
MANAGEMENT DISCUSSION SECTION**David Young, Chief Scientific Officer**

Hi. My name is David Young. I'm the Chief Scientific Officer for Questcor Pharmaceuticals, and what I'd like to do is share with you what's going on with Questcor. The Safe Harbor statement, I'm sure you all can read it at your leisure and so I'll skip over that part .

Just to give you an overview, Questcor is a biopharmaceutical company, whose product to patients – whose products help patients with serious and difficult to treat medical conditions, many of them unmet medical needs. Our main product, as many of you know, is Acthar. Acthar is our flagship product. Right now there are 19 approved indications for Acthar. The main ones are multiple sclerosis, infantile spasms and nephrotic syndrome, and their combined market opportunity exceeds \$1.5 billion.

Our strategy all along has been to sell more Acthar. That's our key market message. That's the message we tell our sales reps, that's the message we share with everybody because everybody knows it's sell more Acthar.

Our financial summary is that we're profitable, we're cash flow positive. We have \$127 million in cash and we're debt free.

Briefly, the history of Acthar. Acthar was first approved by the Food and Drug Administration in 1952. It was a DESI product. So in 1970s, early 1970s, it was approved as a DESI product, and it had the label from the 1950s and carried over into modern day. In 1978, though, there was new indication for MS flares, which was added to the label based on clinical studies. And in 2001, Questcor acquired Acthar.

In 2007, as many of you know, we had a major change in our strategy. We went from a typical drug to an orphan pricing structure. And then in 2002, we had the sNDA for infantile spasms, which was approved in October 2010. And during that time we modernized the label, got rid of indications, improved the label, and now we only have 19 indications.

There are significant barriers to the entry of generics or biosimilars to the market for Acthar and the first one we have is the formulation. Acthar is a biologic; it is extracted from the pituitary of pigs. There's an undisclosed procedure for the extraction, an undisclosed composition. In addition, when we actually manufacture the final product, the process to manufacture the final product is very complex, again, trade secret, proprietary, and the final product composition is also unknown by other people than us.

In terms of regulatory, if in fact somebody would try to come on the market as a generic or a biosimilar, this would be very difficult given the chemistry is unknown, also the pharmacology is very complex. And so in order to move forward they would need – actually need to have clinical trials, which again, is another hurdle or barrier.

In addition, from a business point of view, new patents for them are unlikely. It's an old product, it's – a lot is known about ACTH itself. There's limited exclusivity for them because if they were to move forward and try to mimic us, they'd probably only get three years exclusivity at the most, if any. And right now, we have multiple sources of revenue, multiple sclerosis, infantile spasms and we're growing in NS. Right now we have seven years of exclusivity for IS based on this 2010 approval in October.

Our growth engine really comes from three areas: one is multiple sclerosis, second, infantile spasms and the third is nephrotic syndrome. Let me quickly cover some of these so you understand where we're coming from.

In terms of multiple sclerosis, our sales potential is \$500 million to \$2 billion plus. What we sell right now is about \$65 million of sales in multiple sclerosis. Now this is the flares only, because that's really our market. In infantile spasms, which was approved in, again, in 2010, the market is approximately \$100 million and we sell about – our revenue is about \$40 million.

In nephrotic syndrome, which is also on-label, the potential is over \$1 billion and we're only selling right now \$300 million (sic) [\$3 million], that's our revenue from that. And then the other indications that are on-label, again, the revenue potential is about \$1 billion or more and we're only selling about \$5 million a year.

Let me briefly talk about MS, Acthar's use in MS. MS is neurodegenerative disorder, as you know. What we do is we treat the relapse or the flares that occur in MS. We're not treating MS in general. We're not a disease-modifying agent for MS. We actually treat the flares themselves. We dose for approximately one to two weeks. And our revenue during that time – the number of prescriptions and the revenue associated with that is about \$40,000 to \$50,000 per prescription.

