Zacks Small-Cap Research

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Neurocrine Biosciences, Inc. (NBIX - Nasdaq)

NBIX: Acquires North American Rights to ONGENTYS® For the Treatment of Parkinson's Disease…

Based on our probability adjusted DCF model that takes into account potential future revenues from INGRESSA™ in TD and TS along with elagolix in endometriosis and UF, NBIX is valued at $75/share. This model utilizes a 11% discount rate and is highly contingent upon continued clinical success of both INGRESSA™ and elagolix. It will be adjusted accordingly based upon future clinical results.

Current Price (02/16/17)	$42.45
Valuation	**$75.00**

OUTLOOK

On February 9, 2017, Neurocrine Biosciences (NBIX) announced an exclusive licensing agreement with BIAL for the development and commercialization of opicapone (ONGENTYS®) in North America. ONGENTYS® is a catechol-O-methyltransferase (COMT) inhibitor that was approved by the EMA in June 2016 as an adjunct therapy for levodopa/DOPA decarboxylase inhibitors for adults with Parkinson's disease. Neurocrine made an initial upfront payment of $30 million and is responsible for all development activities required for approval in the U.S. and Canada. Once approved, ONGENTYS® will help expand the company's burgeoning movement disorder franchise that will be centered on INGREZZA™, which has a PDUFA data of Apr. 11, 2017.

SUMMARY DATA

52-Week High	**$54.77**
52-Week Low	**$33.63**
One-Year Return (%)	**11.30**
Beta	**0.55**
Average Daily Volume (sh)	**1,010,118**
Shares Outstanding (mil)	**87**
Market Capitalization ($mil)	**$3,698**
Short Interest Ratio (days)	**N/A**
Institutional Ownership (%)	**98**
Insider Ownership (%)	**5**
Annual Cash Dividend	**$0.00**
Dividend Yield (%)	**0.00**
5-Yr. Historical Growth Rates	
Sales (%)	**N/A**
Earnings Per Share (%)	**N/A**
Dividend (%)	**N/A**
P/E using TTM EPS	**N/M**
P/E using 2015 Estimate	**N/A**
P/E using 2016 Estimate	**N/A**

Risk Level	**Below Avg.**
Type of Stock	**Small-Growth**
Industry	**Med-Drugs**

ZACKS ESTIMATES

Revenue
(in millions of $)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2016	15.0 A	0 A	0 A	0 A	15.0 A
2017	0 E	0 E	34.0 E	13.0 E	47.0 E
2018					164.0 E
2019					395.0 E

Earnings per Share
(EPS is operating earnings before non recurring items)

	Q1 (Mar)	Q2 (Jun)	Q3 (Sep)	Q4 (Dec)	Year (Dec)
2016	-$0.22 A	-$0.46 A	-$0.43 A	-$0.51 A	-$1.05 A
2017	-$0.56 E	-$0.62 E	-$0.28 E	-$0.58 E	-$2.06 E
2018					-$1.21 E
2019					$0.80 E

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WHAT'S NEW

Business Update

Neurocrine Acquires North American Rights to ONGENTYS®

On February 9, 2017, Neurocrine Biosciences, Inc. (NBIX) announced an exclusive license agreement with BIAL for the development and commercialization of opicapone (ONGENTYS®) in North America. ONGENTYS® is a once-daily, highly-selective catechol-O-methyltransferase (COMT) inhibitor that was approved in June 2016 by the European Medicines Agency (EMA) as an adjunct therapy along with levodopa/DOPA decarboxylase inhibitors for adults with Parkinson's disease.

Parkinson's Disease

Parkinson's disease (PD) is a slowly progressing neurological disorder characterized by tremor, stiffness, slow and decreased movement, and postural instability affecting approximately 0.4% of the population over age 40 and 1% of those over age 65 (Merck Manual). The disease arises from the death of dopamine-generating cells in the substantia nigra region of the midbrain, believed by many to be in association with the accumulation of a protein called alpha-synuclein in neurons. The disease is named after the English doctor James Parkinson, who published the first detailed description in *An Essay on the Shaking Palsy* in 1817.

