NESBITT BURNS

Moderator: Joanne Wuensch
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Operator: Greetings and welcome to the BMO Capital Markets Hidden Gems Conference Call Series with IRRAS. During today's presentation, all participants' lines will remain in a listen-only mode. Afterwards, we will conduct a question-and-answer session with instructions to follow. If at any time during today's presentation you need to reach an operator, please press star-0. Please note as well that this conference is being recorded, Monday, September 30, 2019. It is with pleasure that I now turn the conference over to Medical Technology Analyst Ms. Joanne Wuensch. Please go ahead.

Joanne Wuensch: Thank you and good afternoon everybody. And I know that we've had a busy - let's call it 10 days of our lives and just last week alone between robots in spine and cardiology products, we were pretty full up.

But today we're going to shift our attention a little bit towards the company IRRAS and so thank you everybody for joining us. We're pleased to have Kleanthis Xanthopoulos who is the President and CEO and Will Martin who is the Chief Commercial Officer join us today. Gentlemen, welcome.

Kleanthis Xanthopoulos: Thank you.

Will Martin: Thank you for having us.

Joanne Wuensch: Excellent. So we're going to start up just big picture and then I'm going to get into more detailed questions as we move throughout the period of time here. Why don't you start a little bit by telling us about yourselves, a brief history of the company and, you know, with the stock trades on the Swedish or Sweden Stock Exchange, how you sort of were attracted to the company and the history of its trading there?

Kleanthis Xanthopoulos: Thank you Joanne. Let me start. This is Kleanthis Xanthopoulos. So I have been in biotech for the most part of the last two, two and a half decades. I've been a CEO of three different companies taking a couple of companies public here in the US and now IRRAS in NASDAQ Stockholm.

I was involved with the company from the very beginning as an advisor to the largest institutional investor in the company. So I've seen the company grow from essentially a concept to what it is today. And I joined as an Executive Chairman and eventually took over as President and CEO about four years ago. Will?

Will Martin: Yes, Will Martin. I'm the Chief Commercial Officer of IRRAS. I've been with the company for about a year and a half at this point responsible for global sales and marketing planning and execution. IRRAS is my fourth early stage startup. I previously been involved in a handful of companies that I have exited; AccessClosure sold to Cardinal Health and AtheroMed which ended up selling to Philips Volcano. I'm very excited to be able to bring a new innovative technology to the world of neurocritical care here at IRRAS.

Joanne Wuensch: Okay. And then what is it - what is the relationship to Sweden?

Kleanthis Xanthopoulos: The company was founded in Sweden, the two major institutional shareholders with a large European family office that as I just mentioned before was advising for some time and then Swedish institutional investor. That was the reason the company was incorporated in late 2011 and started operations in 2012 in Sweden.

Having said that today of course the vast majority of the companies in the US, in Sweden we have a legal and finance and of course we are publicly traded there on the NASDAQ Stockholm Stock Exchange. The probably best market in Europe for young companies and has been performing like that for the past three or four years. But as I said, more than 80% of our employees and activities of the companies are in San Diego, California.

Joanne Wuensch: Excellent. Now, I've been calling it IRRAS and I hear you say IRRAS. So help me understand what this stands for?

Kleanthis Xanthopoulos: We'll talk a little more about this exciting technology of course that is fundamental to all of the products that we have now begun to commercialize in the US and Europe. IRRAS stands for Irrigation & Aspiration, so it's essentially a fusion of those two words.

It's a simple yet extremely powerful concept that we use for intracranial bleedings and that we have a computer that controls an electronic pump that then directs by a lumen catheter which is inserted into the bleeding or the hematoma of the patient. And then in frequent, every 20, 30, 40 seconds, in frequent intervals we'll essentially irrigate and aspirate thus allowing for months better and faster evacuation of the hematoma. And allowing of course to - at the same time monitor intracranial pressure and improve outcomes for

these patients. So the IRRAS is essentially the name of the company connected to the fundamental technology.

Joanne Wuensch: Wonderful. Big picture, how should we think about intracranial bleeding and how do you define the market size in the United States as well as Europe?

