EDISON

Sequana Medical

DSR reduces congestion in heart failure

SAHARA DESERT interim study update

Pharma & biotech

Sequana Medical recently announced positive interim data on six patients in its two-phase SAHARA DESERT study in decompensated heart failure (HF) patients with persistent congestion despite maximal diuretic therapy. While the sample size is small, alfapump DSR was shown to eliminate persistent congestion, restore normal bodily fluid volume and improve diuretic response. The market need for improved HF congestion control is significant, given that there are over one million hospitalisations in the United States annually relating to HF, with c 90% relating to fluid overload (congestion). Sequana expects to report top line data from both phases of the study in H222, which should provide further insight into how effectively once-monthly maintenance DSR therapy can sustain the treatment effect.

Year end	Revenue (€m)	PBT* (€m)	EPS* (€)	DPS (€)	P/E (x)	Yield (%)
12/19	1.0	(14.9)	(1.22)	0.0	N/A	N/A
12/20	1.0	(19.0)	(1.25)	0.0	N/A	N/A
12/21e	0.5	(22.7)	(1.25)	0.0	N/A	N/A
12/22e	1.2	(22.8)	(1.22)	0.0	N/A	N/A

Note: *PBT and EPS are normalised, excluding intangible amortisation, exceptional items and share-based payments.

Robust treatment effect seen to date

Among evaluable patients in the two-phase study, an average weight loss of c 6kg (c 7% of body weight) versus baseline was observed at the end of Phase I. Diuretic response was also markedly improved compared to baseline, showing a more than doubling of sodium excretion levels (towards near-normal levels). Among four patients who, on average, had reached c 90 days into Phase II, the mean loop diuretics dose was reduced to less than 10% of the baseline (pre-study) dose level. Hence, early indications suggest an intense round of initial direct sodium removal (DSR) therapy, followed by a more convenient 'maintenance-level' treatment once-monthly can sustainably reduce congestion and the need for loop diuretics medication, even in patients with persistent congestion despite maximum therapy.

Safety profile generally favourable

There were no clinically significant changes in electrolytes after intense DSR therapy, and the reported adverse events were not substantial, in our view. There was one patient death in a severely ill subject who had a cardiac arrest three days after study initiation, although study site investigators deemed this event as unrelated to the study therapy, procedure or device. The Data Monitoring Committee (DMC) assessed the event as possibly related to the study therapy but recommended that the clinical study continue as planned.

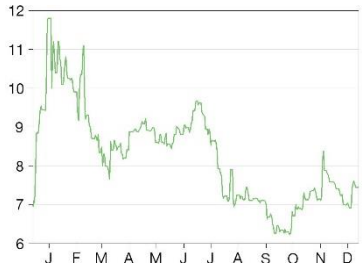
Valuation: Minor adjustments to rNPV

After adjusting our forex assumptions, we obtain a new pipeline rNPV valuation of €255.7m (versus €246.4m previously). After adding H121 net cash of €14.7m (excluding lease liabilities), we obtain an equity valuation of €270.4m or €14.55 per share (€13.30 fully diluted). We expect that Sequana's funds on hand (€21.8m gross cash as of 30 June 2021) should be sufficient for it to maintain operations into Q222, and we model it will raise €20m in 2022.

15 December 2021

Price	**€7.86**
Market cap	**€146m**
	$1.13/€
Net cash (€m) at 30 June 2021 (excluding €0.3m lease liabilities)	14.7
Shares in issue	18.58m
Free float	50%
Code	SEQUA
Primary exchange	Euronext
Secondary exchange	N/A

Share price performance



%	1m	3m	12m
Abs	3.7	21.7	13.3
Rel (local)	9.0	23.2	0.9
52-week high/low	€11.80		€6.22

Business description

Based in Belgium, Sequana Medical develops devices based on its alfapump platform for the treatment of diuretic-resistant fluid overload in liver disease, malignant ascites and heart failure. Alfapump is CE marked for refractory ascites and is in a pivotal North American study for this indication.

