Trickle Research

Every raging river, every great lake, every deep blue sea starts … with a trickle

Allocation Increase &Target Decrease

Perspective Therapeutics, Inc.

(NYSE American: CATX)

Report Date: 12/13/24

12- 24 month Price Target: *$20.50

Allocation: **6

Closing Stock Price at Initiation (Closing Px: 12/28/23): $4.55

Closing Stock Price at Target Increase (Closing Px: 03/19/24): $11.20

Closing Stock Price at This Allocation Increase (Closing Px: 12/12/24): $3.47

(All prices above reflect the impact of a 1 for 10 reverse stock split on 06/14/24)

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Trickle Research

Disclosure: Portions of this report are excerpted from Perspective's filings, website(s), presentations or other public collateral. We have attempted to identify those excerpts by *italicizing* them in the text.

Perspective founder and Chief Science Officer Dr. Michael K. Schultz Ph.D. presented at our conference in Denver, Colorado on November 11, 2024. To access a LiveStream of his presentation, click the link below. A copy of his presentation is available on our site: www.trickleresearch.com under the CONFERENCES tab.

https://youtube.com/playlist?list=PLRjGGqwsyMT4vJh1GoI-knxRJwgnlKF4Q&si=FagqvIV9jB_a6yOO

In retrospect, we thought the presentation was informative and constructive to our thesis that Perspective's platform technology has marked potential to be a first line defense against perhaps a variety of cancer types. However, shortly after the conference, on November 21, 2024, the Company released *initial results* from its ongoing Phase 1/2a clinical trial of [^{212}Pb]VMT-α-NET, which is the Company's novel treatment for neuroendocrine tumors. Here is a brief overview of those results from the Company's release:

- *[212Pb]VMT-α-NET continued to have a favorable safety profile, with no dose-limiting toxicities observed at the two doses tested (2.5 and 5.0 mCi)*
- ***Eight of nine** patients had durable control of disease. Six of nine patients had a measurable reduction of tumor volume, one of whom had a confirmed response as defined by RECIST v1.1. Signal of anti-tumor activity was generally more pronounced in patients with lower body weight*
- *Perspective is continuing all required activities to pursue dose escalation according to Safety Monitoring Committee recommendations; recruitment is ongoing at 5.0 mCi.*

The link below provides the full text of the initial results release:

Press Releases - Perspective Therapeutics

Given the chart below, specifically the compression in the stock since the date of the announcement (denoted by ★) the street clearly found the update disappointing. We will unpack the initial results and the corresponding response below.

From a high level, we would reiterate that the study is a 1/2a (dosing) study. From that perspective, it seems a bit counterintuitive to us that people would be coming to aggressive *efficacy* conclusions around a dosing study. First, from a statistical standpoint, the sample of 9 patients is not significant. Put another way, if the efficacy responses had been outstanding, the likely conclusion from most would (should) be that the results are promising, but still not significant from a statistical point of view. Second, the fact that the dosing to this point reflects no treatment-related serious adverse events (SAEs) suggests that higher dosing protocols are appropriate and are in fact the next logical step in a *dosing* study. It has been suggested that there is some risk that the FDA may not allow additional dosing to extend the study. To be honest, we had not considered that outcome, which we admit, would be a marked setback. To that end, we are not suggesting that *cannot happen*, we just think it is unlikely, given the demonstrated safety profile to this point. We would add, as the respective 1-2a preliminary results presentation notes "the Safety Monitoring Committee *has recommended dose escalation* which will be considered with FDA".

We think some of the consternation in the street regarding the dosing study, centers around some other comparative companies that are also pursuing radiopharmaceutical technologies and perhaps more specifically, ^{212}Pb iterations. We *think* the inference is that clinical results from those studies indicated better efficacy results from similar dosages to those used in Perspective's 1-2a noted above. Our first rection to that is to refer back to the notion above regarding the significance of 9 patients. Furter, as we understand it, there are some nuances to the dosing comparisons and subsequent follow-up that are worth considering.

First, **Table 1** below is from the Company's presentation dated November 21, 2024. The chart includes a comparison of Perspective's NET technology VMT-α-NET. That information is in the far right column. Recognize, this information is from the Company's study in India, not from the 1-2a dosing study. We think it is reasonable to say that in this particular chart/comparison, VMT-α-NET performed well in terms of both safety and relative efficacy. We would note, and specifically with respect to the two Pb studies, these studies were each dosed on the basis of the patients' body weights expressed as µCi/kg (millicuries per each kilogram of the patient's weight).

Table 1.

