VASOMEDICAL INC
Form 10-K
August 21, 2009

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-K

[X] ANNUAL REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 For the fiscal year ended May 31, 2009

[ ] TRANSITION REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 For the transition period from _____ to _____

Commission File No. 0-18105

VASOMEDICAL, INC.
(Exact name of registrant as specified in Its Charter)

Delaware	11-2871434
(State or other jurisdiction of incorporation or organization)	(IRS Employer Identification No.)
180 Linden Avenue, Westbury, New York	11590
(Address of Principal Executive Offices)	(Zip Code)

Registrant's telephone number, including area code: (516) 997-4600
Securities registered under Section 12(b) of the Act: None
Securities registered under Section 12(g) of the Act:

Common Stock, $.001 par value	OTC:BB
(Title of Class)	Name of each exchange on which registered

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. [ ]

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. [ ]

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the past 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.
Yes [X] No [ ]

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (ss.229.405) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [X]

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. Large accelerated filer [ ] Accelerated filer [ ] Non-accelerated filer [ ] Smaller reporting company [X]

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

The aggregate market value of common stock held by non-affiliates was approximately $4,234,912 based on the closing sales price of the common stock as quoted on the OTC-BB on August 12, 2009.

At August 12, 2009, the number of shares outstanding of the issuer's common stock was 99,843,004.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement in connection with its Annual Meeting of Stockholders to be held in September 2009, to be filed pursuant to Regulation 14A of the Securities Exchange Act of 1934, are incorporated by reference into Part III of this Annual Report on Form 10-K.

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VASOMEDICAL, INC.
INDEX TO FORM 10-K

PART I

ITEM 1 -BUSINESS

Except for historical information contained in this report, the matters discussed are forward-looking statements that involve risks and uncertainties. When used in this report, words such as "anticipates", "believes", "could", "estimates", "expects", "may", "plans", "potential" and "intends" and similar expressions, as they relate to the Company or its management, identify forward-looking statements. Such forward-looking statements are based on the beliefs of the Company's management, as well as assumptions made by and information currently available to the Company's management. Among the factors that could cause actual results to differ materially are the following: the effect of business and economic conditions; the effect of the dramatic changes taking place in the healthcare environment; the impact of competitive procedures and products and their pricing; medical insurance reimbursement policies; unexpected manufacturing or supplier problems; unforeseen difficulties and delays in the conduct of clinical trials and other product development programs; the actions of regulatory authorities and third-party payers in the United States and overseas; uncertainties about the acceptance of a novel therapeutic modality by the medical community; and the risk factors reported from time to time in the Company's SEC reports. The Company undertakes no obligation to update forward-looking statements as a result of future events or developments.

General Overview

Vasomedical, Inc. was incorporated in Delaware in July 1987. Unless the context requires otherwise, all references to "we", "our", "us", "Company", "registrant", "Vasomedical" or "management" refer to Vasomedical, Inc. and its subsidiaries. Since 1995, we have been primarily engaged in designing, manufacturing, marketing and supporting EECP(R) Enhanced External Counterpulsation systems based on our unique proprietary technology currently indicated for use in cases of stable or unstable angina, congestive heart failure (CHF), acute myocardial infarction (i.e., heart attack, (MI)) and cardiogenic shock. The EECP(R) therapy is a non-invasive, outpatient treatment of diseases of the cardiovascular system. The therapy serves to increase circulation in areas of the heart with less than adequate blood supply and helps restore systemic vascular function. The therapy also increases blood flow and oxygen supply to the heart muscle and other organs and decreases the heart's workload and reduces oxygen demand, while also improving function of the

endothelium, the lining of blood vessels throughout the body, lessening resistance to blood flow. We provide hospitals, clinics and physician private practices with EECP(R) equipment, treatment guidance, and a staff training and equipment maintenance program designed to provide optimal patient outcomes. EECP(R) is a registered trademark for Vasomedical's Enhanced External Counterpulsation therapy and systems. For more information, visit www.vasomedical.com.

We have FDA clearance to market our EECP(R) therapy for use in the treatment of stable and unstable angina, congestive heart failure, acute myocardial infarction, and cardiogenic shock; however, our current marketing efforts are limited mostly to the treatment of chronic stable angina and congestive heart failure. Medicare and other third-party payers currently reimburse for the treatment of angina pectoris patients with moderate to severe symptoms who are refractory to medications and not candidates for invasive procedures. Patients with co-morbidities of heart failure, diabetes, peripheral vascular disease, etc., are also reimbursed under the same criteria, provided the primary diagnosis and indication for treatment with EECP(R) therapy is angina symptoms.

During the last several years, we incurred operating losses. We have attempted to achieve profitability by reducing operating costs and halting the trend of declining revenue, and to reduce cash usage through bringing our cost structure more into alignment with current revenues. The Company has reduced personnel costs by reorganization. The Company has negotiated new terms on professional fees, facility expenses, and shipping and supply costs. The Company is also looking to obtain a revolving line of credit to help stabilize cash flow and to respond to customers requests for flexible payment terms on our EECP(R) therapy systems.

Market Overview

Cardiovascular disease (CVD) is the leading cause of death in the world and is among the top three diseases in terms of healthcare spending in nearly every country. CVD claimed approximately 2.4 million lives in the United States in 2005 and was responsible for 1 of every 5 deaths, according to The American Heart Association (AHA) Heart and Stroke Statistical 2009 Update (2009 Update). Approximately 80 million Americans suffer from some form of cardiovascular disease. Among these, 16.8 million have coronary heart disease (CHD).

We have FDA clearance to market our EECP(R) therapy for use in the treatment of stable and unstable angina, congestive heart failure, acute myocardial infarction, and cardiogenic shock; however, our current marketing efforts are mostly limited to the treatment of chronic stable angina and congestive heart failure. Medicare and other third-party payers currently reimburse for the treatment of angina pectoris patients with moderate to severe symptoms who are refractory to medications and who, in the opinion of a cardiologist or cardiothoracic surgeon, are not candidates for invasive procedures. Patients with co-morbidities of heart failure, diabetes, peripheral vascular disease, etc. are also reimbursed under the same criteria, provided the primary diagnosis and indication for treatment with EECP(R) therapy is refractory angina symptoms.

Angina

Angina pectoris is the medical term for a recurring pain or discomfort in the chest due to coronary artery disease (CAD). Angina is a symptom of a condition called myocardial ischemia, which occurs when the heart muscle or myocardium doesn't receive sufficient blood, hence as much oxygen, as it needs. This usually happens because one or more of the heart's arteries, the blood

vessels that supply blood to the heart muscle, is narrow or blocked. Insufficient blood supply to meet the need of the organ to function is called ischemia.

The cardinal symptom of stable CAD is anginal chest pain or equivalent symptoms, such as exertional dyspnea or fatigue. Angina is uncomfortable pressure, fullness, squeezing or pain, usually occurring in the center of the chest under the breastbone. The discomfort also may be felt in the neck, jaw, shoulder, back or arm, and shortness of breath and fatigue. Often the patient suffers not only from the discomfort of the symptom itself but also from the accompanying limitations on activities and the associated anxiety that the symptoms may produce. Uncertainty about prognosis may be an additional source of anxiety. For some patients, the predominant symptoms may be palpitations or syncope that is caused by arrhythmias or fatigue, edema, or orthopnea caused by heart failure. Episodes of angina occur when the heart's need for oxygen increases beyond the oxygen available from the blood nourishing the heart. Physical exertion is the most common trigger, but not the only one for angina. For example, running to catch a bus could trigger an attack of angina while walking might not. Angina may happen during exercise, periods of emotional stress, exposure to extreme cold or heat, heavy meals, alcohol consumption or cigarette smoking. Some people, such as those with a coronary artery spasm, may have angina when they are resting.

There are approximately 6.4 million angina patients in the United States and our EECP(R) therapy currently competes with other technologies in the market for approximately 100,000 to 150,000 new refractory angina patients annually who do not adequately respond to or are not amenable to medical and surgical therapy and have the potential to meet the guidelines for reimbursement of EECP(R) therapy. Most angina patients are treated with medications, including beta blockers to slow and protect the heart, and vasodilators which are often prescribed to increase blood flow to the coronary arteries. When drugs fail or inadequately correct the problem, the patients are considered unresponsive to medical therapy. Most angina patients are readily amenable to invasive revascularization procedures such as angioplasty and coronary stent placement, as well as coronary artery bypass grafting (CABG). However, there are approximately 100,000 to 150,000 angina patients each year whose angina cannot be stopped by medication and they are no longer readily amenable to palliative invasive procedures.

In February 1999, the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program for more than 39 million beneficiaries, issued a national coverage policy for the use of external counterpulsation therapy in the treatment of refractory angina. Medicare reimbursement guidelines have a significant impact in determining the available market for EECP(R) therapy. We believe that over 65% of the patients that receive EECP(R) therapy are Medicare patient, and many of the balance are covered by third-party payers. Medicare guidelines, limit reimbursement for

EECP(R) therapy to patients who do not adequately respond to medical therapy and are not readily amenable to invasive therapy. As a result, an important element of our strategy is to grow the market for EECP(R) therapy by expanding reimbursement coverage to include a broader range of angina patients than the current coverage policy provides and enable EECP(R) therapy to compete more with other therapies for ischemic heart disease. Please see the heading "Reimbursement" in the "Item-1 Business" section of this Form 10-K for a more detailed discussion of reimbursement issues.

Congestive Heart Failure (CHF)

CHF is a condition in which the heart loses its pumping capacity to supply the metabolic needs of all other organs. The condition affects both sexes and is most common in people over age 50. Symptoms include angina, shortness of breath, weakness, fatigue, swelling of the abdomen, legs and ankles, rapid or irregular heartbeat and low blood pressure. Causes range from chronic high blood pressure, heart-valve disease, heart attack, coronary artery disease, heartbeat irregularities, severe lung disease such as emphysema, congenital disease, cardiomyopathy, hyperthyroidism, severe anemia and others.

CHF is treated with medication and, sometimes, surgery on heart valves or the coronary arteries and, in certain severe cases, heart transplants. Left ventricular assist devices (LVADs) and the use of cardiac resynchronization and implantable defibrillators are useful in selected patients with heart failure. Still, no consensus therapy currently exists for CHF and patients must currently suffer their symptoms chronically and have a reduced life expectancy.

According to the 2009 Update, in 2005 approximately 3.2 million men and 2.5 million women in the United States had CHF and about 670,000 new cases of the disease occur each year. The prevalence of the disease is growing as a result of the aging of the population and the improved survival rate of people after heart attacks. Because the condition frequently entails visits to the emergency room and in-patient treatment centers, two-thirds of all hospitalizations for people over age 65 are due to CHF. The economic burden of congestive heart failure is enormous with an estimated cost to the health care system in 2005 in the United States of $37.2 billion. Congestive heart failure offers a good strategic fit with our current angina business and offers an expanded market opportunity for EECP(R) therapy. Unmet clinical needs in CHF are greater than those for angina, as there are few consensus therapies, invasive or otherwise, beyond medical management for the condition. It is noteworthy that data collected from the International EECP(R) Patient Registry(TM) (IEPR) at the University of Pittsburgh Graduate School of Public Health shows that approximately one-third of angina patients treated with EECP(R) also have a history of CHF and 70% to 80% have demonstrated positive outcomes from EECP(R) therapy.

We sponsored a pivotal, randomized clinical trial to demonstrate the efficacy of EECP(R) therapy in the most prevalent types of heart failure patients. This trial, known as PEECH(TM) (Prospective Evaluation of EECP(R) in Congestive Heart Failure), was intended to provide additional evidence of the safety and efficacy of EECP(R) therapy in the treatment of mild-to-moderate heart failure and to support our application for expansion of the Medicare national reimbursement coverage policy to include mild-to-moderate heart failure as a primary indication. The PEECH(TM) trial was a positive clinical trial, having met the statistical requirement of meeting at least one of its co-primary endpoints, a significant difference in the proportion of patients satisfying a prespecified threshold of improvement in exercise duration. The trial also demonstrated significant improvements in favor of EECP(R) therapy on several important secondary endpoints, including exercise duration and improvement in symptom status and quality of life. Measures of change in peak oxygen consumption were not statistically significant in the overall study population, though a trend favoring EECP(R) therapy was present in early follow-up. Patients in the trial who had an ischemic etiology (i.e. pre-existing coronary artery disease), demonstrated a greater response to EECP(R) therapy than those who had an idiopathic (non-ischemic) etiology.

The preliminary results of the PEECH(TM) trial were presented at the American College of Cardiology scientific sessions in March 2005. On June 20, 2005, CMS accepted our application for expansion of reimbursement coverage of EECP(R) therapy to include patients with New York Heart Association (NYHA) Class II/III stable heart failure symptoms with an ejection fraction of less than or equal to 35% (i.e. chronic, stable, mild-to-moderate systolic heart failure as a primary indication), as well as patients with Canadian Cardiovascular Society Classification (CCSC) II (i.e. chronic, stable mild angina).

On March 20, 2006, CMS issued their Decision Memorandum regarding this reconsideration with the opinion that the evidence was not adequate to support an extension of coverage.

They did, however, reiterate in the decision memorandum that "Current coverage as described in Section 20.20 of the Medicare National Coverage Determination (NCD) manual will remain in effect" for refractory angina patients.

On August 25, 2006 the results of the PEECH(TM) trial were initially published online by the Journal of the American College of Cardiology (JACC) and in print in its September 19, 2006 issue. JACC is the official journal of the American College of Cardiology.

In the November-December 2006 issue of the journal Congestive Heart Failure, a second report of results from the PEECH(TM) trial was published, focusing on the results of a prespecified subgroup analysis in trial patients age 65 and over. This analysis demonstrated a statistically positive response on both co-primary endpoints of the trial in patients receiving EECP(R) therapy versus those who did not, i.e. a significantly larger proportion of patients undergoing EECP(R) therapy met or exceeded prespecified thresholds of improvement in exercise duration and peak oxygen consumption. Moreover, the patients age 65 and older who received EECP(R) therapy demonstrated the greatest differences in exercise duration, peak oxygen consumption and functional class (symptom status) compared with those who did not receive EECP(R) therapy.

These papers were submitted to CMS and we were advised to continue to gather more clinical evidence for future submission.

We will continue to educate the marketplace that EECP(R) therapy is a therapy for ischemic cardiovascular disease and that patients with a primary diagnosis of heart failure, diabetes, peripheral vascular disease, etc. are also eligible for reimbursement under the current coverage policy, provided the primary indication for treatment with EECP(R) therapy is angina or angina equivalent symptoms and the patient satisfies other listed criteria. Additionally, we will continue to pursue expansion of coverage for EECP(R) therapy with Medicare and other third-party payers as evidence of its clinical utility develops.

The EECP(R) Therapy Systems

The EECP(R) therapy systems are noninvasive treatment systems utilizing fundamental hemodynamic principles to augment coronary blood flow and, at the same time, reduce the workload of the heart while improving the overall vascular function. The treatment is completely noninvasive and is administered to patients on an outpatient basis, usually in daily one-hour sessions, five days per week over seven weeks for a total of 35 treatments. The procedure is well tolerated and most patients begin to experience relief of chest pain due to their coronary artery disease after 15 to 20 hours of therapy. As demonstrated in our clinical studies, positive effects have been shown in most patients to continue for years following a full course of therapy.

During EECP(R) therapy, the patient lies on a contoured treatment table while three sets of inflatable pressure cuffs, resembling oversized blood pressure cuffs, are wrapped around the calves, and the lower and upper thighs, including the buttocks. The system is synchronized to the individual patient's cardiac cycle triggering the system to inflate the cuffs rapidly and sequentially -- via computer-interpreted ECG signals -- starting from the calves and proceeding upward to the buttocks during the relaxation phase of each

heartbeat (diastole). This has the effect of creating a strong retrograde arterial wave in the arterial system, forcing freshly oxygenated blood towards the heart and coronary arteries at a time when resistance to coronary blood flow is at its lowest level. The inflation of cuffs also simultaneously increases the volume of venous blood that is returned to the heart when the heart is filling up for ejection in the contracting phase. Just prior to the next heartbeat when the heart begins to eject blood by contracting (systole), all three cuffs simultaneously deflate, leaving an empty vascular space to receive blood ejecting from the heart, thereby significantly reducing the workload of the heart. This is achieved because the vascular beds in the lower extremities are relatively empty when the cuffs are deflated, significantly lowering the resistance, and provide vascular space to receive the blood ejected by the heart, reducing the amount of work the heart must do to pump oxygenated blood to the rest of the body. The inflation/deflation activity is monitored constantly and coordinated by a computerized console that interprets electrocardiogram signals from the patient's heart, monitors heart rhythm and rate information, and actuates the inflation and deflation in synchronization with the cardiac cycles. The end result of this sequential "squeezing" of the legs is to create a

pressure wave that significantly increases peak diastolic pressure benefiting circulation to the heart muscle and other organs, increases venous return so that the heart has more blood volume to eject out, and increases cardiac output. The release of external pressure produces reduction of systolic pressure, thereby reducing the workload of the heart. This reduction of vascular resistance insures that the heart does not have to work as hard to pump large amounts of blood through the body to help supply its metabolic needs.

While not all of the precise scientific means by which EECP(R) therapy achieves its long-term beneficial effects have been explained, there is evidence to suggest that the EECP(R) therapy triggers a neurohormonal response that induces the production of growth and vasodilatation factors that promotes recruitment of new arteries and dilates existing blood vessels. The recruitment of new arteries known as "collateral blood vessels" bypass blocked or narrowed vessels and increase blood flow to ischemic areas of the heart muscle that are receiving an inadequate supply of blood. There is also evidence to support a mechanism related to improved function of the endothelium (the inner lining of the blood vessels), which regulates the luminal size of the arteries and controls the dilation of the arteries to insure adequate blood flow to all organs, thus reducing constriction of blood vessels that supply oxygenated blood to the body's organs and tissues and as a result the required workload of the heart.

Clinical Studies

Early History

Early experiments with counterpulsation at Harvard in the 1950s demonstrated that this technique markedly reduces the workload, and thus oxygen consumption, of the left ventricle. This basic effect has been demonstrated over the past forty years in both animal experiments and in patients. The clinical benefits of external counterpulsation were not consistently achieved in early studies because the equipment used then lacked some of the features found in the current EECP(R) systems, such as the computerized electrocardiographic signal for triggering, and the use of pneumatic versus hydraulic actuating media that makes sequential cuff inflation possible. As the technology improved, however, it became apparent that both internal (i.e. intra-aortic balloon pumping) and external forms of counterpulsation were capable of improving survival in patients with cardiogenic shock following myocardial infarction. Later, in the 1980s, Dr. Zheng and colleagues in China reported on their extensive experience in treating angina using the newly developed "enhanced" sequentially inflating

EECP(R) device that incorporated three sets of cuffs including the buttocks cuff instead of a single cuff used in the previous system. The Chinese investigators were able to show that a 36-hour course of treatment with the EECP(R) system reduced the frequency and severity of anginal symptoms during normal daily functions and also during exercise, and also that the improvements were sustained for years after therapy.

These results prompted a group of investigators at the State University of New York at Stony Brook (Stony Brook) to undertake a number of open label studies with the EECP(R) system between 1989 and 1996 to reproduce the Chinese results, using both subjective and objective endpoints. These studies, though open label and non-randomized, showed significant improvement in exercise tolerance by patients as evidenced by exercise treadmill stress testing, improvement in the perfusion of ischemic regions of the heart muscle by thallium radionuclide imaging stress testing, and partial or complete resolution of coronary perfusion defects. All of these results have been reported in medical literature and support the assertion that EECP(R) therapy is an effective and durable treatment for patients suffering from chronic angina pectoris.

The MUST-EECP(R) Study

In 1995, we began a randomized, controlled and double-blinded multicenter clinical study (MUST-EECP(R)) at seven leading university hospitals in the United States to confirm the patient benefits observed in the open studies conducted at Stony Brook and to provide definitive scientific evidence of EECP(R) therapy's effectiveness. MUST-EECP(R) was completed in July 1997 and the results presented at the annual meetings of the American Heart Association in November 1997 and the American College of Cardiology in March 1998. The results of MUST-EECP(R) were published in the Journal of the American College of Cardiology (JACC), a major peer-review medical journal, in June 1999.

This 139 patient study, which included a sham-EECP(R) control group, demonstrated that patients treated with EECP(R) therapy were able to increase the amount of time on exercise testing before they showed signs of cardiac ischemia (i.e. ST-segment depression on their electrocardiogram) and experienced a reduction in the frequency of their angina attacks compared to patients who did not receive EECP(R) therapy. In 1999, physician collaborators completed a quality-of-life study with the EECP(R) system in a subset of the same patients that participated in MUST-EECP(R). Two highly regarded standardized means of measurement were used to gauge changes in patients' outlook and ability to participate in normal daily living during the treatment phase and for up to 12 months after treatment. Results of this study, which have been presented at major scientific meetings and published in the January 2002 Journal of Investigative Medicine, show that after one-year of follow-up the group of patients receiving EECP(R) therapy enjoyed significantly improved aspects of health-related quality of life compared to those who received a sham treatment.

The PEECH(TM) Study

As part of our program to expand the therapy's indications for use beyond the treatment of angina, we applied for and received FDA approval in April 1998 to study, under an Investigational Device Exemption (IDE) protocol, the application of EECP(R) therapy in the treatment of CHF. A 32 patient feasibility study was conducted simultaneously at the University of Pittsburgh, the University of California San Francisco and the Grant/Riverside Methodist Hospitals in Columbus, Ohio. The results of this study were presented at the 49th Scientific Sessions of the American College of Cardiology in March 2000 and the Heart Failure Society of America's Annual Meeting in September 2000 and were published in the July/August 2002 issue of Congestive Heart Failure. This study indicated that EECP(R) therapy could improve exercise capacity, increase

functional capacity was beneficial to left ventricular function in patients with NYHA Class II and III (i.e. mild to moderate) heart failure and a reduced left ventricular ejection fraction (i.e. LVEF = 35% or less).

