Adaptimmune Therapeutics
Second Quarter 2024 Conference Call Transcript

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Presenters:

Dan Od-Cohen
Investor Relations

Adrian Rawcliffe
Chief Executive Officer

Cintia Piccina
Chief Commercial Officer

Joanna Brewer
Chief Scientific Officer

Dennis Williams
Senior Vice President, Late-Stage Development

John Lunger
Chief Patient Supply Officer

Dr. Elliot Norry
Chief Medical Officer

Operator:
Good day and welcome to the Adaptimmune Second Quarter 2024 Conference Call.

All participants will be in a listen-only mode. Should you need assistance, please signal a conference specialist by pressing the star key followed by zero. After today's presentation, there will be an opportunity to ask question. To ask a question, you may press star, then one, on a touch-tone phone. To withdraw your question, please press star, then two. Please note, this event is being recorded.

I would now like to turn the conference over to Dan Od-Cohen, Investor Relations. Please go ahead.

Dan Od-Cohen:
Thank you, Operator. Good morning and welcome to Adaptimmune's conference call to discuss our second quarter 2024 financial results and business updates.

I would ask you to review the full text of our forward-looking statements from this morning's press release. We anticipate making projections during this call, and actual results could differ materially due to several factors, including those outlined in our latest filings with the SEC.

Adrian Rawcliffe, our Chief Executive Officer, is here with me for the prepared portion of the call, and other members of our leadership team will be available for Q&A.

With that, I'll turn the call over to Adrian Rawcliffe. Ad?

Adrian Rawcliffe:
Thanks, Dan, and thanks everyone for joining us.

We are incredibly proud that Adaptimmune is now a commercial-stage cell therapy company following the U.S. FDA approval and the launch of our first product in our sarcoma franchise, Tecelra. This is a fantastic achievement for the Company, for the cell therapy field and for people with synovial sarcoma.

Tecelra is the first engineered cell therapy for a solid tumor, the first medicine in its class. It's also the first new treatment option for synovial sarcoma in over a decade and the culmination of groundbreaking R&D, our investment in manufacturing, the demonstrable clinical benefit exhibited throughout development, and incredible execution of the regulatory process.

Tecelra is a vindication of autologous cell therapy for solid tumor cancers, and together with the synovial sarcoma community, we're going to redefine how synovial sarcoma is treated.

Launch activities for Tecelra started the instant we received approval, and we hit the ground running. I want to provide some updates on how Tecelra's launch is going, bearing in mind that we're only 10 days in.

As synovial sarcoma is a rare disease, treatment is concentrated in sarcoma centres of excellence. We've already recruited, trained and deployed a commercial footprint to deliver Tecelra to people with sarcoma. Our commercial, med affairs, manufacturing and supply teams are all in place and engaging patients, physicians, payers and treatment centres.

The companion diagnostics HLA and MAGE-A4 testing were approved concurrently with Tecelra, so healthcare providers can arrange for patients to get tested to establish their biomarker eligibility. Incidentally, we believe this is the first time that a therapy has been approved together with two new diagnostics at the same time.

AdaptimmuneAssist, our patient support program, is up and running to ensure a personalized experience throughout the treatment journey, and we've previously discussed our plans to activate 6 to 10 authorized treatment centres during Tecelra's launch periods. We are on track to do this. We have five ATCs available in our locator tool on the tecelra.com website, and all of our internal systems are in place to accept orders and to manufacture and deliver Tecelra.

Over the next few quarters, and prior to having trends for patients treated and for sales, we'll be updating you on two key performance indicators for launch execution as we go forward: firstly, the number of ATCs opened, and secondly, the number of patients apheresed. As we move through the first half of next year, we will transition to patients treated and, obviously, to sales as the key metrics.

Moving on to the positioning of Adaptimmune beyond the launch of Tecelra, I want to touch a little on our balance sheet and our pipeline.

At the end of Q1 this year, we had approximately $144 million in total liquidity and runway guidance into late 2025. During Q2, we signed a collaboration agreement with Galapagos and entered into a debt facility with Hercules. At the end of the quarter, we have total liquidity of $215 million. We believe we are well capitalized to deliver the successful launch of Tecelra and also develop the rest of the pipeline.

