AVI BioPharma Incorporated 2005 Fourth Quarter and Year–End Financial Results Conference Call Transcript

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Moderator: Denis Burger

March 8, 2006 8:00 a.m. Pacific Time

Operator: Welcome to the AVI BioPharma 2005 Fourth Quarter and Year–End Financial Results conference call.

At this time all participants are in a listen–only mode.

Following management's prepared remarks we'll hold a Q&A session. To ask a question please press star followed by 1 on your touchtone phone. If anyone has difficulty hearing the conference please press star 0 for operator assistance.

As a reminder this conference is being recorded March 8, 2006.

I would now like to turn the conference over to Jody Cain. Please go ahead ma'am.

Jody Cain: This is Jody Cain with Lippert Heilshorn & Associates. Thank you for participating in today's call. Joining me from AVI BioPharma are Denis Burger, Chairman and Chief Executive Officer, Alan Timmins, President and Chief Operating Officer and Mark Webber, Chief Financial Officer.

This morning AVI BioPharma released financial results for the 2005 fourth quarter and full year. If you have not received this news release or you'd like to be added to the companies distribution list please call Lippert Heilshorn in Los Angeles at 310–691–7100 and speak with Cheryl Park.

This call is being broadcast live over the Internet at www.avibio.com and a replay of the call will be available on the company's website for the next two weeks.

Before we begin I'd like to note that comments made by management during this conference call will include forward–looking statements within the meaning of Federal Securities law. These forward–looking statements involve material risks and uncertainties. For a discussion of risk factors I encourage you to review the AVI BioPharma Annual Report on Form 10–K and subsequent reports as filed with the Securities and Exchange Commission.

Furthermore, the content of this conference call contains time sensitive information that is accurate only as of that date of the live broadcast, March 8, 2006. The company undertakes no obligation to revise or update any statements to reflect events or circumstances after the date of this conference call.

With that said I'd now like to turn the call over to Denis Burger.

Denis.

Denis Burger: Thank you, Jody, and thank you all for joining us today. I will start today's call with a brief recap of our recent accomplishments. Mark Webber will summarize our financial results and Alan Timmins will spotlight several programs in greater detail. I will conclude with a review of key near–term activities and milestones and we will then take your questions.

I am extremely pleased with our achievements during the past year. We initiated clinical trials with our third generation NeuGene antisense compounds in our cardiovascular disease program targeting restenosis and in our infectious disease program for the treatment of chronic hepatitis C. Cardiovascular restenosis and hepatitis C each represent large market opportunities and these program advancements reflect our focus on drug commercialization.

While moving our internal programs forward we reported progress with our collaborative projects with leading scientists, institutions, government agencies and pharmaceutical companies.

Among these collaborations include Cooperative Research and Development Agreements, or CRADAs, with Walter Reed Army Institute of Research, The Center for Disease Control and Prevention, or the CDC, and the U.S. Army Medical Research Institution of Infectious Diseases, or UAMRID.

These programs have advanced preclinical drug development to treat viral diseases and represent niche market opportunities. They also establish our ability do develop specific drugs that can be quickly produced in response to known emerging or genetically engineered bioterrorism threats. Further, they add to our collected NeuGene knowledge–base while allowing us to focus the majority of our resources on internal program.

We continue to build credibility for a proprietary NeuGene antisense technology. Study results consistently indicate that NeuGene compounds compared with earlier generation of antisense therapeutics show increased specificity, improved biological stability and reliable delivery into target tissues. Importantly our NeuGene compounds continue to have a stellar record of safety in contrast to failures by other antisense technologies by other companies, which had been primarily due to dose limiting toxicity.

Also we received recognition and funding from the U.S. government for a bioterrorism program. Last year was the third term that we provided testimony to a U.S. Congressional Committee. Our presentation highlighted our ability to develop and manufacture drugs to target a variety of viruses and toxins listed as bioterror and public health threat. And to do so at a speed exceeding any other modern drug development timeframe.

We received $4.6 million in allocations from the government to develop drugs to combat certain bioterrorism threats included in the Domestic Homeland Security list of bioterrorism threats.

During 2005 we strengthened our infrastructure to support further progress. We raised approximately $43 million in net proceeds to fund our programs and operations. We expanded our management team with the addition of expertise in the cardiology device area. We strengthened our board of directors, and we named several prestigious scientists to our scientific advisory board, adding significant expertise in infectious diseases, particularly in avian influenza.