Initially, PD patients are affected by tremor, typically of a single hand or foot while at rest. As the disease progresses, tremors become less of a problem while rigidity becomes more prominent. In addition, patients typically find it more difficult to initiate movement (akinesia, or 'off' periods) and movement generally becomes slower (bradykinesia) and reduced in amplitude. Muscle pain and fatigue are commonly reported along with these symptoms. The face eventually becomes masklike with open mouth and drooling, and speech becomes unclear and difficult to initiate. Postural instability becomes more prominent as the disease progresses, resulting in difficulty walking and maintaining balance. Without warning, voluntary movement may suddenly halt. Overall, patients with PD find it increasingly difficult to initiate and control movement as the disease progresses, leading to disability, isolation, and loss of independence. In the most advanced stages of the illness, increasing physical disability may be accompanied by a variety of other neurological symptoms, including insomnia, psychosis, and dementia.

Treatments for PD

There is no cure for PD. Instead, the goal of treatment is to reduce symptoms, which can often be maintained at manageable levels for many years. In the early stages of the disease, patients may be treated with dopamine agonists such as Mirapex™, which binds to and turns on dopamine receptors in the brain in a manner closely analogous to dopamine itself. Alternatively, drugs called monoamine oxidase inhibitors may be used. Monoamine oxidase (MAO) plays an important role in the healthy brain by metabolizing dopamine and preventing its level from rising excessively. In Parkinson's patients, inhibitors of this enzyme help offset the effect of reduced dopamine production.

As the disease progresses, treatment with MAO inhibitors or dopamine agonists are no longer sufficient to control symptoms and treatment with levodopa is initiated. Levodopa (L-DOPA), discovered in the 1960's, is an amino acid derivative that enters the brain via specific amino acid transporters and is converted to dopamine by an enzyme called dopa decarboxylase (Hauser, 2009). The administration of levodopa temporarily diminishes the motor symptoms associated with the lack of dopamine in the substantia nigra. Unfortunately, only about 1% of L-DOPA crosses the blood-brain barrier. The remainder is often metabolized to dopamine elsewhere, causing a variety of side effects including nausea, dyskinesia, and joint stiffness.

In the 1970's, the dopamine decarboxylase (DDC) inhibitor carbidopa was discovered. DDC is an enzyme that breaks down L-DOPA in the periphery and converts it to dopamine. By inhibiting the breakdown of L-DOPA to dopamine outside of the brain, the addition of carbidopa reduces the amount of levodopa required to produce a given response by approximately 75%. When administered with levodopa, carbidopa increases plasma levels of levodopa, increases the plasma half-life of levodopa, and decreases plasma and urinary dopamine. A combination levodopa/carbidopa formulation called SINEMET® CR is available in the U.S. This approach helps to reduce some

of the side effects of dopamine therapy, but does not slow disease progression or inhibit dyskinesia, nausea, hallucinations, and other psychiatric disorders from developing.