Next events

Completion of implantations within POSEIDON alfapump study	Q122
Top line results of SAHARA DESERT study	H222

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Edison profile page

SAHARA DESERT interim data show benefit in HF

Sequana Medical announced on 7 December positive interim data on six patients in its SAHARA DESERT study in HF patients with persistent congestion.

As explained in our initiation report, HF can often lead to sodium retention and resulting fluid retention and accumulation (congestion). Congestion in HF patients is generally treated with diuretics in the first line, most commonly loop diuretics (eg furosemide, bumetanide and torsemide), but these drugs become less effective with disease progression. Consequently, there are over one million hospitalisations for HF per year in the United States[1] and in Europe and of such admissions, c 90% is due to fluid overload[2]. Sequana's DSR approach aims to resolve persistent congestion through the periodic and controlled introduction of a zero-sodium infusate solution, which is designed to remove excess sodium in patients and would then be expected to lead to more regular fluid release into the kidneys and excretion.

The SAHARA DESERT interim results suggest that alfapump DSR can effectively and rapidly eliminate persistent congestion and restore euvolemia (normal bodily fluid volume) in diuretic-resistant HF patients.

Review of SAHARA DESERT study protocol

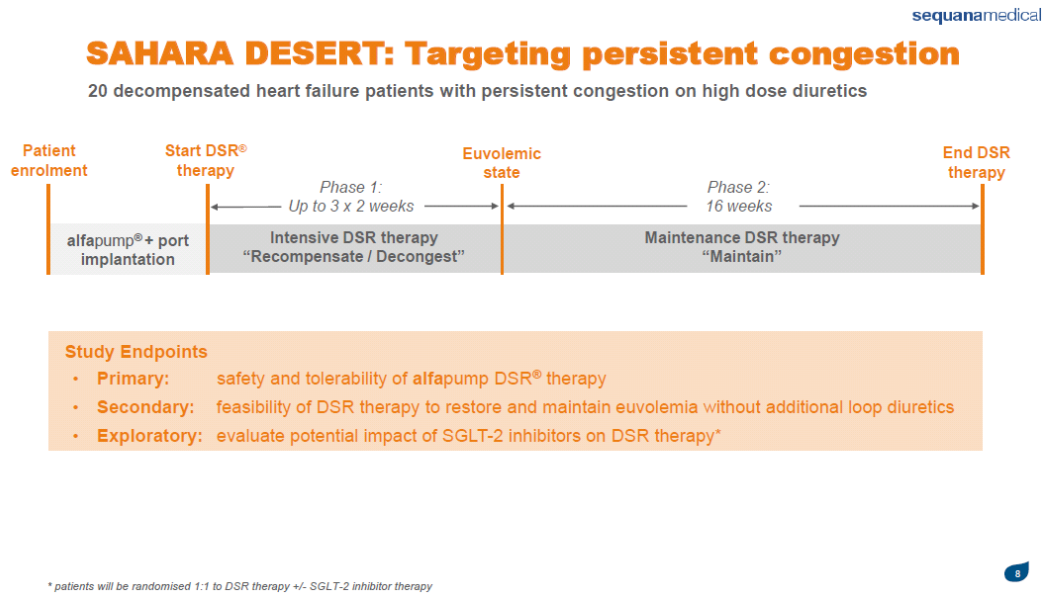
In May 2021, the company reported positive data from the RED DESERT study of repeated-dose alfapump DSR in chronic HF patients (taking high doses of oral diuretics), showing that the treatment led to significant and sustained reductions in patients' required dosing of diuretics after the six weeks of DSR treatment, lasting several months after the last treatment. The SAHARA DESERT trial assesses alfapump DSR in a more severely diseased HF population, namely those with decompensated HF with persistent congestion who were resistant to diuretic medication at study onset. Whereas patients in RED DESERT could manage their fluid overload with high-dose loop diuretics, the SAHARA DESERT study will enrol c 20 evaluable patients in the Republic of Georgia, who even despite taking high dose loop diuretics, still suffer from persistent congestion or fluid volume overload. Initial enrolment began in June 2021 and the open label randomised study consists of two arms (10–12 subjects each); where each arm uses alfapump DSR therapy, but one arm will also add the use of the SGLT2 inhibitor dapagliflozin (orally) to see if the drug provides added benefit. No specific data relating to the use of dapagliflozin were provided in the interim results.

