13/14

ANNUAL REPORT

DESIGN: CATINO

IMMUNICUM
ALLOGENEIC DC-BASED IMMUNOTHERAPIES

Immunicum carries out clinical trials with the cancer vaccine INTUVAX and has an ongoing phase I/II study in primary liver cancer. A recently completed phase I/II study in metastatic renal cell carcinoma shows promising survival data and a follow-up phase II study is in the final stages of planning and is expected to begin early 2015.

RESULTS

- Profit/loss after financial items was -16.2 MSEK (-6.9).
- The number of shares at end of period was 20,030,000 (13,775,000).
- Profit/loss per share was -0.81 SEK (-0.50) calculated before and after dilution.
- Operating expenses were 17.2 MSEK (7.0).

FINANCIAL SITUATION AND LIQUIDITY

- Immunicum's cash and cash equivalents at the end of the financial year were 107.8 MSEK (25.6).
- Total equity at end of period was 100.2 MSEK (24.6) and the equity/assets ratio was 92% (92).
- Equity per share was 5.00 SEK (1.78).

IMMUNICUM
DENDRITIC CELL-BASED IMMUNOTHERAPEUTICS

Contents

Immunicum in brief

Immunicum AB (publ) develops vaccines for the treatment of cancer. The Company's most advanced project is INTUVAX® *for the treatment of renal cell carcinoma. The project portfolio contains three additional projects against various tumor indications, including liver cancer.*

Follow-up data from a completed phase I/II study in mRCC with INTUVAX® was presented at one of the world's largest scientific cancer conferences – ASCO. The results indicate that INTUVAX® may boost the body's immune system and thereby prolong overall survival of patients with renal cell carcinoma. There were also signs of synergistic effects with tyrosine kinase inhibitors, which is another type of drugs against tumor indications. No observable vaccine related side effects have been reported.

Based on the positive results from the phase I/II study, Immunicum will conduct a comprehensive phase II study, which is expected to begin early 2015. Alongside this work, the Company is running a clinical study with INTUVAX® for the treatment of liver cancer.

Immunicum's project portfolio consists of four different projects – two of which are in clinical phase – protected by one Swedish, one European and one U.S. patent, and five pending patent applications.

STRATEGY

Immunicum's strategy is to advance therapeutic cancer vaccines through clinical phase II studies and then seek to out-license the product candidates to larger pharmaceutical companies developing cancer immunotherapies.

The Company's goal is to offer cancer patients treatment alternatives that will improve survival and quality of life. Since Immunicum's vaccines are based on platform technologies, the company can develop vaccines against many different types of cancer indications. In addition to royalties, the licensing agreements are expected to generate one-time payments as well as substantial sums for each milestone reached, which will enable the Company to validate the effect of the vaccine for additional indications.

PROJECT PORTFOLIO

Immunicum has developed two different technology platforms for the development of immunotherapies: COMBIG and CD70. The Company also recently acquired a technology platform (adenovirus vector) which can be used in SUBCUVAX® for antigen production and oncolytic therapy of different cancer indications.

Both COMBIG and CD70 are based on findings showing that dendritic cells from other individuals function as great immune boosters in combination with tumor antigens when used for cancer vaccination. The main difference between the technologies is that COMBIG aims at activating the patient's T-cells specifically against cancer, so that they can kill tumor cells, while the CD70 platform aims at powerful in vitro expansion of already tumor-specific T-cells and then injecting them into the patients and this way create a stronger immune reaction against cancer. The latter method is generally referred to as adoptive immunotherapy, and is a relatively new way to treat cancer. The difference between Immunicum's CD70 platform and the adoptive immunotherapies developed by other organizations is that tumor-specific T-cells expanded using Immunicum's CD70 method are expected to show significantly improved survival rate in the human body.

Drugs based on the COMBIG and CD70 platforms are presently being developed for use as stand-alone products, but there may be future opportunities to combine the two treatments. Immunicum currently runs four different projects, but with a strong focus on the one based on the COMBIG platform, on which the vaccines INTUVAX® and SUBCUVAX® are being developed.

The CD70-platform is in a preclinical phase and is currently under development in collaboration with a research group at Uppsala University Hospital. SUBCUVAX® has undergone several important animal studies with positive results and thanks to the recently acquired adenovirus vector, it may now be scheduled for clinical testing.