In the few months since our last call we announced positive results from the first phase from our clinical trial in hepatitis C infection, results from 30 healthy volunteers demonstrated that our NeuGene compound, AVI–4065, was safe, exhibited favorable pharmacokinetic parameters and was well tolerated.

These results are important as the current therapy for chronic hepatitis C, a treatment regime with interferon and ribavirin is successful in less than half of the patients infected with genotype 1 hepatitis C virus, the most common form of the virus in the U.S.

The high failure rate is due to the severity of side effects, which make it difficult for infected patients to tolerate the recommended dosages and duration of treatment. We are currently in the second efficacy phase of this important clinical trial. Alan will discuss the program in greater detail.

We have also taken steps to protect our entry into the market with a hepatitis C drug. In January we signed an agreement with Chiron Corporation to license its patents and patent applications covering research, development and commercialization of antisense therapeutics against hepatitis B virus.

This license agreement, combined with our own patents, provide us with a solid intellectual property base in hepatitis C to protect us and ultimately our commercial partners.

Thus far in the first quarter of 2006 we have had a number of significant milestones for the company. First, our very successful collaborative work targeting the deadly Ebola virus was published in two peer–reviewed journals and the results highlighted by Nature Reviews.

We have received an allocation of $11 million from the Department of Defense for this work and for other bio–defense programs.

Finally, three independent laboratories from around the world confirmed our earlier collaborative results that our influenza virus antisense drug was efficacious against most influenza strains, including avian influenza in preclinical studies.

In this call we are again going to focus on our infectious disease program. I appreciate that this is a deviation from what we indicated on the last call, but the progress and scope of our infections disease program requires additional attention today. We plan to highlight progress in our cardiovascular program and progress with our ESPRIT technology in the 2006 first quarter conference call in May.

With those opening remarks, I ask Mark Webber to review our recent financial performance.

Mark Webber: Thanks, Denis. Today I'd like to review our 2005 fourth quarter and year–end financial results, our cash position and then I'm going to discuss our 2006 financial guidance.

Our revenues from license fees, grants and research contracts in the -- first quarter — fourth quarter of 2005 increased to $1.4 million, up from revenue of approximately $286,000 reported in the fourth quarter of 2004. This increase reflects recognition of $1.4 million in research contract revenues from government funding for work on viral disease research projects.

Operating expenses in the 2005 fourth quarter increased to $6.3 million, compared with $5.2 million in the fourth quarter of 2004. Most of this increase was due to higher research and development costs from contacting for the production of GMP subunits, which are used to manufacture compounds for future clinical trials. The remaining increase was due primarily to increases in clinical trial expenses and to employee costs.

General and administrative expenses remained essentially unchanged at $1.4 million for both the fourth quarter of 2005 and 2004.

We reported net loss for the fourth quarter of 2005 of $4.6 million, or 10 cents per share, which compares with a net loss of $5 million, or 14 cents per share, for the fourth quarter of 2004.

Revenues for the full year 2005 were approximately $4.8 million, compared with revenues of approximately $430,000 reported for 2004. Higher revenues in 2005 reflect recognition of $4.6 million in research contact revenues from government funding.

Operating expenses in 2005 decreased to $22.3 million from $25.5 million in 2004. This decrease was due to lower R&D costs of approximately $17.1 million in 2005, compared with $20.7 million in 2004, primarily as a result of a decrease in contracting costs for the production of GMP subunits. This was offset by increases in clinical trial expenses, lab supplies and employee costs.

Our net loss for 2005 was $16.7 million or 37 cents please share, down considerably from the net loss for 2004 of $24.8 million or 69 cents per share. Reviewing our balance sheet, we reported cash, cash equivalent and short–term securities of $47.1 million as of December 31, 2005. This represents an increase of $27.5 million from December 31, 2004.

This increase is attributed primarily to the completion of two private equity placements in 2005 resulting in net proceeds to the company of $43.3 million. This was offset by $14.7 million used in operations and approximately $1.5 million used for purchase of equipment and patent related costs.

Regarding financial guidance for 2006, we expect expenditures to be in line with 2005 and the cash burn for 2006 to be in the range of $15 to $20 million. With that overview, I would like now to turn the call over to Alan Timmins.

Alan.