The type of patients we're treating actually are a little different than all the other compounds that exist on the market right now. We're treating patients who – in which steroids are not suitable. That means steroids are inadequate for treatment. In other words, they get no response, you have poor venous access, you have too many side effects, or problematic side effects or they just don't want to take the drug, they don't want to take an intravenous drug. So these are the patients who really Acthar's directed to in terms of the market.

Our MS sales have recorded a constant growth since we've changed the price. And as you can see, well, down here – it's kind of hard because this number's off here, this is actually an eight here. So in 2008 we had eight sales reps and it increased, we had 24 Rxs and then 35. We increased it to 15, as you can see. As time went on, we increased the sales reps from 8, 15, 30, 38, and now we have 77. And continually as we increase the reps and as the reps get more used to selling the product, we've had a continual increase in prescriptions prescribed all the way up to 354, with our present sale reps of 77, who just joined in November or just got on the floor actually selling in November of 2010. So the fourth quarter of 2010 doesn't even represent a full quarter from the selling aspect, but you can see that the scripts have continually increased.

In terms of multiple sclerosis, the premise is approximately 400,000 patients. There are approximately 200,000 to 250,000 relapses annually for MS patients and of that 200,000 to 250,000, approximately 10,000 to 70,000 patients who relapse or who have these flares are estimated to be in the market for Acthar. These are ones who are – can't take steroids or won't take steroids. And of those 10,000 to 70,000 patients, approximately 1,400 patients presently, currently receive Acthar. So as you can see, if we take 1,400 patients and go up to a potential of 10,000 to 70,000, the amount of the market potential for us is enormous. And again, the potential market would be approximately \$500 million to over \$2 billion for this full 10,000 to 70,000 patient population.

The trends in MS are very good. In the Q4 2010 results, Q4 '10 we had new paid Rxs of up 66% over Q4 '09. MS sales were over 50% of our sales in Questcor, over \$65 million annualized run rate. And approximately one in six Rxs is a repeat patient, because flares repeat every 15 or so months.

We have a growing number of Acthar prescribers. Out of 8,000 neurologists, approximately 400 actually prescribe Acthar. So you can see there's a large area of physicians that we have

opportunity to grow – for growth. And we're expanding our speaker's bureau, which helps to share the information about Acthar and its use in MS flares.

In terms of MS sales calls, this is the sales calls plotted over time since September in '08. And you can see that we continue to have more sales calls and a lot of these bumps here are because we added more reps and then of course there's an increase in sales calls, we added more reps, an increase in sales calls. And this last one over here at this end was because, again, holidays. We added more sales reps, but in November, December, there were holidays.

If you look at the corresponding prescriptions written, there's a continual increase in prescriptions with the sales reps, and you can see the continual increase. There's some variability, of course, that you expect month-to-month or quarter-to-quarter, but we have a continual increase in sales at the end of 2010.

As you know, we had a sales force expansion in 2010, and again, that was 77 reps on the street in November of 2010. We doubled that sales force from the 38 that existed before. The sales force really are geared towards MS physicians and spending some time with child neurologists, but the majority of the time – 80% of the time is really with the MS treating neurologists and that's the real target.

The MS paid Rx's have increased since November 1st, since these reps have been on the street. November matched previous monthly records, December set a new record, and then January was a near previous record. And then in February we set a new record again. So we see this, what we think is a positive result with the sales force in that January was – had good results, February was even better. But as you know, sales reps, it often takes three to six months for them to get going in their new areas and so we expect to see better results as we move forward.

Infantile spasms is the other indication that we have and that's the one that was just recently approved. Infantile spasms is a devastating, refractory form of childhood epilepsy. The development of the child, if they have infantile spasms and are not properly treated, is devastating and in fact can lead to death. Most of these patients are not responsive to standard anti-epileptic drugs.