GOALS

Immunicum has set the following goals through 2015:

- COMPLETE THE CLINICAL PHASE I/II STUDY IN PATIENTS WITH PRIMARY LIVER CANCER.
- DELIVER FOLLOW-UP SURVIVAL DATA FROM THE CLINICAL PHASE I/II TRIAL IN PATIENTS WITH METASTATIC RENAL CELL CARCINOMA.
- INITIATE A PHASE II TRIAL IN PATIENTS WITH METASTATIC RENAL CELL CARCINOMA.
- COMPLETE THE PRECLINICAL DEVELOPMENT OF THE CD70 PLATFORM.

2015

A few words from the CEO

During the financial year 2013/14, Immunicum has reached the company goals and made much progress relative to the plan. We have been able to continually deliver better-than-expected survival data for the renal cell carcinoma patients that have been treated with INTUVAX in our phase I/II study.

The Company performs a clinical study to evaluate safety and efficacy in patients with primary liver cancer. We have strengthened our financial position through a directed new share issue and an oversubscribed rights issue. Another important milestone during the financial year was the approval in the U.S. of the patent application for Immunicum's core technology.

Preparations of the phase II study of INTUVAX in patients with metastatic renal cell carcinoma are in progress and we expect the study to begin in early 2015. The follow-up analysis continues of the seven patients who were part of the phase I/II study and are still alive. Information regarding these patients gives us hope for the future that INTUVAX may play an important part as a standard treatment of renal cell carcinoma. The median survival for patients with a poor prognosis continues to increase and now has more than doubled, compared with what is expected of the standard treatment used today for metastatic renal cell carcinoma.

The clinical trial in patients with liver cancer continues. Our estimates indicate that the initial results of the study can be reported in late 2014. The study in liver cancer is designed to allow an evaluation of safety and efficacy. Even though liver cancer is a much more aggressive and multifaceted disease than renal cell cancer, we are still hopeful that INTUVAX will improve the prognosis also for these severely ill patients.

Besides developing of INTUVAX, we are making progress in other projects. During spring, we presented promising preclinical results for our CD70 technology, and we recently announced the acquisition of the rights to a vector that gives Immunicum independence with regards to the production of tumor antigens, which is one of the key components of our therapeutic cancer vaccine SUBCUVAX, which can be injected in healthy subcutaneous tissue. A variant form of the vector can also be used to produce tumor cell killing virus particles for so-called oncolytic therapy of various forms of cancer, by which our product portfolio is expanded even further.

Immunotherapy and therapeutic vaccines are in focus in the development of future treatments of cancer, and the clinical data we have presented at leading scientific congresses such as ASCO 2014, 3rd Annual Cancer Vaccines Conference and 22nd Annual International Cancer Vaccine Symposium has resulted in a great interest – both from researchers and clinicians as well as the pharmaceutical industry. We view our participation in scientific events as an excellent way to present Immunicum's technology platforms not only to scientists but to the pharmaceutical and biotech industries as well. Immunicum strives to initiate future collaboration with both research institutes and commercial partners. Several discussions regarding collaboration are in progress and the focus continues to be out-licensing deals for our renal cancer project after we have conclusive phase II data.

Immunicum's position in the development of therapeutic vaccines for various types of cancer has strengthened considerably during the year and we have the financial strength needed to complete the next important clinical trial in INTUVAX.

A third of the population will some time in their life be the victim of cancer, and Immunicum continues its high-pace work to make a contribution to new treatments that can increase quality of life and survival for a large part of the affected patients.

JAMAL EL-MOSLEH,
CEO

The stages of drug development

All drug development begins with preclinical research that spans everything from the detection of an active compound or therapy, to the development and improvement of the concept, including tests in appropriate animal models. Tests in animals are important in order to determine that the drug does not have any serious side effects, and that is has the desired physiological effect. The tests in animals are also subject to regulatory approval. Based on the results of this preclinical work, an application can be submitted to seek approval for tests of the drug in humans. When an application is filed with the relevant regulatory authorities – in Sweden this means the Medical Products Agency ("Läkemedelsverket") – an evaluation of the entire scientific documentation provided by the applicant is carried out by independent medical experts in order to determine whether studies in humans, so-called clinical trials, may be initiated. If an approval to initiate a clinical trial is granted, the trial must be conducted through three distinct phases, where each phase has its well-defined purpose. Each successfully completed phase increases the probability to receive market approval, which also increases the value of the project. Below, we present a short description of the different phases of clinical trials (from Fass 2012 and other sources).