Alan Timmins: Thanks, Mark. And let me add my welcome to those of you joining us this morning on the call and on the Internet. Today I want to update you as to our progress on several of our antiviral programs. As background our NeuGene antisense drug candidates have demonstrated efficacy in pre–clinical studies against Hepatitis C virus or HCV, influenza A virus, dengue virus, SARS Corona virus, West Nile virus, Ebola virus and Marburg virus.

We are currently focusing clinical development on diseases with large commercial markets, including HCV and influenza. Starting with HCV, we're conducting a multi–center exploratory Phase I/II clinical trial in which patients receive 50, 100 or 300 milligrams of AVI–4065 by daily subcutaneous injection for 14 days.

As Denis discussed we reported favorable safety, tolerability and pharmacokinetic results from the first trial phase. No serious drug related adverse events occurred at any dosage level, which is once again consistent with our clinical experience with all NeuGene drug candidates to date. All dosages in this trial were well tolerated with no injection site reactions or any events that required intervention.

The apparent plasma elimination half–life ranged from 10 hours to 12 hours with a peak concentration at about 4 hours. This pharmacokinetic profile suggested that the target dosage for the efficacy phase of this trial will fall between the 100- and 300–milligram doses.

In conjunction with this clinical trial, supporting safety and pharmacokinetic study has been completed in non–human primates that further supports the safety and tolerability of AVI 4065. Groups of primates received daily injections of up to 15 times the largest human dose used and for twice the duration of the highest dose administered in our clinical trial. No serious adverse events, toxicities or tolerability issues were observed.

Importantly the liver accumulation of AVI 4065 was found to be approximately three times the plasma concentration. These data allowed for a direct calculation of the potential live concentration of the drug in humans from the clinical cohorts.

We're now in the second phase of this trial. This phase includes up to 40 patients with chronic hepatitis C divided into two cohorts. First those patients who are naïve to hepatitis C treatment, meaning they've never received other therapies for this disease, and second those patients who have tried and failed the current interferon and ribavirin therapy.

In addition to safety, tolerability and pharmacokinetics this second phase assesses efficacy as measured by hepatitis C, virologic responses over the 14–day treatment period and at intervals 1, 3 and 6 months after treatment to assess the duration of the hepatitis C virologic response to AVI 4065. We expect to report some preliminary data from the second phase of the hepatitis C trial in late March or in early April.

Also earlier this year we confirmed our efficacy against multiple strains of influenza A virus, including H5N1, the avian flu strain. On average 5% to 20% of the U.S. population is infected with influenza each year.

This kills about 35,000 Americans each year according to the Centers for Disease Control and it is this commercial market that AVI was initially addressing when we started this program about 18 months ago.

Our program against the influenza A virus specifically targets genetic regions of the virus that are highly conserved between six viral subtypes that cause human disease. These include three subtypes that cause pandemics in the 20th century, the 1980, excuse me, the 1918 Spanish Flu or H1N1, the 1957 avian flu or H2N2 and the 1968 Hong Kong Flu or H3N2. It also includes three subtypes of avian flu that have been reported to cause disease in humans, H5N1, H7N7 and H9N2.

The current influenza outbreak in birds throughout Asia, Eastern Europe, Turkey and more recently in France and Germany is caused by the H5N1 subtype. It's thought that co–infection of humans or certain animals with both H1N1 and H5N1 can result in the emergence of a virus to which the human population has no natural immunity and which has the ability to spread easily from person to person.

In January we reported that three independent laboratories confirmed efficacy in the preclinical experiments with our NeuGene compounds against multiple strains of influenza. First an academic institution in Bangkok, Thailand confirmed a NeuGene antisense efficacy against H5N1 viral isolate in a relevant assay system. Then the Public Health Agency of Canada in Winnipeg completed an initial dose response study in cell culture demonstrating NeuGene efficacy against both H1N1 and H3N2 strains.

And third, at Oregon State University in Corvallis, efficacy was confirmed using the same NeuGene antisense agents against the H7N7 and H3N8 strains. With these data we've now observed efficacy from four independent laboratories using different endpoints and different methodologies. These confirmations validate our approach to blocking replication of influenza virus.

We now believe that a single NeuGene drug could be effective against most influenza subtypes including the H5N1 avian strain.

Based on these findings and other results from additional studies we plan to file an IND application with the FDA for the treatment of Influenza A virus with NeuGene antisense drugs later this year.