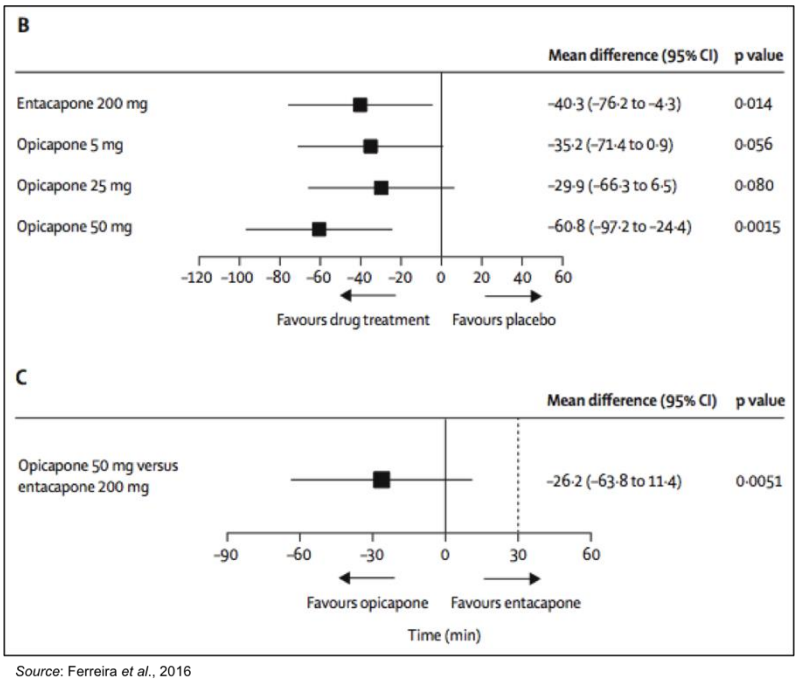
Unfortunately, even with DDC inhibition only 5-10% of an oral dose of levodopa crosses the blood-brain barrier (Männistö *et al*., 1989). In addition, DDC inhibition causes an increase in the metabolism of levodopa by the catechol-O-methyltransferase (COMT) pathway, thus suggesting that inhibition of COMT could lead to an increase in levodopa in the brain. The COMT inhibitors tolcapone and entacapone were approved in 1998 and 1999. While tolcapone was shown to have a greater effect on levodopa metabolism, it can also cause rare, fatal hepatotoxicity (Borges, 2005). Results from four separate clinical trials showed that adding entacapone to levodopa/DDC inhibitor therapy increased 'on' time, decreased 'off' time, and prolonged the duration of response to levodopa.

Opicapone for Treating PD

Opicapone is a third-generation COMT inhibitor with a highly favorable pharmacodynamics profile. Preclinical data showed that opicapone was nontoxic in an *in vitro* assay (Kiss *et al*., 2010) suggesting that it was unlikely to have liver toxicity, unlike tolcapone. Interestingly, while opicapone is rapidly cleared from plasma (Cmax at 1.5-3.5 hours following a single dose and 1-2.5 hours after multiple doses), the half-life of opicapone-induced COMT inhibition in erythrocytes is >100 hours (Rocha *et al*., 2013). This is due to opicapone's very slow dissociation rate from COMT.

The clinical efficacy of opicapone was shown in two Phase 3 clinical trials, BIPARK I (NCT01568073) and BIPARK II (NCT01227655).

BIPARK I (Ferreira *et al*., 2016): This was a randomized, double blind, placebo controlled, and active controlled trial of opicapone as an adjunct to levodopa in patients with Parkinson's disease with end-of-dose motor fluctuations. A total of 600 patients were randomly assigned 1:1:1:1:1 to receive placebo, entacapone, 5 mg opicapone, 25 mg opicapone, or 50 mg opicapone. The following charts show that patients in the 50 mg opicapone group were significantly more likely to experience less time in the 'off' state compared to placebo (panel B; *P*=0.0015) and that 50 mg opicapone was non-inferior to entacapone (panel C; *P*=0.0051). Opicapone was well tolerated, with a very low percentage of patients discontinuing due to treatment-emergent adverse events and ≤7% of patients in all groups experiencing serious treatment-emergent adverse events, of which 35% were deemed unrelated to study drug.



Source: Ferreira *et al*., 2016

BIPARK II (Lees *et al*., 2016): This was a randomized, double blind, placebo controlled trial to evaluate the safety and efficacy of opicapone as adjunct to levodopa therapy. A total of 427 patients were randomized 1:1:1 to receive placebo, 25 mg opicapone, or 50 mg opicapone for a total duration of 14-15 weeks. This was followed by a 52 week open label extension phase. At the end of the double-blind phase, the mean change in 'off' time was -64.5 min for placebo group, -101.7 min for the 25 mg opicapone group, and -118.8 min for the 50 mg opicapone group. The

adjusted treatment difference compared with the placebo group was significant for the 50 mg opicapone group (*P*=0.008), but not for the 25 mg opicapone group (*P*=0.11). 'Off' time reduction was sustained through the open label extension phase as the adjusted mean change from start to finish of the open label phase in 'off' time was -18.3 min. Overall, opicapone was well tolerated with most adverse events being mild or moderate in intensity. The most common adverse events were dyskinesia, constipation, and dry mouth. There were no relevant liver function findings in either phase of the trial.

