these third parties will

be beneficial to the Corporation. The loss of any of the Corporation's commercialization partners could have a material adverse effect on DiagnoCure's business, financial condition or results of operations.

Uncertainty Regarding Access to Additional Funds

With its unallocated funds, and the operating expenses reduction implemented in October 2014, management is of the opinion that it currently has adequate cash resources and will monitor its cash level in order to achieve its short term goals. However, the Corporation may be unable to obtain additional financing on acceptable terms if market and economic conditions, the financial condition or operating performance of the Corporation or investor sentiment are unfavourable. If the Corporation was unable to obtain the necessary capital required to finance any special situations, it is possible that this would adversely affect the Corporation's ability to complete certain internal development and commercialization projects.

Rapid Technological Changes and Competition

The technologies of the biotechnological industry are evolving rapidly. There is also intense competition within the industry. Certain biotechnological companies have established technologies, which could lead to the appearance of products competing with those of the Corporation. Some of these products use entirely different approaches or means to obtain diagnostic results, which could be more effective or less expensive than the products being developed by DiagnoCure for similar indications. Moreover, many competitors, both present and potential, have considerably greater resources at their disposal than the Corporation in terms of technology, distribution, sales, commercialization and capital resources. These competitors may have already filed applications for regulatory approval of their respective products or may have substantial advantages over the Corporation in terms of research and development expertise, experience in clinical trials, experience in regulatory issues, production efficiencies, brand name exposure, expertise in sales and marketing as well as distribution networks. Many of these organizations have financial, manufacturing, marketing and human resources greater than DiagnoCure's; therefore there can be no assurance that the Corporation can successfully compete with present or potential competitors or that such competition will not have a materially adverse effect on the Corporation's business, financial position or results of operations.

Government Regulation

The process for obtaining regulatory approval from governmental authorities to commercialize the Corporation's products varies from country to country and by types of products. Depending on the circumstances, the process can be costly and time consuming, with ensuing delays in commercialization of a product or service. In addition, regulatory approval may only be granted in part or refused, which could prejudice sales and profitability. The Corporation's clinical laboratory operations acquired by Signal Genetics in June 2011 had received the specific CLIA certification and all state-specific licenses required to perform and market the Previstage® GCC Colorectal Cancer Staging Test in its service laboratory in all U.S. states. Hologic Gen-Probe's PROGENSA® PCA3 test for prostate cancer received full CE mark in Europe in November 2006, was approved by Health Canada in August 2011 and by the U.S. FDA in February 2012. Nevertheless, new regulations may be implemented for medical devices in markets where

DiagnoCure and its partners offer their products, which may necessitate demonstration of compliance with the new requirements.

Uncertainty Regarding the Outcome of Clinical Studies

In most industrialized countries, the sale of diagnostic tests is regulated by government agencies in order to ensure that only safe and effective products or services are offered. In order for DiagnoCure's products or services to obtain the approval of regulatory organizations and to gain a certain degree of commercial success, clinical trials must demonstrate their safety and effectiveness. There can be no assurance that any particular study pertaining to any product or research and development program of the Corporation will achieve satisfactory results. If results are not satisfactory, the Corporation could be obliged to reduce its commitment to such product or research and development program. In addition, government policies may change and additional government regulations may be established that could prevent or delay regulatory approval of the Corporation's products.

Intellectual Property and Technologies

DiagnoCure's success depends, in part, on the Corporation's ability to obtain patents or rights thereto, protect trade secrets and operate without violating the exclusive rights of third parties. Although the Corporation already owns certain pending applications or issued patents or has, through licensing agreements, secured rights to certain technologies belonging to others, such as the Radboud University Medical Centre of Nijmegen, the Johns Hopkins University, the Thomas Jefferson University and the Roger Williams Medical Center, there is no guarantee that such patents are valid, that the pending applications will be allowed or that the Corporation will develop other patentable technologies in the future. Moreover, there can be no assurance that a patent granted to the Corporation or in respect of which the Corporation holds a license will make the related product more competitive, that third parties will not contest the protection granted by the patent, or that the patents of third parties will not be detrimental to the Corporation's commercial activities.

In order to protect or enforce the intellectual property rights owned, used or commercialized by the Corporation, including rights acquired under license, DiagnoCure may have to initiate legal proceedings against third parties. The Corporation may also have to defend claims brought against it or any purchaser or user of its products asserting that such product or process infringes intellectual property rights of third parties. Legal proceedings relating to intellectual property typically are expensive, take significant time and divert management's attention from other business matters. The cost of this litigation could adversely affect the business of the Corporation. Further, if the Corporation does not prevail in an infringement lawsuit brought against it, the Corporation might have to pay substantial damages, and could be required to stop the infringing activity or obtain a license to use the patented technology. Such royalty or licensing agreements, if required, may not be available on acceptable terms, if at all. In the event a claim is successful against the Corporation and the Corporation cannot obtain a license to the relevant technology on acceptable terms, license a substitute technology or redesign potential products to avoid infringement, the business, financial condition and operating results of the Corporation could be materially adversely affected. Loss of patent protection could lead to new competition for the Corporation's current and future products, which could materially and adversely affect the financial prospects for the Corporation's products.

There is no guarantee that other companies will not independently develop products similar to those of DiagnoCure, that they will not imitate DiagnoCure's products or that the Corporation's competitors will not develop products designed to circumvent DiagnoCure's exclusive proprietary rights. The Corporation may also need to obtain rights for other technologies belonging to third parties, but there is no guarantee that such technologies will be offered to DiagnoCure on acceptable terms. If DiagnoCure does not obtain such licenses, the commercialization of one or more of its products could be delayed. In addition, the Corporation could incur considerable costs to prosecute or defend proceedings in which DiagnoCure asserts its proprietary rights against third parties.

Recruitment and Retention of Key Personnel

DiagnoCure's success is largely dependent upon the members of the Corporation's management team and the Corporation's capacity to attract and retain highly competent scientific personnel. The loss of such persons could compromise the pace and success of the development of the Corporation's product offering research and development activities, and commercialization programs.