In summer 2000, an IDE supplement to proceed with a pivotal study to demonstrate the efficacy of EECP(R) therapy in the most prevalent types of heart failure patients was approved. This study, known as PEECH(TM), began patient enrollment in March 2001. The PEECH(TM) clinical trial involved nearly thirty centers including: the Cleveland Clinic, Mayo Clinic, Scripps Clinic, Thomas Jefferson University Hospital, the University of North Carolina at Chapel Hill, the Minnesota Heart Failure Consortium, Advocate Christ Hospital, Hull Infirmary (UK), the University of California at San Diego Medical Center, the University of Pittsburgh Medical Center, the Lindner Clinical Trial Center and the Cardiovascular Research Institute. Vasomedical obtained 510(k) clearance for CHF from FDA in June 2002, obviating the need to continue this trial for FDA regulatory reasons. However, we decided to complete the clinical trial in order to use the anticipated clinical outcomes to help establish the clinical validation of EECP(R) therapy as a treatment for CHF and to provide additional scientific support for Medicare, Medicaid and other third-party payers to expand reimbursement coverage of EECP(R) therapy to include the CHF indication.

The protocol for the study required that patients have NYHA II or III symptoms, have an LVEF of 35% or less, be able to undergo exercise testing and complete patient examinations 1-week, 3-months and 6-months following treatment that evaluated changes from baseline in exercise capacity, symptom status and quality of life. Patients were randomized to receive either optimal (i.e. guideline-recommended) pharmaceutical therapy (OPT) or EECP(R) therapy in addition to OPT. Enrollment of patients into the PEECH(TM) trial was completed in February 2004, with 187 patients, and the six-month follow-up examinations were completed by the end of December 2004.

The preliminary results of the PEECH(TM) trial were presented at the American College of Cardiology scientific sessions in March 2005. On June 20, 2005, CMS accepted our application for expansion of reimbursement coverage of EECP(R) therapy to include patients with NYHA Class II/III stable heart failure symptoms with an ejection fraction of less than or equal to 35%, (i.e., chronic, stable, mild-to-moderate systolic heart failure as a primary indication), as well as patients with CCSC II, (i.e., chronic, stable mild angina).

In designing the PEECH(TM) trial, success was demonstrated if the difference between EECP(R) therapy combined with OPT compared to OPT alone achieved a p-value less than 0.025 in at least one of two pre-defined co-primary endpoints:

1. percentage of subjects with greater than or equal to 60 seconds improvement in exercise duration from baseline to six months, or

2. percentage of subjects with at least 1.25 mL/kg/min increase in peak oxygen consumption from baseline to six months.

Additional secondary endpoints were actual changes in exercise duration and peak oxygen consumption, changes in NYHA functional classification, changes in quality of life, adverse experiences and pre-defined clinical outcomes.

The study was a positive clinical trial on the basis that a significantly greater proportion of patients who underwent EECP(R) therapy improved their exercise duration by 60 seconds or more six months following completion of therapy compared to those who received OPT alone (35.4% vs. 25.3%, p=0.016). The proportion of patients achieving a 1.25 mL/kg/min improvement in peak oxygen consumption was not significantly different between the two groups at six

months.

Consistent with the results on the primary endpoint of exercise duration, statistically significant differences favoring the EECP(R)-treated group were seen in changes in average exercise duration, symptom status and quality of life during follow-up. Average peak oxygen consumption showed a trend favoring the EECP(R) group at 1 week, but there were no differences detected at later follow-up. Results in patients with heart failure of ischemic etiology were noted to be clearly superior to those patients of idiopathic etiology though the benefit in these later patients could not be ruled out statistically. Lastly, EECP(R) therapy was deemed safe and well tolerated in this group of patients, as patients in the EECP(R)-treated group did not suffer more adverse events than those in the control group.

Moreover, results of a predefined subgroup analysis showed that patients 65 years of age or older not only had a significantly greater response rate (co-primary endpoint) and average change in exercise duration favoring EECP(R)-treated patients, but the response rate (co-primary endpoint) and average change in peak oxygen consumption were also significantly better out to completion of the study at six months follow-up.

The results of the PEECH(TM) trial indicate that EECP(R) therapy provides beneficial adjunctive therapy in patients with NYHA Class II-III systolic heart failure receiving optimal pharmacological therapy, especially in those 65 years of age or older. There can be no assurance that the results of the PEECH(TM) clinical trial will be sufficient to expand reimbursement coverage or the adoption by the medical community of EECP(R) therapy for use in the treatment of congestive heart failure.

The International EECP(R) Patient Registry (IEPR(TM))

The International EECP(R) Patient Registry at the University of Pittsburgh Graduate School of Public Health was established in January 1998 to track the outcomes of angina patients who have undergone EECP(R) therapy. More than one hundred centers have participated in the registry and data from more than 5,000 patients from an initial cohort enrolled between 1998 and 2001 (IEPR-1) have been tabulated and reported in several peer-reviewed publications.

The American Journal of Cardiology published a report in February of 2004 on the two-year outcomes after EECP(R) therapy observed in 1,097 patients with two-year follow-up enrolled in IEPR-1. The authors noted that 73% of patients in this cohort had a decrease in their angina symptom status upon completion of EECP(R) therapy and that the average number of angina episodes for the group was reduced from 10.6 to 2.8 per week. They characterized this improvement as a "significant and dramatic reduction in CCSC" and stated that the adverse clinical event rate was low. (CCSC is a rating scale used by physicians to assess the limitations imposed on patients' lives by angina.) Patients also reported improvement in health status, quality of life and satisfaction with life.

At two-years follow-up, 74.9% of patients reported their angina symptom status (CCSC class) was improved compared to before EECP(R) therapy, and the accompanying improvements in angina frequency and quality of life measures were largely sustained as well. Nine percent of patients had died over the two-year follow-up and 15% had undergone a revascularization procedure (angioplasty, stenting or coronary bypass surgery).

The authors summarize the results by stating "Most patients experienced a significant reduction in angina and improvement in quality of life after EECP(R) therapy, and this reduction was sustained in most patients at 2-year follow-up."

In a separate report that appeared in The American Journal of Cardiology in 2005, physician investigators participating in the IEPR(TM) reported on the results of EECP(R) therapy in patients with angina who also had severe left ventricular dysfunction (LVD, a reduced pumping capacity of the heart). Previously it was thought that such patients, and those with a diagnosis of heart failure, would be put at risk if treated with EECP(R) therapy, due to the increase in venous return to the heart caused by compression of the leg veins by enhanced external counterpulsation.

The 363 patients in this cohort had long-standing and extensive coronary artery disease, had a high prevalence of cardiovascular disease risk factors, were not amenable to invasive revascularization procedures, and suffered from severe angina. Following completion of EECP(R) treatment, 77% decreased their CCSC angina class by at least one severity rating. The average number of angina episodes per week was greatly reduced and many were able to discontinue the use of nitroglycerin pills designed to relieve angina. As in the overall IEPR population, measures of quality of life were significantly improved after treatment.

The rate of major adverse clinical events, while somewhat more frequent in this group of patients with significant comorbid disease, was characterized as low over the course of EECP(R) therapy. Exacerbation of heart failure was significantly more frequent in patients who did not complete therapy compared to those who did (16% vs. 0%) in patients with a previous history of heart failure.

At two-years of follow-up, 83% remained alive and 70% were free of death, heart attack or invasive revascularization procedures (coronary artery bypass surgery, angioplasty and/or stenting) during that period. The majority of patients experienced sustained relief of their angina and improved quality of life. Twenty per cent of the group underwent repeat EECP(R) therapy during the two-year follow-up, mostly due to failure to complete the original course of therapy.

A second phase of enrollment into the registry (IEPR-2) enrolled approximately 2,500 patients between 2002 and 2004 and these patients were followed to 2-year follow-up. IEPR-2 incorporated sub-studies regarding treatment beyond 35 hours, possible predictors of response, effects on certain aspects of peripheral vascular disease and sexual dysfunction in men. Notably, the data set was modified in February 2003 to capture information on changes in heart failure symptom status, occurrence of clinical events due to heart failure and to include a heart failure-specific quality of life questionnaire in IEPR-2 patients with concomitant heart failure.

Vasomedical considers the IEPR(TM) to be a vital source of information about the effectiveness and safety of EECP(R) therapy in a real-world environment for the medical community at large. To date, twenty full-length articles reporting data from the IEPR(TM) have been published in peer-reviewed medical journals and more than seventy-eight abstracts have been presented at a variety of major cardiovascular scientific conferences. For this reason, we continue to provide an ongoing grant to fund the analysis of the registry data to be published in medical journals.

Registry data, while considered a valuable source of complementary clinical data, is deemed by scientific cardiologists and others to be less convincing than data from randomized, blinded, clinical trials and from certain other well-controlled clinical study designs. There can be no assurance that the Company will be able to obtain regulatory, reimbursement or other types of approvals, or a favorable standing in medical professional practice guidelines, based upon results observed in patients enrolled in registries.

Other studies and publications

A search on the term "external counterpulsation" of the PubMed database available through the National Library of Medicine conducted on August 14, 2009, identified two-hundred-fifty-four (254) citations of articles published in the medical scientific literature, including 28 review articles. Over 95% of these publications have reported results in patients with chronic stable angina and/or heart failure treated with EECP(R) therapy, while others have reported use of the device in other cardiovascular or non-cardiovascular indications. With only a few exceptions, these reports are generated using Vasomedical EECP(R) therapy systems and equipment. In summary, this body of literature contains evidence from a variety of institutions and investigators demonstrating that EECP(R) therapy can provide benefit to appropriate patients in the following ways:

- Enhancement of coronary and peripheral circulation, myocardial perfusion, ventricular function and hemodynamics,
- Improvement in endothelial function and vascular reactivity
- Elimination or reduction of cardiac ischemia,
- Elimination or reduction in symptoms and improved functional class in angina and heart failure,
- Resolution of reversible ischemic defects found on quantitative myocardial perfusion studies,
- Increased exercise duration and increased time to ischemic changes during treadmill exercise in angina and increased exercise duration and peak oxygen consumption in heart failure in properly selected patients,
- Elimination or reduction in use of anti-angina medications,
- Improved quality of life in patients with angina and heart failure.

Strategic Objectives

Our short-and long-term plans are to:

a) Maintain our cost structure alignment with current revenues in the short term by:
   i) continuing to monitor, reduce, or eliminate spending on all but critical new product development and clinical research projects,
   ii) focusing on rebuilding our revenue base through supporting our direct sales effort and expanding our use of independent sales representatives, and
   iii) maintaining tight cost control on all areas of personnel cost and spending.

b) Pursue possible strategic investments and creative partnerships with others who have distinctive competencies or delivery capabilities for serving the cardiovascular and disease management marketplace, as opportunities become available.

c) Increase market penetration in the domestic reimbursable user base for EECP(R) therapy by:
   i) expanding reimbursement to include coverage for the treatment of ischemic NYHA Class II and III CHF patients,
   ii) marketing directly to third-party payers to increase third-party reimbursement, and
   iii) expanding reimbursement coverage in the angina market to include patients with CCS Class II angina.

d) Increase the clinical and scientific understanding of EECP(R) therapy by:
   i) resubmitting data to insurers, including Medicare, for favorable coverage policies;
   ii) continuing to support on a limited basis academic reference centers in the United States and overseas in order to accelerate the growth and prestige of EECP(R) therapy and

e) Increase awareness of the benefits of the EECP(R) therapy in the medical community by:
   i) developing campaigns to market the benefits of EECP(R) therapy directly to clinicians, third-party payers and patients;
   ii) engaging in educational campaigns for providers and medical directors of third-party insurers designed to highlight the cost-effectiveness and quality-of-life advantages of EECP(R) therapy; and
   iii) continuing the development of EECP(R) therapy in certain international markets, principally through the expansion of our distribution network and obtaining of reimbursement approvals.
f) Maintain development efforts to improve the EECP(R) system and expand its intellectual property estate.

These listed strategic objectives are forward-looking statements. We review, modify and change our strategic objectives from time to time based upon changing business conditions. There can be no assurance that we will be able to achieve our strategic objectives and even if these results are achieved risks and uncertainties could cause actual results to differ materially from anticipated results. To a large extent, limited financial resource availability reduces our ability to achieve these strategic objectives. Please see the section of this Form 10-K entitled "Risk Factors" for a description of certain risks, among others that may cause our actual results to vary from the forward-looking statements.

Sales and Marketing

Domestic Operations

We sell EECP(R) therapy systems to treatment providers such as hospitals, clinics and physician private practices in the United States through a direct and indirect sales force. Our sales force has consisted of a combination of employees and independent sales representatives managed by a vice president of sales, and the national sales director, along with in-house administrative support.

The efforts of our sales organization are further supported by clinical educators who are responsible for the onsite training of physicians and therapists as new centers are established. This clinical applications group is also engaged in training and certification of new personnel at each site, as well as for updating providers on new clinical developments relating to EECP(R) therapy.

Our marketing activities support physician education and physician outreach programs, exhibition at national, international and regional medical conferences, as well as sponsorship of seminars at professional association meetings. These programs are designed to support our field sales organization and increase awareness of EECP(R) therapy in the medical community. Additional marketing activities include creating awareness among third-party payers of the benefits of EECP(R) treatment for patients suffering from CHF as well as angina.

We employ service technicians responsible for the repair and maintenance of EECP(R) systems and, in some instances, on-site training of a customer's biomedical engineering personnel. We provide a service arrangement (usually one year) that includes: service by factory-trained service representatives, material and labor costs, emergency and remedial visits, software upgrades, technical phone support and preferred response times. We service our customers after the service arrangement expires either under separately purchased annual service contracts or on a fee-for-service basis.

International Operations

We distribute our product internationally through a network of independent distributors. It has generally been our policy to appoint distributors with exclusive marketing rights to EECP(R) therapy systems in their respective countries, in exchange for their commitment to meet the duties and responsibilities required of a distributor. Each distribution agreement contains a number of requirements that must be met for the distributor to retain exclusivity, including minimum performance standards. Duties of the distributors include registering the product and obtaining any required regulatory or clinical approvals to support local registration or reimbursement for EECP(R) therapy.

Revenues from international operations were 31% and 16% of total revenue for the fiscal years ended May 31, 2009 and 2008, respectively. Our international marketing activities include, among other things, assisting in obtaining national or third-party healthcare insurance reimbursement approval and participating in medical conferences to create greater awareness and acceptance of EECP(R) therapy by clinicians.

International sales may be subject to certain risks, including export/import licenses, tariffs, and other trade regulations. However, tariff and trade policies, domestic and foreign tax and economic policies, currency exchange rate fluctuations and international monetary conditions have not significantly affected our business to date. In addition, there can be no assurance that we will be successful in maintaining our existing distribution agreements or entering into any additional distribution agreements, or that our international distributors will be successful in marketing EECP(R) therapy.

Competition

Presently, we are aware of at least three direct competitors with an external counterpulsation device on the market. In addition, other companies have received FDA 510(k) clearance for external counterpulsation systems since 1998, although we have not seen these systems commercially in the marketplace. While we believe that these competitors' involvement in the market is limited, there can be no assurance that these companies will not become a significant competitive factor or that other companies will not enter the external counterpulsation market.

We view other companies engaged in the development of device-related, biotechnology and pharmacological approaches to the management of cardiovascular disease as potential competitors in the marketplace as well. These include such common and well-established medical devices and treatments as the intra-aortic balloon pump (IABP), ventricular assist devices (VAD), coronary artery bypass graft surgery (CABG), coronary angioplasty, mechanical circulatory support (MCS), transmyocardial laser revascularization (TMR), total artificial hearts, cardiac resynchronization devices, ranolazine and nesiritide (Natrecor(R)); as well as newer technologies currently in FDA-approved clinical trials such as gene therapy and spinal cord stimulation (SCS). There can be no assurance that other companies will not develop new technologies or enter the market intended for EECP(R) therapy systems. Such other companies may have substantially greater financial, manufacturing and marketing resources and technological expertise than those possessed by us and may, therefore, succeed in developing technologies or products that are more efficient than those offered by Vasomedical and that would render our technology and existing products obsolete or noncompetitive.

Government Regulations

We are subject to extensive regulation by numerous government regulatory agencies, including the FDA and similar foreign agencies. Where applicable, we are required to comply with laws, regulations and standards governing the development, preclinical and clinical testing, manufacturing, quality testing, labeling, promotion, import, export, and distribution of our medical devices.

Device Classification

FDA regulates medical devices, including the requirements for premarket review, according to their classification. Class I devices are generally lower risk products for which general regulatory controls are sufficient to provide reasonable assurance of safety and effectiveness. Most Class I devices are exempt from the requirement of 510(k) premarket notification clearance; however, 510(k) clearance is necessary prior to marketing a non-510(k) exempt Class I device in the United States. Class II devices are devices for which general regulatory controls are insufficient, but for which there is sufficient information to establish special controls, such as guidance documents or standards, to provide reasonable assurance of safety and effectiveness. A premarket notification clearance is necessary prior to marketing a non-510(k) exempt Class II device in the United States. Class III devices are devices for which there is insufficient information demonstrating that general and special controls will provide reasonable assurance of safety and effectiveness and which are life-sustaining, life-supporting or implantable devices, are of substantial importance in preventing impairment of human health, or pose a potential unreasonable risk of illness or injury. The FDA generally must approve a premarket approval or PMA application prior to marketing a Class III device in the United States.

A medical device is considered by FDA to be a preamendments device, and generally not subject to premarket review, if it was commercially distributed before May 28, 1976, the date the Medical Device Amendments of 1976 became law. A postamendments device is one that was first distributed commercially on or after May 28, 1976. Postamendments device versions of preamendments Class III devices are subject to the same requirements as those preamendments devices. FDA may require a PMA for a preamendments Class III device only after it publishes a regulation calling for such PMA submissions. Persons who market preamendments devices must submit a PMA, and have it filed by FDA, by a date specified by FDA in order to continue marketing the device. Prior to the effective date of a regulation requiring a PMA, devices must have a cleared premarket notification or 510(k) for marketing.

Certain external counterpulsation devices were commercially distributed prior to May 28, 1976. Our external counterpulsation devices were marketed after 1976; however, they were found to be substantially equivalent to a preamendments Class III device and therefore are subject to the same requirements as the preamendments external counterpulsation devices.

Premarket Review

The 510(k) premarket notification process requires an applicant to give notice to FDA of its intent to introduce its device into commerce. In its premarket notification, the applicant must demonstrate that its new or modified medical device is substantially equivalent to a legally marketed or predicate device marketed before May 28, 1976. Prior to beginning commercialization of the new or modified product it must receive an order from the FDA classifying the

device under section 510(k) in the same classification as the predicate device, and as a result, the new device will be cleared for marketing. Modifications to a previously cleared medical device that do not significantly affect its safety and effectiveness or constitute a major change in the intended use can be made

without having to submit a new 510(k). In February 1995, the Company received 510(k) clearance to market the second-generation version of its EECP(R) therapy system, the MC2, which incorporated a number of technological improvements over the predicate system. In addition, in December 2000, the Company received 510(k) clearance to market its third generation system, the TS3. The FDA's clearance in these cases was for the use of EECP(R) therapy in the treatment of patients suffering from stable or unstable angina pectoris, acute myocardial infarction and cardiogenic shock. In June 2002, the FDA granted 510(k) market clearance for an upgraded TS3, which incorporated the Company's patented CHF treatment and oxygen saturation monitoring technologies, and provided for a new indication for the use of EECP(R) in CHF, which applied to all then-current models of the Company's EECP(R) therapy systems.

Modifications to a previously cleared medical device that do not significantly affect its safety and effectiveness or constitute a major change in the intended use can be made without having to submit a new 510(k). FDA publishes guidance for medical device manufacturers on the types of changes that meet the requirements for a new 510(k) prior to introduction of a device for marketing distribution. Vasomedical followed FDA's guidance on when to submit a new 510(k) for changes to a device and concluded that the changes incorporated into its Model TS4 did not require a new 510(k) prior to its introduction to market. Vasomedical subsequently obtained a 510(k) that applied to the Model TS4 and all of its models in March 2004, when it made changes to the labeling of all of its EECP(R) therapy systems. In November 2004, the Company introduced its Model Lumenair, and again concluded that the changes did not require a new 510(k) at that time. There can be no assurance that the FDA will agree with Vasomedical's conclusions that a new 510(k) was unnecessary on these occasions or in other similar instances, or that our products will not be subject to a regulation requiring a PMA for preamendments Class III external counterpulsation devices.

If a device does not receive a clearance order because the FDA determines that the device is not substantially equivalent to a predicate device and thus the device automatically is considered a Class III device, the applicant may ask the FDA to make a risk-based classification to place the device in Class I or II. However, if a timely request for risk-based classification is not made, or if the FDA determines that a Class III designation is appropriate, an approved PMA will be required before the device may be marketed.

The more rigorous premarket review process is the PMA process. The FDA approves a PMA if the applicant has provided sufficient valid scientific evidence to prove that the device is safe and effective for its intended use(s). Applications for premarket approval generally contain human clinical data. This process is usually much more complex, time-consuming and expensive than the 510(k) process, and is uncertain. Both 510(k)s and PMAs now require the submission of user fees in most circumstances.

There can be no assurance that all the necessary FDA clearances or approvals, including approval of any PMA required by the promulgation of a regulation, will be granted for our products, future-generation upgrades or newly developed products, on a timely basis or at all. Failure to receive, or delays in receipt of such clearances, could have a material adverse effect on our financial condition and results of operations.

Clinical Trials

If human clinical trials of a device are required, whether to support a 510(k) or PMA application, the trials' sponsor, which is usually the manufacturer of the device, first must obtain the approval of the appropriate institutional review boards. If a trial is of a significant risk device, the sponsor also must obtain an investigational device exemption or IDE from FDA before the trial may begin. A significant risk device is a device that presents

a potential for serious risk to the subject and is an implant; is life-sustaining or life-supporting; or is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health. For all clinical testing, the sponsor must obtain informed consent from the patients participating in each trial. The results of clinical testing that a sponsor undertakes may be insufficient to obtain clearance or approval of the tested product.