As we transition into a commercial cell therapy company, we will move away from extending cash runway guidance, given the complexities of estimating future revenues in the near term as we establish our sarcoma franchise; and instead, we'll provide high-level forward cost guidance alongside regular updates on the commercialization progress.

In the first half of this year, our total expenditure was approximately $114 million. This included investments preparing for the launch of Tecelra, as well as hiring and onboarding the commercial team. For the next 18 months, we expect our run rate operating expenses to be broadly consistent with that to the first half of 2024. We will update this cost guidance as we progress, together with the launch metrics that I previously articulated, namely the number of ATCs and the number of patients apheresed.

Moving on to our pipeline, we are progressing our clinical pipeline with the second product in our sarcoma franchise, lete-cel, expanding the number of sarcoma patients we can treat with our cell therapies. Lete-cel is clinically derisked as the pivotal trial IGNYTE-ESO has already met the primary endpoint of efficacy at the interim analysis. This was presented earlier this year at ASCO by Dr. Sandra D'Angelo.

Lete-cel's regulatory pathway will build on our experience with Tecelra's regulatory submission. And as lete-cel also targets soft-tissue sarcomas, the commercial footprint is essentially identical to Tecelra's, and we expect significant channel synergies once we launch lete-cel.

We're also progressing uza-cel, our next-generation cell therapy, in the SURPASS-3 trial in ovarian cancer, which is currently enrolling. We'll be moving forward in partnership with

Galapagos in a head and neck cancer Phase 1 trial with uza-cel on Galapagos' distributed manufacturing platform.

We are an integrated cell therapy company built from the ground up to design, develop and deliver cell therapy products to redefine the treatment of solid tumor cancers, and we are now realizing this vision in real time.

With that, myself and members of the leadership team are happy to take any questions. Operator?

Operator:
We will now begin the question-and-answer session. To ask a question you may press star, then one, on your touch-tone phone. If you are using a speaker phone, please pick up your handset before pressing the keys. If at any time your question been addressed and you would like to withdraw your question, please press star, then two. At this time, we will pause momentarily to assemble our roster.

The first question today comes from Marc Frahm with TD Cowen. Please go ahead.

Marc Frahm:
Hi. Thanks for taking my questions.

Maybe just to start out, you mentioned that you've got a few ATCs already loaded on the website. Are you seeing patients flow through that website? Maybe could you characterize any new sources of patients that you're seeing in terms of referrals and things like that? I know it's very early days, but just anything you're seeing there.

Adrian Rawcliffe:
Thanks, Marc. I'll ask Cintia Piccina to give you an update on early, early patient flows, etc.

Cintia Piccina:
Yes. Thank you for the question. It is really very exciting to see the enthusiasm from not only our treatment centres and future treatment centres as well, but also beyond and across other sarcoma centres of excellence. Now with the approval, they're very excited to be able to treat

patients. We are aware of patients that started the testing journey. They're in that process of identifying their eligibility for Tecelra, and the majority of the new sources that we're seeing in terms of questions and interest and having potential patients to refer to the ATCs are coming from other sarcoma centres of excellence across the country.

Marc Frahm:
Okay. Thank you.

Adrian Rawcliffe:
Cheers, Marc.

Operator:
The next question comes from Jonathan Chang with Leerink Partners. Please go ahead.

Matt Cowper:
This is Matt Cowper on for Jonathan Chang. Thanks for taking my question.

Could you comment on how the first version of ADP-600 stands out within the PRAME targeted space? Additionally, will the initial clinical version incorporate next-generation enhancements like CD8, or will those be reserved for future iteration? If so, would introducing enhancements be stepwise and similar to the MAGE experience? Thanks.

Adrian Rawcliffe:
I'm going to ask Jo Brewer, our Chief Scientific Officer, to talk to that. Jo?

Joanna Brewer:
Hi. Thanks. Yes, so we are looking at next-gen approaches with our ADP-600 program. We are evaluating several in research, and we're looking at how we can bring those forward to the clinic. We will update on more firm plans with the ADP-600 program in the future.

Matt Cowper:
All right. Thank you.

Operator:
The next question comes from Michael Schmidt with Guggenheim. Please go ahead.

Paul:
This is Paul on for Michael. Thanks for taking the question.