This is an ultra-rare orphan disorder, about 1,500 to 2,000 patients annually, and it's typically in children less than two years of age. It's characterized by what's called spasms in the children and hypsarrhythmia, which is very abnormal EEG patterns.

Acthar is the gold standard and is the gold standard for infantile spasms. It's been used since 1958 in infantile spasms and right now about half of the child neurologists prescribe Acthar for any patient who has infantile spasms. Again, it was approved in October of 2010, with a seven-year exclusivity because it's an orphan indication. It really is an emergency treatment for these patients, so it's important that we get the drug to them very quickly. And they're treated for about two to four weeks depending on the patients.

In a random – just so you understand the difference between our drug and anything else out on the market, in a randomized, single-blinded control study, 87% of the patients responded who had infantile spasms. And that was an overall response, so it stopped the spasms and stopped the hypsarrhythmia over two weeks versus 29% on prednisone. So we have a very large improvement in the outcome of the patient. Typically these patients have, again, received drug for approximately four weeks, which ends up being about \$100,000 per Rx. However, about half the patients receive drug for free because they're on Medicaid.

In terms of our IS sales plan, there's a lot of variability in terms of our sales and the reason for that variability, as you'd expect, is the growth rate changes, what happens to children, the potential of their getting IS, there's no real – there's not an exact reason why we know it's going on with

patients and why they tend to have IS. So we can't really predict it very well, so there's a lot of variability. However, our Q4 2010 results have been within our historic range. We are starting promotion now that we got approval and there is a potential increase for IS revenue because right now we're only treating about 40% to 50% of IS patients and there's a potential upside there.

In terms of nephrotic syndrome, this is really characterized by protein spilling into the – through the kidney into the urine. And with that protein going into the urine that can result in end-stage renal disease, dialysis, transplant, et cetera. So this can be very serious if untreated. There are a group of patients who, when treated with present medication, do not respond well and actually have a continual decrease of renal function and so that is an unmet medical need within the nephrology community in patients. And again, there are few treatment options. There's just nothing to treat some of these patients because [inaudible].

Acthar and the nephrotic syndrome, it is approved on-label indication for the reduction of proteinuria. It's for the use in idiopathic types of nephrotic syndrome, which is idiopathic membranous, FSGS and IgA. Again, this is all on-label and it's on-label to treat lupus nephritis. The treatment typically is four to six months, but it can be longer depending on the patient. And typically the value of every prescription is around \$200,000 or \$150,000 to \$250,000.

In November of 2010, the American Association of Nephrology had a meeting and we had a number of presentations at that meeting with regards to Acthar. These were presentations given by investigator-initiated studies and many of those studies showed that – the positive results of Acthar both in the clinical studies as well as preclinical studies.

In terms of the clinical studies, there was a case series that showed that Acthar in refractory idiopathic membranous nephropathy, which is on-label, had nine of eleven patients met a response criteria that nephrologists were very happy with and acceptable in terms of treatment.

In terms of diabetic nephropathy, which is off-label, it's not an on-label indication, 9 of 15 patients met response criteria and none required dialysis. And that's a very positive thing given the status of the patients at that time.

The R&D efforts in nephrotic syndrome, we are now looking at a dose response study. But this would be a Phase IV study because it's on-label. To design those a dose response trial for idiopathic membranous nephropathy. The cost is approximately \$5 million or \$7 million at the multi-center trial, approximately 100 patients, and really the end point is the reduction of proteinuria.

We're also discussing the use of Acthar in diabetic nephropathy with the FDA. And the reason we're having discussions with the FDA on this is because it is an off-label indication, it's a new indication. And so we are looking and discussing with them the proof-of-concept study, which looks at different dosing regimens and a placebo. The objectives of this really will be to look at safety and efficacy of Acthar in this controlled environment and hopefully build on the investigator-initiated study that was done previously and reported in 2010. If successful, our plan is then to move to a larger Phase II study, which again will be efficacy, mainly efficacy driven with safety supporting information.