Opicapone Development Plan

Management has indicated that they will need to meet with the FDA in order to determine whether any additional trials will be necessary prior to filing for approval in the U.S., with a meeting likely to take place in late 2017. Right now, we are assuming that at least one Phase 3 trial in the U.S. will be required, thus we view approval in 2021 as the most likely outcome. Following approval, the drug will be sold using the company's sales force that is being built for INGREZZA™ with no additional reps necessary. We will wait to add opicapone to the financial model once there is greater clarity regarding the requirement for an additional clinical trial in the U.S. prior to filing the NDA.

INGREZZA™ Update

On October 11, 2016, Neurocrine announced that the FDA had accepted the New Drug Application (NDA) for INGREZZA™ in tardive dyskinesia (TD). The NDA was accepted for Priority Review and assigned a PDUFA date of April 11, 2017.

The Kinect-3 study, which allowed study subjects to continue receiving additional INGREZZA™ treatment for up to 42 weeks, was completed during the third quarter of 2016. Positive results from that trial were previously announced in the fourth quarter of 2015, which showed a highly significant change from baseline in the Abnormal Involuntary Movement Scale (AIMS) at Week 6 ($p<0.0001$). Neurocrine is currently conducting a separate one-year open-label safety study (Kinect-4), which is now fully enrolled and will complete one year of dosing in early 2017. Lastly, the company is supporting a roll-over study for patients who completed one year of dosing in either Kinect-3 or Kinect-4 (NCT02736955). This roll-over study will allow these patients to continue taking INGREZZA™ for up to an additional 72 weeks, by which time the drug is likely to be approved.

On January 17, 2017, Neurocrine announced results from the Phase 2 T-Forward study of INGREZZA™ in adults with Tourette syndrome (TS). The study did not achieve the pre-specified primary endpoint, which was the change from baseline in the Yale Global Tic Severity Scale (YGTSS) at Week 8 (*P*=0.18). However, the study did show a statistically significant improvement in overall symptoms of Tourette syndrome by the Clinical Global Impression of Change (*P*=0.015). Due to the fact that a number of the same investigators from the T-Forward study are also taking part in the T-Force GREEN study of INGREZZA™ in children and adolescents with TS, the company did not release many details of the results in order to avoid potentially introducing assessor bias into the T-Force GREEN study. However, the company did indicate that a number of positive insights were gained into conducting a clinical trial with TS patients along with appropriate inclusion/exclusion criteria.

The T-Force GREEN study is a Phase 2 study designed to evaluate the safety, tolerability, and efficacy of INGREZZA™ in children and adolescents with TS (NCT02679079). It is a randomized, double blind, placebo controlled, multi-dose, parallel group trial of approximately 90 children and adolescents. Patients are receiving once-daily dosing of INGREZZA™ or placebo in a 1:1:1 fashion during a six-week treatment period. The final patient will be randomized this week and we anticipate results being announced in May 2017. The primary endpoint of the study is the change in baseline of the YGTSS between placebo and active groups at the end of six weeks.

The company is also conducting a long-term Phase 2 clinical study of INGREZZA™ in patients with TS. The study is an open label, fixed dose study of up to 180 patients (90 children/adolescents and 90 adults) with the primary purpose being the assessment of long-term safety and tolerability of INGREZZA™. Enrollment is limited to subjects who completed either the T-Forward or T-Force GREEN studies. Patients are receiving once daily dosing of INGREZZA™ for a 24-week treatment period.