Risk of Product Liability

Although DiagnoCure's products are for *in vitro* diagnostic use only and do not involve the testing of experimental or approved drugs or biological products on human beings, the Corporation continues to manage its liability risk by obtaining insurance and, in certain cases, by negotiating contractual indemnity clauses with partners. The Corporation maintains liability insurance coverage for issues of testing safety as well as errors and omissions. This insurance coverage is considered adequate for the type of activity DiagnoCure currently conducts. However, there is no guarantee that the insurance or indemnification, as the case may be, will be adequate or continue to be available under conditions acceptable to the Corporation. Should it prove impossible to obtain this type of insurance at reasonable rates or to otherwise protect the Corporation against potential liability proceedings, DiagnoCure might be required to cease the development of its products.

The sale or use of the products acquired or developed solely by DiagnoCure or under collaborative arrangements carries the risk of legal proceedings based on product liability. Although DiagnoCure has the intention to negotiate with partners who manufacture and sell the Corporation's products to name DiagnoCure as covered beneficiary in their product liability insurance, it is impossible to guarantee that DiagnoCure will not be sued or that any coverage which they obtain or under which DiagnoCure is named as a covered beneficiary will be sufficient to protect the Corporation. Should it prove impossible to obtain this type of insurance at reasonable rates or to otherwise protect the Corporation against potential liability proceedings, DiagnoCure could be required to cease the commercialization of products that it has developed or even be prevented from beginning the commercialization of products. The Corporation's obligation to pay indemnities or to withdraw a product following complaints could seriously affect DiagnoCure's financial position as well as the Corporation's future.

Exchange Rates

A substantial portion of the Corporation's revenues is expected to be realized in U.S. dollars while the Corporation's operating expenses are mainly in Canadian dollars. Fluctuation in the exchange rate between the U.S. dollar and the Canadian dollar may have a material effect on

DiagnoCure's results of operations. The Corporation does not use derivative instruments to hedge its foreign currency risk nor does it plan to do so in the near future.

Global Political and Economic Conditions

The general economic and business conditions around the world affect the Corporation's business prospects and the demand for its products. Such conditions include interest rates, inflation, exchange rates, the debt crisis affecting certain countries, volatility in the financial markets throughout the world, the tightening of liquidity in selected financial markets, and the strength of the regional and international economies.

These factors may lead to a decrease in spending by businesses and consumers alike, and a corresponding decrease in global infrastructure spending and may adversely affect the demand for the products developed or being developed by DiagnoCure, DiagnoCure's liquidity and financial condition and its ability to raise further financing and access the capital markets to meet liquidity needs.

The Corporation has no control on inflation, changes in interest rates, and foreign currency exchange rates nor on other economic factors affecting its business or the possibility of political unrest and legal and regulatory changes in jurisdictions in which the Corporation operates. These factors could negatively affect the Corporation's future results of operations in those markets, but are not expected to be material for the Corporation overall.

Volatility of Share Price

Market prices for securities in general, and that of biopharmaceutical companies in particular, tend to fluctuate. Factors such as the announcement (to the public or at scientific conferences) of technological innovations, new commercial products, patents, the obtaining of exclusive rights by the Corporation or other companies, the results of clinical studies, a change in regulations, publications, quarterly financial results, public concerns over the risks of pharmaceutical products, future sales of Common Shares by the Corporation or current shareholders, and many other factors could have considerable repercussions on the price of DiagnoCure's Common Shares. In addition, the financial markets may experience significant price and value fluctuations that affect the market prices of equity securities of companies that sometimes are unrelated to the operating performance of these companies. Broad market fluctuations, as well as economic conditions generally, and in the healthcare sector specifically, may adversely affect the market price of the Common Shares.

Future sales of Common Shares

The market price of the Common Shares could decline as a result of issuances by the Corporation or sales by its existing shareholders of Common Shares in the market or the perception that these sales could occur. Sales by shareholders might also make it more difficult for the Corporation to sell securities at a time and price that it deems appropriate.

Rank of Common Shares

In the event of any liquidation, dissolution or winding-up of the Corporation, DiagnoCure shall pay to the holders of Series A Convertible Preferred Shares an amount of $1.24 per share plus any declared but unpaid dividends before any payments to the holders of Common Shares. Such preferential payment obligations in case of liquidation, dissolution or winding-up have been

secured by a hypothec on certain intellectual property rights of the Corporation. Payment obligations under Common Shares are not subject to similar security interest.

Dividends

The Corporation has paid no cash dividends on any of its Common Shares or of Preferred Shares to date and currently intends to retain its cash on hand and future earnings, if any, to fund the development growth of its businesses. In addition, the terms of any future debt or credit facility may preclude the Corporation from paying these dividends.

Dilution

The Corporation may consider issuing convertible debt or equity securities or Preferred Shares, which may rank prior to the Common Shares, in the future to fund potential acquisitions or investments, or for general corporate purposes. The articles of the Corporation provide that DiagnoCure has an unlimited number of authorized Common Shares and Preferred Shares that may be issued. Under applicable corporate laws, shareholders' approval is not required for the Corporation to issue shares. If the Corporation issues convertible debt or equity securities or Preferred Shares to raise additional funds, its existing shareholders may experience dilution, and the new convertible debt or equity securities or Preferred Shares may have advantageous rights, preferences and privileges when compared to those of the Corporation's existing shareholders. The Corporation is unable to predict the future amount of such issuances or dilution. If the Corporation incurs debt, it may increase its leverage relative to its earnings or to its equity capitalization, requiring the Corporation to pay interest expenses.

SECTION 4 - DESCRIPTION OF SHARE CAPITAL

Authorized Capital

The authorized capital of DiagnoCure consists of an unlimited number of Common Shares, without par value and an unlimited number of Preferred Shares, all without par value, issuable in series, of which a maximum of 4,900,000 Series A Preferred Shares are authorized (the "Series A Convertible Preferred Shares").

The following is a brief summary of the attributes of the Common Shares, the Preferred Shares and the Series A Convertible Preferred Shares. This summary is subject to the more detailed provisions set out in the articles of DiagnoCure, including the article of amendment to create the Series A Convertible Preferred Shares, a copy of which was filed on SEDAR at www.sedar.com on May 8, 2009.