At study onset, subjects are implanted with the alfapump device and discontinue all loop diuretics and then undergo DSR therapy in two phases: an intensive treatment phase (Phase I), followed by maintenance treatment and follow-up phase (Phase II) of 16 weeks.

[1] . Jackson SL, Tong X, King RJ et al. Circ Heart Fail. 2018 Dec;11(12):e004873. doi: 10.1161/CIRCHEARTFAILURE.117.004873. PMID: 30562099

[2] Costanzo MR, Ronco C, Abraham WT et al. J Am Coll Cardiol. 2017 May 16; 69(19): 2428–2445. doi: 10.1016/j.jacc.2017.03.528

Exhibit 1: SAHARA DESERT trial protocol



Source: Sequana Medical presentation

The intensive treatment phase (Phase I) lasts between two and six weeks (depending on patient response). In Phase I, DSR treatment will be performed for each subject with the baseline treatment regimen being 1L DSR infusate with a two-hour dwell time. Patients then receive up to once daily titrated DSR treatments for the remainder of Phase I. At the end of two weeks, if certain criteria are met including normalisation in fluid volume, the patient can move on to Phase II. If not Phase I can be repeated two more times up to a maximum of three two-week sessions lasting six weeks in total. During Phase II, all subjects will receive DSR in a monthly maintenance treatment session for four months in total. At study onset, patients underwent an IV diuretic challenge to measure their 'baseline' diuretic responsiveness and sodium content in urine output. Additional diuretic challenges are performed in the transition between both phases, and also at the end of Phase II, to evaluate the change in response compared to baseline.

Interim data shows improved diuretic response and euvolemia

All six evaluable patients had severe HF at baseline, as mean left ventricle ejection fraction (LVEF) and NT-proBNP (N-terminal pro b-type natriuretic peptide; levels increase when the heart is not pumping sufficient blood) were in the low 20% range and >6,000pg/mL respectively, versus typical values seen in healthy individuals of 50–70% and <125pg/mL (or <450pg/mL for those above the age of 75), respectively. Of the six evaluable patients, one had completed Phase II, three were still within the Phase II stage, one had completed Phase I (and was about to enter Phase II), and one was in the Phase I stage.

The results showed that at the end of Phase I, evaluable patients (n=6) had an average weight loss of c 6kg (c 7% of body weight) versus baseline. DSR therapy was rapidly effective, as three patients only required one two-week session of intensive therapy to meet the criteria needed for entering Phase II, whereas the other evaluable patients met the criteria after two two-week sessions.

Diuretic response at the end of Phase I markedly improved compared to baseline, showing a more than doubling of sodium excretion levels (towards near-normal levels, although specific figures were not provided), as measured by six-hour excretion of sodium after IV administration of 40mg furosemide. Four patients (to date) who had entered Phase II were able to reduce their loop diuretics dose to less than 10% of the baseline (pre-study) dose level, when evaluated on average

at c 90 days into Phase II. Hence, while we caution that the sample size remains small at this stage, it appears that the company's proposed approach of an intense round of initial DSR therapy, followed by a more convenient once-monthly maintenance-level treatment round thereafter can sustainably reduce congestion and the need for loop diuretics medication, even in patients for whom there was persistent congestion pre-DSR despite maximum loop diuretic therapy.

There was also a benefit of cardio-renal status shown at the end of Phase I, as the mean NT-proBNP level was reduced by more than 30% versus baseline. eGFR (estimated glomerular filtration rate) and creatinine measures were similar to baseline (quantities not specified), which the company views as a positive, as it had anticipated that a worsening in kidney function could occur in severely-ill HF patients immediately following rapid and significant volume removal, but this does not appear to be the case in the results to date. We believe it could be possible that in the Phase II (maintenance) part of the study, there could be potential improvements in renal parameters (eg increases in eGFR, as was shown in the six-week RED DESERT trial) as the reduction in sodium levels and congestion following the DSR treatment rounds, if maintained, would reduce kidney function burden.