Kleanthis Xanthopoulos: The intracranial bleeding as basically the term indicates is anything that introduces unwanted blood outside of the circulation into the brain. That immediately becomes a very problematic and then unfortunately in many cases lethal for two reasons. One, and it of course accumulation of blood in a constrained volume which is where the brain is, increases pressure and the so called intracranial pressure in the brain and that immediately causes a number of issues, depletion of oxygen to neurons and you have a steady state of neuronal death. And ultimately of course if that is not taken care of, in other words if the intracranial pressure does not return to normal then you have some very significant neurological issues as long-term and in some cases fatal.

The second of course issue is that the blood outset of circulation is frankly toxic. There is tremendous amount of antigens presence in the blood that creates immunoinflammatory, in this case neuroinflammatory reaction. And that has some very severe consequences. So intracranial bleedings are very serious conditions, they need to be addressed graphically, intracranial pressure increases need to be managed very, very aggressively following the initial insult which maybe the rupture of an artery due to a stroke, hypertension, few more infection, et cetera. And of course prevent a secondary impact which will be a longer line, I just described the negative effects of increase intracranial pressure or immunoinflammatory reaction.

The second part of your question Joanne addresses the total market between traumatic brain injury and intracranial pressure - intracranial bleedings rather

based on the conditions that I just described mildly driven by chronic subdural hematomas and hemorrhagic strokes exceeds 1.2 billion in the US alone and it's growing rapidly with about 8% rate partially due to the aging of population this with the exception of traumatic brain injury and the conditions that we're described to see here are mostly conditions of the elderly.

And so it's a very healthy market and one that has been on top, has not been served, has not been the focus of attention of big companies for a long, long time.

Will, anything to add?

Will Martin: You hit the key pain points here Kleanthis. At the end of the day, as the population globally ages as cardiovascular disease that Joanne you referenced earlier continues to spread in advance away from the heart into other vascular bed such as the brain. The rate in incidence of stroke goes up tremendously.

And at our price points, a total addressable market of approximately 350,000 patients in the US and the EU alone very quickly adds up to over $1 billion market opportunity that truly is on top, because most of the competitors in the world of stroke have focused on a ischemic stroke which is the blockages of blood going through the brain, not the actual hemorrhagic stroke patients where blood escapes into the brain tissue.

Joanne Wuensch: Okay. For those who need a little bit of education, can you just give us some of the difference between a chronic subdural hematoma and acute subdural hematoma, some verbiage here I want to make sure that we unpack and everybody is on the same page.

Will Martin: Sure. I'll take even one step back from there as well. So you have a hemorrhagic stroke which is actual bleeding in the brain typically caused due to acute trauma or the rupture of a vessel - a weakened vessel or aneurysm in the brain which allows blood to escape into the surrounding tissue.

You also have the possibility of a subdural hematoma which is blood that is collected on the surface of the brain typically caught between the brain tissue itself and the skull. And as that blood collects, it places pressure upon the brain tissue and pushes the brain tissue out of the way.

These subdural hematomas typically happen after false and head trauma and those can be classified either as acute which happens right away or within the first couple of weeks or chronic which the blood collects over a period of time. And after it's been present for a couple of weeks, the symptoms start to become problematic and intervention is required.

Joanne Wuensch: Okay, very good. And how are these two situations right now, subdural hematomas and hemorrhagic strokes currently traded? What are you - what technology are you disrupting with your system?

Kleanthis Xanthopoulos: You do a very good work in that we are using a disrupting technology. But before we describe ours, let's talk about the standard of care today which is - frankly hasn't changed in over a two and a half, three decades and it's pretty archaic.

So basically what happens is the patient will be presented with a neurological symptom, severe headaches, vomiting, dilated pupils and will be rushing to the hospital sometimes in coma. And at that point the neurosurgeon or the ICU - head of ICU will determine after scanning and imaging to see how long

and how big the hematoma and how long it's been there, how big the hematoma is, where it is and basically categorize that.