Common Shares

The Common Shares rank junior to the Preferred Shares with respect to the payment of dividends, return of capital and distribution of assets in the event of liquidation, dissolution or winding-up of the Corporation. The holders of the Common Shares are entitled to receive dividends out of the assets of the Corporation legally available therefore at such times and in such amounts as the Board of Directors of the Corporation may determine. The holders of the Common Shares are entitled to receive notice of any meeting of shareholders of the Corporation and to attend and vote thereat on all matters to be voted on by the shareholders of the Corporation, except at a meeting where only the holders of shares of a different class are

entitled to vote separately. At each such meeting, the holders of the Common Shares are entitled to one vote for each share held. Subject to the rights of the holders of Preferred Shares and the Series A Convertible Preferred Shares, upon the liquidation, dissolution or winding-up of the Corporation, the holders of the Common Shares are entitled to participate equally in the remaining property and assets of the Corporation available for distribution.

Preferred Shares

The Preferred Shares are issuable from time to time in one or more series as determined by the Board of Directors of the Corporation. The Preferred Shares are non-voting and rank senior to the Common Shares with respect to the payment of dividends, the return of capital and the distribution of assets in the event of the liquidation, dissolution or winding-up of the Corporation.

Series A Convertible Preferred Shares

The Series A Convertible Preferred Shares are non-voting (except in circumstances where holders of Preferred Shares are entitled to vote pursuant to applicable law or if their rights are affected by a proposed modification to the articles of the Corporation) and may be exchanged for Common Shares on a one-for-one basis, subject to adjustments as a result of a subdivision or consolidation of the Common Shares, at any time and from time to time at the option of their holder. DiagnoCure has the option (i) to redeem the Series A Convertible Preferred Shares prior to their conversion by the holders thereof at a redemption price per Series A Convertible Preferred Share equal to the greater of $1.24 plus interest at 6% per annum from their date of issuance and the average closing price of the Common Shares during the 30 consecutive trading days on the TSX prior to such redemption, or (ii) to require their conversion into Common Shares if the closing price per share of the Common Shares for any 30 consecutive trading days on the TSX is equal or superior to $2.50. When and as the Board of Directors of the Corporation shall declare dividends, the holders of Series A Convertible Preferred Shares shall be entitled, from April 29, 2010, to receive a fixed, preferential and non-cumulative dividend of 6% per year on the sum of $1.24 per Series A Convertible Preferred Shares before any dividend is declared and paid on the Common Shares. There is however no obligation of the Board of Directors of the Corporation to declare and pay such dividends and the Corporation currently intends to retain its cash on hand and future earnings, if any, to fund the development growth of its business. In the event of any liquidation, dissolution or winding-up of the Corporation, DiagnoCure shall pay to the holders of Series A Convertible Preferred Shares an amount of $1.24 per share plus any declared but unpaid dividends, before any payment to the holders of Common Shares or any shares of the Corporation ranking junior to the Series A Convertible Preferred Shares.

SECTION 5 - DIVIDEND POLICY

The Corporation has paid no cash dividends on any of its Common or Preferred Shares to date and currently intends to retain its future earnings, if any, to fund the growth of its business.

SECTION 6 - SECURITIES MARKET

The Common Shares of the Corporation are listed on the Toronto Stock Exchange and are traded under the symbol “CUR”. Since April 2, 2013, the Common Shares are traded on OTCQX International under the symbol "DGCRF".

The following table sets forth the price of Common Shares of the Corporation and the volume of shares traded on the Toronto Stock Exchange over the past fiscal year.

	Price		
Period	**$ High**	**$ Low**	**Volume**
October 2014	0.15	0.10	571,664
September 2014	0.17	0.15	193,011
August 2014	0.165	0.15	103,396
July 2014	0.18	0.14	353,723
June 2014	0.20	0.14	180,668
May 2014	0.19	0.15	470,435
April 2014	0.21	0.17	274,825
March 2014	0.21	0.18	390,872
February 2014	0.20	0.175	327,524
January 2014	0.24	0.145	511,502
December 2013	0.23	0.14	1,120,362
November 2013	0.24	0.19	424,197

The following table sets forth the options that have been granted by the Corporation during the past fiscal year:

Date of Grant	**Number of Options Granted**	**Exercise Price**
January 29, 2014	203,000	$0.20

SECTION 7 - MANAGEMENT’S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITIONS AND RESULTS OF OPERATIONS

Management’s discussion and analysis are contained in the Corporation’s Annual Report for the fiscal year ended October 31, 2014.

SECTION 8 - DIRECTORS AND EXECUTIVE OFFICERS

The following table sets forth the name, municipality of residence, position at DiagnoCure, the number of Common Shares of the Corporation beneficially owned, directly or indirectly, or over which control is exercised, and the principal occupation of each director and officer of DiagnoCure as of January 22, 2015. Each director holds office until the close of the next annual meeting of shareholders.

Directors

Name, province or state and country of residence	Position held with DiagnoCure	Number of Common Shares	Current principal occupation	Director since
Dr. Yves Fradet Québec, Canada	Chairman of the Board, President and Chief Medical Officer	2,040,444	In addition to his position with the Corporation, Dr. Fradet is also Professor, Department of Surgery, School of Medicine, Université Laval	Dec. 8, 1994
Dr. Louise Proulx Québec, Canada	Director[(1), (2)]	54,695	Chief Development Officer of Therillia Development Company Inc.	March 16, 2006
Andy Sheldon, Québec, Canada	Director [(1)]	21,500	President and Chief Executive Officer of Medicago Inc.	November 26, 2012
Dr. Jacques Simoneau, Québec, Canada	Director[(1), (2)]	12,500	President and Chief Executive Officer of Gestion Univalor L.P.	November 26, 2012
Dr. Vincent R. Zurawski, Jr., Pennsylvania, U.S.A.	Lead Director[(2)]	28,207	President and Chief Executive Officer, Hepregen Corporation, Founding President and Chief Scientific Officer, Varinel, Inc.	April 16, 2003

(1) Member of the Audit and Risk Management Committee
(2) Member of the Corporate Governance, Human Resources and Nominating Committee

Executive Officers

Name and Municipality of Residence	Position Held with DiagnoCure	Number of Common Shares
Dr. Yves Fradet, Québec, Canada	President and Chief Medical Officer (CEO) Chairman of the Board	2,040,444
Frédéric Boivin, Lévis, Canada	Sr Director, Finances and Administration (Interim Chief Financial Officer)	1,500

As of January 22, 2015 the Directors and Executive Officers of the Corporation, as a group, beneficially owned, directly or indirectly, 2,158,846 Common Shares representing approximately 5.0% of the total outstanding Common Shares.