PHASE I/II

A drug candidate is usually tested in healthy volunteers, but in Immunicum's case, the vaccine is tested on cancer patients, with the primary objective to study safety.

PHASE II

The drug candidate is tested in various patient groups and the goal is to determine the optimal dose, the dosage schedule and to study efficacy.

PHASE III

The drug candidate is tested in large patient groups and the goal is to ensure statistically significant efficacy prior to market approval.

PHASE IV

Even after approval, the drug is subject to further scrutiny in follow-up studies in treated patients.

THE PHASE I TRIAL is the first time a new compound is administered to human subjects. Normally, the test subjects are a group of healthy volunteers, kept under constant medical surveillance. The purpose of the study is to determine whether the test subjects tolerate the drug and whether it behaves in the body in the way indicated by the animal studies and other research. Phase I trials are also used preliminarily to try out what dosage may be given to future patients: the study begins with the lowest dosage considered sufficient to determine the safety profile of the therapy, but if everything goes according to plan, it may be increased as the study progresses. Since Immunicum's vaccine, INTUVAX®, is tested in cancer patients and not in healthy volunteers, the Company has the opportunity not only to study any side effects (primary purpose), but also to study efficacy of the treatment (secondary purpose). That is why the first therapeutic cancer vaccine study is referred to as a phase I/II trial.

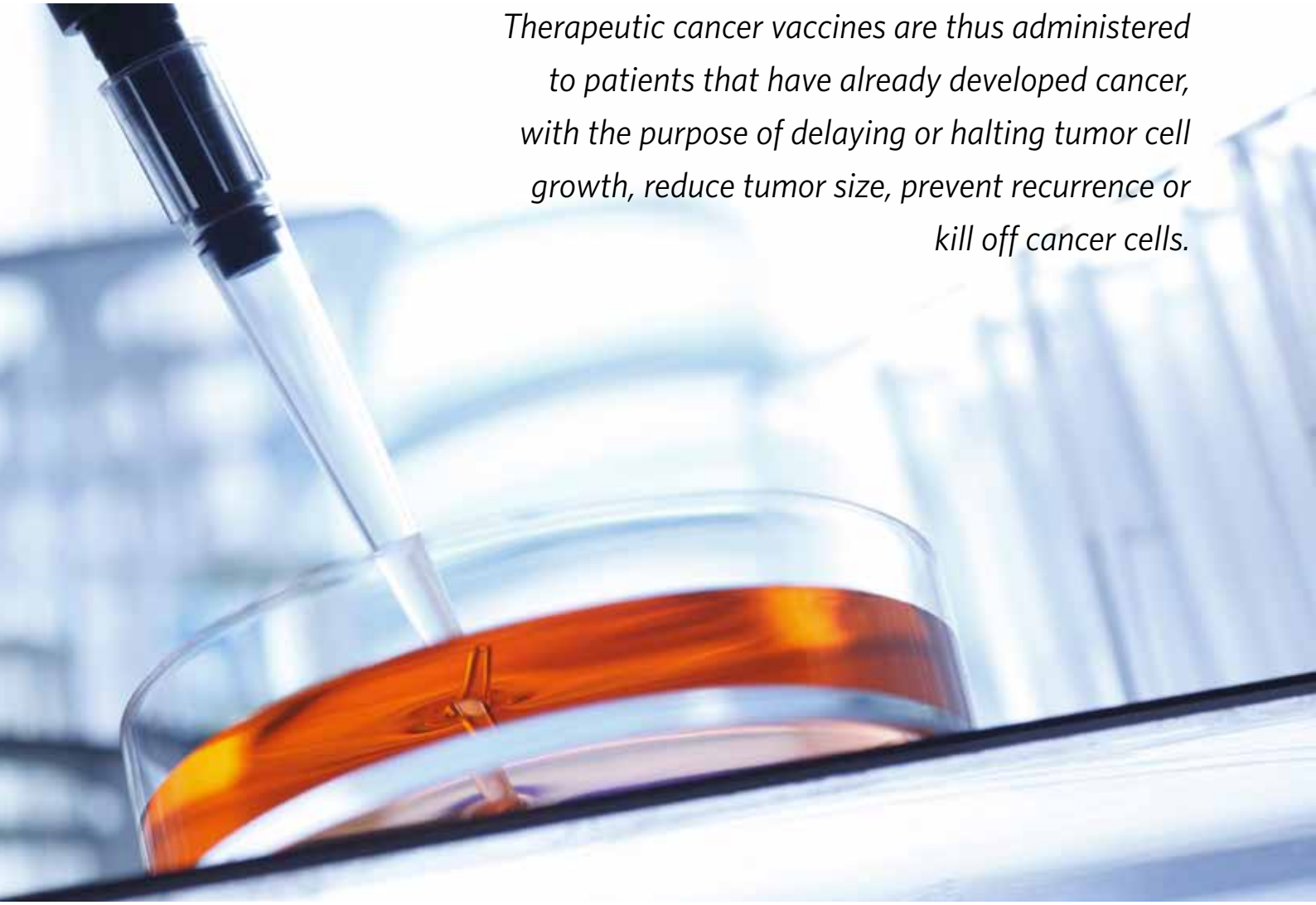
THE PHASE II TRIAL is normally the first time the drug is administered to patients with the disease in question. During the trial, the dosage, along with other parameters, is adjusted and the effects of the drug on the disease and/or its symptoms are studied. The number of patients in phase II is still limited. If the patient group is of the appropriate size, a phase II trial may give a clear indication of the efficacy of the new drug.