If the decisions is made to attempt to evacuate that with an external ventricular drain which is what the standard of care is then a small hole will be introduced into the skull typically between six and eight millimeters and a catheter will be inserted, this will be a single lumen catheter that would essentially try to be placed in the middle of the hematoma. And then that will be connected to a collection bag and allow gravity alone to essentially evacuate the hematoma.

At the same time, either within that system or a secondary probe will be inserted to measure intracranial pressure. As I mentioned before, this is very significant particularly if one can do that on a continuous - in a continuous mode so you can read ICP values over a period of time at any given period you want to look at, in any given time you want to report that ICP.

That is the standard of care. It is full of shortcomings and limitations. Primary on this limitations the fact that these catheters typically will clot, especially if you treat them for more than 24 hours or so which is what you need to do for the more severe cases. The reports out there in the literature indicate that up to 47% will be included meaning that catheter will essentially stop draining because of the hematoma, all the debrief there that will prevent that catheter from being - doing the job and evacuating hematoma.

If that is to happen and as I said happens about 47% of the cases, now the nurse once they have realized that this happening, the nurse will come and attempt to de-clot the catheter which is typically opening the system and maybe disconnecting it from the collection bag and then inserting a syringe and sensibly putting back a logical solution to try to de-block the catheter.

That works some of the time, but it doesn't work most of the time. And if that doesn't work, now you have to replace the catheter and you risk infection and you risk secondary hematoma due to the extra manipulation.

Those numbers are after 28% risking of secondary hematoma because of the manipulation by taking one catheter out and introducing a second. And on an average, about 11% infection rates which of course are detrimental both the patient and the prognosis or the outcome and also the - financial impact, negative financial impact that it has to the hospital. So that is the standard of care that we're disrupting and we're disrupting it by taking this traditional treatment which is plugged with shortcomings. It's a manual intensive analog system, essentially the nurse has to go and check that the drainage is working, monitor manually the ICP and there is no way to be alerted if something goes wrong other than regular inspections on an hourly basis.

What we're doing here is we're completely taking this analog treatment and digitize it. So we're introducing a system that is controlled by a computer. That computer as I said dictates through an electronic pump, cycle segregation and aspiration through by lumen catheter and plus allowing the hematoma to be evacuated much faster and of course if anything in the process goes wrong, there is all this audio visual signals and alerts that through communication to the workstation over the nurses can alert them to the effect that there is an either elevated intracranial pressure which we monitor on a continuous basis or if there is any other major issue.

So what we have seen now both in the EU and the US having treated now clinically several 100, I mean several dozen in the US patients and over 100 in the EU, we can do this in a much faster way, much more productive in terms of evacuating the hematoma and therefore increasing the chances of a better outcome and reducing the overall cost. That's why we're actually believe that

we fundamentally transforming the way the intracranial bleedings are treated today.

Joanne Wuensch: Excellent. So let's talk a little bit about the IRRAflow device and given the shortcomings of what you've just gone through, talk about us competitive advantage.

Will Martin: Yes. When you look at the IRRAflow system, the competitive advantages complements the - exactly what Kleanthis just referenced in terms of historical treatments, shortcomings.

If you look at hemorrhagic strokes, whereas hemorrhagic strokes account for 15% to 20% of overall stroke volumes, they account for up to 50% of stroke deaths. These are critically ill emergent patients. And the historic standard of care has been a passive wait and see approach, see if we can get the patient stabilized and then assess if it's worth trying to continue therapy based on potential quality of life for these patients moving forward.

With IRRAflow, the key competitive advantage is taking that passive wait and see approach and transforming it into a proactive therapeutic approach. Being able to take the collective blood out of the brain faster, making sure that the system is irrigating continuously so that drainage is not affected and drainage can continually be ongoing and the patients - situation of the patient's condition, their intracranial pressure can be monitored nonstop and that's the key competitive advantage with IRRAflow.

IRRAflow takes a computerized digital pump, allows the physician and the neurocritical care staff to input parameters to therapeutically proactively treat the patient. The system automates irrigation of typically sailing or other physiological fluids every 20 seconds to every three minutes and that

irrigation allows the catheter, the drainage catheter to remain unblocked and that irrigation also exchanges a neutral solution into the ventricle, into the brain that allows the toxic blood byproducts to stay in suspension. And the longer these solid particulate can stay in suspension, the easier it is to drain them out and prevent their toxic impact.