Pervasive and Continuing FDA Regulation

We are also subject to other FDA regulations that apply prior to and after a product is commercially released. These include current Good Manufacturing Practice (GMP) requirements set forth in FDA's Quality System Regulation (QSR), that require manufacturers to have a quality system for the design, manufacture, packaging, labeling, storage, installation and servicing of medical devices intended for commercial distribution in the United States. This regulation covers various areas including management and organization, device design, purchase and handling of components, production and process controls such as those related to buildings and equipment, packaging and labeling control, distribution, installation, complaint handling, corrective and preventive action, servicing, and records. We are subject to periodic inspection by the FDA for compliance with the GMP requirements and Quality System Regulation.

The FDA also enforces post-marketing controls that include the requirement to submit medical device reports to the agency when a manufacturer becomes aware of information suggesting that any of its marketed products may have caused or contributed to a death or serious injury, or any of its products has malfunctioned and that a recurrence of the malfunction would likely cause or contribute to a death or serious injury. The FDA relies on medical device reports to identify product problems and utilizes these reports to determine, among other things, whether it should exercise its enforcement powers. The FDA also may require postmarket surveillance studies for specified devices.

We are subject to the Federal Food, Drug, and Cosmetic Act's, or FDCA's, general controls, including establishment registration, device listing, and labeling requirements. If we fail to comply with any requirements under the FDCA, we, including our officers and employees, could be subject to, among other things, fines, injunctions, civil penalties, and criminal prosecution. We also could be subject to recalls or product corrections, total or partial suspension of production, denial of premarket notification clearance or PMA approval, and rescission or withdrawal of clearances and approvals. Our products could be detained or seized, the FDA could order a recall, repair, replacement, or refund of our devices, and the agency could require us to notify health professionals and others that the devices present unreasonable risks of substantial harm to the public health.

The advertising of our products is subject to regulation by the Federal Trade Commission, or FTC. The FTC Act prohibits unfair or deceptive acts or practices in or affecting commerce. Violations of the FTC Act, such as failure to have substantiation for product claims, would subject us to a variety of enforcement actions, including compulsory process, cease and desist orders and injunctions, which can require, among other things, limits on advertising, corrective advertising, consumer redress and restitution, as well as substantial fines or other penalties.

Foreign Regulation

In most countries to which we seek to export the EECP(R) system, a local regulatory clearance must be obtained. The regulatory review process varies from country to country and can be complex, markings costly, uncertain, and

time-consuming. Current Vasomedical EECP(R) systems are all CE marking certified for European Union countries as well as covered by our Health Canada license.

We are also subject to periodic audits by organizations authorized by foreign countries to determine compliance with laws, regulations and standards that apply to the commercialization of our products in those markets. Examples include auditing by a European Union Notified Body organization (authorized by a member state's Competent Authority) to determine conformity with the Medical Device Directives (MDD) and by an organization authorized by the Canadian government to determine conformity with the Canadian Medical Devices Regulations (CMDR).

There can be no assurance that we will obtain desired foreign authorizations to commercially distribute our products in those markets or that we will comply with all laws, regulations and standards that pertain to our products in those markets. Failure to receive or delays in receipt of such authorizations or determinations of conformity could have a material adverse effect on our financial condition and results of operations.

Patient Privacy

Federal and state laws protect the confidentiality of certain patient health information, including patient records, and restrict the use and disclosure of that protected information. The U.S. Department of Health and Human Services (HHS) published patient privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA privacy rule) and the regulation was finalized in October 2002. The HIPAA privacy rule governs the use and disclosure of protected health information by "Covered Entities," which are (1) health plans, (2) health care clearinghouses, and (3) health care providers that transmit health information in electronic form in connection with certain health care transactions such as benefit claims. Currently, the HIPAA privacy rule affects us only indirectly in that patient data that we access, collect and analyze may include protected health information. Additionally, we have signed some Business Associate agreements with Covered Entities that contractually bind us to protect protected health information, consistent with the HIPAA privacy rule's requirements. We do not expect the costs and impact of the HIPAA privacy rule to be material to our business.

Practice Guidelines

Medical professional societies periodically issue Practice Guidelines to their members and make them available publicly. The American College of Cardiology (ACC) and the American Heart Association (AHA) have jointly engaged in developing practice guidelines since 1980 to critically evaluate the use of diagnostic procedures and therapies in the management or prevention of cardiovascular diseases. These guidelines are meant to "improve the effectiveness of care, optimize patient outcomes and affect the overall cost of care favorably by focusing resources on the most effective strategies". Recommendations incorporated into the guidelines are based upon an assessment of the strength of evidence for or against a treatment or procedure and estimates of expected health outcomes stemming from a formal review of peer-reviewed published literature. These guidelines may not be updated for some time.

The "ACC/AHA 2002 Guideline Update for the Management of Patients with Chronic Stable Angina" was issued in 2003. Comments on external counterpulsation appear in a section entitled "Recommendations for Alternative Therapies for Chronic Stable Angina in Patients Refractory to Medical Therapy Who Are Not Candidates for Percutaneous Intervention or Surgical Revascularization" and

include a so-called Class IIb recommendation. ACC/AHA guideline classifications I, II and III are used to "provide final recommendations for both patient evaluation and therapy" and a Class IIb rating is defined as "Usefulness/efficacy is less well established by evidence/opinion".

The ACC/AHA 2005 Guidelines for the Diagnosis and Management of Chronic Heart Failure in the Adult were issued in 2005. External counterpulsation is listed as one of the devices under investigation in a section entitled "Drugs and Interventions Under Active Investigation".

The 2006 Comprehensive Heart Failure Practice Guideline, issued in February 2006 by the Heart Failure Society of America, does not include any comments on the use of external counterpulsation therapy for treating heart failure patients.

In summary, while evaluations of the use of EECP(R) therapy in patients with chronic angina and heart failure continue to appear in oral or poster presentations at major scientific meetings and in peer-reviewed publications each year, there continues to be skepticism in the cardiology community about its broader use. Additional evidence regarding the efficacy of EECP(R) therapy continues to appear, however the evidence may not be sufficient to warrant a modification of practice guidelines to a more favorable recommendation and increased acceptance by the medical community.

Reimbursement

In addition to regulatory approvals for commercialization by government agencies, reimbursement coverage and payment rates are factors in the sales of our products and we depend in large part on the availability of reimbursement programs. Medicare, Medicaid, as well as private health care insurance and managed-care plans determine eligibility for coverage of a product or therapy based on a number of factors, including the payer's determination that the product is reasonable and necessary for the diagnosis or treatment of the illness or injury for which it is administered according to the scope of

clinical evidence available, accepted standards of medical care in practice, the product's cost effectiveness, whether the product is experimental or investigational, impact on health outcomes and whether the product is not otherwise excluded from coverage by law or regulation. The coverage process for Medicare reimbursement is legislated by Congress and administered by the Centers for Medicare and Medicaid Services (CMS), and is highly variable in the commercial market. There may be significant delays in obtaining coverage for newly-approved products, and coverage may be more limited than the purposes for which the product is approved or cleared by FDA. Even when we obtain authorization from the FDA or a foreign authority to begin commercial distribution, there may be limited demand for the device until reimbursement approval has been obtained from governmental and private third-party payers. Moreover, eligibility for coverage does not imply that a product will be reimbursed in all cases or at a rate that allows us to market our EECP(R) systems at a price that will enable us to make a profit or even cover our costs. Reimbursement rates may vary according to the use of the product and the clinical setting in which it is used, may be based on payments allowed for lower-cost products that are already reimbursed, may be incorporated into existing payments for other products or services, and may reflect budgetary constraints and/or imperfections in Medicare or Medicaid data. Even if successful, demand for products may be driven more by the scope of peer-reviewed evidence and acceptance, endorsement by regulatory and clinical bodies, or foreign country authorities than by the reimbursement rates available. Securing

coverage at adequate reimbursement rates from government and third party payers can be a time consuming and costly process that could require us to provide supporting scientific, clinical, and cost-effectiveness data for the use of our products to each payer. Our inability to promptly obtain coverage and profitable reimbursement rates from government-funded and private payers for our products could have a material adverse effect on our financial condition and operating results.

Our reimbursement strategies are currently focused in the following primary areas: expanding Medicare coverage to include congestive heart failure and mild angina, expanding coverage with other third-party payers, expanding Medicare coverage for angina and obtaining coverage in selected international markets.

Current Medicare Coverage in Angina

In February 1999, CMS, the federal agency that administers the Medicare program for more than 39 million beneficiaries, issued a national coverage policy under HCPCS code G0166 for the use of the EECP(R) therapy system. Key excerpts from the coverage read as follows:

> "Although ECP devices are cleared by the Food and Drug Administration (FDA) for use in treating a variety of cardiac conditions, including stable or unstable angina pectoris, acute myocardial infarction and cardiogenic shock, the use of this device to treat cardiac conditions other than stable angina pectoris is not covered, since only that use has developed sufficient evidence to demonstrate its medical effectiveness."
>
> "for patients who have been diagnosed with disabling angina (class III or class IV, Canadian Cardiovascular Society Classification or equivalent classification) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical interventions such as balloon angioplasty and cardiac bypass because:
>
> 1. their condition is inoperable, or at high risk of operative complications or post-operative failure;
> 2. their coronary anatomy is not readily amenable to such procedures; or
> 3. they have co-morbid states, which create excessive risk."

The 2009 national average payment rate per hourly session in the physician office setting and the hospital outpatient facility is approximately $150.04 and $102.23, respectively. Reimbursement rates vary throughout the country and range from $105 to $215 per hourly session. The 2008 national average payment rate per hourly session in the physician office setting and the hospital outpatient facility was approximately $156.15 and $109.47, respectively. Under the Medicare program, physician reimbursement of the provision of EECP(R) therapy is higher if the therapy is performed in a physician office setting as compared to a hospital outpatient facility in order to reflect higher costs associated with the physician office. Since January 2000, the national average payment rate has varied considerably. The initial national average payment rate for the physician office setting and the hospital outpatient facility in 2000 was approximately $130 and $112, respectively per hourly session. The average payment rate for the physician office setting climbed to $208 per treatment session in 2003 before being reduced approximately 37% in 2004 to $132 per treatment session. In 2005 the physician rate increased approximately 5% and remained unchanged in 2006.

The average payment rate for the hospital outpatient facility declined steadily to 2005 before increasing approximately 2% in 2006.

In order to bill and receive payment from Medicare, an individual or entity

must be enrolled in the Medicare program for EECP(R) therapy. The physician office setting and the hospital outpatient facility are the only entities currently authorized to receive reimbursement for the EECP(R) therapy under the Medicare program and reimbursement is not permitted to other individuals or entity types, which include, but are not limited to, nurse practitioners, physical therapists, ambulatory surgery centers, nursing homes, comprehensive outpatient rehabilitation facilities, outpatient dialysis facilities, and independent diagnostic testing facilities. For each of these provider types there is statutory authorization and accompanying regulations that govern the terms and conditions of Medicare program participation.

If there were any material change in the availability of Medicare coverage, or if the reimbursement level for treatment procedures using the EECP(R) therapy system is determined to be inadequate, it would adversely affect our business, financial condition and results of operations. Moreover, we are unable to forecast what additional legislation or regulation, if any, relating to the health care industry or Medicare coverage and payment level may be enacted in the future, or what effect such legislation or regulation would have on us.

Application to Expand Medicare Coverage to include Class II Angina and Class II/III CHF

On May 31, 2005, we submitted an application to CMS to expand the national coverage policy for external counterpulsation treatment to patients with Canadian Cardiovascular Class II stable angina and to patients with NYHA Class II and III stable heart failure symptoms with an ejection fraction less than 35%.

On June 20, 2005, CMS accepted our application for expansion of reimbursement coverage of EECP(R) therapy to include patients with NYHA Class II/III stable heart failure symptoms with an ejection fraction of less than or equal to 35%, i.e. chronic, stable, mild-to-moderate systolic heart failure as a primary indication, as well as patients with CCSC II, i.e. chronic, stable mild angina.

On June 23, 2005, CMS also received a request from a competing manufacturer of external counterpulsation therapy equipment, to reconsider the reimbursement coverage policy. They requested expansion of coverage to include 1) treatment of congestive heart failure, to include NYHA Class II, III with a left ventricular ejection fraction (LVEF) less than or equal to 40%, and acute heart failure; 2) treatment of stable angina to include CCSC II angina; 3) treatment of acute myocardial infarction; 4) treatment of cardiogenic shock. On September 15, 2005, they amended their request to include NYHA Class IV heart failure.

On March 20, 2006, CMS issued their Decision Memorandum regarding this reconsideration with the opinion "that the evidence is not adequate to conclude that external counterpulsation therapy is reasonable and necessary for the treatment of:

- CCSC II angina
- Heart Failure
  - NYHA Class II/III stable heart failure symptoms with an ejection fraction of less than or equal to 35%
  - NYHA Class II/III stable heart failure symptoms with an ejection fraction of less than or equal to 40%
  - NYHA Class IV heart failure
  - Acute heart failure
- Cardiogenic shock
- Acute myocardial infarction."

They did, however, reiterate in the decision memorandum that "Current coverage as described in Section 20.20 of the Medicare National Coverage

Determination (NCD) manual will remain in effect" for refractory angina patients.

On August 25, 2006, the results of the trial were initially published on line by the Journal of the American College of Cardiology (JACC), and in print in its September 19, 2006 issue. JACC is the official journal of the American College of Cardiology.

In the November-December issue of the journal Congestive Heart Failure, a second report of results from the PEECH(TM) trial was published, focusing on the results of a prespecified subgroup analysis in trial patients age 65 and over. This analysis demonstrated a statistically positive response on both co-primary endpoints of the trial in patients receiving EECP(R) therapy versus those who did not, i.e. a significantly larger proportion of patients undergoing EECP(R) therapy met or exceeded prespecified thresholds of improvement in exercise duration and peak oxygen consumption. Moreover, the patients age 65 and older who received EECP(R) therapy demonstrated the greatest differences in exercise duration, peak oxygen consumption and functional class (symptom status) compared with those who did not receive EECP(R) therapy.

These papers were submitted to CMS and we were advised to continue to gather more clinical evidence for future submission.

We will continue to educate the marketplace that EECP(R) therapy is a therapy for ischemic cardiovascular disease and that patients with a primary diagnosis of heart failure, diabetes, peripheral vascular disease, etc., are also eligible for reimbursement under the current coverage policy, provided the primary indication for treatment with EECP(R) therapy is angina or angina equivalent symptoms and the patient satisfies other listed criteria. Additionally, we will continue to pursue expansion of coverage for EECP(R) therapy with Medicare and other third-party payers as evidence of its clinical utility develops.

Expanding Coverage with Other Third-Party Payers

Some private insurance carriers continue to adjudicate EECP(R) treatment claims on a case-by-case basis. Since the establishment of reimbursement by the federal government, however, an increasing number of these private carriers now routinely pay for use of EECP(R) therapy for the treatment of angina and have issued positive coverage policies, which are generally similar to Medicare's coverage policy in scope. We estimate that over 300 private insurers are reimbursing for EECP(R) therapy for the treatment of angina today at favorable payment levels and we expect that the number of private insurers and their related health plans that provide for EECP(R) therapy as a covered benefit will continue to increase. In addition, we are aware of two third-party payers that have begun limited coverage of EECP(R) therapy for the treatment of CHF.

We intend to pursue a constructive dialogue with many private insurers for the establishment of positive and expanded coverage policies for EECP(R) treatment that include CHF patients. If there were any material change in the availability of third-party private insurers or the adequacy of the reimbursement level for treatment procedures using the EECP(R) therapy system, it would adversely affect our business, financial condition and results of operations. Moreover, we are unable to forecast what additional legislation or regulation, if any, relating to the health care industry or third-party private insurers coverage and payment levels may be enacted in the future or what effect such legislation or regulation would have on us.

Reimbursement in International Markets

The reimbursement environment for EECP(R) therapy in international markets is fragmented and coverage varies as a mix of available private and public healthcare providers may not yet be aware of coverage of this therapy. Our reimbursement strategy has been opportunistic and responsive to the selling opportunities presented through our distribution partners. During this fiscal year our efforts on behalf of EECP(R) therapy in both the private and public healthcare sectors of selected international markets have been initiated by our distributors, in support of the therapy, in their designated territory. Additionally, efforts have been initiated to obtain coverage in the public sector in certain overseas markets; however, we do not anticipate an impact on financial performance in the next fiscal year, given the long lead times from submission to approval of international dossiers for each reimbursement authority.

Patents and Trademarks

We own thirteen US patents including eight utility and three design patents that expire at various times between 2009 and 2023. In addition, more than 20 foreign patents have been issued that expire at various times from 2009 to 2023. We are also planning to file other patent applications regarding specific enhancements to the current EECP(R) models, future generation products, and methods of treatment in the future. Moreover, trademarks have been registered for the names "EECP(R)" and "Natural Bypass".

We pursue a policy of seeking patent protection, both in the US and abroad, for our proprietary technology. We believe that we have a solid patent foundation in the field of external counterpulsation devices and that the number of patents and applications demonstrates our technical leadership, dating back to the mid-1980s. Our patent portfolio focuses on the areas of external counterpulsation control and the overall design and arrangement of the external counterpulsation apparatus, including the console, treatment bed, fluid distribution, and inflatable cuffs. None of our current competitors have a significant patent portfolio in the area of external counterpulsation devices.

There can be no assurance that our patents will not be violated or that any issued patents will provide protection that has commercial significance. As with any patented technology, litigation could be necessary to protect our patent position. Such litigation can be costly and time-consuming, and there can be no assurance that we will be successful. The loss or violation of our EECP(R) patents and trademarks could have a material adverse effect upon our business.

Employees

As of May 31, 2009, we employed 25 full-time persons with 5 in direct sales, sales and clinical applications support, 10 in manufacturing, quality control and technical service, 3 in marketing and customer support, 2 in engineering, regulatory and clinical research and 5 in administration. None of our employees are represented by a labor union. We believe that our employee relations are good.

Manufacturing

Under our Supplier Agreement with Living Data Technology Corporation dated June 21, 2007, Living Data is our exclusive supplier for the ECP therapy systems that we market under the registered trademark EECP(R). However, Vasomedical will continue the manufacturing operations to fulfill certain obligations and needs.

Under the agreement with Living Data, we continue to manufacture products from our existing inventory, as well as other products, at our leased facility located in Westbury, New York.

ITEM 1A. RISK FACTORS

Investing in our common stock involves risk. You should carefully consider the following information about these risks together with the other information contained in this Report. If any of the following risks actually occur, our business could be harmed. This could cause the price of our stock to decline, and you may lose part or all of your investment.

Financial Risks

We have incurred recurring losses over the past few years and may continue to sustain losses, which could result in a further decline in the value of our common stock.

During the last few fiscal years we incurred large operating losses. We currently anticipate that we may continue to sustain operating losses. Our ability to achieve profitability is largely dependent on our ability to reduce operating costs sufficiently, as well as halting the current trend of declining revenue. Our ability to maintain our current base of revenue and increase revenue is largely dependent upon restructuring our sales and marketing efforts in the angina market where reimbursement is currently available and operating in a more efficient manner.

Risks Related to Our Business

We are materially dependent on medical reimbursement for treatment procedures using EECP(R) therapy on patients with congestive heart failure in order to achieve growth.

We are currently dependent on a single product platform which, based on current medical reimbursement policies, provides coverage for a restricted class of heart patients. On May 31, 2005, we submitted an application to CMS to expand the national coverage policy for external counterpulsation treatment to patients with Canadian Cardiovascular Class II stable angina and to patients with New York Heart Association (NYHA) Class II and III stable heart failure symptoms with an ejection fraction less than 35%. The application was accepted by CMS effective June 20, 2005, and CMS announced their decision to maintain the existing coverage as stated prior to the application and not to expand it to include Class II Angina and Class II/III CHF on March 20, 2006. Results of the PEECH(TM) trial have been published in the Journal of the American College of Cardiology in September 2006, and the subgroup analysis of CHF patients age 65 and over has also been published in the November-December 2006 issue of the Journal of Congestive Heart Failure. These two papers have been submitted to CMS for reconsideration of our application. We had met with representatives from CMS in February 2007 and presented our case. CMS has requested additional data from us. We will continue our dialogue with CMS to obtain coverage for heart failure patients. However, there is no assurance that the Company will have sufficient resources to gather the necessary data to be sufficient to support expansion of the Medicare National Coverage Policy for EECP(R) treatment for NYHA class II and III heart failure patients.

If we do not receive medical coverage for treatment procedures using EECP(R) therapy on patients with CHF, it will adversely affect our future business prospects.

Material changes in the availability of Medicare, Medicaid or third-party reimbursement at adequate price levels could adversely affect our business.

Health care providers, such as hospitals and physician private practices,

that purchase or lease medical devices such as the EECP(R) therapy system for use on their patients generally rely on third-party payers, principally Medicare, Medicaid and private health insurance plans, to reimburse all or part of the costs and fees associated with the procedures performed with these devices. If there were any material change in the availability of Medicare, Medicaid or other third-party coverage or the adequacy of the reimbursement level for treatment procedures using the EECP(R) therapy system, it would adversely affect our business, financial condition and results of operations. Moreover, we are unable to forecast what additional legislation or regulation, if any, relating to the health care industry or Medicare or Medicaid coverage and payment level may be enacted in the future or what effect such legislation or regulation would have on our business. Even if a device has FDA clearance, Medicare, Medicaid and other third-party payers may deny reimbursement if they conclude that the device is not "reasonable and necessary" according to their criteria. In addition, reimbursement may not be at, or remain at, price levels adequate to allow medical professionals and hospitals to realize an appropriate return on the purchase of our products.

Increased acceptance by the medical community is important for growth.