Competitive Landscape: NET Radiopharmaceutical Trials

Rationale for testing higher doses of VMT-α-NET

	^{177}Lu-DOTATATE	^{177}Lu-DOTATATE	^{212}Pb-DOTAMTATE	^{225}Ac-DOTATATE	VMT-α-NET
Study	NETTER-1 [1] [2] RCT; randomized 2:1 N = 229	NETTER-2 [4] RCT; randomized 2:1 N = 226	Phase I/II [5] Single arm N=44	ACTION-1 Phase Ib/III [6] Phase Ib: Single arm N=17	Investigator led research [7] N=13
Dose Level (administered)	4 x Q8W 200 mCi	4 x Q8W 200 mCi	4 x Q8W 67 µCi/kg → 4.7 mCi/70 kg	4 x Q8W 3.2 uCi/kg → 0.23 mCi/70 kg	4 x Q8W 67 µCi/kg → median 2.9 mCi
Patient Population	SSTR2+, GEP-NETs	SSTR2+, GEP-NETs	SSTR2+, GEP-NETs	SSTR2+, GEP-NETS	SSTR2+ GEP-NETs, B-NETs, MTCs
Prior PRRT	0%	0%	0%	100%	62%
Median time from dx	3.8 years	1.9 months	5 years	5 years	N/A
Performance Status	Karnofsky Performance Scale Median was 90	Karnofsky Performance Scale 83% at 90-100	N/A	ECOG 0 (59%), 1 (41%)	ECOG 0 (38%), 1(31%), 2 (31%)
Histology	Well differentiated G1 (66%), G2 (35%)	Well differentiated G2 (73%), G3 (27%)	Well differentiated G1 (18%), G2 (68%), G3 (7%)	Well differentiated G1 (47%), G2 (53%)	Well differentiated G1 (15%), G2 (85%)
PFS	Median 28.4 vs 8.5 months [3]	Median 22.8 vs 8.5 months	74.3% at 24 months	NE (95% CI: 12 months, NE)	Median 16.4 months
ORR (CR/PR)	13% (1%/12%) vs. 4% (0%/4%)	43% (5%/38%) vs. 9% (0%/9%)	56%	29.4% confirmed 41.2% (6%/35%) w/ unconfirmed	62% (0%/62%) confirmed
AEs (>20%)	Nausea, vomiting, fatigue, diarrhea, abdominal pain, multiple laboratory abnormalities	Nausea, diarrhea	Alopecia, nausea, fatigue, appetite↓, diarrhea, dysphagia, lymphocyte count↓, abdominal pain, vomiting, weight↓, blood glucose↑	Nausea, fatigue, weight↓, hyperglycemia, abdominal pain, constipation, vomiting, multiple laboratory abnormalities	>10 events: alopecia, anemia, fatigue, nausea
Grade 3+ (>10%)	Lymphopenia (44%), GGT↑ (20%)	TEAE: 35%	TEAE: 52% Lymphocyte count↓ (25%)	TEAE: 53% Anemia (18%), lymphocyte count↓ (18%), creatinine clearance↓ (12%)	Anemia (2 events)
Other notes	5 Lu-177 treated patients withdrew due to renal-related events	Nephrotoxicities 13 (8.8%) vs. (2.0%)	Dysphagia treated with Botox injection		Transient dysphagia resolved without intervention

(1) US prescribing information; (2) DOI: 10.1056/NEJMoa1607427; (3) NANETS 2021; (4) DOI: 10.1016/S0140-6736(24)00701-3; (5) ASCO 2024; (6) ASCO 2024; (7) SNMMI 2024.
No head-to-head studies between the products have been conducted. Given the different study designs and methods, cross-trial comparisons cannot be made.
The information on this slide is not intended to promote the products referenced herein or otherwise influence healthcare prescribing decisions. The safety and efficacy of the agents under investigation have not been established. There is no guarantee that the investigational agents will receive regulatory approval or become commercially available for the uses being investigated.

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In contrast to the data in **Table 1**, Perspective's 1-2a dosing study was not administered on the basis of patient body weight. Rather, as **Table 2** below reflects, the study was designed with each patient in each respective Cohort receiving 4 doses of the same measure. For instance, those in Cohort 1 received 2.5 millicuries ("mCi"), while those in Cohort 2 were given escalated dose of 5 millicuries. To reiterate, that is a different dosing protocol than that which was used in the competing ^{212}Pb-DOTAMTATE study, as well as in Perspective's own India trial.

Table 2.