If these solid particulate blood byproducts are allowed to settle, they clog communication channels in the brain, they're able to clot, they're almost impossible to remove. And so the fluid exchange process with IRRAflow really is the key strategic competitive advantage that differentiates just from the historic standard of care.

Joanne Wuensch: Excellent. Now, if I was looking at the IRRAflow system which I've seen, can you describe it for those who haven't seen it yet?

Will Martin: Yes. It truly is a razor and razor blade model. We have a small piece of capital equipment that is the brains of the system, the physician's treatment preferences are entered into the interface of the capital equipment, how much drainage I requested, how much irrigation needs to occur, high and low intracranial pressure alarms, these are offset within the small piece of capital equipment.

On the other side, there are two pieces of disposable equipment that are used on each patient in a single used fashion. There is a bilumen - dual lumen drainage catheter that is inserted into the patient's brain. The catheter insertion is actually almost identical to historic treatment which makes the learning curve very short for customers with the IRRAflow system. That catheter is placed into the brain and then is connected to the capital equipment with a small digital pump and that digital pump is what controls all of the

drainage and irrigation based on user setting preferences and based on patient treatments.

So in our ongoing revenue projections, 15% to 20% of our revenue is projected to be driven by the capital equipment and the other 80% or so will be driven by single used disposables on each patient.

Joanne Wuensch: Terrific. Let's talk about commercialization, where you are in terms of regulatory approvals.

Kleanthis Xanthopoulos: Let me start with the regulatory approvals and I will turn it over to Will to give you our commercialization strategy and specifically where we stand.

We as I said started the company in Europe and incorporated in Sweden and received a CE Mark in 2014, very early on based on some very early prototypes and some clinical work that was happening in Germany.

We then have been - we knew that CE Mark in 2016 and so we had a valid CE Mark until this year. And based on that, we launched in Europe in 2017 some changes that are required because of a change in notifying body, our original notifying body was a British company called Intratech. We - that essentially have exited the business from being in a regulatory body necessitated that we identified another notifying body, in this case it's a French company called G-MED/LNE and we are now being recertified by them. We are in the process of being recertifying and until we get that recertification we cannot formally market in the EU. But we expect that to happen in the next couple of months.

In United States, we received an FDA approval last year and we start building our own shelter marketing team and formally launched a product in the beginning of this year.

I'll turn it over to Will to give it a bigger overview of both the EU and US and our global view of how we're going to commercialize our products.

Will Martin: Thanks Kleanthis. It really is an exciting time for IRRAS with the transformation from a development company to a commercial company. Any time that you have the opportunity to bring a transformational type of technology to market, it changes the dynamic within the company on so many different levels.

For us, as a small European founded company launching globally, a key pillar of our strategy has been to control as many channels of distribution as we can. So we have built a small dedicated direct sales force in the key markets globally that allow our team to focus on our product and building the appropriate foundation for a legacy company.

Here in the US, after receiving FDA clearance in the third quarter of last year, we began building a direct team of territory managers. At this point, we have six direct territory managers as part of our team in key markets and in key geographies here in the US We started our commercialization in (earnest) at the beginning of 2019 navigating our way through which is approximately about a six-month sales cycle in the US to get the product into hospital systems to drive physician support, to gain initial patient experience and start to generate revenue.

Each of these territory managers has been focused on identifying physician champions and navigating that sales cycle and it was a very exciting

opportunity and period for us as a company and that we were able to report our initial US commercial revenue in the second quarter of this year. That commercial launch continues to grow with each passing day starting evaluations in additional hospitals and taking necessary steps forward to move from interest to revenue generation in the US and we expect that to continue in subsequent quarters.

Outside the US while we've been waiting for the recertification of our CE Mark which will allow us to recommence commercial activities in most European markets, we've been focused on other geographies globally that are more dependent upon FDA clearance as oppose to CE Mark. We've received regulatory approval in Israel which is a small but very advanced western medical market. We've generated our initial revenue in Israel and treated our initial patients there.