Moving on to our collaborative projects with the lethal Ebola virus, earlier this year results from significant research based on our USAMRIID collaboration were published online in the Public Library of Science Pathogens. This is a peer–reviewed monthly journal published by the Public Library of Science.

Our results are nothing short of a breakthrough as our NeuGene–based compound is the first to show antiviral intervention against this class of viruses in three animal species including primates. The extensive study results showed that a combination of Ebola specific NeuGene agents protected rodents in both pre- and post–exposure therapeutic regimens.

In addition the investigator showed that administration of Ebola specific NeuGene agents before lethal exposure to the Ebola virus protected 75% of rhesus macaque monkeys in the trial. For those interested, access to this research is titled "Gene–Specific Counter Measures Against Ebola Virus Based on Antisense Phosphorodiamidate Morpholino Oligomers" and can be accessed at pathogens.plosjournals.org.

Nature Reviews highlighted this exciting work in their March issue with several positive comments about our technology. Additional support for this study was published in the March issue of the peer–reviewed journal Antimicrobial Agents and Chemotherapy in collaboration with the Department of Virology, Philips University in Marburg, Germany and with USAMRIID.

Finally I'd like to briefly discuss ESPRIT or Exxon Skipping Pre–RNA Interference Technology, which we introduced last September. ESPRIT therapeutics allow for a fine genetic surgery at the RNA processing level, deleting mutated or disease causing genetic sequences or the skipping of functional sequences that are over expressed or harmful in certain diseases. As announced, we're applying the ESPRIT therapeutic approach in genetic disorders including Duchene muscular dystrophy. Results from research conducted in mice with our ESPRIT therapeutic approach were published in last month's issue of the peer–reviewed journal Nature Medicine.

Our approach has the ability to remove mutated portions of the gene creating a shortened but functional dystrophin protein and allowing increased skeletal muscular function. We anticipate that our NeuGene ESPRIT technology will be used in a clinical trial starting later this year.

We expect this trial to be conducted with a consortium including pharmaceutical companies, academic institutions and foundations with an interest in muscular dystrophy. The clinical trial outline has been posted on the FDA Web site clintrials.gov by GlaxoSmithKline.

With that, I'd like to turn the call back to Denis.

Denis Burger: Thanks, Alan. Needless to say we expect to continue to be very active this year. In reviewing our clinical milestones let me start with our cardiovascular program and please remember that we plan a detailed update of the cardiovascular program in our next call in May.

With that said, enrollment continues in our late stage Resten–MP trial called APPRAISAL for the reduction of restenosis following angioplasty. This study is being conducted at multiple major medical centers in Germany, including the University of Essen and the University of Heidelberg in collaboration with the Harvard Clinical Research Institute, which is an internationally recognized organization specializing in the management of coronary artery disease and stent trials.

Resten–MP our microparticle formulation of AVI 4126 is being delivered by IV, intravenous, injection to angioplasty patients after bare metal stent placement. The primary goal of this study is to assess Resten–MP's ability to reduce luminal diameter, or late loss, from the time of intervention to follow up at six months. We will compare these results with the historical data from Harvard Clinical Research Institute's database, which includes information from more than 20,000 patients.

Our Resten–NG drug eluting stent program is on track and moving forward toward clinical trial initiation this year. Finally our CABG program or coronary artery bypass graft program is finishing preclinical development and is slated to move into a Phase II clinical trial later this year.

Turning to our infectious disease program, first in our hepatitis C trial, as Alan stated, we expect to report preliminary efficacy results around the end of this month. In our influenza program we have initiated animal studies and expect to file an IND with the FDA for our clinical development program later this year.

Our next program under development is for dengue virus and we are completing preclinical development at this time.

Finally we plan to initiate a collaborative clinical trial evaluating our ESPRIT approach in patients with Duchene muscular dystrophy by year's end.

We are exceptionally pleased with our $11 million allocation included in the final version of the 2006 Department of Defense Appropriations Act, which was signed by the President in January. This has more than doubled the amount we received last year and we believe that this dollar amount indicates strong support for our ongoing bio–defense related programs.

In closing, last year was very productive for AVI and we believe that 2006 will be even a more exciting year. We anticipate clinical advances in our lead cardiovascular and antiviral programs and we have a strong development pipeline that allows us to use our internal resources to develop drug candidates that target large markets.