Elagolix Update

On February 10, 2016, AbbVie announced positive topline results from the second Phase 3 study of elagolix in patients with endometriosis, the Solstice study (NCT01931670). This was a 24-week, randomized, double blind, placebo controlled study evaluating the safety and efficacy of elagolix in 815 women age 18-49 with moderate to severe endometriosis-associated pain. The study was conducted across 226 sites in 13 countries, with equal representation of enrollment between U.S. and ex-U.S. countries. The Solstice study followed the Violet Petal study

(NCT01620528), which was designed just as the Solstice study but enrolled 872 women at 160 sites in the U.S., Canada, and Puerto Rico.

Results from the Solstice study showed that after six months of continuous treatment, both doses of elagolix (150 mg once daily and 200 mg twice daily) met the study's co-primary endpoints of reducing scores of non-menstrual pelvic pain (NMPP) and menstrual pain (or dysmenorrhea), associated with endometriosis as measured by the Daily Assessment of Endometriosis Pain scale. The responder rates from the second Phase 3 study were consistent with the results from the Violet Petal study, the results of which were released in January 2015.

The side effect profile for elagolix in the Solstice study was consistent with what was seen in the previous Phase 3 study as well as prior elagolix studies. The most common treatment-related adverse events (TEAEs) included hot flush, headache, and nausea. Overall discontinuation rates were similar between treatment groups (25.3%, 21.2%, 19.7% for placebo, 150 mg once daily, and 200 mg twice daily, respectively) while discontinuation due to TEAEs were 6.1%, 4.4%, and 10.0% for placebo, 150 mg once daily, and 200 mg twice daily, respectively.

Based upon it mechanism of action (discussed below), a loss in bone mineral density (BMD) is a potential side effect of elagolix treatment. AbbVie reported the following results in regards to mean percent change from baseline in BMD at the lumbar spine.

<table>
<tr><th colspan="3">Mean % Change from Baseline in Bone Mineral Density at Lumbar Spine (Month 6)</th></tr>
<tr><th>Placebo (n = 269)</th><th>Elagolix 150 QD (n = 174)</th><th>Elagolix 200 BID (n = 180)</th></tr>
<tr><td>0.49 (0.20, 0.78)</td><td>-0.71 (-1.07, -0.35)</td><td>-2.45 (-2.81, -2.10)</td></tr>
<tr><th colspan="3">Between Group Comparison vs. Placebo at Month 6</th></tr>
<tr><td rowspan="2">N/A</td><td>-1.2 (-1.67, -0.74)</td><td>-2.95 (-3.41, -2.49)</td></tr>
<tr><td colspan="2">P value vs. Placebo (<0.001 for both doses)</td></tr>
</table>

Source: Neurocrine Biosciences, Inc.

While both doses of elagolix resulted in a statistically significant decrease in BMD compared to placebo at the six month mark, the results for the 150 mg once daily dose were consistent with what had been seen in previous studies, while the 200 mg twice daily dose is indicative of a dose dependent effect. To put these data into perspective, after six months of treatment with Lupron, patients experienced an average loss in BMD of 3.2% (Lupron prescribing information). We do not find the loss in BMD caused by elagolix to be concerning and do not think it will interfere with getting elagolix approved, particularly given the statistically significant effect in the 150 mg once daily dosing group compared to placebo that resulted in much lower loss of BMD compared to Lupron.

AbbVie presented a number of abstracts on the results from the two Phase 3 studies at the 72nd American Society for Reproductive Medicine Scientific Congress & Expo in October 2016. We anticipate an NDA for elagolix in endometriosis being filed in the third quarter of 2017.

AbbVie is also evaluating elagolix in women with uterine fibroids (UF) in two replicate Phase 3 randomized, double blind, placebo controlled trials that are expected to enroll 400 subjects for an initial six-month placebo-controlled dosing period followed by an additional six-month dosing period in a safety and efficacy extension study. The primary efficacy endpoint of the studies is an assessment of the change in menstrual blood loss utilizing the alkaline hematin method comparing baseline to month six. We anticipate top-line efficacy data to be reported in late 2017.