THE PHASE III TRIAL is only initiated if the results of phase II are promising enough to motivate further studies. In phase III, the new therapy is evaluated relative to a copy of a drug with no effect, referred to as placebo. The new drug can also be evaluated relative to an already approved drug for the same indication. Combinatorial studies, where the established therapy and the new drug are combined, are also possible, as a comparison to treatment using only the new therapy. The distribution of patients between different study groups must be random, and neither physicians nor patients can know which of the treatments the patient receives. If both of these criteria are fulfilled, the trial is called "double-blind randomized", which is the method that provides the best and most objective results. Since the trial constitutes a comparison between various therapy groups, the number of patients in this phase is considerably larger than in previous phases. The objective of a completed phase III is to be able, with statistical significance, to determine whether the new drug has a better efficacy, or minimizes side effects to a greater extent than existing treatment alternatives. If the new drug appears promising and is well tolerated by patients, further tests are carried out in order to verify the results. Only then a request for approval can be submitted to the relevant regulatory authorities – preferably the European Medicines Agency (EMA) in Europe, or the Food and Drug Administration (FDA) in the U.S.

The duration of the trials depends on the indication to be treated. In a trial where existing treatment alternatives have low efficacy, the duration can be significantly reduced. Following market approval, further studies – sometimes referred to as phase IV trials – are conducted to ensure that no unexpected side effects appear, e.g. in new patient groups.

Technology

In contrast to prophylactic vaccines, which are used to prevent the occurrence of a certain disease, therapeutic vaccines have a treating (therapeutic) effect and are given to patients already affected. Therapeutic cancer vaccines are thus administered to patients that have already developed cancer, with the purpose of delaying or halting tumor cell growth, reduce tumor size, prevent recurrence or kill off cancer cells.



BACKGROUND

Traditional cancer therapies, such as surgery, radiation and chemotherapy, are often insufficient in treating patients and usually cause severe side effects. Today, about 60 percent of all cancer patients are cured from their disease. Cancer vaccines trigger the immune system to specifically target tumor cells and may become important as more effective treatments with fewer side effects. The immune system recognizes and attacks that which is foreign to the body, but the problem with cancer is that tumor cells are usually not considered unknown invaders. This makes it difficult for the immune system to effectively neutralize tumor cells, which is why several methods have been developed, mainly cell-based vaccines, to enhance the immune response against cancer.

It is now well established that the immune system has cells, particularly CD8+ cytotoxic T-lymphocytes (CTL) that can recognize and potentially kill tumor cells. Nevertheless, a major problem is that these T-cells are rarely induced spontaneously. One possibility is that there is inadequate tumor antigen presentation by dendritic cells (DCs), "nature's immune boosters/adjuvants", for eliciting t-cell immunity. Another is that tumor-reactive T-cells are made tolerant by the tumors.

THE DENDRITIC CELL IS VITAL IN ALL SPECIFIC IMMUNE RESPONSES

The dendritic cell is vital in specific immune responses and activates systems that help the body eliminate cells infected by viruses or bacteria. In fact, the discoverer of the dendritic cell was awarded the Nobel Prize in Medicine 2011. Dendritic cells engulf and process protein antigens and then present these to antigen-specific T-cells. This leads to an activation and proliferation of the T-cells, whose task is then to attack other cells that express this antigen. In the same way, the immune system could be trained to attack tumor cells.