Our business plan in nephrotic syndrome is in – based on the 2010 meeting, in the nephrology meeting, we had our first meeting with the commercial team actually at that meeting so we had – that's the first time we've ever had a booth there where we could actually share our on-label indications with nephrologists. Prior to this meeting in 2010, we never had a booth, we never were sharing anything, but we actually had a booth at this meeting to share what Acthar can do in nephrology.

Data was presented at podiums, data was presented in posters for different indications and we had a 30+ doctor advisory meeting where they gave us input on the data that we had, they advised us

on what kind of studies to move forward with. And with that advice became our Phase IV study that we're now designing and moving forward with.

At the same time, based on the response we had at that meeting and investigations into nephrology and the need for the patients, we have hired five reps to sell Acthar to nephrologists. These are five dedicated nephrologists reps and right now we're developing the sales – the selling process, how to generate sales. And in fact, last week they were at an educational program and training program to train and sell to nephrologists. All five have nephrology experience, so we're not starting from ground zero, but again, they have to take time to learn our product Acthar.

We hope to really start the sales pretty heavily in March 2011 and if the sales increase, then we would consider expanding. We will have a peer review publication of case series that was actually reported at this nephrology meeting in 2010 and that will be published in 2011, which allows the sales force to have something to hand out to physicians in order to sell Acthar to nephrologists in nephrotic syndrome.

Immediate Acthar growth really is in three areas. The most important one and the biggest one of course is in MS. We have added these 77 sales reps. We see there's a lot of upside to the sale of Acthar in this market. So we hope to build on our momentum in the fourth quarter of 2010 to – as I said before, increase sales and as we've seen in January and February and hopefully in March and beyond.

In terms of IS, there's an incremental potential of growth there, but not a lot, again, because if you look at the – what we're doing right now, we have 40% of the market already. So to increase that's a little more difficult.

In terms of NS, in order to sell more in NS, we need that data. We need to obtain some information to share with physicians on dosing and side effects, et cetera. And so that first publication, which would be the first piece of information that we'll be able to hand out to physicians, and again, we hope to establish more information and more data in order to move forward.

And also during the same time, what we're learning is we're going to learn from the physicians who are prescribing and the new physicians who prescribe with our sales force what they'd like to see, how they view Acthar and there will be a kind of a learning on both sides. From their point view, about Acthar, as well as our point of view of what a nephrologist would like to see in terms of data and information.

In terms of our financials, we are profitable, debt free and cash flow positive. Briefly, if you look at our financial results, all right, we had record sales, we're up 30%, and solid earnings, up 35% of EPS between 2010 and 2009. The net sales, again, \$115 million versus \$88 million in 2009. 93% gross margin versus 92%, our operating income of \$53.8 million in 2010 versus \$41.2 million and an EPS of \$0.54 versus \$0.40 in 2009. We are cash flow positive, as I said, and our cash, we presently have \$127 million and we have accounts receivable of \$17 million and we are debt free in our balance sheet.

If you look at our go forward plan, again, it's the same thing we've always said, it's sell more Acthar, that's our goal. So we did expand our sales force to pursue more MS and IS. We dedicated a group of NS sales reps and they'll start on the ground in 2011 after training. We are looking at developing other markets for Acthar that are on-label. We have other – 15 other indications on-label that we can investigate, get some more information, share with physicians and so we are looking at those. So we really have a pipeline within this drug right now. And we're defining the unique characteristics of Acthar. This is important to us because understanding Acthar allows us to show that with physicians and give a rationale of why it works and specific indications.

At this time we have no business development efforts planned moving forward.

So in terms of our investment highlights, we are streamlined. As you know, we're very focused and we are profitable. We have a – we hope to sustain our competitive advantage with Acthar, protect it, keep it -brand – the brand moving forward. We hope to do more research to understand Acthar. In order to do that, we have a lot of focus on the MS sales this year, 2011. That's our biggest growth opportunity and we see a lot of effort in MS sales going on. We're – the MS sales is being supported not only by marketing, but the research and development as well as Medical Affairs is supporting MS sales in order to expand the growth in MS sales.