We also have a proven capability to opportunistically develop and manufacture NeuGene compounds to combat emerging viral diseases and continue to seek collaborations and partnerships to support smaller market and longer–term opportunities.

At this time we'd like to open the call to questions. Operator.

Operator: Ladies and gentlemen, if you would wish to register for a question for today's question and answer session you will need to press star then the number 1 on your telephone. You will hear a prompt to acknowledge your request. If your question has been answered and you wish to withdraw your polling request you may do so by pressing star then the number 2. If you are using a speakerphone please pick up your handset before entering your request. One moment please for the first question.

Denis Burger: While we wait for the first questions to queue up, I might add some of the meetings we had planned to attend in the near future this week we're presenting preclinical data on our CABG program at the Society of Toxicology Meetings.

Late in March we'll be at the prestigious International Keystone conference in Colorado where we'll present our current data on influenza. At April, the last week in April we will be presenting our avian influenza data on H5N1 at the International Workshop on Antiviral Compounds in Germany.

Also in April that week, April 26, 27 is one of the two most important hepatitis C conferences in the world. Its' called EASLD — European Association for the Study of Live Diseases and that will be the first presentation of our formal HCV data in Vienna, Austria.

And finally in the second week in May we have two presentations at the International of Congress on antiviral research, one in HCV and one in influenza again. So you can see over the next month–and–a-half to two months we have four major presentations on our antiviral programs.

Operator: Our first question is from the line of Ren Benjamin with Rodman & Renshaw.

Ren Benjamin: Hi, good morning and congratulations on your ongoing progress. Can you talk to us a little bit more about the HCV program? What kind of preliminary results do you think will be released? So will it just be 14–day, you know, viral titer loads or, you know, would we get something more out of that?

And then also if you kind of project out how long do you think it will take before all of the data is in and potentially you start a full–blown Phase II trial?

Denis Burger: Ren, thank you for the question. We expect that the initial data will evaluate the reduction in viral titer so all of the patients in both cohorts are assessed for viral titer before they enter the protocol and every other day during the study. So we should have early indications of that information in terms of efficacy.

The two key features in any HCV trial involve how long the response is sustained so if there's a reduction in titer how long does that last? And what is the magnitude of reduction? We won't have that information until a couple of weeks after all the patients finish their therapy.

In addition it's very important now because of some of the other drugs that are in development to look at gene sequence during the study protocol.

With some of the other drugs in development the viruses have mutated under treatment and so an assessment of the mutation rate during the protocol will be very important. The specific answer to your question is we expect a real thorough and formal presentation of this available by the time of the EASLD meeting at the end of April. Thank you.

Ren Benjamin: Okay. What about an oral formulation plan? I mean clearly dosing is important in this patient population. Do you guys have any plans to develop an oral formulation?

Denis Burger: That's a great question because we believe that for all infectious diseases, just like for antibiotics for bacterial infections an oral formulation is going to be key.

With our technology over a year–and–a-half ago we demonstrated in a program where we targeted a liver enzyme and we specifically did this because we knew that the liver would be the target for future drug development.

We used both subcutaneous, intravenous and oral formulations of our antisense drug and indicated that we could deliver the drug from an oral formulation to the liver and knock down the target — the gene target. So we have evidence that we can deliver orally.

We elected in this first trial to go with the safest and easiest route of administration to document efficacy without the confounding issue of how much oral bioavailability we achieved. We firmly believe that we'll be able to quickly move to an oral formulation and we have a partner in that regard, which is the oral formulation company in the San Francisco Bay area, Depomed. And we've been working with Depomed on oral formulations.

Ren Benjamin: Okay. And one final question. The animal — the non–primate animal study that you did where you were able to dose a considerable amount higher than what's currently being dosed in the clinical trials was there any way to look at what effect the drug had on viral titers at that point, or were you not looking for that?

Denis Burger: Those animals were not challenged with virus so that was a classic Tox/PK study, so no viral titer information. The important feature of that trial not only was that we administered 15 times the highest human dose without any safety or tolerability issues, but it also, because we biopsied the livers we were able to calculate the relationship between the plasma concentration and the liver loading.

This means extrapolating back to humans that we know in our human clinical trial that we are delivering to the liver — to the target organ where HCV replicates we are delivering an EC 90, an effective concentration that should be 90% effective. And that's sort of the target for how you want to design an efficacy study. So this greater confidence that we're actually getting the right concentration of the drug to the right target organ.