Many vaccine companies have to go through the rigorous process of identifying/characterizing what is thought to be appropriate tumor antigens, namely protein fragments (peptides) that are expressed on the surface of cancer cells but not on normal cells. And even when the antigens have been identified, it is still uncertain whether they will trigger the desired immune response until they have been tested extensively in human trials.

To circumvent some of the problems in cancer therapy, several immunotherapeutic studies have focused on optimizing the antigen presentation function of autologous (from the patient) dendritic cells in vitro (in test tube) so that these antigen-loaded dendritic cells can be transferred back into the body. Ideally, this would yield dendritic cells that, following injection, traffic to the draining lymph node and efficiently activate tumor-specific T-cells, leading to the generation of an effective immune response against tumor cells. However, the immune responses to such DC-based vaccines are often weak, and clinical responses are rarely complete or long lasting.

THE PROBLEMS OF AUTOLOGOUS DC VACCINES

It is common knowledge that dendritic cells from one human being injected into another (allogeneic DCs) will appear foreign to the host and will therefore

be eliminated by the host's immune system. DC research has thus focused on autologous concepts. Autologous DC vaccines extract patients' own dendritic cells, load them with tumor antigens and then stimulate/activate them in vitro before re-injecting them into the patients. However, since autologous DC cancer vaccines have to be tailor made for each individual patient, the method has several drawbacks. Creating a new, unique vaccine for each patient is complex, time consuming, expensive, and physically stressful for the sick patients. The first therapeutic cancer vaccine to reach the market – Dendreon's Provenge – is based on autologous dendritic cells.

ALLOGENEIC DCS ARE GREAT IMMUNE BOOSTERS

Little has been known regarding the function of in vitro activated autologous dendritic cells after they have been injected. The migration pattern of injected vaccine DCs has been tracked in vivo (in human) and notably, less than five percent of the injected DCs reached the draining lymph nodes while the majority of DCs remained at the injection site (Verdijk et al. 2009). These locally trapped vaccine DCs rapidly lost their viability and were subsequently eliminated by recruited antigen-presenting cells. In line with these findings, data has now shown that injected vaccine DCs that have been activated during a limited time (6-18 hours) ex vivo (outside the human body) indirectly prime naive CD8+ T-cells in vivo by acting as a pure immune adjuvant that recruits and activates APCs in the recipient body (Yewdall et al. 2010). By using allogeneic dendritic cells as vaccine cells, they will further be regarded as foreign invaders that will induce an inflammatory reaction that further promotes the recruitment and activation of dendritic cells at the vaccination site (Wallgren et al. 2005). This hypothesis has been verified by Immunicum and other research groups in rat and mouse cancer models in which tumor growth was significantly reduced by therapeutic vaccination with tumor-loaded allogeneic dendritic cells (Alder et al. 2008, Siders et al. 2009, Edlich et al. 2010).

PLATFORMS

Immunicum has developed two different technology platforms for the development of immunotherapies: COMBIG and CD70. The Company also recently acquired a technology platform, an adenovirus vector. The primary intended use of the vector is to effectively load vaccine cells with several tumor antigens in SUBCUVAX. This cancer vaccine does not require injection into a tumor but can be administered under the skin (subcutaneously) for the treatment of various cancer diseases. Another field where it can be used is oncolytic therapy with tumor cell killing virus particles.

Both COMBIG and CD70 are based on findings showing that dendritic cells from other individuals function as great immune boosters in combination with tumor antigens when used for cancer vaccination. The main difference between the technologies is that COMBIG aims at activating the patient's T-cells specifically against cancer, so that they can kill tumor cells, while the CD70 platform aims at powerful in vitro expansion of already tumor-specific T-cells and then injecting them into the patients and this way create a stronger immune reaction against cancer. The latter method is generally referred to as adoptive immunotherapy, and is a relatively new way to treat cancer. The difference between Immunicum's CD70 platform and the adoptive immunotherapies developed by other organizations is that tumor-specific T-cells expanded using Immunicum's CD70 method are expected to show significantly improved survival rate in the human body.