And we also recently just received our first regulatory approval in Costa Rica which is a small overall market, we don't expect it to amount too much from a long-term revenue potential standpoint, but it gives us a critical entry point into Latin America. It allows us to train our Latin American distributor and set the stage for larger Latin American markets where we expect to receive regulatory clearance such as Argentina and Mexico and others over the next six to 12 months.

That's the main focus that we've had commercially outside the US over the past six to 12 months. But our team in Europe, we have a small three-person direct sales team in Germany and we're working to add to that and other key European markets. They were at the European Congress of Neurosurgery last week in Dublin presenting the product, reengaging with customers appropriately as we await CE Mark and they're ready to get going again to

outline and accelerate our commercial experience outside the US much like their counterparts here in the US

Joanne Wuensch: Okay. Let's take a pause there. Operator, can you open it up for any questions and for those of you on the line, if you'd like to email me a question instead of asking it, I'll be happy to ask it.

Operator: Thank you. If you would like to register a question, please press 1-4 on your telephone. You'll hear a three-tone prompt to acknowledge your request. Again, to register questions, please press 1-4 on your telephone. One moment please for the first question. And there do not appear to be any questions on the phone lines at this time. I'll turn the call back to you, please continue.

Joanne Wuensch: Thank you. Let's talk a little bit about the status of the company's IP portfolio.

Kleanthis Xanthopoulos: Yes. So we have of course given the nature of that affirmative technology that we build a company on, we've paid a lot of attention on our intellectual property. And over at this point, a combination of the IRRAflow and the Hummingbird product line, we have over 46 patents or patent spending in - ranging six different families of IP that with different claims.

The very important thing is of course the vast majority of these have been either granted or at very late stages of being granted. Not just in the US and in the EU, but also in multiple other places around the world. So we feel that we have built a very significant IP portfolio. We've used this of course as a strategic asset and such that it will be very difficult for any competitor to enter the space without really infringing our intellectual property.

One distinction here is the number of patents of course that exist. As I said 40 right now, it comprises both of the IRRAflow which is what we have been focusing a lot and talking about so far, but also the Hummingbird product line which is a product line that we acquired earlier this year and is focusing on some very smart intracranial pressure monitoring systems as well as some other accessories that are all used in combination with our products, the IRRAflow products to treat these intracranial bleeding patients.

So we've felt that this is a very complementary product line. We acquired these products. We incorporated the IP and then that IP is also very, very strong both in terms of issued and patent spending.

Joanne Wuensch: Excellent. And can you talk a little bit about the - because we're going to go back to IRRAflow, but we should spend some time on Hummingbird. On IRRAflow, can you talk about the learning curve and the training process and the clinical data that you have to-date that helps on that?

Will Martin: Yes. Well, let's split that up into those two key components. From a learning curve perspective, it is rather straightforward. Any time you have a technology, you want to make sure that the initial experience is a positive one.

So our sales team spends a tremendous amount of time training and working particularly with the nurses in the neurocritical care unit to make sure that their comfort level with the system and with the operation of the software is straightforward.

It truly is a simple to use touch screen system that walks nurses and neurosurgeons very, very succinctly through setup an operation. So we've seen a very short learning curve there. And also our team works very closely with the neurosurgeons to ensure that the system placement, the catheter

placement in the brain is a familiar process for them. As I mentioned earlier, the catheter is placed in a very similar fashion to the traditional standard of care. So again, we've seen a very short, very manageable learning curve which is something that helps to ensure that early experience with the system is a positive one.

If you take the next step over to the other part of your question about clinical data, this is a critical piece not just for learning curve and early adoption, but also taking necessary steps towards becoming a standard of care in the treatment of hemorrhagic stroke patients. For us something we are heavily investing in and we have both short and long-term clinical projects to help in these efforts.

On the short term side, we're capturing a lot of early experience at our customers here in the US and translating that early experience into peer reviewed publications. We just had the first experience from the University of California Irvine with Dr. Sumeet Vadera. One of his early chronic subdural hematoma patients was published in the World Neurosurgery Peer Review Journal and we have several other subsequent publications that are eminent that outline use of the system in ventriculitis, intraventricular hemorrhage and so forth to get that experience out into literature and build an evidence-based upon which other interested physicians can rely.