Safety profile generally favourable to date

There were no clinically significant changes in serum sodium or in other electrolytes after intense DSR therapy, and the reported adverse events [diarrhoea (n=1), catheter blockage (n=1), smart charger communication error (n=2)] were not substantial or indicative of any particular concern with the DSR treatment or alfapump device safety. However, there was one patient death in a severely ill subject who had a cardiac arrest three days after study initiation (and who was in intensive care even prior to the study). The study site investigators deemed this event as unrelated to the study therapy, procedure or device. The clinical study's Data Monitoring Committee (DMC) assessed the event as possibly related to the study therapy but not related to the procedure or device. Overall, we believe the DMC has a more peripheral awareness of the event than the actual study site investigators who determined that the event was fully unrelated to alfapump DSR device or treatment considerations. In any event, to our understanding, the DMC has reviewed the event and conducted a meeting with the company and recommended that the clinical study continue as planned. Top line SAHARA DESERT data continue to be expected in H222.

Altogether, the interim SAHARA DESERT data to date suggest that alfapump DSR treatment, at least after an initial intense round, can result in improved control of fluid overload in HF patients with persistent congestion despite standard of care therapy. We expect the top line data to provide further insight into how effectively once-monthly maintenance therapy can sustain the resolution of persistent congestion, including the level to which systemic loop diuretics therapy can be reduced (vs baseline pre-treatment), as well as provide further indications of cardio-renal function (eg whether eGFR rates will improve versus baseline after Phase II).

RED DESERT follow-up data show continued effect

Sequana also reported expanded follow-up data for the RED DESERT study. Following the six-week trial, in a modified protocol, several patients were followed to determine whether the DSR treatment regimen continued to have sustained effects (ie if they were able to continue to control their fluid congestion at lower doses of loop diuretic drugs compared to baseline (pre-treatment)). Patients have been followed for up to 19 months to date. All patients had a reduction in their oral loop diuretic dose ranging from 40% to 96% at their last visit (versus baseline) within the extended follow-up period (9–19 months after the last DSR treatment in the study), showing a significant durability to the improvement in diuretic responsiveness following alfapump DSR therapy. One patient died nine months after the end of the study (this was deemed unrelated to DSR therapy).

Exhibit 2: RED DESERT longer-term follow-up data

RED DESERT: Long-term follow-up of patients

Durable improvement in diuretic response following alfapump DSR® therapy

Subject	Daily dose of loop diuretics**		Time since last DSR treatment in the study	Current known daily dose***	Currrent known reduction in diuretic dose
	At screening	During DSR treatment (D0 – D42)			
101-001	80	0	19 months	40	-50%
101-002	200	0	19 months	120	-40%
101-003	400	0	16 months	160	-60%
101-005	120	0	16 months	40	-67%
*101-006	80	0	14 month	20 EOD	-88%
*101-007	300 (400 EOD + 200 EOD)	0	9 month	40 BIW	-96%
*101-008†	600	0	9 month	80	-87%
101-009†	800	0	NA	NA	NA

* in follow-up extension with DSR; † subject 101-008 died in follow-up extension (9 months after end of study), subject 101-009 died at D3
** loop diuretics in furosemide equivalents (mg)
*** loop diuretics in furosemide equivalents (mg) – status 5 Nov 2021
EOD: every other day; BIW: two times per week

Source: Company presentation

Altogether, these extended results are encouraging as they continue to demonstrate that even several months after the discontinuation of a DSR infusion, there are lasting effects in terms of reducing a HF patient's need for diuretic medications to control their fluid overload.