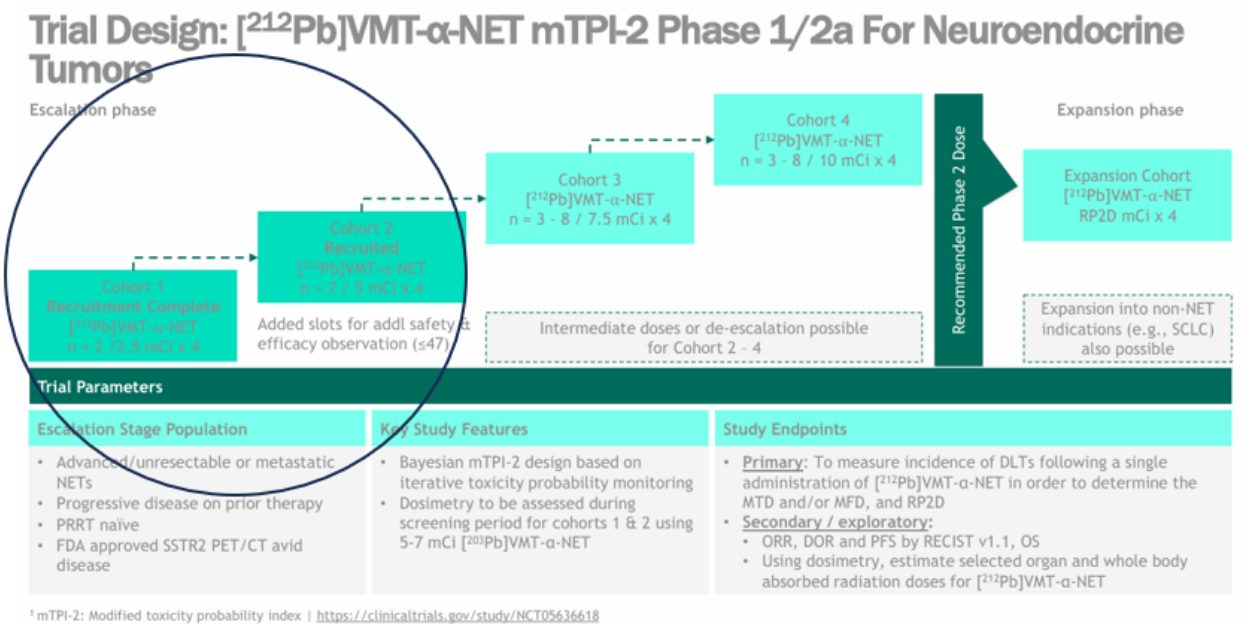
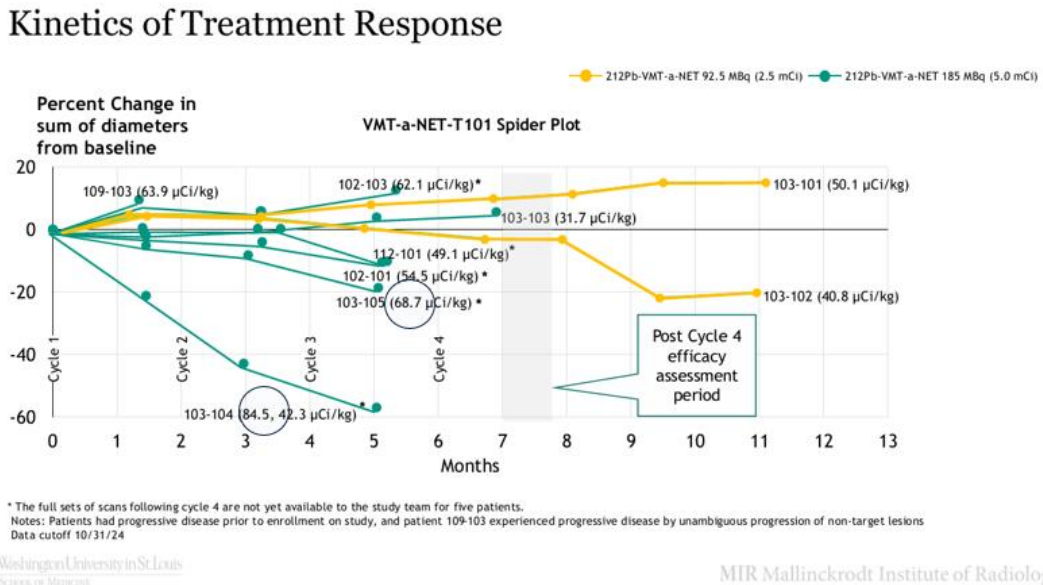


Table 3 below provides some preliminary efficacy data as determined by RECIST v1.1. protocols. We have some observations around this as well.

Table 3.