Taking a step beyond that, we're also investing in the first wave of comparative clinical data that clinics at IRRAflow versus traditional passive drainage that historic standard of care. In fact, later this afternoon, we expect that one of the initial patients will be enrolled in a competitive study that is being conducted between European sites and sites here in the US and we're very excited to be able to accelerate enrollment in that comparative trial. Having those types of comparative data points really will allow us to take

significant steps forward commercially with the system to be able to take an intriguing concept and clear features and benefits and translate those into enhanced patient outcome.

Joanne Wuensch: Excellent. And the economic aspect of this system, one of the things you and I have been talking about includes (reduced) surgical time and ICU length of stay. You know, can you highlight some of the economic data that can help the hospital?

Will Martin: Yes, without a doubt everything that you do anywhere globally these days with medical devices has to have a value-based healthcare component to it. The days of walking in with a new technology and driving a premium price point are no longer here. You have to be able to sell an economic value proposition in addition to advancing patient care. And with IRRAflow that has been and will continue to be a key element of our messaging.

With IRRAflow, obviously we're taking a dated passive price sensitive market and bringing it from our perspective into the 21st Century with advancing the technology. There is a cost to that. However, we're working very closely with our initial customers to show them that even though our system may cost a little bit more upfront, the impact on overall economics for these critically ill patients is significant between reducing complications, between reducing length of stay in the neuro ICU unit, reducing overall surgical time and overall hospitalization time.

Our initial experience through approximately 100 patients globally has shown the ability to save upwards of $15,000 per patient. And if you extrapolate that over a hospital's volume over an annual basis, those numbers add up very, very quickly.

For instance, right here in New York at Mt. Sinai, they published a journal publication earlier this year that stated that the cost of an infection from a historic drainage catheter adds about 17 days on average to patient treatment and approximately $85,000 to the cost of patient care.

With our system and its fluid movement and being a completely close system that minimizes manipulation by the outside world, you also reduce the possible introduction of external pathogens. So our ability to drive down the rate of infection even by a small amount can have a profound impact economically on patient treatment and that's one of the key things from a clinical data standpoint we're constantly working to capture to be able to spread that message.

Joanne Wuensch: Excellent. And what is the current state of reimbursement?

Kleanthis Xanthopoulos: So for hemorrhagic strokes it's very well defined. In the US it is approximately $60,000 per patient and then there is an additional several thousand for the surgeon introducing the catheter. And so there is a very distinctive (BRG code) which will fold nicely under.

In the European Union, in average it's close to EUR 25,000 to EUR 30,000, a little more in Germany, close to EUR 37,000 for the procedure. So again, same thing, we can very nicely fit under the preexisting reimbursement for…

Joanne Wuensch: Okay. So just to be clear, this becomes part of the package of the reimbursement. The IRRAflow is not reimbursed specifically for itself?

Will Martin: No, we're very fortunate that we're able to walk into a market opportunity that has well established reimbursement codes that our system will fit within nicely. And provided that we're able to convince the customer base that we're

providing economic savings then it becomes an even more attractive proposition for hospitals.

Joanne Wuensch: Excellent. Let's talk a little bit about the Hummingbird. Can you describe the product and how it is different in the marketplace?

Kleanthis Xanthopoulos: Yes. So true to our philosophy of addressing the market with transformative products, not simply incrementally better products, we have been very interested in the overall intracranial pressure or neuromodulation monitoring market which today very strong market research analysis that is out there and published. It approaches 400 million globally and it's expected that portion alone meaning the monitoring of the intracranial pressure to exceed 600 million globally.

And one of the things that of course the neurosurgeon immediately thinks of is changes in intracranial pressure. And intracranial pressure is basically think about it as the blood pressure for the brain, too much and too little is bad. It has to be within the (country) limit.

Now, any of these impacts whether it's a hemorrhagic stroke, subdural hematoma or a traumatic brain injury, just traumatic brain injuries alone in the US require about 230,000 hospitalizations a year. And when the imaging happens, of course within the first hours of administration to the hospital you're trying to see if there is an active hematoma or not.