While many abstracts and publications are presented each year at major scientific meetings worldwide with respect to EECP(R) treatment efficacy, there is continued skepticism concerning EECP(R) therapy methodology. The American Heart Association and the American College of Cardiology Practice Guidelines currently list EECP(R) as a therapy currently under investigation for treatment of heart failure and have a classification rating of IIb as a treatment for patients who are refractory to medical therapy and are not candidates for percutaneous intervention or revascularization. A classification rating of IIb indicates the usefulness/efficacy of EECP(R) therapy is less well established by evidence/opinion. The medical community utilizes these guidelines when considering the various treatment options for their patients. Certain cardiologists, in cases where the EECP(R) therapy is a viable alternative, still appear to prefer percutaneous coronary interventions (e.g. balloon angioplasty and stenting) and cardiac bypass surgery for their patients. Additional evidence regarding the efficacy of EECP(R) therapy continues to evolve, however the evidence may not be sufficient to warrant a modification of these guidelines to a more favorable recommendation and increased acceptance by the medical community. We are dependent on consistency of favorable research findings about

EECP(R) therapy and increasing acceptance of EECP(R) therapy as a safe, effective and cost effective alternative to other available products by the medical community for growth.

We face competition from other companies and technologies.

We compete with at least three other companies that are marketing external counterpulsation devices. We do not know whether these companies or other potential competitors who may be developing external counterpulsation devices, may succeed in developing technologies or products that are more efficient than those offered by us, and that would render our technology and existing products obsolete or non-competitive. Potential new competitors may also have substantially greater financial, manufacturing and marketing resources than those possessed by us. In addition, other technologies or products may be developed that have an entirely different approach or means of accomplishing the intended purpose of our products. Accordingly, the life cycles of our products are difficult to estimate. To compete successfully, we must keep pace with technological advancements, respond to evolving consumer requirements and achieve market acceptance.

As of June 2007, the Company entered into a distribution and supplier

agreement with Living Data Technology Corporation, a competitor as of May 31, 2007. This arrangement has subsequently reduced the competitors to at least four other companies.

We may not continue to receive necessary FDA clearances or approvals, which could hinder our ability to market and sell our products.

If we modify our external counterpulsation devices and the modifications significantly affect safety or effectiveness, or if we make a change to the intended use, we will be required to submit a new premarket notification or 510(k) to FDA. We would be unable to market the modified device until FDA issues a clearance for the 510(k).

Additionally, if FDA publishes a regulation requiring a premarket approval application or PMA for external counterpulsation devices, we would then need to submit a PMA, and have it filed by the agency, by the date specified by FDA in its regulation. A PMA requires us to prove the safety and effectiveness of a device to the FDA. The process of obtaining PMA approval is expensive, time-consuming, and uncertain. If FDA were to require a PMA application, we may be required to undertake a clinical study, which likely will be expensive and require lengthy follow-up, to demonstrate the effectiveness of the device. If we did obtain PMA approval, any change after approval affecting the safety or effectiveness of the device will require approval of a PMA supplement.

If we offer new products that require 510(k) clearance or PMA approval, we will not be able to commercially distribute those products until we receive such clearance or approval. Regulatory agency approval or clearance for a product may not be received or may entail limitations on the device's indications for use that could limit the potential market for any such product. Delays in receipt of, or failure to obtain or maintain, regulatory clearances and approvals, could delay or prevent our ability to market or distribute our products. Such delays could have a material adverse effect on our business.

If we are unable to comply with applicable governmental regulation, we may not be able to continue our operations.

We also must comply with Current Good Manufacturing Practice (CGMP) requirements as set forth in the Quality System Regulation (QSR) to receive FDA approval to market new products and to continue to market current products. The QSR imposes certain procedural and documentation requirements on us with respect to manufacturing and quality assurance activities, including packaging, storage, and record keeping. Our products and activities are subject to extensive, ongoing regulation, including regulation of labeling and promotion activities and adverse event reporting. Also, our FDA registered facilities are subject to inspection by the FDA and other governmental authorities. Any failure to comply with regulatory requirements could delay or prevent our ability to market or distribute our products. Violation of FDA statutory or regulatory requirements could result in enforcement actions, such as voluntary or mandatory recalls, suspension or withdrawal of marketing clearances or approvals, seizures, injunctions, fines, civil penalties, and criminal prosecutions, all of which could have a material adverse effect on our business. Most states also have similar postmarket regulatory and enforcement authority for devices.

We cannot predict the nature of any future laws, regulations, interpretations, or applications, nor can we predict what effect additional governmental regulations or administrative orders, when and if promulgated, would have on our business in the future. We may be slow to adapt, or we may never adapt to changes in existing requirements or adoption of new requirements or policies. We may incur significant costs to comply with laws and regulations in the future or compliance with laws or regulations may create an unsustainable

burden on our business.

We may not receive approvals by foreign regulators that are necessary for international sales.

Sales of medical devices outside the United States are subject to foreign regulatory requirements that vary from country to country. Premarket approval or clearance in the United States does not ensure regulatory approval by other jurisdictions. If we, or any international distributor, fail to obtain or maintain required pre-market approvals or fail to comply with foreign regulations, foreign regulatory authorities may require us to file revised governmental notifications, cease commercial sales of our products in the applicable countries or otherwise cure the problem. Such enforcement action by regulatory authorities may be costly.

In order to sell our products within the European Union, we must comply with the European Union's Medical Device Directive. The CE marking on our products attests to this compliance. Future regulatory changes may limit our ability to use the CE mark, and any new products we develop may not qualify for the CE mark. If we lose this authorization or fail to obtain authorization on future products, we will not be able to sell our products in the European Union.

We depend on suppliers for the supply of our ECP therapy systems.

Under our Supplier Agreement with Living Data Technology Corporation dated June 21, 2007, Living Data is our exclusive supplier for the ECP therapy systems that we market under the registered trademark EECP(R). With certain exceptions, including the use of existing inventory, we are required to purchase this product from Living Data at specified prices. While we do not foresee any difficulties in timely receiving products at competitive prices, this inability would adversely affect our business.

We depend on management and other key personnel.

We are dependent on a limited number of key management and technical personnel. The loss of one or more of our key employees may harm our business if we are unable to identify other individuals to provide us with similar services. We do not maintain "key person" insurance on any of our employees. In addition, our success depends upon our ability to attract and retain additional highly qualified sales, management, manufacturing and research and development personnel. We face competition in our recruiting activities and may not be able to attract or retain qualified personnel.

We may not have adequate intellectual property protection.

Our patents and proprietary technology may not be able to prevent competition by others. The validity and breadth of claims in medical technology patents involve complex legal and factual questions. Future patent applications may not be issued, the scope of any patent protection may not exclude competitors, and our patents may not provide competitive advantages to us. Our patents may be found to be invalid and other companies may claim rights in or ownership of the patents and other proprietary rights held or licensed by us. Also, our existing patents may not cover products that we develop in the future. Moreover, when our patents expire, the inventions will enter the public domain. There can be no assurance that our patents will not be violated or that any issued patents will provide protection that has commercial significance. Litigation may be necessary to protect our patent position. Such litigation may be costly and time-consuming, and there can be no assurance that we will be successful in such litigation.

The loss or violation of certain of our patents and trademarks could have a material adverse effect upon our business.

Since patent applications in the United States are maintained in secrecy until such patent applications are issued, our current product development may infringe patents that may be issued to others. If our products were found to infringe patents held by competitors, we may have to modify our products to avoid infringement, and it is possible that our modified products would not be commercially successful.

We do not intend to pay dividends in the foreseeable future.

We do not intend to pay any cash dividends on our common stock in the foreseeable future.

Risks Related to Our Industry

Technological change is difficult to predict and to manage.

We face the challenges that are typically faced by companies in the medical device field. Our product line has required, and any future products will require, substantial development efforts and compliance with governmental clearance or approval requirements. We may encounter unforeseen technological or scientific problems that force abandonment or substantial change in the development of a specific product or process.

We are subject to product liability claims and product recalls that may not be covered by insurance.

The nature of our business exposes us to risks of product liability claims and product recalls. Medical devices as complex as ours frequently experience errors or failures, especially when first introduced or when new versions are released.

We currently maintain product liability insurance at $7,000,000 per occurrence and $7,000,000 in the aggregate. Our product liability insurance may not be adequate. In the future, insurance coverage may not be available on commercially reasonable terms, or at all. In addition, product liability claims or product recalls could damage our reputation even if we have adequate insurance coverage.

We do not know the effects of healthcare reform proposals.

The healthcare industry is undergoing fundamental changes resulting from political, economic and regulatory influences. In the United States, comprehensive programs have been suggested seeking to increase access to healthcare for the uninsured, control the escalation of healthcare expenditures within the economy and use healthcare reimbursement policies to balance the federal budget.

We expect that the United States Congress and state legislatures will continue to review and assess various healthcare reform proposals, and public debate of these issues will likely continue. There have been, and we expect that there will continue to be, a number of federal and state proposals to constrain expenditures for medical products and services, which may affect payments for products such as ours. We cannot predict which, if any of such reform proposals will be adopted and when they might be effective, or the effect these proposals may have on our business. Other countries also are considering health reform. Significant changes in healthcare systems could have a substantial impact on the manner in which we conduct our business and could require us to revise our

strategies.

Risks Related to our Securities

The application of the "penny stock" rules could adversely affect the market price of our common stock and increase your transaction costs to sell those shares.

As long as the trading price of our common shares is below $5 per share, the open-market trading of our common shares will be subject to the "penny stock" rules. The "penny stock" rules impose additional sales practice requirements on broker-dealers who sell securities to persons other than established customers and accredited investors (generally those with assets in excess of $1,000,000 or annual income exceeding $200,000 or $300,000 together with their spouse). For transactions covered by these rules, the broker-dealer must make a special suitability determination for the purchase of securities and have received the purchaser's written consent to the transaction before the purchase. Additionally, for any transaction involving a penny stock, unless exempt, the broker-dealer must deliver, before the transaction, a disclosure schedule prescribed by the Securities and Exchange Commission relating to the penny stock market. The broker-dealer also must disclose the commissions payable to both the broker-dealer and the registered representative and current quotations for the securities. Finally, monthly statements must be sent disclosing recent price information on the limited market in penny stocks. These additional burdens imposed on broker-dealers may restrict the ability or decrease the willingness of broker-dealers to sell our common shares, and may result in decreased liquidity for our common shares and increased transaction costs for sales and purchases of our common shares as compared to other securities.

Our common stock is subject to price volatility.

The market price of our common stock historically has been and may continue to be highly volatile. Our stock price could be subject to wide fluctuations in response to various factors beyond our control, including, but not limited to:

- medical reimbursement;
- quarterly variations in operating results;
- announcements of technological innovations, new products or pricing by our competitors;
- the rate of adoption by physicians of our technology and products in targeted markets;
- the timing of patent and regulatory approvals;
- the timing and extent of technological advancements;
- results of clinical studies;
- the sales of our common stock by affiliates or other shareholders with large holdings; and
- general market conditions.

Our future operating results may fall below the expectations of securities industry analysts or investors. Any such shortfall could result in a significant decline in the market price of our common stock. In addition, the stock market has experienced significant price and volume fluctuations that have affected the market price of the stock of many medical device companies and that often have been unrelated to the operating performance of such companies. These broad market fluctuations may directly influence the market price of our common stock.

Additional Information

We are subject to the reporting requirements under the Securities Exchange

Act of 1934 and are required to file reports and information with the Securities and Exchange Commission (SEC), including reports on the following forms: annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports files or furnished pursuant to Section 13(a) or 15(d) of the Securities Act of 1934.

ITEM 2 - PROPERTIES

We historically owned our 18,000 square foot headquarters and manufacturing facility at 180 Linden Avenue, Westbury, New York 11590.

On August 15, 2007, we sold our facility under a five-year leaseback agreement for $1.4 million. The net proceeds from the sale was approximately $425,000, after payment in full of the two secured notes on our facility, brokers fees, closing costs, and the opening of a certificate of deposit in accordance with the provisions of the new lease. The annual rental expense for the lease is approximately $144,200. We believe that our current facility is adequate to meet our current needs and should continue to be adequate for the immediately foreseeable future.

ITEM 3 - LEGAL PROCEEDINGS

There were no material legal proceedings under applicable rules.

ITEM 4 - SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

There were no matters submitted to a vote of security holders during the fourth quarter of the fiscal year.

PART II

ITEM 5 - MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Our common stock currently trades on the Over-the-Counter Bulletin Board under the symbol VASO.OB. On May 26, 2006, our common stock ceased trading on the Nasdaq Capital Market tier of the Nasdaq Stock Market and began trading on the NASD Pink Sheets. Effective June 20, 2006, our common stock began trading on the Over-the- Counter Bulletin Board (OTCBB). The number of record holders of common stock as of August 12, 2009, was approximately 1,050, which does not include approximately 14,930 beneficial owners of shares held in the name of brokers or other nominees. The table below sets forth the range of high and low trade prices of the common stock for the fiscal periods specified.

	Fiscal 2009		Fiscal 2008	
	High	Low	High	Low
First Quarter	$0.10	$0.06	$0.19	$0.06
Second Quarter	$0.08	$0.02	$0.13	$0.06
Third Quarter	$0.03	$0.02	$0.10	$0.05
Fourth Quarter	$0.09	$0.02	$0.09	$0.07

The last bid price of the Company's common stock on August 12, 2009, was $0.07 per share.

Dividend Policy

We have never paid any cash dividends on our common stock and do not intend

to pay cash dividends in the foreseeable future.

Entry Into A Material Definitive Agreement

On June 21, 2007, we entered into a Securities Purchase Agreement with Kerns Manufacturing Corp. (Kerns). Concurrently with our entry into the Securities Purchase Agreement, we also entered into a Distribution Agreement and a Supplier Agreement with Living Data Technology Corporation, an affiliate of Kerns (Living Data).

We sold to Kerns, pursuant to the Securities Purchase Agreement, 21,428,572 shares of our common stock at $.07 per share for a total purchase price of $1,500,000, as well a five-year warrant to purchase 4,285,714 shares of our common stock at an initial exercise price of $.08 per share (the Warrant). The agreement further provided for the appointment to our Board of Directors of two representatives from Kerns. In furtherance thereof, Dr. Jun Ma and Mr. Simon Srybnik, Chairman of both Kerns and Living Data, have been appointed members of our Board of Directors. On October 15, 2008, Dr. Jun Ma was appointed Chief Executive Officer. Pursuant to the Distribution Agreement, we have become the exclusive distributor in the United States of the AngioNew ECP systems manufactured by Living Data. As additional consideration for such agreement, we agreed to issue an additional 6,990,840 shares of our common stock to Living Data. Pursuant to the Supplier Agreement, Living Data now is the exclusive supplier to us of the ECP therapy systems that we market under the registered trademark EECP(R). The Distribution Agreement and the Supplier Agreement each have an initial term extending through May 31, 2012.

On November 20, 2008, the Company entered into an Amendment to the Distribution Agreement with Living Data to expand the territory covered in the Distribution Agreement to provide for exclusive distribution rights worldwide. In consideration for these rights, the Company agreed to issue Living Data 3,000,000 restricted shares of its common stock having a fair market value of $60,000 at time of issue.

Pursuant to a Registration Rights Agreement, we granted to Kerns and Living Data, subject to certain restrictions, "piggyback registration rights" covering the shares sold to Kerns as well as the shares issuable upon exercise of the Warrant and the shares issued to Living Data.

ITEM 7 - MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

This Management's Discussion and Analysis or Plan of Operations contains descriptions of our expectations regarding future trends affecting our business. These forward looking statements and other forward-looking statements made elsewhere in this document are made under the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Please read the section titled "Risk Factors" in "Item One - Business" to review certain conditions, among others, which we believe could cause results to differ materially from those contemplated by the forward-looking statements.

Except for historical information contained in this report, the matters discussed are forward-looking statements that involve risks and uncertainties. When used in this report, words such as "anticipates", "believes", "could", "estimates", "expects", "may", "plans", "potential" and "intends" and similar expressions, as they relate to the Company or its management, identify forward-looking statements. Such forward-looking statements are based on the beliefs of the Company's management, as well as assumptions made by and information currently available to the Company's management. Among the factors that could cause actual results to differ materially are the following: the

effect of business and economic conditions; the effect of the dramatic changes taking place in the healthcare environment; the impact of competitive procedures and products and their pricing; medical insurance reimbursement policies; unexpected manufacturing or supplier problems; unforeseen difficulties and delays in the conduct of clinical trials and other product development programs; the actions of regulatory authorities and third-party payers in the United States and overseas; uncertainties about the acceptance of a novel therapeutic modality by the medical community; and the risk factors reported from time to time in the Company's SEC reports. The Company undertakes no obligation to update forward-looking statements as a result of future events or developments.

The following discussion should be read in conjunction with the financial statements and notes thereto included in this Annual Report on Form 10-K.

Overview

Vasomedical, Inc. was incorporated in Delaware in July 1987. Unless the context requires otherwise, all references to "we", "our", "us", "Company", "registrant", "Vasomedical" or "management" refer to Vasomedical, Inc. and its subsidiaries. Since 1995, we have been primarily engaged in designing, manufacturing, marketing and supporting EECP(R) enhanced external counterpulsation systems based on our unique proprietary technology currently indicated for use in cases of stable or unstable angina, congestive heart failure (CHF), acute myocardial infarction (i.e., heart attack, (MI)) and

cardiogenic shock. The EECP(R) therapy is a non-invasive, outpatient treatment of diseases of the cardiovascular system. The therapy serves to increase circulation in areas of the heart with less than adequate blood supply and helps restore systemic vascular function. The therapy also increases blood flow and oxygen supply to the heart muscle and other organs and decreases the heart's workload and reduces oxygen demand, while also improving function of the endothelium, the lining of blood vessels throughout the body, lessening resistance to blood flow. We provide hospitals, clinics and physician private practices with EECP(R) equipment, treatment guidance, and a staff training and equipment maintenance program designed to provide optimal patient outcomes. EECP(R) is a registered trademark for Vasomedical's Enhanced External Counterpulsation therapy and systems. For more information, visit www.vasomedical.com.

We have FDA clearance to market our EECP(R) therapy for use in the treatment of stable and unstable angina, congestive heart failure, acute myocardial infarction, and cardiogenic shock; however, our current marketing efforts are limited mostly to the treatment of chronic stable angina and congestive heart failure. Medicare and other third-party payers currently reimburse for the treatment of angina pectoris patients with moderate to severe symptoms who are refractory to medications and not candidates for invasive procedures. Patients with co-morbidities of heart failure, diabetes, peripheral vascular disease, etc. are also reimbursed under the same criteria, provided the primary diagnosis and indication for treatment with EECP(R) therapy is angina symptoms.

During the last several years, we incurred operating losses. We have attempted to achieve profitability by reducing operating costs and halting the trend of declining revenue, and to reduce cash usage through bringing our cost structure more into alignment with current revenues. The Company has reduced personnel costs by reorganization. The Company has negotiated new terms on professional fees, facility expenses, and shipping and supply costs. The Company is also looking to obtain a revolving line of credit to help stabilize cash flow and to respond to customers requests for flexible payment terms on our EECP(R) therapy systems.

Results of Operations
Fiscal Years Ended May 31, 2009 and 2008

Net revenue from sales, leases and service of our EECP(R) systems for the fiscal years ended May 31, 2009 and 2008, was $4,471,186 and $5,182,768, respectively, which represented a decline of $711,582, or 14%. We reported a net loss attributable to common stockholders of $1,524,711 and $676,695 for fiscal 2009 and 2008, respectively. The increase in the net loss was primarily due to the increase in our operating expenses from the comparative prior period, combined with a decrease in revenue. Our net loss per basic and diluted common share was $0.02 for the fiscal year ended May 31, 2009 compared to a net loss of $0.01 per diluted common share for the fiscal year ended May 31, 2008.

Revenues

Revenue from equipment sales increased approximately 6% to $2,219,729 for the fiscal year ended May 31, 2009 as compared to $2,087,365 for the prior year. The increase in equipment sales is due primarily to a 5% increase in the total number of units sold. The average sales price of EECP(R) systems decreased slightly. The number of unit sales for new and used equipment increased by approximately 73% within the international market and decreased by 32% within the domestic market.

We believe the decline in the sales price per unit reflects weakened demand in the refractory angina market as existing capacity is more fully utilized, coupled with increased direct and indirect competition. We anticipate that demand for EECP(R) systems will remain soft unless there is greater clinical acceptance for the use of EECP(R) therapy in treating patients with angina or angina equivalent symptoms who meet the current reimbursement guidelines or an expansion of the current CMS national reimbursement policy to include some or all Class II & III heart failure patients. Patients with angina or angina equivalent symptoms eligible for reimbursement under current policies include many with serious comorbidities, such as heart failure, diabetes, peripheral vascular disease and/or others. Despite this, many cardiology clinicians appear to be waiting for approval of reimbursement coverage for heart failure as a primary indication before they will move forward with the treatment of ischemic heart failure patients with angina equivalent symptoms. Reluctance to bill for ischemic heart failure patients under the current coverage guidelines, and failure to get or maintain adequate reimbursement coverage for angina and heart failure would adversely affect our business prospects. We anticipate that a prevailing trend of declining prices will continue in the immediate future as our competition attempts to capture greater market share through pricing discounts.

Our revenue from the sale of EECP(R) systems and related products to international distributors in fiscal 2009 increased approximately 67% to $1,392,401 compared to $835,546 in the prior year reflecting increased sales volume.

Our revenue from equipment rental and services decreased 27% to $2,251,457 in fiscal 2009 from $3,095,403 in fiscal year 2008. Revenue from equipment rental and services represented 50% and 60% of total revenue in fiscal 2009 and 2008 respectively. The decrease in revenue generated from equipment rentals and services is due to a decrease in the service business compared to the prior fiscal year. The decline was also due to a decrease in the rental install base from the prior fiscal year ended May 31, 2008.

Gross Profit

Gross profit in total declined to $1,905,370, or 43% of revenues for fiscal 2009 compared to $2,352,398 or 45% of revenues for fiscal 2008. The decline in total gross profit when compared to prior year in absolute dollars is principally due to lower service contract sales of $600,923 or 33% as compared to fiscal year 2008. For equipment sales in fiscal year 2009 there is an increase in gross profit in absolute dollars of $225,363 or 55% when compared to fiscal year 2008. This is due mainly to decreased manufacturing overhead costs.