Update on Essential Tremor

NBI-640756 is being developed for the treatment of essential tremor (ET), which is the most common movement disorder and affects an estimated 10 million people in the U.S. (American Academy of Neurology). That is ten times more Americans than have Parkinson's disease. The syndrome is characterized by a slowly progressing postural and/or kinetic tremor and usually affects both upper extremities. The condition affects all ethnic and geographic

populations and while it can become apparent during childhood or adolescence, onset is typically in adulthood, with a mean age of approximately 45.

While ET is rarely if ever fatal, the condition does cause significant functional disability that can affect handwriting, speech, and various activities of daily living including the ability to feed oneself, drink from a cup, or dress. In addition, the disability associated with ET can cause embarrassment that results in withdrawal from social activities, leading to a decreased quality of life.

Current treatment options for patients with ET include primidone, a structural analog of phenobarbital, and propranolol, a beta-andrenergic receptor antagonist. Surgical management of ET is typically reserved for patients with severe ET that does not respond to medication and includes ablative therapy through stereotactic thalamotomy (destruction of the thalamus) and deep-brain stimulation, which involves the placement of electrodes into the thalamus that are connected to a pulse generator that is implanted subcutaneously in the shoulder.

Neurocrine has successfully completed a Phase 1 single site, randomized, double blind, placebo controlled, sequential dose escalation, pharmacokinetic study to assess the safety and tolerability of a single dose of NBI-640756 in up to 32 healthy volunteers. Based on the results of that study, the company has initiated a second Phase 1, single site, randomized, double blind, placebo controlled, multiple dose, sequential dose escalation study to evaluate the safety, tolerability, and pharmacokinetics of NBI-640756 in up to 30 healthy volunteers over a week of continuous dosing. We anticipate data from this study later in 2017. Since the compound is just starting out in clinical trials we are not yet including it in our financial model, however with a patient population totaling 10 million, there is certainly a large potential opportunity for the company in ET.

Financial Update

On February 14, 2017, Neurocrine announced financial results for the fourth quarter and full year ending December 31, 2016. The company did not report any revenues for the fourth quarter, as expected, and had full year revenues of $15 million due to a milestone payment from AbbVie related to the initiation of Phase 3 clinical trials for elagolix for uterine fibroids. Neurocrine reported a net loss of $44.7 million, or $0.51 per share, for the fourth quarter, while for the full year the net loss totaled $141.1 million, or $1.63 per share. This compares to a net loss of $88.9 million, or $1.05 per share, for the full year ending 2015.

The net loss in 2016 was comprised of $94.3 million in research and development expenses and $68.1 million in general and administrative expenses, compared with $81.5 million in research and development and $32.5 million in general and administrative expenses for 2015. The increase in research and development expense was due primarily to expenses related to the efforts associated with the NDA filing for INGREZZA™ and additional scientific consulting expenses. The majority of the increase in general and administrative expenses between 2015 and 2016 was due to increased personnel expenses and additional expenses associated with market research, commercial launch preparation, and other professional services.

The company has provided initial financial guidance for 2017. Management expects revenues from milestones to be $30 million, with total operating expenses of $230-240 million, of which approximately $40 million will be non-cash share-based compensation expense. While no cash burn guidance was provided, the company exited 2016 with approximately $350 million, and we believe there is currently at least two years worth of cash to fund operations.

Conclusion

We believe there is a high likelihood of approval for INGREZZA™ for the treatment of TD on or before the PDUFA date of Apr. 11, 2017. The treatment of TD is a very meaningful market opportunity for Neurocrine. There are an estimated 500,000 TD patients in the U.S. with no real treatment options besides tetrabenazine. For valuation purposes, we assume U.S. approval of INGREZZA™ in TD will target roughly 150,000 of the total patients in the U.S. that are moderate-to-severe in disease state. For modeling purposes, we estimate the yearly cost of INGREZZA will be $20,000, which could end up being conservative, as management has guided for the cost to be $20,000 to $60,000 per year. If Neurocrine can capture 33% market share, which we believe is reasonable given the superior characteristics of INGREZZA™ vs. generic tetrabenazine, then peak sales estimates are approximately $1.6 billion in this indication in the U.S. alone.