On the ATCs for Tecelra, it looks like the five active sites you've put on the website overlap with those that have afami-cel clinical trial experience. Can you speak to roughly what proportion of synovial sarcoma patients are seen in those particular centres? And then how long until the remaining 6 to 10 that you're targeting for initial sites are onboarded? Can you also comment on expectations for patient capacity in terms of perhaps treated patients per centre, I guess, on a monthly basis? Thank you.

Adrian Rawcliffe:
Cintia.

Cintia Piccina:
Thank you for your question. We are planning to onboard over time, getting to 30 ATCs. These ATCs in total represent about 80% of the patients that are in the sarcoma centres of excellence today, which we believe to be about 50% to 70% of all the patients with synovial sarcoma that are across the country.

The ones that we have in our locator tool already and the ones that are next in line in the process of finalizing their onboarding are most of them clinic trial sites for afami-cel, and they are the ones that we are planning to be the first ones that will be up and running. They already have experience. We started engaging with them several months ago. And then beyond that, some of the other ATCs would be lete-cel sites and then some others beyond just based on the volume of patients that they see.

Adrian Rawcliffe:
We've not given guidance into how many patients go through each site on a monthly basis, and it does vary somewhat depending on which site it is.

Cintia Piccina:
We expect also that referral base to grow and change significantly now that there is a treatment available for synovial sarcoma at those specific sites. So as we see that volume coming in, we'll see that being reflected in our numbers.

Paul:
Got it. Great. Thank you. Then, perhaps just a quick follow-up. You mentioned that patients don't necessarily have to be tested at the treatment centre. Do you have full visibility into sort of real-time testing metrics? How many patients are ID-ed that might be appropriate for treatments? Is it possible to provide, I guess, qualitative updates on that metric? Thank you.

Cintia Piccina:
The testing is approved and it's available commercially. They are run by labs that are independent labs that we don't really manage or control. We are going to have visibility to part of the testing metrics, but we don't have visibility to the full number of patients that are being tested. So for that reason, we're not going to be providing accurate testing numbers because we don't know what they are. We don't have a way to know what they are specifically.

We hear anecdotal information. That's why I shared that we are aware of patients that are in the testing process, but we're not aware of all of them. Some of them, when the treatment sites or the centres of excellence share with us, then we are aware of what's happening.

The testing can happen from anywhere. We did provide in our tecelra.com website the path to testing for both MAGE-A4 and HLA as well. At the moment that, that testing is initiated, then the labs will take over. We just send it to the labs.

Operator:
The next question comes from Tony Butler with Rodman & Renshaw. Please go ahead.

Tony, your line is open. You may ask your question.

Tony Butler:
Thank you very much. Adrian, I wanted to move to SURPASS-3 for a moment. ClinicalTrials.gov suggests that 28 sites have been identified. What's interesting, though, is roughly maybe even

slightly less than a third are in the U.S.; the majority, ex-U.S. I assume that's somewhat strategic, but I guess the question is will more U.S. sites be opened? Any thoughts around that? It may not necessarily matter, but the rate of enrollment is kind of important. Then the part two of this question is, I would assume, and this is just an assumption, that given the ramp in the trial costs, if in fact more sites were to be open and, in fact, the $114 million or, let's call it, $230 million a year roughly in costs would actually ramp, maybe not appreciably, but certainly ramp higher than the guidance you've given. Any colour would be help. Thanks.

Adrian Rawcliffe:
Yes, thanks. So why don't I take a stab at that, and if you have follow-up questions, we can do that, too.

The majority of the sites that are going to be open for SURPASS-3 are already open. And you're right, there are a significant number of sites ex-U.S., and that mirrors the pattern that we've had quite a lot of success recruiting, both in the U.S. and ex-U.S. Just a reminder, we're working with the Gynecological Oncology Group, GOG, to recruit the SURPASS-3 trial. Enrollment is going well at the moment, and we look forward to being able to complete enrollment next year and provide data subsequent to that. So, that's going well.

In terms of the cost, the overall cost profile that I gave is a mix of—what you've got to think about is there's also the costs of SURPASS-3, which is up and running and ongoing and a significant trial, but also, there's been the historic costs over 2023 and '24 of, for example, the SPEARHEAD set of trials associated with the approval of Tecelra. Then also, of course, we've got to factor in the ongoing IGNYTE-ESO trial and the costs associated with that now we've taken that over from GSK. That's why we're comfortable with the position that our overall run rate will remain relatively consistent. That includes the fact that we've already recruited and made the investments in the commercial team in the first half of this year. That's why we believe that the cost will be broadly consistent going forward for the next 18 months.