Gross profits are dependent on a number of factors, particularly the mix of EECP(R) models sold domestically and internationally and their respective average selling prices, the mix of EECP(R) units sold, rented or placed during the period, service contract sales, and the ongoing costs of service, and certain fixed period costs, including facilities, payroll and insurance. Gross profit margins are generally less on non-domestic business due to the use of distributors resulting in lower selling prices. Consequently, the gross profit realized during the current period may not be indicative of future margins.

Selling, General and Administrative

Selling, general and administrative ("SG&A") expenses for fiscal 2009 and 2008 were $3,013,276, or 67% of revenues, and $2,626,045, or 51% of revenues, respectively, reflecting an increase of $387,231 or approximately 15%. The increase in SG&A expenditures in fiscal 2009 resulted primarily from increased direct expenditures of $191,853 due to increased corporate expenses, and Director's fees, offset by decreases in insurance and accounting fees. Marketing expenses increased $154,266 due to increased expenditures in personnel and their associated costs in the marketing and clinical application support areas, as well as associated travel, plus increased market research, product promotion, advertising, and trade show expenses. Sales expenses increased $41,112 as a result of increased expenditures in personnel and their associated costs.

During fiscal 2009 the Company recorded a provision for doubtful accounts of $537 compared to fiscal 2008 when the Company reversed its provision for doubtful accounts by $42,837. The reversal of the provision is primarily a result of the fiscal 2008 decrease in accounts receivable balances in addition to the continuous efforts to ensure collection of accounts receivable.

Research and Development

Research and development ("R&D") expenses of $519,509 or 12% of revenues for fiscal 2009 increased by $45,398, or 10%, from $474,111, or 9% of revenues for fiscal 2008. The increase is primarily attributable to more engineering consulting and associated expenditures and new product spending, offset by a slight decrease in spending on clinical trials.

Interest Expense and Financing Costs

Interest expense and financing costs decreased to zero for fiscal 2009 from $16,616 for the prior year. Interest expense primarily reflects interest on loans secured to refinance the November 2000 purchase of the Company's headquarters and warehouse facility. The decrease is a direct result of the sale-leaseback agreements for the Company's headquarters and warehouse facility which occurred during the first quarter of fiscal 2008.

Interest and Other Income, Net

Interest and other income for fiscal 2009 and 2008 were $55,334 and $61,083, respectively. Interest income primarily reflects interest earned on the Company's cash balances. Other income has been derived primarily from the liquidation of equipment and fixtures used in previously leased properties.

Amortization of Deferred Gain on Sale-leaseback of Building

The amortization of deferred gain on sale-leaseback of building for fiscal 2009 and 2008 were $53,245 and $44,371, respectively. The gain resulted from the Company's sale-leaseback of its facility.

Income Tax Expense, Net

During fiscal 2009 and 2008 we recorded a provision for income taxes of $5,875 and $18,045, respectively.

As of May 31, 2009, the recorded deferred tax assets were $20,336,652, reflecting an increase of $517,300 during the fiscal year ended May 31, 2009, which was offset by a valuation allowance of the same amount.

Ultimate realization of any or all of the deferred tax assets is not assured due to significant uncertainties and material assumptions associated with estimates of future taxable income during the carryforward period. In November 2005, we concluded that, based upon the weight of available evidence, it was "more likely than not" that the net deferred tax asset would not be realized and increased the valuation allowance to bring the net deferred tax asset carrying value to zero.

Liquidity and Capital Resources

Cash and Cash Flow

We have financed our operations primarily from working capital and in fiscal years 2009 and 2008, from a private equity financing and by the sale of our facility under a leaseback agreement. At May 31, 2009, we had cash and cash equivalents and short-term investments in the form of certificates of deposit of $914,580 and working capital of $1,300,647 compared to cash and cash equivalents of $2,653,999 and working capital of $2,851,901 at May 31, 2008.

Cash used in operating activities was $1,716,860 during fiscal 2009, which consisted of a net cash loss after adjustments of $1,180,039 and cash used by operating assets and liabilities of $536,821. The changes in the accounts balances primarily reflect a decrease in accounts receivable of $233,510, increased inventory of $180,441 and an increased in trade payable to related party of $260,000, offset by an increase in other assets of $119,278, and decreases in Accounts payable, deferred revenue, accrued expenses and other liabilities of $717,996, and an increase in Other liabilities of $7,384. Net accounts receivable were 15% of revenues for the period ended May 31, 2009, as compared to 14% for the period ended May 31, 2008, and accounts receivable turnover decreased to 6.5 times as of May 31, 2009, as compared to 7.1 times as of May 31, 2008.

Standard payment terms on our domestic equipment sales are generally net 30 to 90 days from shipment and do not contain "right of return" provisions. We have historically offered a variety of extended payment terms, including sales-type leases, in certain situations and to certain customers in order to expand the market for our EECP(R) products in the US and internationally. Such extended payment terms were offered in lieu of price concessions, in competitive situations, when opening new markets or geographies and for repeat customers. Extended payment terms cover a variety of negotiated terms, including payment in full - net 120, net 180 days or some fixed or variable monthly payment amount for a six to twelve month period followed by a balloon payment, if applicable. During fiscal 2009 and 2008, there were no revenues generated from sales in which initial payment terms were greater than 90 days and we offered no sales-type leases during either period. In general, reserves are calculated on a formula basis considering factors such as the aging of the receivables, time

past due, and the customer's credit history and their current financial status. In most instances where reserves are required, or accounts are ultimately written-off, customers have been unable to successfully implement their EECP(R) program. As we are creating a new market for the EECP(R) therapy and recognizing the challenges that some customers may encounter, we have opted, at times, on a customer-by-customer basis, to recover our equipment instead of pursuing other legal remedies, which has resulted in our recording of a reserve or a write-off.

Investing activities used cash of $393,082 during the fiscal year ended May 31, 2009, which represented investments on equipment of $22,559 and the purchase of short-term investments of $370,523. Investing activities during the fiscal year ended May 31, 2008, provided net cash of $1,310,857, which represented proceeds received from the building sale, net of related costs.

Our financing activities provided net cash of $524,875 during the fiscal year ended May 31, 2008, reflecting proceeds, net of related expenses, of $1,375,890 from the Securities Purchase Agreement, which was offset by loan repayments on the building of $851,015.

Liquidity

During the last several years, we incurred operating losses. We have attempted to achieve profitability by reducing operating costs and halting the trend of declining revenue, and to reduce cash usage through bringing our cost structure more into alignment with current revenues. The Company has reduced personnel costs by reorganization. The Company has negotiated new terms on professional fees, facility expenses, and shipping and supply costs. The Company is also looking to obtain a revolving line of credit to help stabilize cash flow and to respond to customers requests for flexible payment terms on our EECP(R) therapy systems.

Based on our current operations we believe that we have sufficient working capital to continue our operations through at least May 31, 2010.

Off-Balance Sheet Arrangements

We do not participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities (SPES), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of May 31, 2009, we are not involved in any unconsolidated SPES.

Related Party Transactions

On June 21, 2007, we entered into a Securities Purchase Agreement with Kerns Manufacturing Corp. (Kerns). Concurrently with our entry into the Securities Purchase Agreement, we also entered into a Distribution Agreement and a Supplier Agreement with Living Data Technology Corporation, an affiliate of Kerns (Living Data).

We sold to Kerns, pursuant to the Securities Purchase Agreement, 21, 428,572 shares of our common stock at $.07 per share, for an aggregate of $1,500,000 as well a five-year warrant to purchase 4,285,714 shares of our common stock at an initial exercise price of $.08 per share (the Warrant). The agreement further provided for the appointment to our Board of Directors of two representatives from Kerns. In furtherance thereof, Mr. Jun Ma and Mr. Simon Srybnik, Chairman of both Kerns and Living Data, have been appointed members of our Board of Directors. On October 15, 2008, Dr. Jun Ma was appointed Chief Executive Officer. Pursuant to the Distribution Agreement, we have become the

exclusive distributor in the United States of the AngioNew ECP systems manufactured by Living Data. As additional consideration for such agreement, we agreed to issue an additional 6,990,840 shares of our common stock to Living Data. Pursuant to the Supplier Agreement, Living Data now is the exclusive supplier to us of the ECP therapy systems that we market under the registered trademark EECP(R). The Distribution Agreement and the Supplier Agreement each have an initial term extending through May 31, 2012.

On November 20, 2008, the Company entered into an Amendment to the Distribution Agreement with Living Data to expand the territory covered in the Distribution Agreement to provide for exclusive distribution rights worldwide. In consideration for these rights, the Company agreed to issue Living Data 3,000,000 restricted shares of its common stock having a fair market value of $60,000 at time of issue.

Pursuant to a Registration Rights Agreement, we granted to Kerns and Living Data, subject to certain restrictions, "piggyback registration rights" covering the shares sold to Kerns as well as the shares issuable upon exercise of the Warrant and the shares issued to Living Data.

30

On July 10, 2007, the Board of Directors appointed Mr. Behnam Movaseghi, Treasurer and Chief Financial Officer of Kerns Manufacturing Corporation, to our Board of Directors.

As affiliates of Living Data and Kerns, Dr. Ma, Mr. Movaseghi and Mr. Srybnik have each been directly involved in the transactions between Living Data and Kerns, and the Company, with respect to the Securities Purchase Agreement, the Distribution Agreement and the Supplier Agreement, as well as consulting services to the Company with no compensation.

During fiscal 2009, the Company purchased ECP therapy systems under the Supplier Agreement for $595,000 from Living Data. Payment terms on certain purchases leave a balance of $160,000 in Trade Payable to Related Party - current portion on the accompanying consolidated balance sheet as of May 31, 2009. In addition, during fiscal 2009, Living Data purchased $3,118, worth of ECP therapy system components from the Company.

During fiscal 2009 Living Data assigned to Vasomedical, Inc. all of its rights and interests under its Distributorship Agreement with a corporation organized and existing under the laws of the People's Republic of China, that manufactures Ambulatory Blood Pressure Monitors, Ambulatory ECG Recorders and Holter & ABPM Combiner Recorders, for $20,000 payable to Living Data based on certain terms and conditions. Vasomedical Inc., also must pay to Living Data 5% of the selling price or 5% of the cost of all goods sold (whichever is higher), and 5% of the cost of all goods transferred but not sold under the Assignment Agreement to Living Data based on sales of this equipment. The Company will sell these systems in the United States and other countries now that regulatory clearance had been obtained.

During fiscal 2009 Living Data assigned to Vasomedical, Inc. all of its rights and interests under its Distributorship Agreement with a corporation organized and existing under the laws of the People's Republic of China, that manufactures Ultrasound Scanners, for $20,000 payable to Living Data based on certain terms and conditions. Vasomedical Inc., also must pay to Living Data 5% of the selling price or 5% of the cost of all goods sold (whichever is higher), and 5% of the cost of all goods transferred but not sold under the Assignment Agreement to Living Data based on sales of this equipment. The Company intends to sell these systems in the United States and other countries subject to obtaining regulatory clearance.

Further, Kerns provides the Company, free of charge, part-time use of one of its Information Technology (IT) employees as well one of their IT consultants to provide the Company with IT and database support services. In addition, a clinical applications support specialist and a service engineer from Living Data may were used by the Company to provide customers with clinical training and technical service. The Company was charged $3,900 for the services of the clinical applications support specialist and $2,700 for the services of the service engineer during fiscal 2009.

Effects of Inflation

We believe that inflation and changing prices over the past two years have not had a significant impact on our revenue or on our results of operations.

Critical Accounting Policies

Financial Reporting Release No. 60, which was released by the Securities and Exchange Commission, or SEC, in December 2001, requires all companies to include a discussion of critical accounting policies or methods used in the preparation of financial statements. Note B of the Notes to Consolidated Financial Statements included in our Annual Report on Form 10-K for the year ended May 31, 2009, includes a summary of our significant accounting policies and methods used in the preparation of our financial statements. In preparing these financial statements, we have made our best estimates and judgments of certain amounts included in the financial statements, giving due consideration to materiality. The application of these accounting policies involves the exercise of judgment and use of assumptions as to future uncertainties and, as a result, actual results could differ from these estimates. Our critical accounting policies are as follows:

Revenue Recognition

The Company recognizes revenue when persuasive evidence of an arrangement exists, delivery has occurred or service has been rendered, the price is fixed or determinable and collectibility is reasonably assured. In the United States, we recognize revenue from the sale of our EECP(R) systems in the period in which we deliver the system to the customer. Revenue from the sale of our EECP(R) systems to international markets is recognized upon shipment of the product to a common carrier, as are supplies, accessories and spare parts delivered to both domestic and international customers. Returns are accepted prior to the in-service and training subject to a 10% restocking charge or for normal warranty matters, and we are not obligated for post-sale upgrades to these systems. In addition, we use the installment method to record revenue based on cash receipts in situations where the account receivable is collected over an extended period of time and in our judgment the degree of collectibility is uncertain.

In most cases, revenue from domestic EECP(R) system sales is generated from multiple-element arrangements that require judgment in the areas of customer acceptance, collectibility, the separability of units of accounting, and the fair value of individual elements. We follow the provisions of Emerging Issues Task Force, or EITF, Issue No. 00-21, "Revenue Arrangements with Multiple Deliverables" ("EITF 00-21"). The principles and guidance outlined in EITF 00-21 provide a framework to determine (a) how the arrangement consideration should be measured (b) whether the arrangement should be divided into separate units of accounting, and (c) how the arrangement consideration should be allocated among the separate units of accounting. We determined that the domestic sale of our EECP(R) systems includes a combination of three elements that qualify as

separate units of accounting:

i. EECP(R) equipment sale,
ii. provision of in-service and training support consisting of equipment set-up and training provided at the customer's facilities, and
iii. a service arrangement (usually one year), consisting of: service by factory-trained service representatives, material and labor costs, emergency and remedial service visits, software upgrades, technical phone support and preferred response times.

Each of these elements represent individual units of accounting as the delivered item has value to a customer on a stand-alone basis, objective and reliable evidence of fair value exists for undelivered items, and arrangements normally do not contain a general right of return relative to the delivered item. We determine fair value based on the price of the deliverable when it is sold separately or based on third-party evidence. In accordance with the guidance in EITF 00-21, we use the residual method to allocate the arrangement consideration when it does not have fair value of the EECP(R) system sale. Under the residual method, the amount of consideration allocated to the delivered item equals the total arrangement consideration less the aggregate fair value of the undelivered items. Assuming all other criteria for revenue recognition have been met, we recognize revenue for:

i. EECP(R) equipment sales, when delivery and acceptance occurs based on delivery and acceptance documentation received from independent shipping companies or customers,
ii. in-service and training, following documented completion of the training, and
iii. the service arrangement, ratably over the service period, which is generally one year.

In-service and training generally occurs within a few weeks of shipment and our return policy states that no returns will be accepted after in-service and training has been completed. The amount related to in-service and training is recognized as service revenue at the time the in-service and training is completed and the amount related to service arrangements is recognized ratably as service revenue over the related service period, which is generally one year. Costs associated with the provision of in-service and training and the service arrangement, including salaries, benefits, travel, spare parts and equipment, are recognized in cost of equipment sales as incurred.

The Company also recognizes revenue generated from servicing EECP(R) systems that are no longer covered by the service arrangement, or by providing sites with additional training, in the period that these services are provided. Revenue related to future commitments under separately priced extended service agreements on our EECP(R) system are deferred and recognized ratably over the service period, generally ranging from one year to four years. Costs associated with the provision of service and maintenance, including salaries, benefits, travel, spare parts and equipment, are recognized in cost of sales as incurred. Amounts billed in excess of revenue recognized are included as deferred revenue in the consolidated balance sheets.

Revenues from the sale of EECP(R) systems through our international distributor network are generally covered by a one-year warranty period. For these customers we accrue a warranty reserve for estimated costs to provide warranty parts when the equipment sale is recognized.

The Company has also entered into lease agreements for our EECP(R) systems, generally for terms of one year or less, that are classified as operating leases. Revenues from operating leases are generally recognized, in accordance with the terms of the lease agreements, on a straight-line basis over the life of the respective leases. For certain operating leases in which payment terms

are determined on a "fee-per-use" basis, revenues are recognized as incurred (i.e., as actual usage occurs). The cost of the EECP(R) system utilized under operating leases is recorded as a component of property and equipment and is amortized to cost of sales over the estimated useful life of the equipment, not to exceed five years. There were no significant minimum rental commitments on these operating leases at May 31, 2009.

Accounts Receivable, net

The Company's accounts receivable are due from customers engaged in the provision of medical services. Credit is extended based on evaluation of a customer's financial condition and, generally, collateral is not required. Accounts receivable are generally due 30 to 90 days from shipment and are stated at amounts due from customers net of allowances for doubtful accounts, returns, term discounts and other allowances. Accounts that remain outstanding longer than the contractual payment terms are considered past due. Estimates are used in determining the allowance for doubtful accounts based on the Company's historical collections experience, current trends, credit policy and a percentage of its accounts receivable by aging category. In determining these percentages, we look at historical write-offs of our receivables. The Company also looks at the credit quality of their customer base as well as changes in their credit policies. The Company continuously monitors collections and payments from our customers, and writes off receivables when all efforts at collection have been exhausted. While credit losses have historically been within expectations and the provisions established, the Company cannot guarantee that it will continue to experience the same credit loss rates that they has in the past.

Inventories, net

The Company values inventory at the lower of cost or estimated market, with cost being determined on a first-in, first-out basis. The Company often places EECP(R) systems at various field locations for demonstration, training, evaluation, and other similar purposes at no charge. The cost of these EECP(R) systems is transferred to property and equipment and is amortized over the next two to five years. The Company records the cost of refurbished components of EECP(R) systems and critical components at cost plus the cost of refurbishment. The Company regularly reviews inventory quantities on hand, particularly raw materials and components, and records a provision for excess and obsolete inventory based primarily on existing and anticipated design and engineering changes to its products as well as forecasts of future product demand.

We comply with the provisions of Statement of Financial Accounting Standards No. 151, "Inventory Costs", on a prospective basis. The statement clarifies that abnormal amounts of idle facility expense, freight, handling costs, and wasted materials (spoilage) should be recognized as current-period charges and requires the allocation of fixed production overheads to inventory based on the normal capacity of the production facilities.

Deferred Revenues

The Company records revenue on extended service contracts ratably over the term of the related contract period. In accordance with the provisions of EITF 00-21, we began to defer revenue related to EECP(R) system sales for the fair value of installation and in-service training to the period when the services are rendered and for warranty obligations ratably over the service period, which is generally one year.

Warranty Costs

Equipment sold is generally covered by a warranty period of one year. Under the provisions of EITF 00-21, for certain arrangements, a portion of the overall

system price attributable to the first year service arrangement is deferred and recognized as revenue over the service period. As such, we do not accrue warranty costs upon delivery but we rather recognize warranty and related service costs as incurred.

Equipment sold to international customers through our distributor network is generally covered by a one-year warranty period. For these customers the Company accrues a warranty reserve for estimated costs of providing a parts only warranty when the equipment sale is recognized.

The factors affecting our warranty liability included the number of units sold and historical and anticipated rates of claims and costs per claim.

Net Loss per Common Share

Basic loss per share is based on the weighted average number of common shares outstanding without consideration of potential common stock. Diluted loss per share is based on the weighted number of common and potential dilutive common shares outstanding. The calculation takes into account the shares that may be issued upon the exercise of stock options and warrants, reduced by the shares that may be repurchased with the funds received from the exercise, based on the average price during the period. Options and warrants to purchase shares of common stock are excluded from the computation of diluted earnings per share because the effect of their inclusion would be antidilutive.

Income Taxes

Deferred income taxes are recognized for temporary differences between financial statement and income tax bases of assets and liabilities and loss carryforwards for which income tax benefits are expected to be realized in future years. A valuation allowance is established, when necessary, to reduce deferred tax assets to the amount expected to be realized. In estimating future tax consequences, we generally consider all expected future events other than an enactment of changes in the tax laws or rates. The deferred tax asset is continually evaluated for realizability. To the extent our judgment regarding the realization of the deferred tax assets changes, an adjustment to the allowance is recorded, with an offsetting increase or decrease, as appropriate, in income tax expense. Such adjustments are recorded in the period in which our estimate as to the realizability of the asset changed that it is "more likely than not" that all of the deferred tax assets will be realized. The "more likely than not" standard is subjective, and is based upon our estimate of a greater than 50% probability that the deferred tax asset will be realized.

Deferred tax assets and liabilities are classified as current or non-current based on the classification of the related asset or liability for financial reporting. A deferred tax asset or liability that is not related to an asset or liability for financial reporting, including deferred tax assets related to carryforwards, are classified according to the expected reversal date of the temporary difference. The deferred tax asset the Company previously recorded, and then reversed fully in fiscal 2006, related primarily to the realization of net operating loss carryforwards, of which the allocation of the current portion, if any, reflected the expected utilization of such net operating losses for the following twelve months. Such allocation was based on the Company's internal financial forecast and may be subject to revision based upon actual results.

The Company also complies with the provisions of the Financial Accounting Standards Board ("FASB") Interpretation No. 48, "Accounting for Uncertainty in Income Taxes - an interpretation of FASB Statement No. 109" ("FIN 48"). FIN 48

prescribes a recognition threshold and a measurement attribute for the financial statement recognition and measurement of tax positions taken or expected to be taken in a tax return. For those benefits to be recognized, a tax position must be more-likely-than-not to be sustained upon examination by taxing authorities. The Company recognizes accrued interest and penalties related to unrecognized tax benefits as income tax expense. No amounts were accrued for the payment of interest and penalties at May 31, 2009. Management is currently unaware of any issues under review that could result in significant payments, accruals or material deviations from its position.

Stock-based Employee Compensation

The Company complies with Statement of Financial Standards (SFAS) No. 123 (revised 2004), "Share-Based Payment"

SFAS No. 123(R) requires all companies to recognize the cost of services received in exchange for equity instruments, to be recognized in the financial statements based on their fair values.