DSR Infusate 2.0 progressing and MOJAVE DESERT on track

The company has also reported continued progress on its development of a proprietary DSR Infusate 2.0, which is designed to deliver a superior therapeutics profile (ie potentially reducing the amount of infusate that needs to be administered to render an equivalent therapeutic response) while providing the potential for a higher-margin recurring revenue stream. The infusate solution is a vital part of the DSR treatment approach since it will need to be administered repeatedly (providing revenue per infusion), and a simple 10% dextrose solution (ie the current DSR formulation) would not carry the premium pricing potential of a more specialised formulation (eg DSR Infusate 2.0).

DSR Infusate 2.0 is a proprietary formulation of the sugars, dextrose and icodextrin, and Sequana indicates pre-clinical development work and chemistry, manufacturing and control activities on it are progressing well and it expects to complete the process in or around mid-2022. We expect all human DSR studies after SAHARA DESERT will employ DSR Infusate 2.0 (as will the commercial products assuming eventual approval), starting with the MOJAVE DESERT study. MOJAVE DESERT is a US study on short-term DSR therapy in chronic HF patients with persistent congestion and it remains on track to start in H222.

As a reminder, short-term DSR therapy will involve repeated DSR treatment for c two weeks, using DSR Infusate 2.0 in combination with a peritoneal catheter (instead of requiring alfapump implantation). Similar to alfapump DSR, the goal of short-term DSR therapy would be to treat fluid overload by allowing the renal system to itself excrete excess sodium more effectively with diuretics (improving the patient's diuretic response) and improve cardio-renal parameters. The short-term DSR approach would require insertion or usage of a peritoneal catheter each time DSR therapy is applied, whereas the implantation of the alfapump ('alfapump DSR', also referred to as 'long-term DSR approach') avoids the need for repeated catheter insertion.

We believe that the company's rationale for advancing short-term DSR (without alfapump) therapy is primarily to provide clinicians with the option of a 'gateway' or one-off treatment for HF patients with persistent congestion, with the goal of transitioning them to alfapump DSR as the DSR interventions become required more often. Adding a short-term DSR approach (ie as a 'gateway product') may not increase the potential market for HF patients suffering from congestion, in our view, but could help accelerate DSR product adoption among clinicians by providing them with one-off DSR treatment options.

The company expects to start the first anticipated North American-based alfapump DSR trial, SONORAN (not a registration study) in H223, after the completion of long-term good laboratory practice (GLP) animal safety studies (expected in early 2023). We anticipate the completion of SONORAN in H224. For alfapump DSR and short-term DSR, we expect Sequana to enter into a sales and distribution partnership or agreement with an established medical device marketer with experience in the cardiovascular markets.[3] We expect the company to enter into such discussions while the SONORAN study is ongoing.

Exhibit 3: DSR therapy and alfapump DSR for fluid overload in HF milestones and timelines

Event	Start date	Approx. completion
Start SAHARA feasibility study in decompensated HF patients	Q221	Mid-2022
Formulation and manufacturing of DSR Infusate 2.0	Ongoing	Mid-2022
GLP animal study for short-term DSR (w/o alfapump)	Mid-2022	H222
MOJAVE Proof-of-concept short-term DSR US study	H222	Mid-2023
Phase IIb study for short-term DSR	Mid-2023	Mid-2024
GLP animal study for alfapump DSR	Mid-2022	Mid-2023
SONORAN alfapump DSR US study	H223	H224
Registration-enabling alfapump DSR and short-term DSR studies	Late 2024 (*)	H126 (*)
Partnership negotiations for alfapump DSR and short-term DSR	Mid-2023 (*)	Mid-2026 (*)
Potential US launch	H226 (*)	
Potential European launch	2028 (*)	

Source: Sequana Medical guidance and *Edison Investment Research estimates

Financials and valuation

Sequana had a net cash position of €14.7m at 30 June 2021 (€21.8m in cash offset by €7.1m in long-term debt) excluding €0.3m in lease liabilities. We have not modified our forecasts in local currency terms (for instance, in US dollars for the US market) and we continue to forecast net operating cash burn rates for 2021 and 2022 of €22.6m and €23.9m. We continue to expect that Sequana's funds on hand should be sufficient for it to maintain operations into Q222 and we believe the company will likely raise additional funds in the coming months. Our fundraising forecast needs are unchanged. We model that it will need to raise a total of €125m up until it starts to generate sustained positive operating cash flows in H127. We assume the company will raise €20m in 2022, €25m in 2023 and an additional €80m before FY27.