For INGREZZA™ in TS, we estimate there are approximately 200,000 patients (approximately 70% are children/adolescents) with TS severe enough to require treatment in the U.S. Even with a conservative 15% peak market share, the opportunity for INGREZZA™ in TS is another billion-dollar opportunity.

We believe AbbVie will file an NDA for elagolix for endometriosis in the third quarter of 2017 and approval will occur in 2018. We model for peak sales of elagolix in endometriosis of $1.5 billion worldwide. Using a composite 20% royalty rate, we estimate peak royalties to Neurocrine of approximately $300 million from sales in endometriosis.

For elagolix in UF, we estimate that the topline data from the Phase 3 program will be available at the end of 2017, thus an NDA filing would most likely not occur until 2019, putting approval for elagolix in UF in 2020. We estimate that peak sales of elagolix in UF could top $2.6 billion worldwide. Using a composite 20% royalty rate, we estimate peak royalties to Neurocrine of over $500 million from sales in UF.

We believe the future is bright for Neurocrine and that the stock would make a solid core holding in the portfolio of any investor interested in the biotechnology sector. We have built a probability adjusted discounted cash flow model that yields a current valuation for Neurocrine's shares of $75.

PROJECTED FINANCIALS

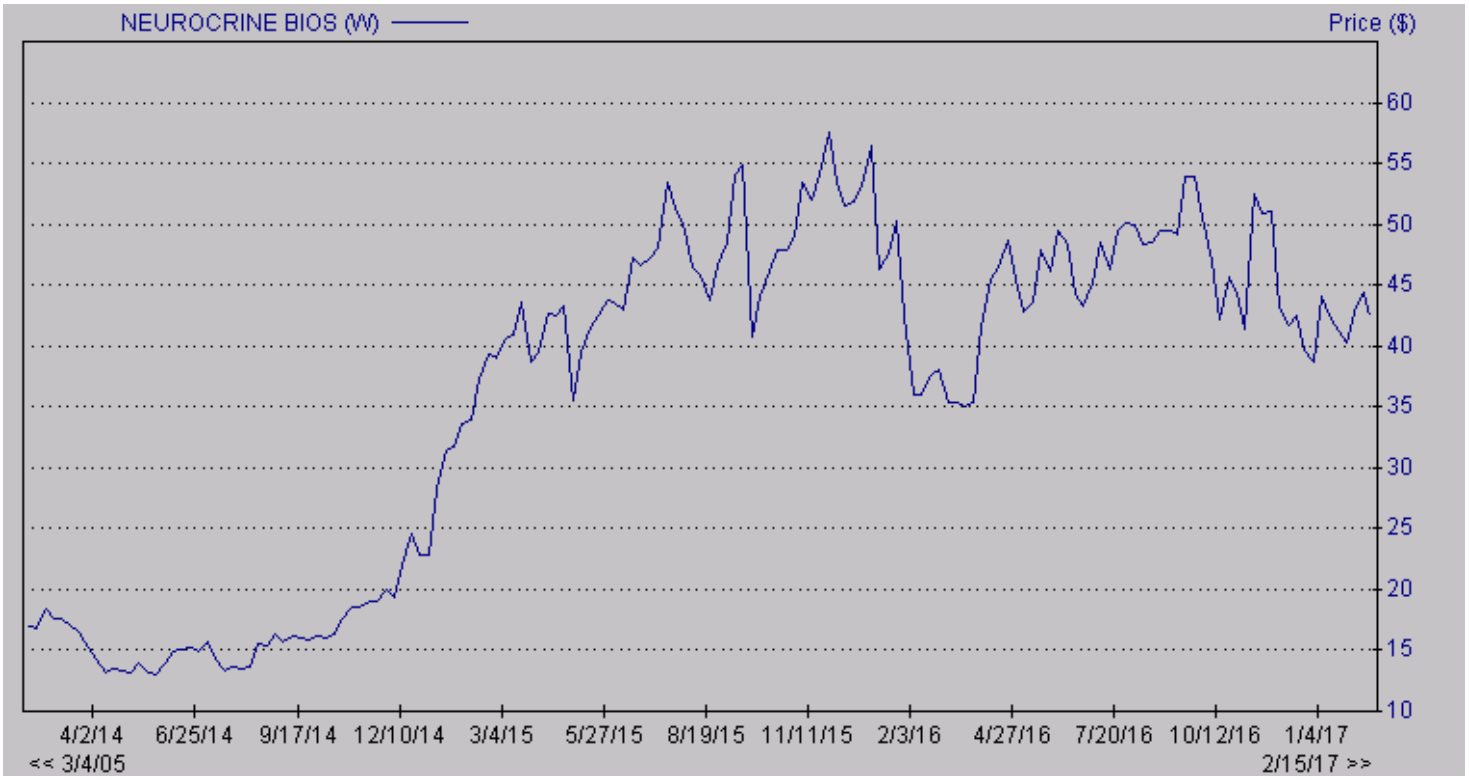
Neurocrine Biosciences Inc.
Income Statement