In May 2006, the compensation committee of the board of directors accelerated the vesting provision of all outstanding stock options and warrants so that they were fully vested at May 31, 2006, and as a result the adoption of SFAS No. 123(R) did not have an immediate material effect on the financial statements. However, as new stock options are issued by the Company this may have a material effect on its quarterly and annual financial statements, in the form of additional compensation expense. It is not possible to precisely determine the expense impact of adoption since a portion of the ultimate expense that is recorded will likely relate to awards that have not yet been granted. The expense associated with these future awards can only be determined based on factors such as the price for the Company's common stock, volatility of the Company's stock price and risk free interest rates as measured at the grant date.

For purposes of estimating the fair value of each option on the date of grant, the Company utilized the Black-Scholes option-pricing model.

The Black-Scholes option valuation model was developed for use in estimating the fair value of traded options, which have no vesting restrictions and are fully transferable. In addition, option valuation models require the input of highly subjective assumptions including the expected stock price volatility. Because changes in the subjective input assumptions can materially affect the fair value estimate, in management's opinion, the existing models do not necessarily provide a reliable measure of the fair value of its employee stock options.

Equity instruments issued to non-employees in exchange for goods, fees and services are accounted for under the fair value-based method of SFAS No. 123 (R).

Recently Issued Accounting Pronouncements

The Company continually assesses any new accounting pronouncements to determine their applicability to the Company. Where it is determined that a new accounting pronouncement affects the Company's financial reporting, the Company undertakes a study to determine the consequence of the change to its financial statements and assures that there are proper controls in place to ascertain that the Company's financials properly reflect the change. New pronouncements assessed by the Company recently are discussed below:

In December 2007, the Financial Accoutning Standards Board ("FASB") issued

SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements", which changes the way the consolidated income statement is presented. It requires consolidated net income to be reported at amounts that include the amounts attributable to both the parent and the noncontrolling interest. It also requires disclosure, on the face of the consolidated statement of income, of the amounts of consolidated net income attributable to the parent and to the noncontrolling interest. Previously, net income attributable to the noncontrolling interest generally was reported as an expense or other deduction in arriving at consolidated net income. It also was often presented in combination with other financial statement amounts.

In April 2009, the FASB issued FASB Staff Position ("FSP") SFAS No. 107-1 and Accounting Principles Board ("APB") Opinion No. 28-1 ("APB No. 28-1"), "Interim Disclosures about Fair Value of Financial Instruments," which amends SFAS No. 107, "Disclosures about Fair Value of Financial Instruments," and requires disclosures about the fair value of financial instruments for interim reporting periods of publicly traded companies as well as in annual financial statements. FSP SFAS No. 107-1 and APB No. 28-1 also amends APB Opinion No. 28, "Interim Financial Reporting," to require those disclosures in summarized financial information for interim reporting periods. FSP SFAS No. 107-1 and APB No. 28-1 is effective for interim reporting periods ending after June 15, 2009. The Company is in the process of evaluating the impact of FSP SFAS No. 107-1 and APB No. 28-1 on our financial position and results of operations.

In May 2009, the FASB issued Statement of Financial Accounting Standards ("SFAS") No. 165, "Subsequent Events" ("SFAS 165"). This standard is intended to establish general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or

are available to be issued. Specifically, this standard sets forth the period after the balance sheet date during which management of a reporting entity should evaluate events or transactions that may occur for potential recognition or disclosure in the financial statements, the circumstances under which an entity should recognize events or transactions occurring after the balance sheet date in its financial statements, and the disclosures that an entity should make about events or transactions that occurred after the balance sheet date. SFAS 165 is effective for fiscal years and interim periods ended after June 15, 2009 and will be applied prospectively. We adopted SFAS 165 during the second quarter of 2009, and its adoption did not have a material impact on our results of operations and financial position.

In June 2009, the FASB issued SFAS No. 168, The FASB Accounting Standards Codification TM and the Hierarchy of Generally Accepted Accounting Principles--a replacement of FASB Statement No. 162 ("SFAS 168"). The statement confirmed that the FASB Accounting Standards Codification (the "Codification") will become the single official source of authoritative U.S. GAAP (other than guidance issued by the SEC), superseding existing FASB, American Institute of Certified Public Accountants, Emerging Issues Task Force ("EITF"), and related literature. After that date, only one level of authoritative U.S. GAAP will exist. All other literature will be considered non-authoritative. The Codification does not change U.S. GAAP; instead, it introduces a new structure that is organized in an easily accessible, user-friendly online research system. The Codification, which changes the referencing of financial standards, becomes effective for interim and annual periods ending on or after September 15, 2009. We will apply the Codification beginning in the third quarter of fiscal 2009. The adoption of SFAS 168 is not expected to have any substantive impact on our condensed consolidated financial statements or related footnotes.

ITEM 8 - FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The consolidated financial statements listed in the accompanying Index to Consolidated Financial Statements are filed as part of this report.

ITEM 9 - CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A - CONTROLS AND PROCEDURES

Report on Disclosure Controls and Procedures

Disclosure controls and procedures reporting as promulgated under the Exchange Act is defined as controls and procedures that are designed to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act are recorded, processed, summarized and reported within the time periods specified in the SEC rules and forms. Disclosure controls and procedures include without limitation, controls and procedures designed to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure.

Our CEO and our CFO have evaluated the effectiveness of the design and operation of our disclosure controls and procedures as of May 31, 2009 and have concluded that the Company's disclosure controls and procedures were effective as of May 31, 2009.

ITEM 9A(T) - CONTROLS AND PROCEDURES

Management's Annual Report on Internal Control over Financial Reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting for the Company as defined in Rule 13a-15(f) of the Exchange Act. Internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial statements for external purposes in accordance with accounting principles generally accepted in the United States of America. Internal control involves maintaining records that accurately represent our business transactions, providing reasonable assurance that receipts and expenditures of company assets are made in accordance with management authorization, and providing reasonable assurance that unauthorized acquisition, use or disposition of company assets that could have a material affect on our financial statements would be detected or prevented on a timely basis.

Because of its innate limitations, internal control over our financial statements is not intended to provide absolute guarantee that a misstatement can be detected or prevented on the statements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation. Also projections of any evaluation of effectiveness to future periods are subject to risk that controls may become inadequate because of changes in condition, or that the degree of compliance with the policies or procedures may deteriorate.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Based on this evaluation and those criteria, the Company's CEO and CFO concluded that the Company's internal control over

financial reporting was effective as of May 31, 2009. This annual report does not include an attestation report of the Company's Independent Registered Public Accounting Firm regarding internal control over financial reporting.

This annual report does not include an attestation report of the Company's Independent Registered Public Accounting Firm regarding internal control over financial reporting. Management's report was not subject to attestation by the Company's Independent Registered Public Accounting Firm pursuant to temporary rules of the Securities and Exchange Commission that permit the Company to provide only Management's report in this Annual Report.

ITEM 9B - OTHER INFORMATION

None.

PART III

The information required by Part III is intended to be included in our definitive Proxy Statement, which will be filed with the Securities and Exchange Commission in connection with our 2009 Annual Meeting of Stockholders and is incorporated herein by reference.

PART IV

ITEM 15 - EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) Financial Statements and Financial Statement Schedules

(1) See Index to Consolidated Financial Statements on page F-1 at beginning of attached financial statements.

(b) Exhibits

(3) (a) Restated Certificate of Incorporation (2)
(b) By-Laws (1)
(4) (a) Specimen Certificate for Common Stock (1)
(10 (a) 1995 Stock Option Plan (3)
(b) Outside Director Stock Option Plan (3)
(c) 1997 Stock Option Plan, as amended (4)
(d) 1999 Stock Option Plan, as amended (5)
(e) 2004 Stock Option/Stock Issuance Plan (6)
(f) Securities Purchase Agreement dated June 21, 2007 between Registrant and Kerns Manufacturing Corp. (7)
(g) Form of Common Stock Purchase Warrant to dated June 21, 2007 (7)
(h) Registration Rights Agreement dated June 21, 2007 between Registrant, Kerns Manufacturing Corp. and Living Data Technology Corporation. (7)
(i) Purchase and Sale Agreement dated June 1, 2007 between 180 Linden Avenue Corp and 180 Linden Realty LLC. (8)
(j) Lease Agreement dated August 15, 2007 between 180 Linden Realty LLC and Registrant (8)
(21) Subsidiaries of the Registrant

Name	State of Incorporation	Percentage Owned by Company
Viromedics, Inc.	Delaware	61%
180 Linden Avenue Corp.	New York	100%

(23.1) Consent of Rothstein Kass & Company, P.C.
(23.2) Consent of Miller, Ellin & Company, LLP
(31) Certification Reports pursuant to Securities Exchange Act Rule 13a -

14

(32) Certification Reports pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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(1) Incorporated by reference to Registration Statement on Form S-18, No. 33-24095.
(2) Incorporated by reference to Registration Statement on Form S-1, No. 33-46377 (effective 7/12/94).
(3) Incorporated by reference to Report on Form 8-K dated January 24, 1995.
(4) Incorporated by reference to Report on Form 10-K for the fiscal year ended May 31, 1999
(5) Incorporated by reference to Report on Form 10-K for the fiscal year ended May 31, 2000.
(6) Incorporated by reference to Notice of Annual Meeting of Stockholders dated October 28, 2004.
(7) Incorporated by reference to Report on Form 8-K dated June 21, 2007.
(8) Incorporated by reference to Report on Form 10-KSB for the fiscal year ended May 31, 2007.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, we have duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized on the 21st day of August 2009.

VASOMEDICAL, INC.

By: /s/ Jun Ma

Jun Ma
President, Chief Executive Officer, and Director
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below on August 21, 2009, by the following persons in the capacities indicated:

/s/ Jun Ma --- Jun Ma	President, Chief Executive Officer and Director (Principal Executive Officer)
/s/ Abraham E. Cohen --- Abraham E. Cohen	Chairman of the Board
/s/ John C. K. Hui --- John C. K. Hui	Vice Chairman of the Board, Chief Technology Officer
/s/ Tarachand Singh --- Tarachand Singh	Chief Financial Officer (Principal Financial and Accounting Officer)
/s/ Derek Enlander --- Derek Enlander	Director

/s/ Behnam Movaseghi	Director
Behnam Movaseghi	
/s/ Photios T. Paulson	Director
Photios T. Paulson	
/s/ Simon Srybnik	Director
Simon Srybnik	
/s/ Martin Zeiger	Director
Martin Zeiger	

Vasomedical, Inc. and Subsidiaries

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS
For the years ended May 31, 2009 and 2008

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Vasomedical, Inc

We have audited the accompanying consolidated balance sheet of Vasomedical, Inc. and Subsidiaries, (collectively, the "Company") as of May 31, 2009, and the related consolidated statement of operations, changes in stockholders' equity, and cash flows for the year then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. Our audit included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vasomedical, Inc. and Subsidiaries as of May 31, 2009, and the consolidated results of their operations and their cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

/s/ Rothstein, Kass & Company P.C.
Roseland, New Jersey
August 20, 2009

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Shareholders
Vasomedical, Inc. and Subsidiaries

We have audited the accompanying consolidated balance sheet of Vasomedical, Inc. and Subsidiaries (the "Company") as of May 31, 2008 and the related consolidated statements of operations, changes in stockholders' equity and cash flows for the year then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. The Company is not required to have, nor were we engaged to perform an audit of its internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Vasomedical, Inc. and Subsidiaries as of May 31, 2008 and the consolidated results of their operations and their consolidated cash flow for the year then ended in conformity with accounting principles generally accepted in the United States of America.

/s/ Miller, Ellin & Company, LLP
MILLER, ELLIN & COMPANY, LLP

New York, New York
August 20, 2008

Vasomedical, Inc. and Subsidiaries

CONSOLIDATED BALANCE SHEETS

	May 31, 2009
ASSETS	
CURRENT ASSETS	
Cash and cash equivalents	$ 544,057
Short-term investments, at fair value	370,523
Accounts receivable, net of an allowance for doubtful accounts of $94,973 at May 31, 2009, and $270,183 at May 31, 2008	659,551
Inventories, net	1,479,724
Other current assets	175,511
Total current assets	3,229,366
PROPERTY AND EQUIPMENT, net of accumulated depreciation of $1,562,891 at May 31, 2009, and $2,178,566 at May 31, 2008	180,409
DEFERRED DISTRIBUTOR COSTS, net of accumulated amortization of $213,234 at May 31, 2009, and $101,776 at May 31, 2008	375,643
OTHER ASSETS	178,332
	$ 3,963,750
LIABILITIES AND STOCKHOLDERS' EQUITY	
CURRENT LIABILITIES	
Accounts payable and accrued expenses	$ 504,773
Sales tax payable	143,693
Deferred revenue - current portion	957,258
Deferred gain on sale-leaseback of building - current portion	53,245
Accrued professional fees	9,750
Trade Payable to related parties	260,000
Total current liabilities	1,928,719
LONG-TERM LIABILITIES	
Deferred revenue, less current portion	330,449

Accrued rent expense	16,040
Deferred gain on sale-leaseback of building , net of current portion	115,365
Other long-term liabilities	11,900
Total long-term liabilities	473,754
COMMITMENTS AND CONTINGENCIES	
STOCKHOLDERS' EQUITY	
Preferred stock, $.01 par value; 1,000,000 shares authorized; none issued	-
Common stock, $.001 par value; 110,000,000 shares authorized; 99,843,004 shares at May 31, 2009, and 93,768,004 at May 31, 2008, issued and outstanding	99,843
Additional paid-in capital	48,281,711
Accumulated deficit	(46,820,277)
Total stockholders' equity	1,561,277
	$ 3,963,750

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

Vasomedical, Inc. and Subsidiaries

CONSOLIDATED STATEMENTS OF OPERATIONS

	Years Ended May 31,	
	2009	2008
Revenues		
Equipment sales	$ 2,219,729	$ 2,087,365
Equipment rentals and services	2,251,457	3,095,403
Total revenues	4,471,186	5,182,768
Cost of Sales and Services		
Cost of sales, equipment	1,586,633	1,679,632
Cost of equipment rentals and services	979,183	1,150,738
Total cost of sales and services	2,565,816	2,830,370
Gross profit	1,905,370	2,352,398
Operating Expenses		
Selling, general and administrative	3,013,276	2,626,045
Research and development	519,509	474,111
Total operating expenses	3,532,785	3,100,156
Loss from operations	(1,627,415)	(747,758)

Other Income (Expenses)		
Interest and financing costs	-	(16,616)
Interest and other income, net	55,334	61,083
Amortization of deferred gain on sale-leaseback of building	53,245	44,371
Total other income (expense), net	108,579	88,838
Loss before income taxes, net	(1,518,836)	(658,920)
Income tax expense, net	(5,875)	(18,045)
Net loss applicable to common stockholders	$(1,524,711)	$ (676,965)
Net loss per common share - basic and diluted	$ (0.02)	$ (0.01)
Weighted average common shares outstanding - basic and diluted	99,556,191	92,211,788

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

Vasomedical, Inc. and Subsidiaries

CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY

	Common Stock Shares	Amount	Additional Paid-in Capital	Accumulated Deficit
Balances at May 31, 2007	65,198,592	$ 65,198	$ 46,165,998	$ (44,618,60
Common stock and warrants (net of expenses incurred) issued pursuant to Securities Purchase Agreement	21,428,572	21,429	1,354,461	
Common stock and warrants issued for Distribution and Supply agreement	6,990,840	6,991	461,395	
Common stock issued to a Director	150,000	150	8,850	
Stock based compensation	-	-	77,728	
Net-loss	-	-	-	(676,96
Balances at May 31, 2008	93,768,004	93,768	48,068,432	(45,295,56
Common stock issued pursuant to Distribution and Supply agreement	3,000,000	3,000	57,000	
Common stock issued to				

Directors for fiscal year 2008 compensation	2,075,000	2,075	122,424	
Stock-based compensation	1,000,000	1,000	33,855	
Net-loss	-	-	-	(1,524,71
Balance at May 31, 2009	99,843,004	$ 99,843	$ 48,281,711	$ (46,820,27

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

Vasomedical, Inc. and Subsidiaries

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Years Ended May 31, 2009	2008
Cash flows from operating activities		
Net loss	$ (1,524,711)	$ (676,965)
Adjustments to reconcile net loss to net cash used in operating activities		
Depreciation and amortization of patent, property and equipment	102,245	187,628
Amortization of deferred gain on sale-leaseback of building	(53,245)	(44,371)
Provision for doubtful accounts	(175,210)	42,837
Amortization of deferred distributor costs	111,458	101,776
Reserves for obsolete inventory	200,070	(83,124)
Stock-based compensation	159,354	86,728
Changes in operating assets and liabilities:		
Accounts receivable	233,510	(27,031)
Inventories	(180,441)	592,427
Deferred distributor costs	(20,000)	(40,490)
Other assets	(119,278)	(24,172)
Accounts payable, accrued expenses, and other current liabilities	(387,650)	(24,947)
Deferred revenue	(330,346)	(138,299)
Other liabilities	7,384	15,982
Trade payable to related party	260,000	-
Net cash used in operating activities	(1,716,860)	(32,021)
Cash flows from investing activities		
Proceeds from the building sale-leaseback	-	1,400,000
Expenses paid for sale-leaseback of building	-	(89,143)
Purchases of property and equipment	(22,559)	-
Purchases of short-term investments	(370,523)	-
Net cash provided by (used in) investing activities	(393,082)	1,310,857
Cash flows from financing activities		
Payments on long-term debt and notes payable	-	(851,015)
Proceeds from Securities Purchase Agreement	-	1,500,000

Expenses paid in relation to Securities Purchase Agreement	-	(124,110)
Net cash provided by financing activities	-	524,875
NET INCREASE (DECREASE) IN CASH	(2,109,942)	1,803,711
Cash and cash equivalents - beginning of the fiscal year	2,653,999	850,288
Cash and cash equivalents - end of the fiscal year	$ 544,057	$ 2,653,999
SUPPLEMENTAL DISCLOSURE OF CASH INFORMATION:		
Interest paid	$ -	$ 16,616
Income taxes paid	$ -	$ 11,685
SUPPLEMENTAL SCHEDULE OF NON-CASH INVESTING AND FINANCING ACTIVITIES		
Inventories transferred to property and equipment, attributable to operating leases, net	$ 153,325	$ (44,354)
Common stock issued for distribution agreement	$ 60,000	$ 468,386

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

Vasomedical, Inc. and Subsidiaries

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
May 31, 2009 and 2008

NOTE A - DESCRIPTION OF BUSINESS AND LIQUIDITY

Vasomedical, Inc. was incorporated in Delaware in July 1987. Unless the context requires otherwise, all references to "we", "our", "us", "Company", "registrant", "Vasomedical" or "management" refer to Vasomedical, Inc. and its subsidiaries. Since 1995, we have been primarily engaged in designing, manufacturing, marketing and supporting EECP(R) enhanced external counterpulsation systems based on our unique proprietary technology currently indicated for use in cases of stable or unstable angina (i.e., chest pain), congestive heart failure (CHF), acute myocardial infarction (i.e., heart attack, (MI)) and cardiogenic shock. The EECP(R) therapy system is a non-invasive, outpatient therapy for the treatment of diseases of the cardiovascular system. The therapy serves to increase circulation in areas of the heart with less than adequate blood supply and helps to restore systemic vascular function. The therapy also increases blood flow and oxygen supply to the heart muscle and other organs and decreases the heart's workload and need for oxygen, while also improving function of the endothelium, the lining of blood vessels throughout the body, lessening resistance to blood flow. We provide hospitals, clinics and physician private practices with EECP(R) equipment, treatment guidance, and a staff training and equipment maintenance program designed to provide optimal patient outcomes. EECP(R) is a registered trademark for our enhanced external counterpulsation systems.

We have Food and Drug Administration (FDA) clearance to market our EECP(R) therapy for use in the treatment of stable and unstable angina, congestive heart failure, acute myocardial infarction, and cardiogenic shock, however, our current marketing efforts are limited to the treatment of chronic stable angina and congestive heart failure. Medicare and other third-party payers currently reimburse for the treatment of angina symptoms in patients with moderate to severe symptoms who are refractory to medications and not candidates for invasive procedures, including patients with serious comorbidities, such as heart failure, diabetes, and peripheral vascular disease. Patients with primary diagnoses of heart failure, diabetes, and peripheral vascular disease are also reimbursed under the same criteria, provided the primary indication for treatment with EECP(R) therapy is angina symptoms.

During the last several years, we incurred operating losses. We have attempted to achieve profitability by reducing operating costs and halting the trend of declining revenue, and to reduce cash usage through bringing our cost structure more into alignment with current revenues. The Company has reduced personnel costs by reorganization. The Company has negotiated new terms on professional fees, facility expenses, and shipping and supply costs. The Company is also looking to obtain a revolving line of credit to help stabilize cash flow and to respond to customers requests for flexible payment terms on our EECP(R) therapy systems.

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A summary of the significant accounting policies consistently applied in the preparation of the consolidated financial statements follows:

Principles of Consolidation

The consolidated financial statements include the accounts of the Company, its wholly-owned subsidiary and its inactive majority-owned subsidiary. Significant intercompany accounts and transactions have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Significant estimates and assumptions relate to estimates of collectibility of accounts receivable, the realizability of deferred tax assets, and the adequacy of inventory and warranty reserves. Actual results could differ from those estimates.

Revenue Recognition

The Company recognizes revenue when persuasive evidence of an arrangement exists, delivery has occurred or service has been rendered, the price is fixed or determinable and collectibility is reasonably assured. In the United States, we recognize revenue from the sale of our EECP(R) systems in the period in which we deliver the system to the customer. Revenue from the sale of our EECP(R) systems to international markets is recognized upon shipment, during the period in which we deliver the product to a common carrier, as are supplies, accessories and spare parts delivered to both domestic and international

customers. Returns are accepted prior to the in-service and training subject to a 10% restocking charge or for normal warranty matters, and we are not obligated for post-sale upgrades to these systems. In addition, we use the installment method to record revenue based on cash receipts in situations where the account receivable is collected over an extended period of time and in our judgment the degree of collectibility is uncertain.