We continue to value Sequana Medical using a risk-adjusted NPV model with a 12.5% cost of capital for alfapump (in recurrent and refractory ascites, or RRA) in North America and alfapump DSR, and a 10% rate for alfapump in ex-North American markets (where it is commercialised). We are encouraged by the interim SAHARA DESERT data to date, showing that the treatment appears to address persistent congestion and improve diuretic response in HF patients with persistent congestion, and we await the release of top line results prior to reassessing our current probability

[3] We believe Sequana Medical may also consider partnering the alfapump DSR and short-term DSR programmes with a pharmaceutical company, but we believe an arrangement with a medical devices company is more likely.

of success estimate of 25% for the programme. We continue to apply a 60% probability of success for alfapump in RRA.

Exhibit 4: Sequana Medical rNPV assumptions

Product contribution	Indication	Stage	NPV (€m)	Probability of success	rNPV (€m)	rNPV/ basic share (€)	Launch year	Sales (€m) in 2032
alfapump in North America (net of R&D and SG&A costs)	Refractory and recurrent ascites and malignant ascites	Pivotal studying ongoing	219.3	60%	126.1	6.79	Mid-2024	184.9
alfapump in Europe and ex-NA regions (net of SG&A costs)	Refractory and recurrent ascites and malignant ascites	Commercial/ marketed	2.2	100%	2.2	0.12	2013	3.4
alfapump DSR and short-term DSR	Fluid overload in HF	Human feasibility studies	801.4	25%	185.0	9.96	H226 in US	457*
Corporate costs			(57.6)	100%	(57.6)	(3.10)		
Total			965.4		255.7	13.76		
Net cash (H121) excluding lease liabilities			14.7		14.7	0.79		
Total equity value			980.0		270.4	14.55		
Basic shares outstanding (000)			18,577					
Outstanding warrants and share options			1,747					
FD shares outstanding (000)			20,324					

Source: Edison Investment Research. Note: *Reflects estimate of projected transfer pricing revenue to Sequana Medical rather than end-market commercial sales.

We have made a slight revision to our forex assumptions ($1.13/€ versus $1.16/€ previously), resulting in a new pipeline rNPV valuation of €255.7m (versus €246.4m previously). After adding H121 net cash of €14.7m (excluding lease liabilities), we obtain an equity valuation of €270.4m or €14.55 per share (€13.30 fully diluted).