Following are brief biographies of DiagnoCure's Board of Directors and Executive Officers:

Directors

YVES FRADET, M.D., FRCS(c). Dr. Fradet is co-founder of the Corporation and Chairman of the Board of Directors of DiagnoCure. He graduated from Medical School at Université Laval in 1976 and is member of the Royal College of Physicians and Surgeons of Canada since 1981. He has been full professor of surgery/urology at Université Laval since 1992. He is also Director, Urology Services, and Director of the Experimental Uro-Oncology Laboratory at the CHUQ – Hôtel-Dieu de Québec. Dr. Fradet studied at the Memorial Sloan-Kettering Cancer Center in New York from 1981 to 1983, where he sub-specialized in urologic oncology. He is a member of several national and international associations, including the American Association of Genito-Urinary Surgeons since 2002. This society is limited to 75 members from North America admitted by invitation from the most recognized researchers in urology. He serves as consultant for numerous national and international organizations and he is a frequent invited speaker around the world. He was the founding President of the Canadian Urological Oncology Group, which conducts clinical trials

in the field of genito-urinary cancers in Canada. He has published over 300 articles and more than 500 abstracts. Dr. Fradet was appointed Chairman of the Board in January 2010 and President of DiagnoCure in February 2010.

LOUISE PROULX, PH.D. Dr. Proulx holds a Ph.D. in physiology from Université Laval and pursued postdoctoral studies at the Karolinska Institute in Stockholm. She has close to 30 years experience in research and science management. She has held, over the years, scientific positions of increasing responsibilities, notably as Vice President, Scientific Affairs at Hoechst Marion Roussel Canada, Vice President, Therapeutic Product Development at Biochem Pharma Inc., Vice President, Business Development of Genome Québec and Vice Principal Research at McGill University. She then returned to the pharmaceutical industry where she has been Vice President, Product Development at ViroChem Pharma, Inc. She then became Vice-President, and Site Head, at Vertex Pharmaceuticals (Canada) Incorporated after the acquisition of ViroChem Pharma by Vertex Pharmaceuticals. She is now Chief Development Officer of Therillia Development Company Inc. Dr. Proulx has been a member of several boards of directors over her career and she is currently a member of the board of directors of the Canada Foundation for Innovation, the Research Institute of the McGill University Health Center, Gestion Univalor, Oncozyme Pharma and CQDM. Dr. Proulx is certified ICD.D by the Institute of Corporate Directors.

ANDY SHELDON Mr. Sheldon has been President and Chief Executive Officer of Medicago Inc., a clinical-stage biopharmaceutical company, since August 2003. He has thirty years of experience in the pharmaceutical industry, and was named CEO of the Year by the Vaccine Industry Excellence awards at the World Vaccine Congress in April 2012. Before joining Medicago, Mr. Sheldon was Vice-President, Sales and Marketing of Shire Biologics, where he was responsible for international expansion with European, American and Asian private partnership agreements and was also responsible for distribution, customer service, maintenance and engineering at the Shire facility. From 1998 to 2000, he was Senior Manager of Commercial Operations where he successfully managed the approval of a bladder cancer therapeutic vaccine by the FDA. In 1997 and 1998, he was Marketing Manager for Merial Canada Inc. From 1992 to 1997, he was Director of Canadian Operations with Rhône Mérieux. From 1988 to 1992, he was National Sales Manager for SmithKline Beecham. Mr. Sheldon has a Bachelor's degree in agricultural sciences from Université Laval, Québec City and a Bachelor's of science degree with honors in biological sciences from the University of East Anglia, Norwich, England.

JACQUES SIMONEAU, PH.D. Dr. Jacques Simoneau is President & CEO and director of Gestion Univalor, L.P., a limited partnership responsible for the commercialization and transfer of technologies and innovations created at Université de Montréal, its affiliated schools Polytechnique Montréal (engineering) and HEC Montréal (business), and its hospitals and health research centres. Dr. Simoneau is a corporate director with a comprehensive experience in venture capital and private equity. Prior to joining Univalor, he was Executive Vice President, Investments of the Business Development Bank of Canada (BDC). In that capacity, he was responsible for the venture capital and subordinate financing portfolios. Prior to that, he was President and CEO of Hydro-Québec CapiTech Inc., Senior Vice-President of the *Fonds de solidarité FTQ* and CEO of *Société Innovatech du sud du Québec*. He also held executive positions at Advanced Scientific Computing and Alcan. Dr. Simoneau is a director of Transat A.T., of Azimut Exploration, of Sustainable Development Technology Canada and of *Genome Québec*.

Dr. Simoneau was a member of the *Conseil de la science et de la technologie du Québec* from 2004 to 2011, and was also director of three other public companies and 15 private companies between 1995 and now. Jacques Simoneau is a mechanical engineer and holds a M.Sc. from Université Laval and a Ph.D. from Queen's University. He is a member of the *Ordre des ingénieurs du Québec,* of Professional Engineers Ontario and he is certified ICD.D by the Institute of Corporate Directors.

VINCENT R. ZURAWSKI, JR, PH.D. Dr. Zurawski earned his Ph.D. from Purdue University in 1973 and completed post-doctoral training at the Massachusetts General Hospital and Harvard Medical School. Dr. Zurawski was a pioneer in the biotechnology industry. In 1979, he was one of the founders of Centocor, Inc., where he played a major role in developing and implementing the successful business strategy of the company and the development of its cancer diagnostic products. In 1992, Dr. Zurawski was founder, President and Chief Executive Officer of Apollon, Inc. and during his six-year tenure at Apollon, he built an operation from the ground up that established itself as a leader in the development of DNA-based vaccines with five Apollon-manufactured products in clinical trials. In 1998, the company was sold to American Home Products (Wyeth Pharmaceuticals), which has since been acquired by Pfizer & Company. From 1998 to 2000, Dr. Zurawski served as Director for Research Business Development for the University of Pennsylvania, Health System and School of Medicine and in 2000 he joined, as Chief Executive Officer of Compugen, Inc., the wholly-owned U.S. subsidiary of Compugen, Ltd., a company specialized in the commercialization of bioinformatics software systems. Since he left Compugen, Inc., Dr. Zurawski has been engaged in a number of start-up biotechnology companies. He served as Interim President and Chief Executive Officer of Nucleonics, Inc. He is currently President and Chief Executive Officer of Hepregen Corporation, a leader in the development of micro-liver products. He is also Founding President and Chief Scientific Officer of Varinel, Inc. and Executive Chairman of the Board of Varinel LDC, Inc., an affiliate of Varinel, which specialize in the development of drugs for treatment of diseases of the central nervous system.