In most cases, revenue from domestic EECP(R) system sales is generated from multiple-element arrangements that require judgment in the areas of customer acceptance, collectibility, the separability of units of accounting, and the fair value of individual elements. We follow the provisions of Emerging Issues Task Force Issue No. 00-21, "Revenue Arrangements with Multiple Deliverables" ("EITF 00-21"). The principles and guidance outlined in EITF 00-21 provide a framework to determine (a) how the arrangement consideration should be measured (b) whether the arrangement should be divided into separate units of accounting, and (c) how the arrangement consideration should be allocated among the separate units of accounting. We determined that the domestic sale of our EECP(R) systems includes a combination of three elements that qualify as separate units of accounting:

i. EECP(R) equipment sale,
ii. provision of in-service and training support consisting of equipment set-up and training provided at the customer's facilities, and
iii. a service arrangement (usually one year), consisting of: service by factory-trained service representatives, material and labor costs, emergency and remedial service visits, software upgrades, technical phone support and preferred response times.

Each of these elements represent individual units of accounting as the delivered item has value to a customer on a stand-alone basis, objective and reliable evidence of fair value exists for undelivered items, and arrangements normally do not contain a general right of return relative to the delivered item. We determine fair value based on the price of the deliverable when it is sold separately or based on third-party evidence. In accordance with the guidance in EITF 00-21, we use the residual method to allocate the arrangement consideration when it does not have fair value of the EECP(R) system sale. Under the residual method, the amount of consideration allocated to the delivered item equals the total arrangement consideration less the aggregate fair value of the undelivered items. Assuming all other criteria for revenue recognition have been met, we recognize revenue for:

i. EECP(R) equipment sales, when delivery and acceptance occurs based on delivery and acceptance documentation received from independent shipping companies or customers,
ii. in-service and training, following documented completion of the training, and
iii. the service arrangement, ratably over the service period, which is generally one year.

In-service and training generally occurs within a few weeks of shipment and our return policy states that no returns will be accepted after in-service and training has been completed. The amount related to in-service and training is recognized as service revenue at the time the in-service and training is completed and the amount related to service arrangements is recognized ratably as service revenue over the related service period, which is generally one year. Costs associated with the provision of in-service and training and the service arrangement, including salaries, benefits, travel, spare parts and equipment, are recognized in cost of equipment sales as incurred.

The Company also recognizes revenue generated from servicing EECP(R) systems that are no longer covered by the service arrangement, or by providing sites with additional training, in the period that these services are provided. Revenue related to future commitments under separately priced extended service agreements on our EECP(R) system are deferred and recognized ratably over the

service period, generally ranging from one year to four years. Costs associated with the provision of service and maintenance, including salaries, benefits,

travel, spare parts and equipment, are recognized in cost of sales as incurred. Amounts billed in excess of revenue recognized are included as deferred revenue in the consolidated balance sheets.

Revenues from the sale of EECP(R) systems through our international distributor network are generally covered by a one-year warranty period. For these customers we accrue a warranty reserve for estimated costs to provide warranty parts when the equipment sale is recognized.

The Company has also entered into lease agreements for our EECP(R) systems, generally for terms of one year or less, that are classified as operating leases. Revenues from operating leases are generally recognized, in accordance with the terms of the lease agreements, on a straight-line basis over the life of the respective leases. For certain operating leases in which payment terms are determined on a "fee-per-use" basis, revenues are recognized as incurred (i.e., as actual usage occurs). The cost of the EECP(R) system utilized under operating leases is recorded as a component of property and equipment and is amortized to cost of sales over the estimated useful life of the equipment, not to exceed five years. There were no significant minimum rental commitments on these operating leases at May 31, 2009.

Shipping and Handling Costs

All shipping and handling expenses are charged to cost of sales. Amounts billed to customers related to shipping and handling costs are included as a component of sales.

Research and Development

Research and development costs attributable to development are expensed as incurred. Included in research and development costs is amortization expense related to the capitalized cost of EECP(R) systems under loan for clinical trials.

Stock-Based Employee Compensation

The Company complies with Statement of Financial Accounting Standards (SFAS) No. 123 (revised 2004), "Share-Based Payment" (SFAS 123(R)). SFAS 123(R) requires all companies to recognize the cost of services received in exchange for awards of equity instruments in the financial statements based on their fair values.

During the fiscal year ended May 31, 2009, the Company's Board of Directors granted 100,000 shares of common stock to one employee of the Company having a fair market value of $0.08 per share at the time of the respective grant, 700,000 shares to two officers of the Company having a fair market value of $0.02 per share at the time of the respective grant, and 200,000 shares to one employee of the Company having a fair market value of $0.02 per share at the time of the respective grant.

Stock-based compensation expense recognized under SFAS 123(R) for the fiscal year ended May 31, 2009 was $159,354 and $86,728 for the fiscal year

ended May 31, 2008, which was comprised of the fair value of the common stock issued during the year and the costs of prior years' grants of stock options.

The Black-Scholes option valuation model was developed for use in estimating the fair value of traded options, which have no vesting restrictions and are fully transferable. In addition, option valuation models require the input of highly subjective assumptions including the expected stock price volatility. Because changes in the subjective input assumptions can materially affect the fair value estimate, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

The fair value of the Company's stock options were estimated using the following weighted-average assumptions for options granted during the year ended May 31, 2008:

Expected life (years)	5
Expected volatility	103.25%
Risk-free interest rate	4.95%
Expected dividend yield	0.0%

No stock options were issued during the year ended May 31, 2009.

Cash and Cash Equivalents

Cash and cash equivalents represent cash and short-term, highly liquid investments either in certificates of deposit, treasury bills, money market funds, and investment grade commercial paper issued by major corporations and financial institutions that generally have maturities of three months or less from the date of acquisition. Dividend and interest income are recognized when earned. The cost of securities sold is calculated using the specific identification method.

Short-Term Investments

The Company's short-term investments consist of certificates of deposit with original maturities greater than 3 months. They are bought and held principally for the purpose of selling them in the near-term and are classified as trading securities. Trading securities are recorded at fair value on the balance sheets in current assets, with the change in fair value during the years included in earnings.

Accounts Receivable, net

The Company's accounts receivable are due from customers engaged in the provision of medical services. Credit is extended based on evaluation of a customer's financial condition and, generally, collateral is not required. Accounts receivable are generally due 30 to 90 days from shipment and are stated at amounts due from customers net of allowances for doubtful accounts, returns, term discounts and other allowances. Accounts that remain outstanding longer than the contractual payment terms are considered past due. Estimates are used in determining the allowance for doubtful accounts based on the Company's historical collections experience, current trends, credit policy and a

percentage of its accounts receivable by aging category. In determining these percentages, the Company reviews historical write-offs of their receivables. The Company also looks at the credit quality of their customer base as well as changes in their credit policies. The Company continuously monitors collections and payments from our customers, and writes off receivables when all efforts at collection have been exhausted. While credit losses have historically been within expectations and the provisions established, the Company cannot guarantee that it will continue to experience the same credit loss rates that they have in the past.

The changes in the Company's allowance for doubtful accounts are as follows:

	May 31, 2009	May 31, 2008
Beginning balance	$ 270,183	$ 364,809
Provision for losses on accounts receivable	-	(53,142)
Direct write-offs, net of recoveries	(175,210)	(41,484)
Ending balance	$ 94,973	$ 270,183

Concentrations of Credit Risk

We market the EECP(R) system principally to hospitals and physician private practices. We perform credit evaluations of our customers' financial condition and, as a consequence, believe that our receivable credit risk exposure is limited. For the years ended May 31, 2009 and 2008, no customer accounted for 10% or more of revenues or accounts receivable.

The Company maintains cash balances in certain financial institutions, which, at time, may exceed federally insured limits. The Company has not experienced any losses on these accounts and believes it is not subject to any significant credit risk on these accounts.

Our revenues were derived from the following geographic areas:

	Years ended May31,	
	2009	2008
Domestic (United States)	$ 3,078,785	$ 4,347,222
Non-domestic (foreign)	1,392,401	835,546
	$ 4,471,186	$ 5,182,768

Inventories, net

The Company values inventory at the lower of cost or estimated market, with cost being determined on a first-in, first-out basis. The Company often places

EECP(R) systems at various field locations for demonstration, training, evaluation, and other similar purposes at no charge. The cost of these EECP(R) systems is transferred to property and equipment and is amortized over two to five years. The Company records the cost of refurbished components of EECP(R) systems and critical components at cost plus the cost of refurbishment. The Company regularly reviews inventory quantities on hand, particularly raw materials and components, and records a provision for excess and obsolete inventory based primarily on existing and anticipated design and engineering changes to its products as well as forecasts of future product demand.

We comply with the provisions of SFAS No. 151, "Inventory Costs" (SFAS 151). The statement clarifies that abnormal amounts of idle facility expense, freight, handling costs, and wasted materials (spoilage) should be recognized as current-period charges and requires the allocation of fixed production overhead to inventory based on the normal capacity of the production facilities.

Property and Equipment

Property and equipment are stated at cost less accumulated depreciation and amortization. Major improvements are capitalized and minor replacements, maintenance and repairs are charged to expense as incurred. Upon retirement or disposal of assets, the cost and related accumulated depreciation are removed from the consolidated balance sheet. Depreciation is provided over the estimated useful lives of the assets, which range from two to twenty years, on a straight-line basis. Accelerated methods of depreciation are used for tax purposes. We amortize leasehold improvements over the useful life of the related leasehold improvement or the life of the related lease, whichever is less. (See Note E.)

Deferred Revenue

We record revenue on extended service contracts ratably over the term of the related warranty contracts. Under the provisions of EITF 00-21, we began to defer revenue related to EECP(R) system sales for the fair value of installation and in-service training to the period when the services are rendered and for warranty obligations ratably over the service period, which is generally one year. (See Note G.)

Warranty Costs

Equipment sold is generally covered by a warranty period of one year. In accordance with SFAS No. 5 "Accounting for Contingencies", we accrue a warranty reserve for estimated costs of providing a parts only warranty when the equipment sale is recognized.

The factors affecting our warranty liability include the number of units sold and the historical and anticipated rates of claims and costs per claim. (See Note I.)

Income Taxes

Deferred income taxes are recognized for temporary differences between financial statement and income tax bases of assets and liabilities and loss carryforwards for which income tax benefits are expected to be realized in future years. A valuation allowance is established, when necessary, to reduce

deferred tax assets to the amount expected to be realized. In estimating future tax consequences, we generally consider all expected future events other than an enactment of changes in the tax laws or rates. The deferred tax asset is continually evaluated for realizability. To the extent our judgment regarding the realization of the deferred tax assets changes, an adjustment to the allowance is recorded, with an offsetting increase or decrease, as appropriate, in income tax expense. Such adjustments are recorded in the period in which our estimate as to the realizability of the asset changed that it is "more likely than not" that all of the deferred tax assets will be realized. The "realizability" standard is subjective and is based upon our estimate of a greater than 50% probability that the deferred tax asset can be realized.

Deferred tax assets and liabilities are classified as current or non-current based on the classification of the related asset or liability for financial reporting. A deferred tax asset or liability that is not related to an asset or liability for financial reporting, including deferred tax assets related to carryforwards, are classified according to the expected reversal date of the temporary difference.

The Company also complies with the provisions of the Financial Accounting Standards Board ("FASB") Interpretation No. 48, "Accounting for Uncertainty in Income Taxes - an interpretation of FASB Statement No. 109" ("FIN 48"). FIN 48 prescribes a recognition threshold and a measurement attribute for the financial statement recognition and measurement of tax positions taken or expected to be taken in a tax return. For those benefits to be recognized, a tax position must be more-likely-than-not to be sustained upon examination by the relevant taxing authority based on the technical merits. The Company recognizes accrued interest and penalties related to unrecognized tax benefits as income tax expense. No amounts were accrued for the payment of interest and penalties at May 31, 2009. Management is currently unaware of any issues under review that could result in significant payments, accruals or material deviations from its position.

Fair Value of Financial Instruments

The Company adopted the provisions of SFAS No. 157, "Fair Value Measurements" ("SFAS 157"), effective June 1, 2008. Under SFAS 157, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (i.e., the "exit price") in an orderly transaction between market participants at the measurement date.

In determining fair value, the Company uses various valuation approaches. SFAS 157 establishes a fair value hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are those that market participants would use in pricing the asset or liability based on market data obtained from sources independent of the Company. Unobservable inputs reflect the Company's assumptions about the inputs market participants would use in pricing the asset or liability developed based on the best information available in the circumstances. The fair value hierarchy is categorized into three levels based on the inputs as follows:

Level 1 - Valuations based on unadjusted quoted prices in active markets for identical assets or liabilities that the Company has the ability to access. Valuation adjustments and block discounts are not applied to Level

May 31, 2009 and 2008

1 securities. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these securities does not entail a significant degree of judgment.

Level 2 - Valuations based on quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3 - Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

Valuation Techniques

The Company values investments in securities and securities sold short that are freely tradable and are listed on a national securities exchange or reported on the NASDAQ national market at their last sales price as of the last business day of the fiscal year.

The carrying amounts of cash and cash equivalents, accounts receivable and accounts payable approximate fair value due to the short-term maturities of the instruments.

Net Loss Per Common Share

Basic loss per common share is based on the weighted average number of common shares outstanding without consideration of potential common stock. Diluted loss per common share is based on the weighted number of common and potential dilutive common shares outstanding. The diluted calculation takes into account the shares that may be issued upon the exercise of stock options and warrants, reduced by the shares that may be repurchased with the funds received from the exercise, based on the average price during the period.

Options and warrants to purchase 10,275,183 and 12,000,462 shares of common stock were excluded from the computation of diluted earnings per share for the years ended May 31, 2009 and 2008, respectively, because the effect of their inclusion would be antidilutive.

Reclassifications

Certain reclassifications have been made to prior years' amounts to conform with the current year's presentation.

Recently Issued Accounting Pronouncements Not Yet Effective

The Company continually assesses any new accounting pronouncements to determine their applicability to the Company. Where it is determined that a new accounting pronouncement affects the Company's financial reporting, the Company undertakes a study to determine the consequence of the change to its financial statements and assures that there are proper controls in place to ascertain that the Company's financials properly reflect the change. New pronouncements assessed by the Company recently are discussed below:

In December 2007, the Financial Accoutning Standards Board ("FASB") issued SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements", which changes the way the consolidated income statement is presented. It requires consolidated net income to be reported at amounts that include the amounts attributable to both the parent and the noncontrolling interest. It also requires disclosure, on the face of the consolidated statement of income, of the amounts of consolidated net income attributable to the parent and to the noncontrolling interest. Previously, net income attributable to the

noncontrolling interest generally was reported as an expense or other deduction in arriving at consolidated net income. It also was often presented in combination with other financial statement amounts.

In April 2009, the FASB issued FASB Staff Position ("FSP") SFAS No. 107-1 and Accounting Principles Board ("APB") Opinion No. 28-1 ("APB No. 28-1"), "Interim Disclosures about Fair Value of Financial Instruments," which amends SFAS No. 107, "Disclosures about Fair Value of Financial Instruments," and requires disclosures about the fair value of financial instruments for interim reporting periods of publicly traded companies as well as in annual financial

statements. FSP SFAS No. 107-1 and APB No. 28-1 also amends APB Opinion No. 28, "Interim Financial Reporting," to require those disclosures in summarized financial information for interim reporting periods. FSP SFAS No. 107-1 and APB No. 28-1 is effective for interim reporting periods ending after June 15, 2009. The Company is in the process of evaluating the impact of FSP SFAS No. 107-1 and APB No. 28-1 on our financial position and results of operations.

In May 2009, the FASB issued Statement of Financial Accounting Standards ("SFAS") No. 165, "Subsequent Events" ("SFAS 165"). This standard is intended to establish general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. Specifically, this standard sets forth the period after the balance sheet date during which management of a reporting entity should evaluate events or transactions that may occur for potential recognition or disclosure in the financial statements, the circumstances under which an entity should recognize events or transactions occurring after the balance sheet date in its financial statements, and the disclosures that an entity should make about events or transactions that occurred after the balance sheet date. SFAS 165 is effective for fiscal years and interim periods ended after June 15, 2009 and will be applied prospectively. We adopted SFAS 165 during the second quarter of 2009, and its adoption did not have a material impact on our results of operations and financial position.

In June 2009, the FASB issued SFAS No. 168, The FASB Accounting Standards Codification TM and the Hierarchy of Generally Accepted Accounting Principles--a replacement of FASB Statement No. 162 ("SFAS 168"). The statement confirmed that the FASB Accounting Standards Codification (the "Codification") will become the single official source of authoritative U.S. GAAP (other than guidance issued by the SEC), superseding existing FASB, American Institute of Certified Public Accountants, Emerging Issues Task Force ("EITF"), and related literature. After that date, only one level of authoritative U.S. GAAP will exist. All other literature will be considered non-authoritative. The Codification does not change U.S. GAAP; instead, it introduces a new structure that is organized in an easily accessible, user-friendly online research system. The Codification, which changes the referencing of financial standards, becomes effective for interim and annual periods ending on or after September 15, 2009. We will apply the Codification beginning in the third quarter of fiscal 2009. The adoption of SFAS 168 is not expected to have any substantive impact on our condensed consolidated financial statements or related footnotes.

NOTE C - FAIR VALUE MEASUREMENTS

The Company's assets recorded at fair value have been categorized based upon a fair value hierarchy in accordance with SFAS 157.

The following table presents information about the Company's assets and liabilities measured at fair value as of May 31, 2009:

	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets			
Cash equivalents invested in money market fund (included in cash and cash equivalents)	$ 315,002	$ -	$ -
Investment in certificates of deposit (included in short-term investments)	370,523	-	-
Total	$ 685,525	$ -	$ -

The fair values of the Company's cash equivalents invested in money market fund are determined through market, observable and corroborated sources.

NOTE D - INVENTORIES, NET

Inventories, net of reserves consisted of the following:

	May 31, 2009	May 31, 2008
Raw materials	$ 646,775	$ 936,035
Work in process	522,823	603,925
Finished goods	310,126	112,718
	$ 1,479,724	$ 1,652,678

At May 31, 2009 and 2008, the Company maintains reserves for excess and obsolete inventories of $393,972 and $594,042, respectively.

NOTE E - PROPERTY AND EQUIPMENT

Property and equipment is summarized as follows:

	May 31, 2009	May 31, 2008
Office, laboratory and other equipment	$ 919,435	$ 1,368,170
EECP(R) systems under operating leases or under loan for clinical trials	674,400	719,401

Furniture and fixtures	149,465	148,165
	1,743,300	2,235,736
Less: accumulated depreciation	1,562,891	2,178,566
Property and equipment - net	$ 180,409	$ 57,170

Depreciation expense amounted to $52,232 and $104,724 for the years ended May 31, 2009 and 2008, respectively.

NOTE F - INTANGIBLE ASSETS

The Company owns thirteen US patents including eight utility and three design patents that expire at various times between 2009 and 2023. In addition, more than 20 foreign patents have been issued that expire at various times from 2009 to 2023. Cost incurred for submitting the applications to the United States Patent and Trademark Office and other foreign authorities for these patents have been capitalized. Patent costs are being amortized using the straight-line method over the related 10 year lives. The company begins amortizing patent costs once a filing receipt is received stating the patent serial number and filing date from the Patent Office or other foreign authority.

The changes in the Company's intangible assets are as follows:

	May 31, 2009	May 31, 2008
Patent costs		
Costs	$ 469,043	$ 469,043
Accumulated Amortization	(303,649)	(256,745)
	$ 165,394	$ 212,298

Intangible assets are included in other assets on the Company's consolidated balance sheets.

NOTE G - DEFERRED REVENUE

The changes in the Company's deferred revenues are as follows:

	Years Ended May 31,	
	2009	2
Deferred revenue at the beginning of the fiscal year	$ 1,618,053	$ 1
Additions:		
Deferred extended service contracts	1,086,968	1
Deferred in-service and training	37,500	
Deferred service arrangement obligations	133,500	
Deferred service arrangement promotion	600	

Recognized as revenue:		
Deferred extended service contracts	(1,366,062)	(2
Deferred in-service and training	(35,000)	
Deferred service arrangement obligations	(185,452)	
Deferred service arrangement promotion	(2,400)	
Deferred revenue at end of the fiscal year	1,287,707	1
Less: current portion	957,258	1
Long-term deferred revenue at end of the fiscal year	$ 330,449	$

NOTE H - SALE-LEASEBACK

In August 2007, the Company sold its warehouse and corporate facility for $1,400,000. Under the agreement, the Company is leasing back the property from the purchaser over a period of five years. The Company is accounting for the leaseback as an operating lease. The gain of $266,226 realized in this transaction was deferred and is being amortized to income ratably over the term of the lease. The unamortized deferred gain of $168,610 and $221,855 as of May 21, 2009 and 2008, respectively, is shown as "Deferred gain on sale-leaseback of building" in the Company's consolidated balance sheets. The short-term portion of $53,245 is shown in current liabilities and the long-term portion is in other long-term liabilities. The amount recognized as amortization in fiscal 2009, and 2008 was $53,245 and $44,371 respectively.

NOTE I - ACCOUNTS PAYABLE AND ACCRUED EXPENSES

For the years ended May 31, 2009 and 2008 accounts payable and accrued expenses consisted of the following:

	2009	2008
Accounts Payable	$ 142,748	$ 610,199
Accrued Expenses	328,525	156,487
Other	33,500	55,558
	$ 504,773	$ 822,244

NOTE J - WARRANTY LIABILITY

The changes in the Company's product warranty liability are as follows:

	Years ended May31, 2009	2008
Warranty liability at the beginning of the fiscal year	$ 17,250	$ 15,750
Expense for new warranties issued	81,800	49,500
Warranty claims	(75,800)	(48,000)

Warranty liability at the end of the fiscal year	$ 23,250	$ 17,250

Warranty liability is included in accounts payable and accrued expenses on the Company's consolidated balance sheets.