In the majority of the cases where there is no hematoma, you still want to measure intracranial pressure, because there will be changes of ICP even though that has not resulted yet or ever in bleeding of blood into the brain. That's where Hummingbird product line comes in. What we acquired was a very smart product that allows you to very accurately and with zero drift

monitor ICP. And I just mentioned a word that we haven't talked about before meaning zero drift and how does that play to the competition.

So as you measure intracranial pressure, the standard today is such that there is a deviation within 24 hours of the accuracy of the instruments measuring ICP. And that necessitate essentially balancing and then referencing the product on a daily basis which of course adds to the complication of the monitoring of ICP.

The Hummingbird ICP monitoring system does not require timing or rebalancing. It has zero drifting that it can operate over a period of days or weeks without drifting away and therefore because of that zero drift accurately monitoring the intracranial pressure over a large period of time.

In addition to the ICP monitoring system, we acquired some other products including intracranial bolt, those are essentially disposable bolts that you attach to the hole that is being - to the bare hole that you have created into the skull and that allows for multiple prompts to be introduced such that you can look at the metabolic rate of the brain following an injury or a stroke or hemorrhagic stroke. You can monitor at the same time temperature levels, oxygenation levels, et cetera. So that gives a complete picture to the neurosurgeon of what is going on into that brain following that impact that we discussed.

Joanne Wuensch: Excellent. So in the time left, I just want to go through some sort of corporate metrics, you know, that would include trailing 12-month revenue, sales force spilled and operating cash flow breakeven for the company.

Kleanthis Xanthopoulos: Okay. So let's start with sales and projections and we'll give you an - the rest in a minute. Will, do you want to come in?

Will Martin: Sure. We're as I mentioned early in the process of building a long-term sustainable legacy franchise both here in the US and globally with expected receipt of CE Mark in the not too distant future.

Our publicly communicated financial targets include, you know, by the end of 2021, SEK 275 million which is essentially a three-year goal of north of $30 million. You know, we're building the foundation appropriately now. I have a very full sales funnel where we have physician champions that have been identified at more than 40 US hospitals. We have ongoing evaluations at more than 15 - approximately 15 US hospitals. And we're navigating the approval process at approximately 20 to 25 hospitals here in the US.

Our sales funnel is quite full. Now it's a matter of just building physician support, building regular patient treatment and usage so that that foundation is strong and we can accelerate in coming years at our price points of approximately $50,000 for the capital equipments and approximately $4,000 per patient for disposables. The numbers add up very quickly. And in order for us to achieve those three-year revenue targets, it's engagement at approximately 10% of the stroke centers in the US, not getting 10% of the market, but having traction and having ongoing repeatable business at approximately 10% of the 1,000 stroke centers here in the US. That's a high level snapshot from our revenue perspective.

Joanne Wuensch: I like that high level snapshot, thank you. And then before we leave, you know, what are you thinking in regards to a US listing and any plans you can share with us at that front?

Kleanthis Xanthopoulos: Yes. Naturally the US is where the vast majority of the operations of the company is. We have an executive team with experience of operating

public companies in the US As I said before, I've been leading companies in the public domain, I'm taking companies public here in the US So we do - our thinking of a potential dual listing in the US at the appropriate time and of course part of that is a dialogue we're having today.

As our sales cycle becomes more predictable since we're very early in study cycle in the US, as our revenue projections become much more solid as our regulatory process in the rest of the world and importantly in the EU that recertification will allow us to launch in the EU. Having all of these early indications will allow us to think very seriously about a listing in the US

Joanne Wuensch: Excellent. Well, I had to say thank you very much to everybody who's dialed in. And thank you Will and Kleanthis for joining us today. And I hope you all have a great rest of Monday. Take care.

Kleanthis Xanthopoulos: Thanks very much.

Will Martin: Thank you, same to you. Take care.

Operator: Thank you. And that does conclude today's presentation. We thank you for your participation and ask that you please disconnect your lines. Have a great rest of the day everyone.

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