Tony Butler:
Thanks, Adrian. Appreciate it.

Adrian Rawcliffe:
Cheers, Tony.

Operator:
The next question comes from Graig Suvannavejh with Mizuho. Please go ahead.

Graig, your line is open. You may now ask your question.

Graig Suvannavejh:
Good morning. Sorry about that. Thanks for taking my questions and let me congratulate, Ad, you and the team on the approval. It's great achievement for the company and for patients as well.

Adrian Rawcliffe:
Thanks, Graig.

Graig Suvannavejh:
A couple of questions, if I could. Maybe the first question on your sales and projection of $400 million. I realize that's for the sarcoma franchise and I realize that's for the U.S. Any colour on how we should think about between the two products that you have, realizing that lete-cel is not yet approved, but how you think about potentially the split of revenue between those two products?

My second question, maybe it is one that you might be reticent to comment on, but just your level of comfort with how the Street is currently modelling the launch and revenue over the next, let's call it, six quarters as we look at the back half of this year and 2025. I realize that you've been trying to guide us to be relatively gradual in how we think that's going to be, but just wondering if you had an opportunity just to see kind of where the Street is and whether you think we are doing a good job with that kind of more gradual approach.

Adrian Rawcliffe:
Thanks, Graig.

With respect to the breakdown of the peak U.S. sales estimate for the launch indications for our sarcoma franchise of $400 million, the best way of thinking about that is that the patient split is roughly 40% afami-cel, 60% lete-cel; so 40% Tecelra, 60% lete-cel. So the split of that peak year sales estimate, broadly speaking, follows that.

On your second point, I think the key thing that we've been keen to ensure is that whatever you think the ramp-up of the sales for Tecelra is—and I think you'll appreciate I'm not going to comment specifically on the analyst expectations, although I am pleased to see that people have sort of been paying attention over the last six months or so to the opportunity here. Whatever you think that ramp-up is, I think it's important to recognize that it is frame-shifted by two to three months from the launch date. That's the most important thing to get right in the short term and I think by and large people have done, with first sales recognized in Q4 this year and those being relatively modest, representing the very front end of the patients as they flow through the identification and manufacturing and then get treated in the quarter after launch. That's the biggest thing that I think has changed, and I do think the analyst community has picked up on that, that frame shift into Q4 this year.

Graig Suvannavejh:
Okay. Thank you. Then if I could ask one more…

Adrian Rawcliffe:
Please.

Graig Suvannavejh:
Just on lete-cel, you might have mentioned this in your prepared comments. I might have missed it, but what are the gating steps for that BLA submission? And maybe just a follow-up? Are you anticipating that we will see additional data on lete-cel before you file, or is the data, from your perspective, already out there, and pretty much we have basically a view of the data that are available for the product? Thanks.

Adrian Rawcliffe:
Thanks, Graig. I'll ask Dennis Williams to comment on those questions. Dennis?

Dennis Williams:
Sure. I would say that for lete-cel, it follows the exact same regulatory pathway that we did for Tecelra. We need a companion diagnostic. We need to supply the clinical data from IGNYTE-ESO, CMC information. Basically, we'll follow the exact same paradigm that we did for Tecelra.

I will say that we are looking forward to presenting primary data from the IGNYTE-ESO trial later this calendar year.

Graig Suvannavejh:
Okay. Thank you very much. Congratulations again on all of the achievements and progress.

Adrian Rawcliffe:
Thanks, Graig.

Operator:
The next question comes from George Farmer with Scotiabank. Please go ahead.

George Farmer:
Hi. Great. Thanks for taking the questions.

Just wanted to ask about the absence of MRCLS on the label for Tecelra. Wondering what sort of conversations went on with the FDA, and does that really matter? Certainly, you have lete-cel coming up.

Then also with lete-cel, I believe that the product is manufactured in the U.K. Is that where commercial material will ultimately be originating from and are there efforts underway to bring manufacturing over to the U.S.?

Adrian Rawcliffe:
I'm going to ask Dennis to talk about the label for and the data for Tecelra from the SPEARHEAD-1 trial and the MRCLS portion of that. Then I'm going to ask John Lunger to talk about the manufacturing for lete-cel for the approval and launch. Dennis?