Exhibit 5: Financial summary

€'000s	2018	2019	2020	2021e	2022e	2023e	2024e
31-December	IFRS	IFRS	IFRS	IFRS	IFRS	IFRS	IFRS
PROFIT & LOSS							
Revenue	1,029	971	963	525	1,214	1,396	3,716
Cost of Sales	(158)	(198)	(202)	(105)	(243)	(279)	(743)
Gross Profit	871	773	761	420	971	1,117	2,973
General & Administrative	(8,206)	(7,102)	(6,738)	(7,103)	(7,038)	(8,529)	(13,791)
Net Research & Development	(5,816)	(7,652)	(11,835)	(15,606)	(15,500)	(12,000)	(12,500)
Operating profit before exceptionals	(13,150)	(13,981)	(17,813)	(22,289)	(21,567)	(19,412)	(23,318)
EBITDA	(13,070)	(13,737)	(17,506)	(22,117)	(21,380)	(19,275)	(23,214)
Depreciation & other	(81)	(244)	(307)	(172)	(187)	(137)	(104)
Operating Profit (before amort. and except.)	(13,150)	(13,981)	(17,813)	(22,289)	(21,567)	(19,412)	(23,318)
Exceptionals including asset impairment	74	18	41	17	0	0	0
Operating Profit	(13,077)	(13,964)	(17,771)	(22,272)	(21,567)	(19,412)	(23,318)
Net Interest	(883)	(878)	(1,178)	(416)	(1,229)	(3,157)	(5,255)
Profit Before Tax (norm)	(14,033)	(14,859)	(18,991)	(22,705)	(22,795)	(22,569)	(28,573)
Profit Before Tax (FRS 3)	(13,960)	(14,841)	(18,949)	(22,688)	(22,795)	(22,569)	(28,573)
Tax	(24)	(136)	(157)	(129)	0	0	0
Profit After Tax and minority interests (norm)	(14,057)	(14,995)	(19,148)	(22,834)	(22,795)	(22,569)	(28,573)
Profit After Tax and minority interests (FRS 3)	(13,983)	(14,977)	(19,106)	(22,817)	(22,795)	(22,569)	(28,573)
Average Number of Shares Outstanding (m)	10.0	12.3	15.3	18.3	18.7	18.7	18.8
EPS - normalised (€)	(1.41)	(1.22)	(1.25)	(1.25)	(1.22)	(1.20)	(1.52)
EPS - normalised and fully diluted (€)	(1.41)	(1.22)	(1.25)	(1.25)	(1.22)	(1.20)	(1.52)
EPS - (IFRS) (€)	(1.40)	(1.22)	(1.25)	(1.25)	(1.22)	(1.20)	(1.52)
Dividend per share (€)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
BALANCE SHEET							
Fixed Assets	242	829	772	640	486	385	374
Tangible Assets	184	765	705	561	407	305	294
Investments in long-term financial assets	58	63	67	79	79	79	79
Current Assets	3,099	8,522	13,441	12,142	8,372	10,295	7,444
Short-term investments	0	0	0	0	0	0	0
Cash	1,318	5,586	11,016	11,035	7,099	9,705	5,678
Other	1,782	2,935	2,425	1,107	1,273	590	1,766
Current Liabilities	(18,727)	(5,315)	(5,966)	(4,950)	(3,464)	(2,490)	(2,829)
Creditors	(6,654)	(4,855)	(5,966)	(4,950)	(3,464)	(2,490)	(2,829)
Short term borrowings	(12,073)	(459)	0	0	0	0	0
Long Term Liabilities	(3,374)	(3,110)	(8,135)	(7,839)	(27,839)	(52,839)	(77,839)
Long term borrowings	(2,582)	(2,261)	(7,473)	(7,089)	(27,089)	(52,089)	(77,089)
Other long term liabilities	(792)	(849)	(662)	(750)	(750)	(750)	(750)
Net Assets	(18,760)	926	113	(8)	(22,445)	(44,650)	(72,851)
CASH FLOW							
Operating Cash Flow	(8,987)	(17,596)	(15,791)	(22,087)	(22,674)	(19,202)	(23,679)
Net interest and financing income (expense)	(883)	(878)	(1,178)	(416)	(1,229)	(3,157)	(5,255)
Tax	(5)	(9)	(36)	(85)	0	0	0
Net Operating Cash Flow	(9,875)	(18,482)	(17,005)	(22,588)	(23,902)	(22,360)	(28,934)
Capex	(39)	(106)	(138)	(71)	(34)	(35)	(93)
Acquisitions/disposals	0	0	0	0	0	0	0
Financing	2	26,165	19,000	22,768	0	0	0
Dividends	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0
Net Cash Flow	(9,912)	7,576	1,857	109	(23,936)	(22,394)	(29,027)
Opening net debt/(cash)	0	13,337	(2,866)	(3,543)	(3,946)	19,990	42,384
HP finance leases initiated	0	0	0	0	0	0	0
Other	(3,425)	8,627	(1,179)	293	(0)	(0)	(0)
Closing net debt/(cash)	13,337	(2,866)	(3,543)	(3,946)	19,990	42,384	71,411
Lease debt	na	504	387	343	343	343	343
Closing net debt/(cash) inclusive of IFRS16 lease debt	13,337	(2,362)	(3,157)	(3,603)	20,333	42,727	71,754

Source: Company data, Edison Investment Research

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