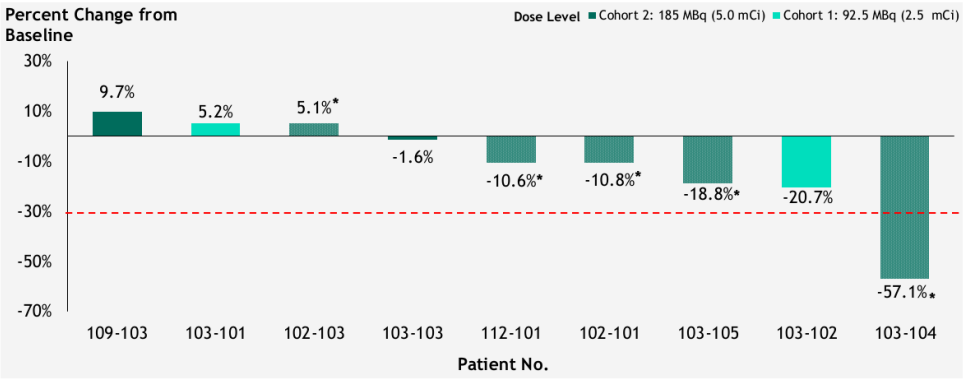
First, we would point out that **Table 3** includes RECIST v1.1 data for each of the 1-2a dosing study subjects. However, the table provides some conversions based on the weights of each subject. That conversion allows

us to draw more direct comparison to results from the ^{212}Pb-DOTAMTATE and Perspective's India studies referenced in **Table 1** above. To that end, we have circled the results from the Company's 1.2a dosing subjects who have as the time of the preliminary results experienced the best results by RECIST v1.1 standards. Notice, on a µCi/kg (millicuries per body weight) basis, the best results among the study patients occurred amongst the two that received the highest relative doses *by body weight* (patients 103-104 and 103-105). We think that points to the likelihood that higher doses of VMT-α-NET may improve outcomes, which by extension supports the continuation of the dosing study cohorts 3 and 4, which will include dose escalations.

Aside from delineating the dosing studies results in the context of patient body weight, there is another item in **Table 3** that we think is topical to the efficacy inferences from the preliminary results. Most notably, that they are preliminary. Notice the shaded area of **Table 3** between months 7 and 8 referred to the "Post Cycle 4 Efficacy Assessment Period". To edify, as part of the protocol, each study participant is scanned prior to the first dosing cycle, and then scanned after each subsequent dosing cycle. Those results are compared against one another to determine if the identified tumors have grown, shrunk or remained the same. Notice, as of the cutoff date (10/31/24) of the preliminary results release, the scans following the 4th and final dose of the 6 remaining subjects in Cohort 2 were available for only 1 patient. In our view, the street's negative reactions to the preliminary results release likely are related to assumptions around the subjects' RECIST v1.1 results. These results are provided below in **Table 4**, but again, for most in Cohort 2, they do not include comparative scans following the 4th and final dosing(s). We think that is quite topical to any assessment regarding the efficacy of dosing levels associated with Cohort 2, which again, includes doses lower than what may prove optimal in terms of both safety and efficacy. Further, as we demonstrated in **Table 3**, only two of the participants in Cohort 2 (and technically only 1½) received doses above those in the 212Pb-DOTAMTATE study and/or the Company's own India study. While we are not suggesting that the 4th and final scans of these participants will definitively reflect improved RECIST v1.1 results, given the trajectories reflected in **Table 3**, we think that outcome looks more likely than not for at least some of the Cohort 2 subjects. In short, the verdict is still out on the final scans/outcomes of Cohort 2, which again we still think represents a suboptimal dosage in any case. That brings us to another topical point, which is the limited nature of RECIST v1.1 data.

Table 4.

Preliminary Response Assessment by RECIST v1.1 by Patient



* The full sets of scans following cycle 4 are not yet available to the study team for five patients.
Note: Patient 109-103 experienced progressive disease by unambiguous progression of non-target lesions
Data cutoff 10/31/24

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In clinical trial vernacular, RECIST v1.1, is known as a "surrogate" endpoint. More specifically:

> (Surrogate End Points and Their Validation in Oncology Clinical Trials | Journal of Clinical Oncology) "The National Institutes of *Health defines a surrogate end point as "a biomarker intended to substitute for a clinical endpoint."2(p91) The FDA considers a surrogate end point of a clinical trial to be "a laboratory measurement or physical sign used as a substitute for a clinically meaningful endpoint that measures directly how a patient feels, functions, or survives and that is expected to predict the effect of the therapy."3(p13235) Compared with a clinical end point, a surrogate end point can usually be measured earlier and requires a smaller sample size and a shorter follow-up time. In oncology, biomarkers measuring a drug's biologic antitumor activity, such as objective response rate (ORR) and progression-free survival (PFS), have been proposed and evaluated as surrogate end points in clinical trials".*