Executive Officers *(not already mentioned above)*

FRÉDÉRIC BOIVIN holds a Bachelor's Degree in Business Administration from Université Laval since 1996. From 1996 to 2001, he was controller at four private companies managed by the same shareholder. Mr. Boivin joined DiagnoCure in March 2001 as Coordinator, Finance & Administration. On November 2003, Mr. Boivin was appointed as Director, Finance & Administration. He is currently Senior Director, Finances & Administration and acting as interim Chief Financial Officer since October 2013. He has been involved in all of DiagnoCure's financings since 2001.

Cease Trade Orders, Bankruptcies, Penalties or Sanctions

None of the directors or officers is, as at the date of this Annual Information Form, or has been, within 10 years before the date of the Annual Information Form, a director or officer of any company that, (i) while that person was acting in that capacity, was subject to a cease trade order, an order similar to a cease trade order or an order that denied the relevant company access to any exemption under securities legislation that was in effect for a period of more than 30 consecutive days; (ii) was subject to a cease trade order, an order similar to a cease trade order or an order that denied the relevant company access to any exemption under securities legislation that was in effect for a period of more than 30 consecutive days, that was issued after

the director or officer ceased to be a director or officer and which resulted from an event that occurred while that person was acting as director or officer.

None of the directors or officers is, as of the date of the Annual Information Form, or has been, within 10 years before the date of the Annual Information Form, a director or an officer of a 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.

None of the directors or officers has, within the 10 years before the date of this Annual Information Form, 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 such director or officer.

In addition, none of the directors or officers has been subject to (i) 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 (ii) any other penalties or sanctions imposed by a Canadian court or regulatory body that would likely be considered important to a reasonable investor in making an investment decision.

Conflicts of Interest

There are no existing or potential material conflicts of interest between the Corporation or its subsidiaries and any director or officer of the Corporation or its subsidiaries.

SECTION 9 - INTERESTS OF MANAGEMENT AND OTHERS IN MATERIAL TRANSACTIONS

To DiagnoCure's knowledge, none of its directors, officers or principal shareholders or their associates or affiliates had any material interest in any transaction during the past three years, or in any planned transaction, which has materially affected or could materially affect the Corporation.

SECTION 10 - MATERIAL CONTRACTS

During the fiscal year ended October 31, 2014, DiagnoCure has not entered into new material contracts as defined pursuant to *Regulation 51-102 respecting Continuous Disclosure Obligations*.

SECTION 11 - LEGAL PROCEEDINGS AND REGULATORY ACTIONS

The Corporation is not a party to any legal proceeding, and its property is not and was not the subject of any legal proceeding, during the fiscal year ended October 31, 2014. The Corporation is not aware of any legal proceeding outstanding, threatened or pending as of the date hereof by or against the Corporation.

The Corporation is not and was not subject to, during the fiscal year ended October 31, 2014: (i) penalties or sanctions imposed by a court relating to Canadian securities legislation or by a Canadian securities regulatory authority; (ii) 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; and (iii) settlement agreements entered into with a court relating to Canadian securities legislation or with a Canadian securities regulatory authority.

SECTION 12 - AUDITOR, TRANSFER AGENT AND REGISTRAR

DiagnoCure's auditor is Ernst & Young LLP, 2875 Laurier Blvd., Suite 410, Québec (Québec) G1V 0C7. The partners and employees of Ernst & Young LLP do not hold any of the issued and outstanding shares of the Corporation. The Corporation's registrar and transfer agent is Computershare Investor Services Inc., at its principal offices in Montréal and Toronto.

SECTION 13 - AUDIT AND RISK MANAGEMENT COMMITTEE

Composition of the Committee

The Corporation has an Audit and Risk Management Committee which currently consists of Dr. Louise Proulx, Dr. Jacques Simoneau and Andy Sheldon. All the members of the Audit and Risk Management Committee are considered "independent" and "financially literate" within the meaning of *Regulation 52-110 respecting Audit Committees*.

Mandate of the Committee

The mandate of the Audit and Risk Management Committee is attached hereto as Appendix 2.

Education and Experience of the Committee Members

The following is a brief summary of the education and experience of each member of the Audit and Risk Management Committee that is relevant to the performance of his or her responsibilities as a member of the Audit and Risk Management Committee with an understanding of the accounting principles used by the Corporation to prepare its annual and interim financial statements.

LOUISE PROULX. Dr. Proulx has close to 20 years of experience as top manager in several pharmaceutical companies. In this capacity, she developed and controlled numerous budgets, and worked closely with finance directors and CFOs on all financial and accounting issues related to R&D activities. In addition, she regularly contributes actively in meetings with external auditors for the review and adoption of companies' financial statements. She is a member of five other boards of directors and a member of the audit and risk management committee on these boards.

ANDY SHELDON. Mr. Sheldon has thirty years of experience in the pharmaceutical industry and has held the position of President and Chief Executive Officer of Medicago Inc. since 2003. He was a member of Medicago's board of directors until September 18, 2013 and serves on several other boards. Mr. Sheldon possesses strong financial acumen, has served on several audit committees and was responsible for reviewing and approving Medicago's financial statements.

JACQUES SIMONEAU. Dr. Simoneau has participated in several intensive executive training courses in finance, accounting, marketing and leadership. As part of the managerial positions he has held in venture capital, private equity and corporate financing, Dr. Simoneau was actively involved in analysing, evaluating, structuring and negotiating investments for private and publicly traded corporations. In doing so, he closely examined and evaluated financial statements, business and strategic plans, and questioned management thereon.

Oversight by the Committee, Policies of Prior Approval

For fiscal year 2014, the Audit and Risk Management Committee has proposed the appointment of Ernst & Young LLP as external auditor and the Board of directors of the Corporation has approved such appointment.