Dennis Williams:
Yes, sure. We made the decision to not pursue myxoid/round cell liposarcoma as a labeled indication some time ago, and it really came down to the fact that the trial, SPEARHEAD-1, was overwhelmingly synovial sarcoma. So it would be challenging, I think, for a regulatory review to have such limited patient numbers. There were only eight patients with myxoid/round cell

liposarcoma treated in the trial and we just thought that it would add a lot of regulatory burden to an application where we really wanted to get the approval in synovial sarcoma.

As you mentioned, right now that we have lete-cel, this is less of a concern for us. Lete-cel, the NY-ESO-1 expression in myxoid/round cell liposarcoma is much higher than MAGE-A4 expression in myxoid/round cell liposarcoma. So, from a target perspective, lete-cel is, where expression is north of 80% of that population, is a much more appropriate target to pursue for that indication.

John?

John Lunger:
Yes. Hi. As far as the manufacturing of lete-cel, the actual manufacturing that was primarily done for the IGNYTE trial was in a contract manufacturer in Germany, not the U.K. As you can imagine, our primary objective is speed to market for lete-cel and so making changes to the supply chain related to that particular filing is probably a risk that we don't necessarily want to take. However, we are looking at adding a U.S. site, whether that's our own or another CDMO, for the future to the lete-cel supply chain to better enable to supply into the States.

George Farmer:
Great. Thanks for that and congratulations on all the progress.

Adrian Rawcliffe:
Thanks, George.

Operator:
The next question comes from Arthur He with H.C. Wainwright. Please go ahead.

Arthur He:
Hey, good morning, team. Thanks for taking my questions.

I have two questions. First, thanks for the update on the onboarding for the ATCs. But at the same time, just curious, could you guys give us the onboarding progress for those centres of

excellence as a referral network? How should we think about those things to support the launch?

Adrian Rawcliffe:
Cintia?

Cintia Piccina:
Sure. Yes, we do have a lot of activity going on with the sites that will eventually become authorized treatment centres and also to the sarcoma centres of excellence that will be referring patients to the future ATCs. So, our field teams across both medical affairs and commercial target both the future ATCs and current ATCs and beyond. That work already started in terms of educating the broader sarcoma centres of excellence into the new biomarkers, the importance of testing patients as early as possible, and then into referring the patients that are positive to both biomarkers to the treatment sites. That work started with our field teams, and we'll see these referrals already started to come in through the ATCs.

Arthur He:
Awesome. Thanks, Cintia. My second question is regarding the lete-cel. Before you guys submit the rolling submission or BLA, do you see a need to meet with the FDA? If so, when or at what circumstance you can request the meeting?

Adrian Rawcliffe:
Dennis?

Dennis Williams:
Yes, sure. We've already had meetings with the FDA, and we will continue to have meetings with the FDA. This is really the advantage of having, in this case, lete-cel has breakthrough therapy designation and one of the main advantages of that is to have frequent interactions with regulatory agencies. We'll be talking about a lot of things related to the rolling submission, how the application should be organized.

Some of this, to be fair, like an earlier comment, some of what we'll do with lete-cel is a bit of, excuse the expression, rinse and repeat of what we did with Tecelra, but there are definitely some things that are unique, right? There's two different populations in this dataset. And as

John mentioned about the supply chain aspect, so there are some differences, but in general, I would expect to have many meetings between now and the submission of the rolling BLA next year.

Arthur He:
Great. Thanks, guys. Talk to you guys soon.

Adrian Rawcliffe:
Thanks.

Operator:
The next question comes from Yanan Zhu with Wells Fargo. Please go ahead.

Kuan-Hung Lin:
Hi. Thanks for taking our question. Congrats on the progress. This is Kuan-Hung for Yanan. Can you share with us the overall timeline from patient screening to the infusion? Roughly how long does it take, and which part of the process can be accelerated? Thank you.

Adrian Rawcliffe:
Cintia?

Cintia Piccina:
Sure. The timelines between patient screening and infusion, over time, the testing can take a few weeks if you do both tests in parallel. Then from the time in which the apheresis takes place all the way until the infusion can be received back into the site or to the patient, it takes about 30 days.

At the beginning of this process, because the testing just got approved and we have to go also through reimbursement journey and the referral pattern from the beginning, we believe that the first patient is going to take a little bit longer into the whole process, can get more on a faster pace. That's why we are anticipating to be able to treat our first patients in the first quarter of the year.