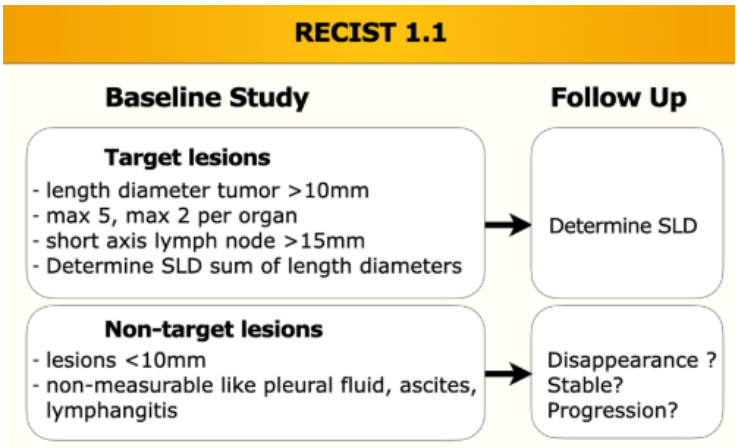
To edify, the industry uses surrogate endpoints to measure the impact of specific therapies (approved and not yet approved) because they may be an indication of a particular outcome (endpoint), but they are not generally regarded as perfectly, or even preponderantly correlated to more definitive endpoints. Recognize, the RECIST v1.1 protocol essentially involves identifying a few tumors (via scan) prior to treatment that are well defined enough to measure (X millimeters wide by Y millimeters long), and then measuring them again following each dosing regiment to monitor if *those specific tumors* have grown, shrunk, or stayed the same.

Tabel 5 below from: The Radiology Assistant : RECIST 1.1 - the basics provides a schematic of the RECIST v1.1 protocol. The following bullet points provide some definition of the quantitative measures and associated vernacular that RECIST uses to describe or categorize the changes in the tumors over time and following particular treatments and/or doses of treatments.

The criteria to determine whether a tumor disappears, shrinks, stays the same or gets bigger are:

- "CR" = Complete Response. The disappearance of all lesions and pathological lymph nodes.
- "PR" = Partial Response.
  - ≥ 30% decrease in the **sum of the length of diameters** ("SLD") of the measured tumors.
  - No new lesions.
  - No progression of non-target lesions.
- "SD" = Stable Disease.
- "PD" = Progressive Disease. ≥20% increase in SLD compared to smallest SLD in study or progressions of non-target lesions or new lesions.

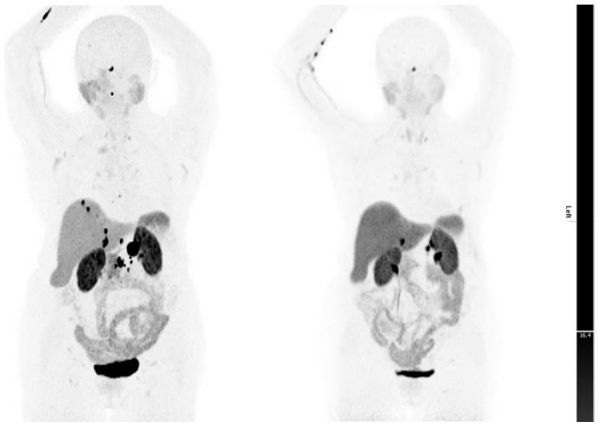
Table 5.



To relate the above general RECIST data to Perspective's 1.2a dosing study, refer back to **Table 4**. The Red dotted horizontal line in **Table 4** represents the "PR-Partial Response threshold (≥ 30% decrease in the **sum of the length of diameters** ("SLD") of the measured tumors, no new lesions and no progression of non-target lesions) of the RECIST categories. That is, patient 103-104 eclipsed that threshold and as their particular scan below reflects (**Table 6**), it appears that several of their non-target lesions shrunk or disappeared as well. Recall, from **Table 3**, based on millicuries dosed per patient body weight, patient 103-104 was the highest dosed patient in the study through the first two of four doses.

Table 6.