Ren Benjamin: Perfect. And one last question regarding ESPRIT technology, can you comment a little bit about how this will progress and maybe how long this trial will take? Alan mentioned that GlaxoSmithKline had put the protocol up on the clinicaltrials.gov Web site. Can you give us any more details as to how this is progressing?

Denis Burger: There's currently a consortium being put together, which involves a number of different pharmaceutical companies, foundations and academic institutions so that this would be a coordinated effort and GlaxoSmithKline is leading that effort. And they've posted the clinical trial up on the clincaltrials.gov FDA Web site and at this point there are very little details available.

We expect this to be firmed up over the next couple of months as the memberships in the group that are being put together is formulated. We're a key part of that because it is our technology that will be used. But we expect the — that the clinical trial as we move forward with other input may be focused and modified and changed so at this time we have no further details than what's been posted by — on the government Web site.

Ren Benjamin: Perfect, thanks and congrats again.

Denis Burger: Thank you.

Operator: Once again ladies and gentlemen if you wish to register for a question please press star then 1 on your telephone keypad.

Our next question comes from Phillip Wiggins with Pharmsouth.

Phillip Wiggins: Yes this is Phillip Wiggins. I have two questions for Dr. Burger. The first concerns the dosage form also and administration of IV AVI–4065 for HCV. Concerning the subcutaneous injection what was the dosage form used for the Phase I trial? And was it a (lifelized) powder for reconstitution or is it ready–to–use vials or pre–fill syringes?

Denis Burger: Thanks, Phillip. We've considered all of these possibilities and for this particular study it's ready–to–use vial. And because we don't think of this as the final dosage form this seems to be appropriate. We selected the subcutaneous route because that gives a slower uptake in the plasma and gives us a better PK profile than a direct IV route.

Phillip Wiggins: Right. And until an oral form comes out -- this is same part of question one -- will the patients be able to inject the product at home themselves?

Denis Burger: That's what's being done at this time. The patients go through a few–day training program with saline injection and as soon as they're comfortable with that then it's all self–administered.

Phillip Wiggins: Right. That sounds like the standard profile for patients being trained. Question two, it's my understanding, Dr. Burger, that Roche Pharmaceuticals is going to be studying a product from Vertex Pharmaceuticals. I believe they're out of Cambridge, Mass. It's a protease inhibitor that Roche would like to add on to their Pegasus drug, which is alpha interferon 2A plus the ribavirin. I just wanted to know your comments on that. It sounds like it'd be — that's a three a drug regimen and a lot of expense and so forth. Would you comment?

Denis Burger: Yes. Vertex has reported data first at last year's EASLD meeting where we'll report our data this year. And they reported reductions in viral titers that were quite impressive. They also reported some data that showed that the virus mutated under therapy, which isn't a good sign.

Phillip Wiggins: Right.

Denis Burger: They're now using their drug in a most recent trial in combination with interferon ribavirin and have gotten some other very nice results.

So it’s a combination therapy at this point.

In our study we’re looking a monotherapy in both cohorts so untreated patients and patients that have failed under interferon ribavirin. So drugs that have — that can be very useful in combination do what you said, they add expense, they add problems in patient compliance and they eliminate half of all patients who fail on ribavirin interferon. So there’s some advantage if you’re drug can be used in monotherapy. Of course it’s too early for us to speculate about our own drug until we have the data.

But we’re well aware of the nice data reported by Virtex in combination with the current therapy.

Phillip Wiggins: Right. I understand from the Roche point of view that it’s at least two years away.

Denis Burger: I can’t…

Phillip Wiggins: Anyway that’s what I heard.

Denis Burger: I don’t know what Roche…

Phillip Wiggins: Yeah.

Denis Burger: Has indicated in that respect.

Phillip Wiggins: Okay. Thank you.

Denis Burger: Thanks, Phillip.

Operator: That is all the time we have today. Please proceed with your presentation or any closing remarks.

Denis Burger: Well I want to thank you from all of us at AVI for joining us on this call today, both live and on the Internet. We truly had a great year last year getting a lot of programs right to the focus point and we’ve seen already in the first two months of this year some nice progress meeting the milestones we’ve set and we’re committed to do that for the rest of the year. We’re looking for a really exciting year.

Thank you very much.

Operator: Ladies and gentlemen, that concludes your conference call for today. We thank you for your participation and we ask that you disconnect your line.

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