Kuan-Hung Lin:
Got it. Thank you so much for that. When do you expect to have broad payer coverage? Thank you.

Cintia Piccina:
Right now, in terms of Medicare, it's already available. It's covered. For commercial patients, we expect similar coverage than what we see for CAR-Ts. At the beginning, it usually is through a single-case negotiation with the payers until a policy is established. But it doesn't mean that we don't have coverage, only that it can take a little bit longer because it will be through single-case agreements until we are established moving forward. We expect to have good coverage at the beginning; it may take just a little longer.

Kuan-Hung Lin:
Thank you so much for all the colour.

Adrian Rawcliffe:
Thanks.

Operator:
The next question comes from Michael Kim with Zacks Small Cap Research. Please go ahead.

Michael Kim:
Hey everyone, good morning and thanks for taking my questions.

First, just assuming similar pricing and penetration rates for Tecelra and lete-cel, my math suggests peak sales of $400 million translates into roughly about a 50% to 55% market penetration rate. Just wondering if you could maybe provide some colour on sort of the underlying drivers behind your thinking.

Adrian Rawcliffe:
Yes. Cintia?

Cintia Piccina:
A couple of thoughts. First, I think that the penetration rate for lete-cel is hopefully going to be faster, so the uptake faster because a lot of the treatment sites will be opened and have experienced with the testing and with having the patients being referred to and treated, so I would expect that to be greater.

The assumption in terms of potential number of patients is given more so by the eligibility based on HLA-A2 and then the MAGE-A4 and the NY-ESO expression in both tumor types. The assumptions beyond that are really mostly assuming similar access rates than other products in the space and similar manufacturing success rates as we've seen in our clinical trials.

Michael Kim:
Got it. Okay. That's helpful. Then maybe just a second question. Appreciate your updated guidance on expenses over the next 18 months, and I know you guys have done a good job in terms of scaling up your sales infrastructure ahead of Tecelra approval. Just curious if your guidance includes the R&D funding from Galapagos. And then any updates on sort of the anticipated timeline for starting the proof-of-concept trial?

Adrian Rawcliffe:
Maybe I'll cover that briefly. We've not included in that expense guidance the revenue sources that offset expenses in that context. You'll look back on our filings and you'll see that there are elements for both partnership income and R&D tax credits and things like that, that offset those expenses, so that's not included.

In terms of the timing, we've not updating beyond what we said at the time of the partnership with Galapagos, which is that we anticipate going into the clinic in head and neck as soon as humanly possible and that we're working with Galapagos to enable that.

Michael Kim:
Understood. Thanks for taking my questions.

Adrian Rawcliffe:
Thanks.

Operator:
The next question comes from Peter Lawson with Barclays. Please go ahead.

Alexandre Bouilloux:
Good morning. This is Alex on for Peter. Thank you for taking our questions.

You previously talked about the possibility to do an interim analysis in the SURPASS-3 study. Just wondering if you could remind us kind of the timing for that and the gating factors for that in the study. Thank you.

Adrian Rawcliffe:
Elliot, do you want to talk about interim reads on SURPASS-3?

Elliot Norry:
Yes, just very briefly. We do anticipate interim analyses that are built into the trial at certain junctures, the first one being after 13 patients are dosed in each arm. We have not provided specific guidance as to the timeline for that. But I also want to just advise that when we see that interim analysis, it will not lead us to disclose clinical data until the entire study has been enrolled in that it has the potential to be registration-enabling and we wouldn't want to put out clinical data that could bias the trial.

Adrian Rawcliffe:
That enrollment, full enrollment, we anticipate happening next year.

Alexandre Bouilloux:
Great. Thank you.

Adrian Rawcliffe:
Thanks.

Operator:
This concludes the question-and-answer session. I would like to turn the conference back over for any closing remarks.

Adrian Rawcliffe:

Thank you everyone for your time today and your questions. We look forward to updating you as we progress the launch of Tecelra and, of course, the development of the rest of the pipeline to redefine how cancer is treated with cell therapies. Please don't hesitate to follow up if you would like to discuss anything further and have a great day. Cheers.

Operator:

The conference has now concluded. Thank you for attending today’s presentation. You may now disconnect.