Patient 103-104 – ^{212}Pb VMT alpha NET Rx 5 mCi x 2, 2.5 mCi x 2



Pre-Rx 3/2024 Post Rx 10/2024

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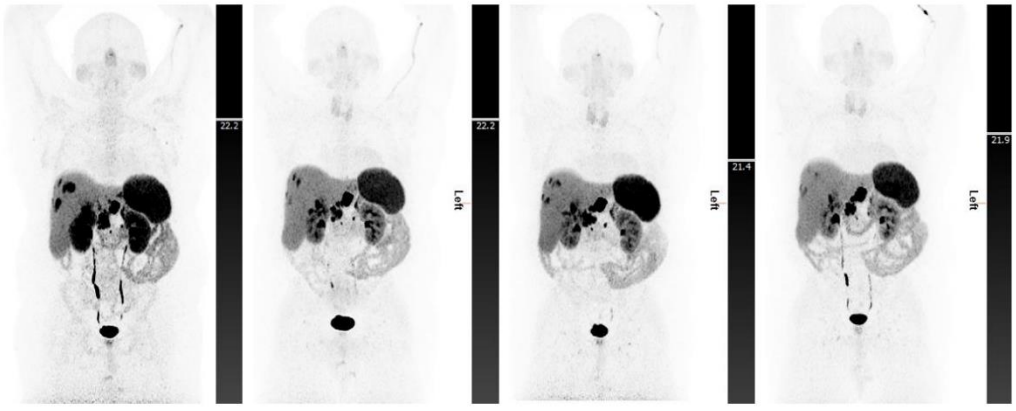
On the other hand, **Table 7** below reflects the scans of patient 103-103.

Table 7.

Patient 103-103 – ^{212}Pb VMT alpha NET 5.0 mCi x 4



Baseline 1/2024 3/2024 5/2024 9/2024

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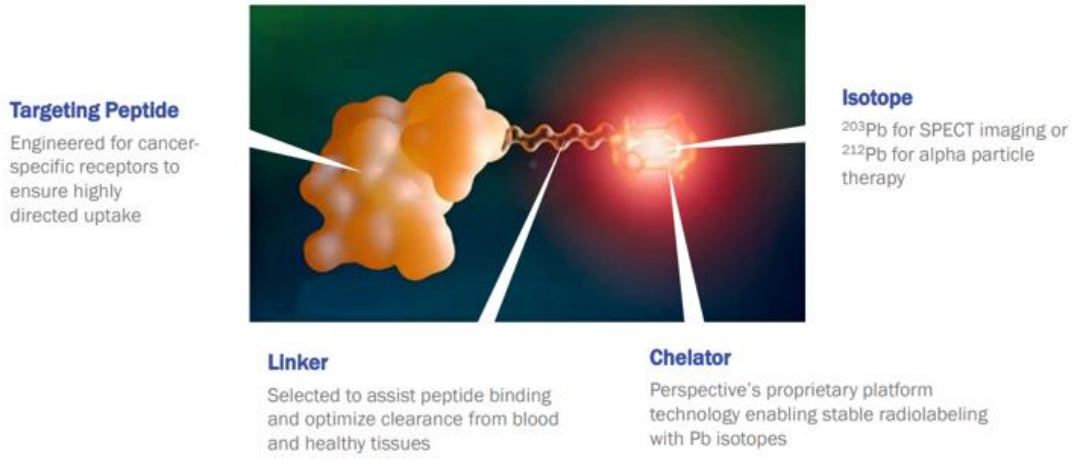
From **Table 3 and Table 4** above, patient 103-103 does not reflect much progress per the RECIST measures. That is, apparently the sum of lengths of the **target lesions** have not shrunk measurably. However, while the scans do not identify the target lesions, it looks to us like the overall number of lesions (likely the non-target lesions) has decreased measurably. We submit, reading these scans is well above our aptitude, but it appears that the patient has experienced positive results from the treatment in terms of overall tumor burden, while at the same time experiencing perhaps less positive results with respect to the target lesions. More specifically, **Table 6** illustrates our point about the information provided by a surrogate endpoint like RECIST v1.1. In short, while the RECIST target lesions information for patient 103-103 may be unremarkable, the scans also appear to indicate efficacy in terms of entirety of the lesions. To be clear, we are not suggesting that the RECIST results from the study are of no value. They most certainly provide good information about the efficacy of this or any other study for that matter. We just believe these results represent a single data point that is not in and of itself definitive in terms of actual endpoints. As we noted, we also believe the dosing data is premature on the face, because, again, the preliminary data do not even reflect results from the final, post treatment scans. To that end, we would add, we are particularly interested in seeing the final scan result from patients 102-103 and 103-103, as they seem to have the least robust results through the cutoff. All of that noted, in our opinion the street may be reading too much into this single data point, although we certainly do not pretend to know what everyone out there is thinking or interpreting. We also admit that as generalists, we lack some of the medical aptitude that others following and/or covering the stock may have, so maybe they know something we do not. Absent that notion, we think the stock has been markedly oversold based on *our interpretation* of the preliminary results.