NOTE K - RELATED-PARTY TRANSACTIONS

On June 21, 2007, we entered into a Securities Purchase Agreement with Kerns Manufacturing Corp. (Kerns). Concurrently with our entry into the Securities Purchase Agreement, we also entered into a Distribution Agreement and a Supplier Agreement with Living Data Technology Corporation (Living Data), an affiliate of Kerns.

We sold to Kerns, pursuant to the Securities Purchase Agreement, 21,428,572 shares of our common stock at $.07 per share for a total purchase price of $1,500,000, as well as a five-year warrant to purchase 4,285,714 shares of our common stock at an initial exercise price of $.08 per share (the Warrant). The agreement further provided for the appointment to our Board of Directors of two representatives from Kerns. In furtherance thereof, Dr. Jun Ma and Mr. Simon Srybnik, Chairman of both Kerns and Living Data, were appointed members of our Board of Directors. On October 15, 2008, Dr. Jun Ma was appointed Chief Executive Officer. Pursuant to the Distribution Agreement, we have become the exclusive distributor in the United States of the AngioNew ECP systems manufactured by Living Data. As additional consideration for such agreement, we agreed to issue an additional 6,990,840 shares of our common stock to Living Data. Pursuant to the Supplier Agreement, Living Data now is the exclusive supplier to us of the ECP therapy systems that we market under the registered trademark EECP(R). The Distribution Agreement and the Supplier Agreement each have an initial term extending through May 31, 2012.

On November 20, 2008, the Company entered into an Amendment to the Distribution Agreement with Living Data to expand the territory covered in the Distribution Agreement to provide for exclusive distribution rights worldwide. In consideration for these rights, the Company agreed to issue Living Data 3,000,000 restricted shares of its common stock having a fair market value of $60,000 at time of issue.

Pursuant to a Registration Rights Agreement, we granted to Kerns and Living Data, subject to certain restrictions, "piggyback registration rights" covering the shares sold to Kerns as well as the shares issuable upon exercise of the Warrant and the shares issued to Living Data.

On July 10, 2007, the Board of Directors appointed Mr. Behnam Movaseghi, Treasurer and Chief Financial Officer of Kerns Manufacturing Corporation, to our Board of Directors.

As affiliates of Living Data and Kerns, Mr. Ma, Mr. Movaseghi and Mr. Srybnik have each been directly involved in the transactions between Living Data and Kerns, and the Company, with respect to the Securities Purchase Agreement, the Distribution Agreement and the Supplier Agreement, as well as consulting services to the Company with no compensation.

During fiscal 2008, the Company purchased ECP therapy systems under the Supplier Agreement for $120,000 from Living Data, which was paid in full by the

Company as of June 2008. In addition, Living Data purchased $5,000 worth of ECP therapy system components from the Company, which was paid in full by Living Data as of June 2008.

During fiscal 2009, the Company purchased ECP therapy systems under the Supplier Agreement for $595,000 from Living Data. Payment terms on certain purchases leave a balance of $260,000 in Trade Payable to Related Party - current portion on the accompanying consolidated condensed balance sheet as of May 31, 2009. In addition, during fiscal year 2009 Living Data purchased $3,118 worth of ECP therapy system components from the Company.

During fiscal 2009, Living Data assigned to Vasomedical, Inc. all of its rights and interests under its distributorship Agreement with a corporation organized and existing under the laws of the People's Republic of China that manufactures Ambulatory Blood Pressure Monitors, Ambulatory ECG Recorders and Holter & ABPM Combiner Recorders, for $20,000 payable to Living Data based on certain terms and conditions. The Company must also pay to Living Data 5% of the selling price or 5% of the cost of all goods sold (whichever is higher), and 5% of the cost of all goods transferred but not sold under the Assignment Agreement to Living Data based on sales of this equipment. The Company will sell these systems in the United States and other countries now that regulatory clearance had been obtained.

During fiscal 2009, Living Data assigned to Vasomedical, Inc. all of its rights and interests under its Distributorship Agreement with a corporation organized and existing under the laws of the People's Republic of China, that manufactures Ultrasound Scanners, for $20,000 payable to Living Data based on certain terms and conditions. The Company must also pay to Living Data 5% of the selling price or 5% of the cost of all goods sold (whichever is higher), and 5% of the cost of all goods transferred but not sold under the Assignment Agreement to Living Data based on sales of this equipment. The Company intends to sell these systems in the United States and other countries subject to obtaining regulatory clearance.

Further, Kerns provides the Company, free of charge, part-time use of one of its Information Technology (IT) employees as well one of their IT consultants to provide the Company with IT and database support services. In addition, a clinical applications support specialist and a service engineer from Living Data were used by the Company to provide customers with clinical training and technical service. The Company was charged $3,900 for the services of the clinical applications support specialist and $2,700 for the services of the service engineer during fiscal year 2009.

NOTE L - STOCKHOLDERS' EQUITY AND WARRANTS

Common stock

See Note K for discussion of common stock issued in fiscal 2009 and 2008 in connection with related party agreements. Additionally during fiscal year 2009 and 2008, the Company issued 3,075,000, and 150,000 share of common stock, respectively, to directors, officers, employees, and/or consultants.

On June 21, 2007, a five-year warrant to purchase 4,285,714 shares of our common stock at an initial exercise price of $.08 per share to Kerns under the Securities Purchase Agreement.

On July 19, 2005, we granted warrants for the purchase of 2,254,538 shares of common stock to investors and consultants. The warrants may be exercised at a price of $0.69 per share for a term of five years, ending July 19, 2010.

Preferred stock

At May 31, 2009 the Company had 1,000,000 shares of preferred stock authorized, with no shares issued and outstanding. There are 850,000 shares that have been designated to a series as shown in the table below, 150,000 shares are available to be designated.

The following table illustrates the various series of preferred stock and their stated value:

	Authorized Shares	Stated Value per share
Series A	500,000	NONE
Series B	150,000	$20.00
Series C	175,000	$20.00
Series D	25,000	$100.00

Series A preferred stock shares are convertible into two shares of common stock to the extent the Company has, at the time of conversion, sufficient authorized but unissued shares of common stock.

Series B preferred stock shares are convertible into shares of common stock at a conversion ratio of the stated value plus accrued but unpaid dividends, over the conversion price, which is equal to the lesser of $2.18 or 85% of the average per share market value for the five (5) trading days immediately preceding the conversion date.

Series C preferred stock shares are convertible into shares of common stock at a conversion ratio of the stated value plus accrued but unpaid dividends, over the conversion price which, is equal to the lesser of $2.08 or 85% of the average per share market value for the five (5) trading days immediately preceding the conversion date.

Series D preferred stock shares are convertible into shares of common stock at a conversion ratio equal to the stated value over the conversion price. The conversion price is equal to 85% of the market value, defined as the weighted average price of the common stock during the five (5) trading days immediately preceding the conversion date. In no event shall the conversion price be less than $0.40 per share or exceed $0.6606 per share.

The Series A preferred stock has voting rights equal to two (2) votes per share. The holders of Series B, Series C, and Series D have no voting rights.

Series A, preferred stock share holders are not entitled to dividends.

Series B and Series C preferred stock share holders are entitled to cumulative dividends of 5% per share per annum (as a percentage of stated value per share) payable in cash or shares of common stock, quarterly in arrears, but in no event later than the conversion date. Dividends on the Series B preferred stock shall accrue daily commencing on the original issue date, and shall be deemed to accrue on such date whether or not earned or declared and whether or not there are profits, surplus, or other funds of the Company legally available for payment of dividends.

Series D preferred stock share holders are entitled to a per share dividend

of the stated value of the shares times the higher of (i) the prime rate as reported by The Wall Street Journal on the first day of the month plus three (3) percent, or (ii) 8.5%. The dividend shall be paid monthly in arrears on the last day of each month in cash, and prorated for any partial month periods. The dividend shall be calculated on the basis of a 360-day year.

Series D has a preference in liquidation to the Series C, Series B, and Series A, common stock and any other capital stock of the Company. Series C, Series B and Series A have preference in liquidation to the common stock and any other capital stock of the Company. Upon liquidation or dissolution, the amount to be paid to Series D, Series C, Series B and Series A are the Series D Stated Value, Series C Stated Value, Series B Stated Value, as indicated above, and Series A at $0.80 per share.

Warrants

Warrant activity for the years ended May 31, 2008 and 2009 is summarized as follows:

	Number of Shares	Weighted Average Pri
Balance at May 31, 2007	2,254,538	$0.69
Warrants Expired	-	
Warrants Issued	4,285,714	$0.08
Balance at May 31, 2008	6,540,252	$0.29
Warrants Expired	-	
Warrants Issued	-	
Number of shares exercisable at May 31, 2009	6,540,252	$0.29

NOTE M - OPTION PLANS

1995 Stock Option Plan

In May 1995, the Company's stockholders approved the 1995 Stock Option Plan for officers and employees of the Company for which the Company reserved an aggregate of 1,500,000 shares of common stock. In December 1997, the Company's Board of Directors terminated the 1995 Stock Option Plan with respect to new option grants.

In fiscal 2009 and 2008, there was no activity under the 1995 Stock Option Plan.

Outside Director Stock Option Plan

In May 1995, the Company's stockholders approved an Outside Director Stock Option Plan (the OD Plan) for non-employee directors of the Company, for which the Company reserved an aggregate of 300,000 shares of common stock. In December 1997, the Company's Board of Directors terminated the OD Plan with respect to new option grants.

In fiscal 2009 and 2008, there was no activity under the OD Plan.

1997 Stock Option Plan

In December 1997, the Company's stockholders approved the 1997 Stock Option Plan (the 1997 Plan) for officers, directors, employees and consultants of the Company for which the Company has reserved an aggregate of 1,800,000 shares of common stock. The 1997 Plan provides that a committee of the Board of Directors of the Company will administer it and that the committee will have full authority to determine the identity of the recipients of the options and the number of shares subject to each option. Options granted under the 1997 Plan may be either incentive stock options or non-qualified stock options. The option price shall be 100% of the fair market value of the common stock on the date of the grant (or in the case of incentive stock options granted to any individual principal stockholder who owns stock possessing more than 10% of the total combined voting power of all voting stock of the Company, 110% of such fair market value). The term of any option may be fixed by the committee but in no event shall exceed ten years from the date of grant. Options are exercisable upon payment in full of the exercise price, either in cash or in common stock valued at fair market value on the date of exercise of the option. The term for which options may be granted under the 1997 Plan expired on August 6, 2007.

In January 1999, the Company's Board of Directors increased the number of shares authorized for issuance under the 1997 Plan by 1,000,000 shares to 2,800,000 shares.

In May 2006, the Board of Directors accelerated the vesting period for all unvested options to May 31, 2006.

In fiscal 2008, the Board of Directors did not grant any non-qualified stock options under the 1997 plan, and there were no options to purchase shares of common stock under the 1997 plan. In fiscal 2008, options to purchase 714,601 shares of common stock under the 1997 Plan at exercise prices ranging $0.88 to $1.91 were retired or cancelled.

In fiscal 2009, the Board of Directors did not grant any non-qualified stock options under the 1997 plan, and there were no options to purchase shares of common stock under the 1997 plan. In fiscal 2009, options to purchase 357,668 shares of common stock under the 1997 Plan at exercise prices ranging $0.88 to $1.09 were retired or cancelled.

1999 Stock Option Plan

In July 1999, the Company's Board of Directors approved the 1999 Stock Option Plan (the 1999 Plan), for which the Company reserved an aggregate of 2,000,000 shares of common stock. The 1999 Plan provides that a committee of the Board of Directors of the Company will administer it and that the committee will have full authority to determine the identity of the recipients of the options and the number of shares subject to each option. Options granted under the 1999 Plan may be either incentive stock options or non-qualified stock options. The option price shall be 100% of the fair market value of the common stock on the date of the grant (or in the case of incentive stock options granted to any individual principal stockholder who owns stock possessing more than 10% of the

total combined voting power of all voting stock of the Company, 110% of such fair market value). The term of any option may be fixed by the committee but in no event shall exceed ten years from the date of grant. Options are exercisable upon payment in full of the exercise price, either in cash or in common stock valued at fair market value on the date of exercise of the option. The term for which options may be granted under the 1999 Plan expired July 12, 2009. In July 2000, the Company's Board of Directors increased the number of shares authorized for issuance under the 1999 Plan by 1,000,000 shares to 3,000,000 shares. In December 2001, the Board of Directors of the Company increased the number of shares authorized for issuance under the 1999 Plan by 2,000,000 shares to 5,000,000 shares.

In May 2006, the Board of Directors accelerated the vesting period for all unvested options to May 31, 2006.

In fiscal 2008, the Board of Directors did not grant any non-qualified stock options under the 1999 Plan. In fiscal 2008, there were no options to purchase shares of common stock under the 1999 Plan. In fiscal 2008, options to purchase 1,006,500 shares of common stock under the 1999 Plan at exercise prices ranging from $0.20 to $5.00 were retired or cancelled.

In fiscal 2009, the Board of Directors did not grant any non-qualified stock options under the 1999 Plan. In fiscal 2009, there were no options to purchase shares of common stock under the 1999 Plan. In fiscal 2009, options to purchase 1,411,832 shares of common stock under the 1999 Plan at exercise prices ranging from $0.22 to $4.28 were retired or cancelled.

At May 31, 2009, there were 2,480,364 shares available for future grants under the 1999 Plan.

2004 Stock Option and Stock Issuance Plan

In October 2004, the Company's stockholders approved the 2004 Stock Option and Stock Issuance Plan (the 2004 Plan), for which the Company reserved an aggregate of 2,500,000 shares of common stock. The 2004 Plan is divided into two separate equity programs: (i) the Option Grant Program under which eligible persons ("Optionees") may, at the discretion of the board of directors, be granted options to purchase shares of common stock; and (ii) the Stock Issuance Program under which eligible persons ("Participants") may, at the discretion of the board or directors, be issued shares of common stock directly, either through the immediate purchase of such shares or as a bonus for services rendered to the Corporation.

Options granted under the 2004 Stock Plan shall be non-qualified or incentive stock options and the exercise price is the fair market value of the common stock on the date of grant except that for incentive stock options it shall be 110% of the fair market value if the Optionee owns 10% or more of our

common stock. The term of any option may be fixed by the board of directors or committee but in no event shall exceed ten years from the date of grant. Stock options granted under the 2004 Plan may become exercisable in one or more installments in the manner and at the time or times specified by the committee. Options are exercisable upon payment in full of the exercise price, either in cash or in common stock valued at fair market value on the date of exercise of

the option. The term for which options may be granted under the 2004 Plan expires July 12, 2014.

Under the stock issuance program, the purchase price per share shall be fixed by the board of directors or committee but cannot be less than the fair market value of the common stock on the issuance date. Payment for the shares may be made in cash or check payable to us, or for past services rendered to us and all shares of common stock issued thereunder shall vest upon issuance unless otherwise directed by the committee. The number of shares issuable is also subject to adjustments upon the occurrence of certain events, including stock dividends, stock splits, mergers, consolidations, reorganizations, recapitalizations, or other capital adjustments. The term for which shares may be issued under the 2004 Plan expires July 12, 2014.

The 2004 Plan provides that a committee of the Board of Directors of the Company will administer it and that the committee will have full authority to determine and designate the individuals who are to be granted stock options or qualify to purchase shares of common stock under the 2004 Stock Plan, the number of shares to be subject to options or to be purchased and the nature and terms of the options to be granted. The committee also has authority to interpret the 2004 Plan and to prescribe, amend and rescind the rules and regulations relating to the 2004 Plan.

In May 2006, the Board of Directors accelerated the vesting period for all unvested options to May 31, 2006.

In fiscal 2008, the Company's Board of Directors granted non-qualified stock options under the 2004 Plan to four directors to purchase an aggregate of 600,000 shares of common stock, at an exercise price of $0.12 per share (which represented the fair market value of the underlying common stock at the time of the respective grants) and the Company's Board of Directors granted 150,000 shares of common stock under the 2004 Plan to one director of the Company having a fair market value of $0.06 per share at the time of the respective grant. These options expire ten years from the date of grant. In fiscal 2008, options to purchase 236,461 shares of common stock under the 2004 Plan at exercise prices $0.57 and $0.58 were retired or cancelled.

In fiscal 2009, the Board of Directors did not grant any non-qualified stock options under the 2004 Plan. In fiscal 2009, there were no options to purchase shares of common stock under the 2004 Plan. In fiscal 2009, options to purchase 692,471 shares of common stock under the 2004 Plan at exercise prices ranging from $0.09 to $0.58 were retired or cancelled.

At May 31, 2009, there were 1,286,399 shares available for future grants under the 2004 Plan.

Stock option activity under all the plans for the years ended May 31, 2008 and 2009 is summarized as follows:

		Outstanding Options		
	Shares Available for Grant	Number of Shares	Range of Exercise Price per Share	Weighte Average Ex Price
Balance at May 31, 2007	1,697,859	6,592,338	$0.20 - $5.00	$1.04
Common Shares Granted	(150,000)			
Options Granted	(600,000)	600,000	$0.12	$0.12
Options cancelled	714,601	(1,737,128)	$0.20 - $3.96	$1.29

Balance at May 31, 2008	1,662,460	5,455,210	$0.09 - $4.28	$0.86
Options cancelled	2,104,303	(2,461,971)	$0.09 - $4.28	$0.99
Balance at May 31, 2009	3,766,763	2,993,239	$0.09 - $3.96	$0.74

The following table summarizes information about stock options outstanding and exercisable at May 31, 2009:

	Options Outstanding			
Range of Exercise Prices	Number Outstanding at May 31, 2009	Weighted Average Remaining Contractual Life (yrs.)	Weighted Average Exercise Price	Ex M
$0.09 - $0.58	1,729,239	7.1	$0.14	
$0.71 - $0.95	320,000	4.1	$0.24	
$1.00 - $1.31	690,000	2.3	$0.44	
$1.69 - $2.49	10,000	0.1	$1.69	
$2.91 - $3.96	244,000	2	$3.50	
	2,993,239	5.3	$0.74	

The weighted-average fair value exercise price of options and warrants granted during fiscal years 2008 was $0.08. At May 31, 2009, there were no remaining authorized shares of common stock after reserves for all stock option plans and stock warrants.

NOTE N - INCOME TAXES

During fiscal 2009 and 2008, the Company recorded a provision for income taxes of $5,875 and $18,045, respectively.

As of May 31, 2009, the recorded deferred tax assets were $20,336,652, reflecting an increase of $517,300 during the fiscal year ended May 31, 2009, which was offset by a valuation allowance of the same amount.

The Company's deferred tax assets (liabilities) are summarized as follows:

	2009	2008
Net operating loss carryforwards	20,123,742	19,422,422
Depreciation and amortization	(16,110)	(17,900)
Deferred rent	5,450	2,940
Deferred gain on sale of building	57,330	75,430
Gain on sale of asset	-	(31,110)
Cost of goods sold	-	98,980
Allowance for doubtful accounts	32,290	91,860
Reserve for obsolete inventory	133,950	176,730

Total gross deferred tax assets	20,336,652	19,819,352
Valuation allowance	(20,336,652)	(19,819,352)
Net deferred tax assets	-	-

At May 31, 2009, the Company had net operating loss carryforwards for Federal and state income tax purposes of approximately $53,411,000, expiring at various dates from 2010 through 2029. In fiscal 2009, $470,994 of net operating loss carryforwards expired. Future expirations of net operating loss carryforwards are as follows:

Fiscal Year	Amount
2010	$ 2,454,009
2011	5,449,010
2012	6,084,026
2013	4,386,716
2014	-
Thereafter	35,037,459
Total	$ 53,411,220

The components of income tax benefit for the years ended May 31, 2009 and 2008 are as follows:

	2009	2008
Federal	$ 496,608	$ 138,000
State	20,692	92,000
	$ 517,300	$ 230,000

Under current tax law, the utilization of tax attributes will be restricted if an ownership change, as defined, were to occur. Section 382 of the Internal Revenue Code provides, in general, that if an "ownership change" occurs with respect to a corporation with net operating and other loss carryforwards, such carryforwards will be available to offset taxable income in each taxable year after the ownership change only up to the "Section 382 Limitation" for each year (generally, the product of the fair market value of the corporation's stock at the time of the ownership change, with certain adjustments, and a specified long-term tax-exempt bond rate at such time). The Company's ability to use its loss carryforwards will be limited in the event of an ownership change.

The following is a reconciliation of the effective income tax rate to the federal statutory rate:

	2009 %	2008 %
Federal statutory rate	(34.0)	(34.0)
State taxes, net	0.0	2.7
Permanent differences	0.0	1.8
Change in valuation allowance relating to operations	34.0	28.6
Other	0.0	(1.8)
	0.0	2.7

NOTE O - COMMITMENTS AND CONTINGENCIES

Leases

On August 15, 2007, we sold our facility under a five-year leaseback agreement. Future rental payments under the operating lease are as follows:

For the years ended:

May 31, 2010	$ 148,488
May 31, 2011	154,427
May 31, 2012	160,604
May 31, 2013	40,541
Total	$ 504,060

Litigation

The Company is currently, and has been in the past, a party to various routine legal proceedings incident to the ordinary course of business. The Company believes that the outcome of all such pending legal proceedings in the aggregate is unlikely to have a material adverse effect on the business or consolidated financial condition of the Company.

NOTE P - 401(K) PLAN

In April 1997, the Company adopted the Vasomedical, Inc. 401(k) Plan to provide retirement benefits for its employees. As allowed under Section 401(k) of the Internal Revenue Code, the plan provides tax-deferred salary deductions for eligible employees. Employees are eligible to participate in the next quarter enrollment period after employment. Participants may make voluntary contributions to the plan up to 15% of their compensation. In fiscal year 2009 and 2008, the Company made discretionary contributions of approximately $9,850 and $9,000, respectively, to match a percentage of employee contributions.