Neurocrine Bio	2016 A	Q1 E	Q2 E	Q3 E	Q4 E	2017 E	2018 E	2019 E
R&D / Milestones & Fees	**$15.0**	**$0**	**$0**	**$30**	**$0**	**$30.0**	**$30.0**	**$0.0**
YOY Growth	-	-	-	-	-	-	-	-
elagolix Royalties	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$23**	**$77**
YOY Growth	-	-	-	-	-	-	-	-
NBI-640756	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
YOY Growth	-					-	-	-
NBI-98854 (VMAT2)	**$0**	**$0**	**$0**	**$4**	**$13**	**$17**	**$111**	**$318**
YOY Growth	-	-	-	-	-	-	-	-
Total Revenues	**$15.0**	**$0**	**$0**	**$34**	**$13**	**$47.0**	**$164.0**	**$395.0**
YOY Growth	-	-	-	-	-	*213.3%*	*248.9%*	*140.9%*
CoGS / Royalties	$0	$0	$0	$0	$0	$3	$17	$48
Gross Margin	-	-	-	-	-	-	-	-
SG&A	$68.1	$25.0	$30.0	$35.0	$40.0	$130.0	$150.0	$160.0
R&D	$94.3	$25.0	$25.0	$25.0	$25.0	$100.0	$110.0	$120.0
Operating Income	($147.4)	($50.0)	($55.0)	($26.0)	($52.0)	($185.6)	($112.7)	$67.3
Operating Margin	-	-	-	-	-	-	-	-
Interest / Other Income	$6.3	$1.5	$1.5	$1.5	$1.5	$6.1	$5.0	$5.0
Pre-Tax Income	($141.1)	($48.5)	($53.5)	($24.5)	($50.5)	($179.5)	($107.7)	$72.3
Taxes	$0	$0	$0	$0	$0	$0	$0	$0
Tax Rate	*30.0%*	*0%*	*0%*	*0%*	*0%*	*30.0%*	*30.0%*	*30.0%*
Net Income	($141.1)	($48.5)	($53.5)	($24.5)	($50.5)	($179.5)	($107.7)	$72.3
YOY Growth	-	-	-	-	-	-	-	-
Net Margin	-	-	-	-	-	-	-	-
Reported EPS	**($1.63)**	**($0.56)**	**($0.62)**	**($0.28)**	**($0.58)**	**($2.06)**	**($1.21)**	**$0.80**
YOY Growth	-	-	-	-	-	-	-	-
Shares Outstanding	86.7	86.8	86.9	87.0	87.1	87.0	89.0	90.0

Source: Zacks Investment Research, Inc. *David Bautz, PhD*

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HISTORICAL STOCK PRICE



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