The recent IS approval has been important to us not only because it put IS on-label, but it also allowed us to modernize the label so we were able to add information about the new mechanisms of action of Acthar, add information about routes of administration, get rid of information that was old, outdated and actually differentiate us from steroids, which is very important to us in the market.

There's also, as we said – as I said earlier, there's a possible upside with nephrotic syndrome. In order for that upside, though, we do need to do more research. We need to get more information and that's what we're in the process of doing. As you saw, the market size is enormous. We have potential that's out of this world. So the key to it is what are we going to do to tap on that potential.

And then the last thing is cash. We're very cash flow positive and we really don't have any debt.

So I'll stop here. And if there's any questions, I'll take questions. And if not, we can all go have a beer.

QUESTION AND ANSWER SECTION

<A – David Young>: Yes?

<Q>: [Inaudible] .

<A – David Young>: Okay. So the question is, for the patients who now are taking Acthar and don't respond to steroids, what are they receiving at this time other than – prior to us, what are they receiving other than Acthar? They actually don't receive anything else other than Acthar. What's going on is that once a patient cannot take a steroid, or is refractory to steroids, or sensitive to the steroids in terms of side effects, there's no other treatment after that. So the key to us selling this is to make sure the physician can identify that patient as one who is steroid – a non-suitable steroid patient. And then make sure that they understand that Acthar is not just a steroid. It has other effects than steroid effects. It has what we call [inaudible] effects. And so it can act different than the steroid, because right now there's nothing else if they don't respond to steroids, except for Acthar now.

<Q>: [Inaudible] .

<A – David Young>: Okay. So the question is, are we helping them to identify the patients and how we are helping them to identify the patients and are we getting any pushback from reimbursement. Well, the first part of the question, are we helping them identify, yes, we are helping them to identify the patients a little bit better. There's a lot of education that has to go on because they don't see, necessarily, a lot of flare patients. They're not likely to see a flare patient every day. And so it's important for them to understand when they see a flare patient, if they're not – if steroids are not suitable, then what is suitable and why is it suitable. So we – there's a lot of time that our sales reps spend with those physicians educating them about Acthar and where we fit in the regimen as a possible therapy. We are trying to develop as much educational material as we can even if – maybe a checklist, they go through a checklist, something to help the physician, the MS physician deal with that.

In terms of the reimbursement, we've had no major problems with reimbursement unless the patient never received the steroid. So if the patient received steroid first and then they get a prescription for Acthar, it really – in terms of MS, it really is not an issue.

If the patient received their prescription for Acthar and never received a steroid, then the natural result is that the payer is going to ask, did they receive a steroid first, have they tried a steroid and that's natural. And so we've actually informed our sales force, why push for those patients. You should be really talking about patients who are unsuitable for steroids. That's really the population that we really need to be looking at. And that's the population that needs us. They really need us. They really need Acthar. Yes?

<Q>: [Inaudible] .

<A – David Young>: Okay. So the question is, when a flare occurs, how long does it occur and how long does it take before they know there's non-response and can they switch to Acthar, kind of three parts to it. Well, a flare can be anywhere from a few days to a couple weeks or longer, okay. What happens typically is that a patient will receive steroids and they'll take the steroid during that whole course of that flare. If they don't respond, they don't really know until the end of the course of their steroids. And they may not switch to Acthar at that time, they just may settle with being not so good in terms of the quality of life.

The next time they have a flare, then they'll typically go with something else. Because flares have their own life span. So after a while, even if you don't take anything, the flare will go away. But the

quality of life after flare's over is worse than the quality of life before the flare, so you kind of get worse. So what occurs is that usually there's a flare, you give the steroids, if it works, fine, if it doesn't work, a lot of times it's not – Acthar's not given, even though it could be given. But right now, it's not given and then the next flare they may get Acthar.