In 2008, the Corporation has revised its written Audit and Non-Audit Services Pre-Approval Policy under which the Audit and Risk Management Committee annually pre-approve certain types of non-audit services (with associated fees limits) that may be provided by the external auditor without obtaining specific pre-approval from the Committee, whenever required by the Corporation. The Policy also states that the external auditor shall never perform work that it could not perform under law or should not perform under auditing best practices.

External Auditor Service Fees

The following table shows fees paid to Ernst & Young LLP in Canadian dollars in the past two fiscal years for various services provided to the Corporation and its subsidiaries:

	2014	2013
Audit Fees	48,503	$52,767
Audit-Related Fees	17,730	$19,039
Tax Fees	2,886	$4,523
All Other Fees	18,538	$2,509

Audit Fees

These fees include professional services rendered by the external auditor for statutory audits of the annual financial statements and for other audits.

Audit-Related Fees

These fees include professional services that reasonably relate to the performance of the audit or review of the Corporation's financial statements. These fees include, but are not limited to, review and translation of the financial statements.

Tax Fees

These fees include professional services for tax compliance, tax advice and tax planning.

All Other Fees

The fees include the total fees paid to the auditor for all services other than those presented in the categories of audit fees, audit-related fees and tax-related fees, including the consultation services for the diligent audit for the purposes of acquisition, expatriates fees and certain filings, if applicable.

SECTION 14 - ADDITIONAL INFORMATION

Additional information, including information on the remuneration and indebtedness of directors and senior executives, the principal shareholders of the Corporation as well as securities authorized for issuance under equity compensation plans, are set forth in the most recent management proxy circular of the Corporation dated March 14, 2014, relating to the April 17, 2014 Annual and Special Meeting of the Corporation, which is available on SEDAR at www.sedar.com.

Additional financial information may be found in the 2014 Annual Report and in the comparative Financial Statements of the Corporation for the year ended October 31, 2014. These documents can be obtained on SEDAR at www.sedar.com or upon request from DiagnoCure at:

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APPENDIX 1 - GLOSSARY

As used in this document, the following terms have the meanings specified below.

Amplification:	A technique allowing the making of multiple copies of a gene or of any sequence of DNA.
Analyte Specific Reagent (ASR):	Reagent commercially distributed for use as a component of a diagnostic test in biological specimens. Being considered as building blocks of LDTs, ASRs are medical devices regulated by the FDA.
Antigen:	Any of a variety of materials that induce the body's immune system to produce antibodies.
Benign prostatic hyperplasia (BPH):	A benign (noncancerous) condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine. Also called benign prostatic hypertrophy or BPH.
Biomarker:	A characteristic biological properties that can be detected and measured in parts of the body like the blood or tissue. They may indicate either normal or diseased processes in the body. It can be specific cells, molecules, or genes, gene products, proteins, enzymes, or hormones. Complex organ functions or general characteristic changes in biological structures can also serve as biomarkers. The Biomarker term is used in pre-clinical research and clinical diagnosis.
Biopsy:	Invasive procedure consisting of the removal of cells or tissues for examination under a microscope. When only a sample of tissue is removed, the procedure is called an incisional biopsy or core biopsy. When an entire tumor or lesion is removed, the procedure is called an excisional biopsy. When a sample of tissue or fluid is removed with a needle, the procedure is called a needle biopsy or fine-needle aspiration.
Cancer:	A term for diseases in which abnormal cells divide without control. Cancer cells can invade nearby tissues and can spread through the bloodstream and lymphatic system to other parts of the body.
Cancer staging:	The process of assigning a descriptor (usually numbers I to IV) of how much a cancer has spread in the body. In the TNM system (for tumor/nodes/metastases), criteria for staging include: extent of local invasion, the degree of lymph node involvement and whether there is distant metastasis.

Carcinoembryonic Antigen (CEA):	A protein that can stimulate an immune response to certain tumors.
Chemotherapy:	Treatment with anticancer drugs.
Clinical trial:	A research study that tests how well new medical treatments or other interventions work in people. Each study is designed to test new methods of screening, prevention, diagnosis, or treatment of a disease.
Colorectal cancer:	Medical condition characterized by presence of cancer cells in the intestinal tract below the small intestine (i.e. the large intestine (colon), including the caecum, ascending colon, transverse colon, descending colon, and sigmoid colon, and rectum)
Cut-off value:	Value of the level of expression of a biomarker above which a test result is considered positive, and below which a test result is considered negative.
Deoxyribonucleic acid (DNA):	Linear sequence of chemical building blocks of chromosomes that store hereditary features.
Detection:	Technique allowing the confirmation of the presence of amplified RNA.
Diagnosis:	The process of identifying a disease by the signs and symptoms.
Diagnostics:	The art or practice of diagnosis. That part of medicine, which has to do with ascertaining the nature of diseases by means of their symptoms or signs.
DNA sequencing:	Determining the exact order of the base pairs in a segment of DNA.
Food and Drug Administration (FDA):	The United States regulatory body that oversees the drug and medical device development process. Most such products cannot be marketed for sale in the United States without FDA clearance or approval.
Formalin-fixed paraffin-embedded (FFPE) tissue:	A piece of human or animal tissue that has been obtained from a surgical resection or biopsy needs to be fixed in order to prevent it from decaying or degenerating and to allow its histological examination typically for pathological or cytological studies. Although other preservatives could be used, formalin is a preferred way of fixing tissues which can then be embedded in wax (paraffin) to allow the sample to be cut in thin sections and eventually stained for observation under a microscope.