Lastly, we are of the view that there are multiple pieces of value to the Perspective story that may not be fully appreciated. As we noted in the initiating coverage, the company's alpha particle deliver system includes fully proprietary components, which include proprietary peptides they develop that bind to receptors often specific to certain cancer types as well as a proprietary linker that tether the peptide to the chelator, which holds the isotope as it its transported to the tumor. The Company's chelator is proprietary as well, and they note that their chelator *"retains 98% of 212Bi after transition in drug formulation whereas generic chelators leak the 212Bi alpha-emitting daughter up to 36%*". (To clarify, ^{212}Pb is not an alpha emitter, but its resulting decay iteration ^{212}Bi {Bismuth} *is an alpha emitter,* which the Company proprietary system is able to deliver to the tumors).

Table 8.



In addition to the above, the Company has also focused on the development of its own *"flexible and scalable isotope supply"*. This is an important attribute especially in terms of being able to take advantage of the safety profile afforded ^{212}Pb radioisotopes with short half-lives that mitigate exposure to healthy tissue vis-à-vis isotopes with much longer half-lives. However, that short half-life is both the good news and the bad news, because along with shorter half-lives, come the challenges involved with generating, transporting and administering the drug before it decays into something of not therapeutic value. The Company believes they have addressed that challenge, in part with their proprietary ^{212}Pb generator. As we noted in our conference overview of Perspective, they recently announced the completion of their (second) ^{212}Pb drug manufacturing facility in Somerset, New Jersey.

In our view, the turnkey nature of the Company's platform (and its proprietary pieces) provides Perspective with an advantage over competitors that may rely on 3rd party suppliers of portions of the delivery system (leaking chelators for instance). As we also noted in our conference overview, the Company is actively developing additional ligands/peptides that can bind to other specific cancer cells. Recently Company presentations have addressed this potential more acutely, and we expect to hear more about those opportunities going forward as well. Our point is that we think there is much more going on here (and more underlying value) than can/will be demonstrated in a single 1.2a dosing study that we think has clearly demonstrated the rational for the continuation of additional (higher) dosing cohorts. To that end, we submit, apparently others see that differently.

In summary, we do not think the stark compression in the stock is congruent with the preliminary results of the 1.2a dosing study. As we addressed in some of the prior coverage, the Company has raised an extraordinary amount of cash through 2024, which we believe has eliminated one of the primary risks associated with small biopharmaceutical companies, namely access to enough capital to conduct and complete clinical trials. Granted, that does not ensure clinical success, but it does ensure the basis for establishing clinical success or failure. Unfortunately, companies cannot get to one without the other. To that end, the Company ended September 2024 with $268 million of cash and short-term investments, which is roughly equal to the current market capitalization of the Company. To reiterate, we think the stock appears markedly oversold

We would add one final thought. Perspective's predecessor was a private company called Viewpoint Molecular Targeting, Inc. The founders of Viewpoint have spent over 15 years developing the technology largely in collaboration with the University of Iowa, and that collaboration remains ongoing and robust today. 15 years is a long time, even in biotechnology terms, and we think it is fair that say that the researchers involved here are some of the pioneers in radiopharmaceutical technology, especially as it pertains to theranostics and the use of alpha particles to identify and kill cancer cells. Granted, studying something for over 15 years does not guarantee success, but we think the depth and the body of that work is not being reflected in the share price.

We are establishing a new 12-18 price target of *$20.50, which is a bit lower based primarily on our assessments around new share counts and in turn assumed additional future share counts to address cash needs. Further, given the price destruction of the shares in the face of trial updates that we clearly interpret differently than others, we are raising our allocation from 5 to **6.