We believe and there are a number of physicians that believe in fact if there's not a complete response with steroids, if you give Acthar at that time, you'll get a complete response. And so some physicians are actually looking at that, and we believe that is a potential market for us. We just haven't been pushing that right now, but we believe there's a potential there for better therapy with Acthar and steroids.

<Q>: [inaudible]

<A – David Young>: Well, the complete response is really defined by the patients in terms of their quality of life coming – going back to quote/unquote normal, or what they were pre-flare.

<Q>: [Inaudible]

<A – David Young>: No.

<Q>: [Inaudible]

<A – David Young>: Well, so the question is, can you use DBS in MS even though it's not used in the clinical practice for flare, so can you use that or some tool to help define when there's not a complete response so then you need Acthar. Yeah, I agree that it would be nice to do that. Right now, as you just said, there is nothing to use. You can't use DBS. There are people looking at new procedures or new scales, new typing procedures to see if a flare and what a flare is and how bad a flare gets and how the quality of life changes. But those are only in investigation mode right now. So right now we're – there's nothing, it's just the quality of life that the patient knows and states themselves.

<Q>: [Inaudible]

<A – David Young>: Okay. So the question is in terms of diabetic nephropathy, if the Phase II study was positive, would you take the next step and to go a Phase III. Yeah. Our discussion with the FDA is a full program. So our discussions is what does it take to get it to approval on this on – off-label indication. It's not just what's the next step. So if in fact we have a positive Phase II, after we agree with the FDA what the Phase II is going to be, the next step actually will be a Phase IIb kind of study. And will we do it or let somebody else do it? I don't – I can't answer that. I don't know, because I don't know the result of the Phase IIa. So we're thinking about all options, but if the Phase II, first study that we do under FDA approval is positive, then there's a lot of options for us. And we just don't know what those options – which one we'll take right now.

<Q>: [Inaudible]

<A – David Young>: Okay. So the question is, if there's a breakdown of patients between getting better spontaneous and getting better and will we have statistical significance if in fact we only have 100 patients. Well, what happens if you look at the resistant patients, it's not a 30% response, it's much less – it's much lower for a 30% spontaneous response.

<Q>: [Inaudible]

<A – David Young>: Yes, yes. Specifically, a resistant patient is defined by clinicians as one who fails one or two treatments of existing therapy. And those patients who fail, for example, two – we'll use two as the number – two treatments of existing therapy, i.e. two different types of therapy, there

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Mar. 7, 2011

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are many clinicians who believe that their spontaneous response is very, very low – very, very low, not even close to 30%, maybe in the 5% to 10% or lower range. So that's what we're working on right now.

<Q>: [Inaudible]

<A – David Young>: Yes, yes. That's a treatment resistance, patients in the Bombback study where we had a 60% or 70% response, yes.

<Q>: [Inaudible]

<A – David Young>: No. When you're treatment resistant, we're talking about a 5% or 10% spontaneous response. So the treatment resistant patients usually only have a 5% to 10% spontaneous response, and so it's much lower spontaneous response. Any other questions?

<Q>: [Inaudible]

<A – David Young>: Correct.

<Q>: [Inaudible]

<A – David Young>: So the question is, when we had the orphan drug strategy in 2007, there was a small population of buy-outs. As we expand sales into other markets, do we see any – foresee any push back in terms of the price. Right now we don't, and we don't because we're looking at unmet medical needs. We're looking at patients who have no other treatment options, right. If we go into a market that they have a lot of options, I agree, there will be push back on the price. But if we stay in the unmet medical need area, I think the push back is less likely. But you never know. And if it happens, then we're going to have to evaluate and make some decisions. Any other questions?

David Young, Chief Scientific Officer

Okay, thank you very much.

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