Gene:	A gene occupies a certain location on a chromosome. It is a self-producing, ultramicroscopic structure capable under certain circumstances of giving rise to a new character, referred to as a mutation. Hereditary traits are controlled by pairs of genes in the same position on a pair of chromosomes.
Genito-urinary:	Pertaining to the genital and urinary organs, urogenital, urinosexual.
Genomics:	Pertaining to the genome, all of the genetic information possessed by any organism. There is, for instance, the human genome, the elephant genome, the mouse genome, the yeast genome, etc. Humans and many other higher animals have two genomes, namely: • A chromosomal genome which is in the nucleus of the cell; and • A mitochondrial genome, which is outside the nucleus in the cytoplasm of the cell. Together these two genomes make up the total genome. The study of a genome is called *genomics*.
Guanylyl Cyclase C (GCC):	A transmembrane receptor protein found exclusively in the lining of the intestine from the duodenum to the rectum. It is involved in multiple functions including water transport, crypt morphology and suppression of tumorigenesis.
Good manufacturing practice (GMP):	Part of a quality system covering the manufacture and testing of, for example, medical devices such as *in vitro* diagnostic devices. In the U.S., GMPs are promulgated under section 520 of the Food, Drug and Cosmetic (FD&C) Act.
Grade:	The grade of a tumor depends on how abnormal the cancer cells look under a microscope and how quickly the tumor is likely to grow and spread. Grading systems are different for each type of cancer. Grading evaluates the aggressiveness of the tumor cells.]
Histopathology:	Refers to the microscopic examination of tissue in order to study the manifestations of disease. Specifically, it refers to the examination of a biopsy or surgical specimen by a pathologist, after the specimen has been processed and histological sections have been placed onto glass slides.
In vitro:	In an unnatural position (e.g. outside the body, in the test tube).
In vivo:	Latin for “in living” (e.g. in the body, in a living organism; the opposite of IN VITRO*)*.

Incidence:	Number of new cases of a disease observed over a period of time.
Laboratory-developed test (LDT):	A test that is developed, evaluated, and validated within a CLIA-certified clinical laboratory. A LDT, often referred to as a "home-brew" or "in-house" test is used solely within the laboratory that developed it and is not distributed or sold to any other laboratories or health care facilities.
Limit of detection (LOD):	The lowest quantity of a biomarker that can be distinguished from the absence of that biomarker within a stated confidence limit (generally 1%).
Malignant:	Tending to be severe and become progressively worse; a malignant tumor is one that has the ability to invade and destroy nearby tissue and/or spread (metastasize) to other parts of the body.
Messenger ribonucleic acid (mRNA):	Sequence of chemical molecules carrying the information of a gene and controlling the synthesis of a peptide (See also *Ribonucleic acid*).
Metastasis:	Cancer that has spread to a distant part of the body from its original site.
Molecule:	A chemical made up of two or more atoms. The atoms in a molecule can be the same (an oxygen molecule has two oxygen atoms) or different (a water molecule has two hydrogen atoms and one oxygen atom). Biological molecules, such as proteins and DNA, can be made up of many thousands of atoms.
Molecular diagnostics:	The measurement of DNA, RNA, proteins or metabolites to detect genotypes, mutations or biochemical changes.
Monitoring:	To watch, observe, or check closely or continuously the recurrence or evolution of a disease. *Monitoring* is a part of patient management.
mRNA:	See *Messenger ribonucleic acid*.
Nucleic acid:	A high-molecule-weight nucleotide polymer. There are two types: deoxyribonucleic acid (DNA) and ribonucleic acid (RNA). Nucleic acids are the building blocks of genes.
Oncology:	Branch of medicine that studies cancer.
PCA3 gene:	Formerly known as DD3, this gene is prostate cancer specific (i.e., found in prostate cancer patients).

Pathology:	Branch of medicine that studies the essential nature of diseases and especially of the structural and functional changes produced by them.
Peptide:	Molecule containing many amino acids linked together.
Prognosis:	A forecast of the probable course and/or outcome of a disease.
Prostate:	A gland found only in men. The prostate surrounds the neck of the bladder and the urethra. It produces enzymes and a fluid component of the ejaculate.
Prostate-specific antigen (PSA):	A protein, more specifically, a serine protease enzyme synthesized by cancerous and normal cells of the prostate. It is secreted by prostatic epithelium in the seminal fluid.
Protein:	Molecule consisting of a number of amino acid peptides. Proteins perform a wide variety of activities in the cell.
Reagent:	A substance used to produce a chemical reaction to detect, measure or produce other substances.
Recurrence:	The return of cancer after treatment. This can be either local (at the site of the original tumor) or distant (beyond the original site).
Resection:	Surgery to remove a cancer and some surrounding tissue.
Ribonucleic acid (RNA):	RNA acts as a messenger, an intermediary, between DNA and protein. The DNA of the gene is transcribed into mRNA, which then is translated into the sequence of amino acids that make up a protein (See MESSENGER RIBONUCLEIC ACID).
Single nucleotide polymorphism (SNP):	DNA sequence variation occurring when a single nucleotide — A, T, C or G — in the genome (or other shared sequence) differs between members of a biological species or paired chromosomes in a human.
Screening:	Checking for disease when there are no symptoms.
Sensitivity:	The probability that a test result is positive given the subject has the disease. Also called true positive rate (equals true positive divided by the added true positives to the false negatives).
Specificity:	The probability that a test result is negative given that the subject does not have the disease. Also called true negative rate (equals true negatives divided by the added true negatives and false positives).

Specimen:	Sample to be tested.
Stage:	The extent of a cancer, especially whether the disease has spread from the original site to other parts of the body.
Tumor:	A swelling or morbid enlargement; a new growth of tissue or neoplasm in which the multiplication of cells is uncontrolled and progressive. Often referring to cancer.

APPENDIX 2

DIAGNOCURE INC.

(The "Corporation")

MANDATE OF THE AUDIT AND

RISK MANAGEMENT COMMITTEE

(the "Committee")

1 PURPOSE OF THE COMMITTEE

The Audit and Risk Management Committee assists the Board of Directors (the "Board") of the Corporation in overseeing (1) the Corporation's business planning and budgeting process; (2) the management of risk and review and implementation of internal controls by the management; (3) the relations with the external auditors and (4) the disclosure of financial information in accordance with regulatory requirements. The Committee has no decisional authority but rather makes recommendations to the Board on the issues under its responsibility. While the Committee has the responsibilities and powers set forth in this mandate, it is not the duty of the Committee to plan or conduct audits or to determine that the Corporation's financial statements are complete, accurate and in accordance with generally accepted accounting principles. This is the responsibility of management and the external auditors. Nor is it the duty of the Committee to conduct investigations or to assure compliance with laws and regulations.

2 RESPONSIBILITIES

2.1 Business Planning & Budget

The Committee:

2.1.1 Reviews and monitors the annual budgets of the Corporation and makes appropriate recommendations to the Board with respect thereto;

2.1.2 Receives and reviews the quarterly report of the Chief Financial Officer regarding various financial matters affecting the Corporation, major acquisitions and dispositions of assets, the risk factors that may affect the financial results or the financial structure of the Corporation, the share market movement, the investments and other issues.