Projected Operating Model

Perspective Therapeutics, Inc.						
Projected Operating Statement						
By Trickle Research						
	(Actual)	(Actual)	(Actual)	(Estimate)	(Estimate)	(Estimate)
	3/31/24	**6/30/24**	**9/30/24**	**12/31/24**	**Fiscal 2024**	**Fiscal 2025**
Sales	$ -	$ -	$ -	$ -	$ -	$ -
Grant revenue	$ 325	$ 526	$ 369	$ 250	$ 1,470	$ 1,000
Total revenue	$ 325	$ 526	$ 369	$ 250	$ 1,470	$ 1,000
Cost of sales	$ -	$ -	$ -	$ -	$ -	$ -
Gross profit	$ 325	$ 526	$ 369	$ 250	$ 1,470	$ 1,000
Operating expenses:						
Research and development	$ 7,452	$ 9,275	$ 12,028	$ 12,112	$ 40,867	$ 49,303
Sales and marketing	$ -	$ -	$ -	$ -	$ -	$ -
General and administrative	$ 5,878	$ 5,514	$ 6,975	$ 7,028	$ 25,395	$ 27,526
Change in estimate of asset retirement obligation	$ -	$ -	$ -	$ -	$ -	$ -
Loss on disposal of property and equipment	$ -	$ -	$ -	$ -	$ -	$ -
Total operating expenses	$ 13,330	$ 14,789	$ 19,003	$ 19,140	$ 66,262	$ 76,828
Operating loss	$ (13,005)	$ (14,263)	$ (18,634)	$ (18,890)	$ (64,792)	$ (75,828)
Non-operating income (expense):	$ -	$ -	$ -	$ -		
Interest income	$ 1,211	$ 3,076	$ 3,581	$ -	$ 7,868	$ -
Interest (expense)	$ (29)	$ (23)	$ (69)	$ -	$ (121)	$ -
Other income (expense)	$ (461)	$ (494)	$ -	$ -	$ (955)	$ -
Non-operating income, net	$ 721	$ 2,559	$ 3,512	$ -	$ 6,792	$ -
Net loss before deferred income tax benefit	$ (12,284)	$ (11,704)	$ (15,122)	$ (18,890)	$ (58,000)	$ (75,828)
Deferred income tax benefit	$ -	$ -	$ -	$ -	$ -	$ -
Net loss	$ (12,284)	$ (11,704)	$ (15,122)	$ (18,890)	$ (58,000)	$ (75,828)
Basic and diluted loss per share (in dollars per share)	$ (0.02)	$ (0.18)	$ (0.21)	$ (0.27)	$ (0.82)	$ (1.07)
Weighted average shares used in computing net loss per share:						
Basic and diluted (in '000's)	495,100	66,648	70,629	70,629	70,629	70,879

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Trickle Research co-sponsors two microcap conferences each year. Trickle Research encourages its coverage companies to present at those conferences and Trickle charges them a fee to do so. Companies are under no obligation to present at these conferences. Perspective Therapeutics, Inc. has paid fees to present at Trickle co-sponsored conferences and we will encourage them to do so in the future.

Portions of this publication excerpted from company filings or other sources are noted in *italics* and referenced throughout the report.

Rating System Overview:

There are no letters in the rating system (Buy, Sell Hold), only numbers. The numbers range from 1 to 10, with 1 representing 1 "investment unit" (for my performance purposes, 1 "investment unit" equals $250) and 10 representing 10 investment units or $2,500. Obviously, a rating of 10 would suggest that I favor the stock (at respective/current levels) more than a stock with a rating of 1. As a guideline, here is a suggestion on how to use the allocation system.

Our belief at Trickle is that the best way to participate in the micro-cap/small cap space is by employing a diversified strategy. In simple terms, that means you are generally best off owning a number of issues rather than just two or three. To that point, our goal is to have at least 20 companies under coverage at any point in time, so let's use that as a guideline. Hypothetically, if you think you would like to commit $25,000 to buying micro-cap stocks, that would assume an investment of $1000 per stock (using the diversification approach we just mentioned, and the 20-stock coverage list we suggested and leaving some room to add to positions around allocation upgrades. We generally start initial coverage stocks with an allocation of 4. Thus, at $1000 invested per stock and a typical starting allocation of 4, your "investment unit" would be the same $250 we used in the example above. Thus, if we initiate a stock at a 4, you might consider putting $1000 into the position ($250 * 4). If we later raise the allocation to 6, you might consider adding two additional units or $500 to the position. If we then reduce the allocation from 6 to 4 you might consider selling whatever number of shares you purchased with 2 of the original 4 investment units. Again, this is just a suggestion as to how you might be able to use the allocation system to manage your portfolio.

For those attached to more traditional rating systems (Buy, Sell, Hold) we would submit the following guidelines.

A Trickle rating of 1 thru 3 would best correspond to a "Hold" although we would caution that a rating in that range should not assume that the stock is necessarily riskier than a stock with a higher rating. It may carry a lower rating because the stock is trading closer to a price target we are unwilling to raise at that point. This by the way applies to all of our ratings.

A Trickle rating of 4 thru 6 might best (although not perfectly) correspond to a standard "Buy" rating.

A Trickle rating of 7 thru 10 would best correspond to a "Strong Buy" however, ratings at the higher end of that range would indicate something that we deem as quite extraordinary..... an "Extreme Buy" if you will. You will not see a lot of these.