Risk Management & Internal Controls

The Committee periodically:

2.2.1 Reviews the risk management and internal controls systems of the Corporation, monitors compliance therewith and makes appropriate recommendations to the Board with respect thereto;

When reviewing these internal control systems, the Committee's particular focus is on the compliance with laws and regulations, material risks and contingencies which could have an important impact on the financial situation or the operating results of

the Corporation, as well as the public disclosure of this information within the quarterly or annual financial statements and MD&A or impact on the Corporation's reported earnings;

2.2.2 Reviews with management the quality and accuracy of the computerized accounting systems, the adequacy of the protections against damage and disruption of these systems, and elaborates an emergency plan for disaster recovery;

2.2.3 Reviews the Whistle Blowing Policy of the Corporation, assesses its efficacy and makes appropriate recommendations to the Board with respect thereto;

When reviewing this Policy, the Committee's particular focus is on controls implemented by management to ensure that anonymity and confidentiality regarding complaints that have been or could be submitted by employees are respected and the communication of this Policy by the management within the Corporation;

2.2.4 Reviews the Corporation's Policy on Disclosure and Securities Trading, assesses its efficacy and makes appropriate recommendations to the Board with respect thereto;

2.2.5 Reviews the Code of Professional Ethics of the Corporation and assesses its efficacy and makes appropriate recommendations to the Board with respect thereto;

2.2.6 Reviews the Corporation's policies regarding the approval of senior management's expenses and monitors compliance therewith;

2.2.7 Reviews the Corporation's Investments Policy and monitors compliance therewith;

When applicable, the Committee also:

2.2.8 Reviews and manages any complaints or reports regarding fraud or other illegal acts brought to the attention of management, the external auditors or the Chairperson of the Committee in accordance with the Whistle Blowing policy;

2.2.9 Reviews the Corporation's hiring policies regarding partners, employees of the present and former external auditors of the Corporation and makes appropriate recommendations to the Board with respect thereto;

2.2.10 Reviews and monitors new and material information regarding accounting matters and information disclosure including statements and policy decisions of the accounting profession or securities regulators and their possible impact on the financial statements and/or financial reporting;

2.3 Disclosure

The Committee:

2.3.1 Reviews the quarterly and annual (1) financial statements and accompanying notes, (2) MD&A, and (3) related press releases and makes appropriate recommendations to the Board with respect thereto;

When reviewing these documents, the Committee's particular focus is on the context of the disclosure, the appropriateness of the Corporation's significant accounting principles and practices and changes thereto, unusual or extraordinary items, significant adjustments made as a result of the audit, disagreement between management and external auditors, significant off-balance sheet transactions, and transactions with non-related parties that have an immediate or important future impact on the financial situation of the Corporation. Additionally, the Committee

reviews the recommendations of the external auditors regarding any proposed changes to the Corporation's internal control procedures, programs and policies, the nature and extent of non-adjusted errors for non-negligible amounts as it is deemed appropriate.

2.3.2 Monitors the certification process by the President & Chief Medical Officer and Chief Financial Officer;

2.3.3 Reviews the Annual Information Form and makes appropriate recommendations to the Board with respect thereto;

2.3.4 Reviews the Management Proxy Circular and makes appropriate recommendations to the Board with respect thereto;

2.3.5 Reviews other such "core documents" and any other public disclosure documentation submitted by the management of the Corporation and makes appropriate recommendations to the Board with respect thereto;

2.4 External auditors

The Committee periodically:

2.4.1 Reviews and monitors the recommendation report of the external auditors and makes appropriate recommendations to the Board with respect thereto;

2.4.2 Meets with the external auditors to receive and discuss the performance of their last audit on annual Financial Statements and MD&A and any obstacle or problem encountered during that process and makes appropriate recommendations to the Board with respect thereto;

2.4.3 Evaluates the competency, the quality of the services and the independence of the external auditors and makes appropriate recommendations to the Board with respect thereto;

2.4.4 Meets with the external auditors and reviews their proposed audit program including the business risks that could affect the financial statements, the scope and timing of the audit and remuneration (fees) of the auditors and makes appropriate recommendations to the Board with respect thereto;

The Committee also:

2.4.5 Makes a recommendation to the Board for the appointment of an auditor for each annual audit;

2.4.6 Reviews the Audit and non-audit services Pre-approval policy for each fiscal year and makes appropriate recommendations to the Board with respect thereto;

2.4.7 Resolves disagreements on audit issues, if any, between management and the external auditors.

3 COMPOSITION

The Committee is composed of at least three (3) and a maximum of five (5) independent directors.

The Committee members comply with the independence requirements set forth in the applicable regulation; more particularly, but not limited to, the members have not received, other than in the course of rendering service as a member of the Board of Directors or as a

member of the Committee or as a member of any other committee of the Board of Directors, any other remuneration, notably professional fees, from the Corporation or from one of its related entities or subsidiaries.

The Committee members are all financially literate, as defined in the regulations.

The Board annually appoints the Committee members. The Board may at any time appoint another member to replace a vacancy or simply replace a member.

The Board appoints one of the Committee members as the chairperson of the Committee.

4 MEETINGS AND QUORUM

The Committee meets at least once every quarter and otherwise as needed. The chairperson of the Committee chairs the meetings.

The Committee meeting is called to order when a majority of Committee members are in attendance.

The Committee reports regularly to the Board on its discussions and submits its recommendations.

The Committee meets on a regular basis without management or the external auditors.

The Committee has at all times a direct line of communication with both the Chief Financial Officer and the external auditors and periodically meets with the external auditors without management.

5 INDEPENDENT ADVISORS

As needed, the Committee can hire an independent advisor(s) to help with issues under its responsibilities, agree on the fees and other contractual conditions and have the Corporation pay for the agreed upon expenses.

6 REVIEW OF THIS MANDATE

The Committee reviews this mandate periodically and recommends amendments to the Board as needed.

7 PERFORMANCE ASSESSMENT

Each year, under the supervision of the Corporate Governance, Human Resources and Nominating Committee of the Corporation, the Committee assesses its performance and reports on its mandate to the Board.

Revised and adopted by the Board of Directors, March 14, 2014.