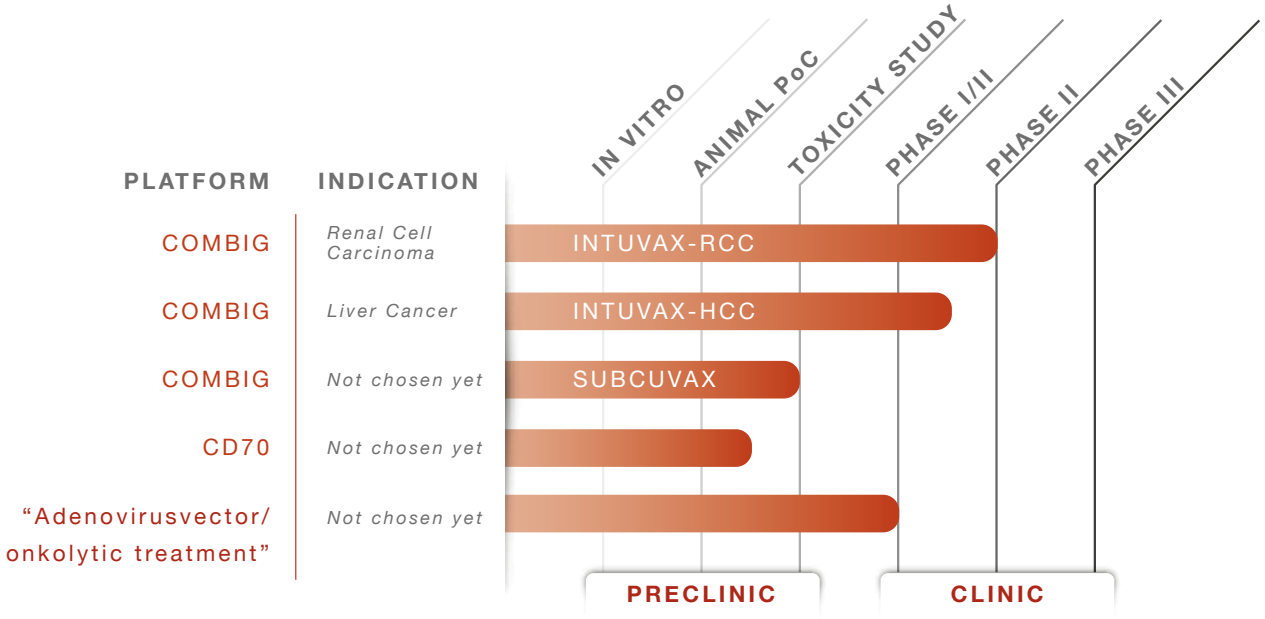
Drugs based on the COMBIG and CD70 platforms are presently being developed for use as stand-alone products, but there may be future opportunities to combine the two treatments.

The plan for the recently acquired adenovirus vector is using it for antigen production in SUBCUVAX, which will allow Immunicum to initiate clinical testing with SUBCUVAX. In addition to this, the vector can be used for oncolytic therapy of various cancer indications. An oncolytic virus infects a cancer cell and replicates in the cell until the cell is disintegrated.

Immunicum has given the seller of the vector, VirEx AB, owned in part by Professor Magnus Essand at Uppsala University, a back license to use the vector for oncolytic therapy of neuroendocrine tumors and will in return receive a small royalty on any future sales as well as the right to a minor part of any milestone and other one-time payments that may be generated if the vector is sold to a third party for oncolytic therapy of neuroendocrine tumors. Professor Magnus Essand will use the vector for oncolytic treatment of neuroendocrine tumors in a clinical trial which is expected to begin during the spring of 2015. At present, however, Immunicum does not plan any development of oncolytic therapies but intends to license the vector for oncolytic therapy in indications other than neuroendocrine tumors, if the planned clinical trial for the indication turns out well.

PIPELINE

Immunicum's projects are based on the unique technology platforms of the Company, COMBIG och CD70, for the development of immunotherapies. Positive results from a phase I/II trial with INTUVAX® in metastatic renal cell cancer have been reported, and a more extensive phase II trial is expected to begin early 2015. In addition to this, a clinical trial in patients with liver cancer is on going.



CLINICAL PHASE I/II TRIAL (RCC)

Positive results from a clinical phase I/II trial with INTUVAX in renal cell cancer have been reported. The study comprised a total of 12 patients with metastatic RCC, which had been diagnosed using computer tomography (CT). The image below shows the first patient to be treated with INTUVAX®.

PRIMARY OBJECTIVE

» The primary objective was to evaluate the safety of INTUVAX® administered twice intra-tumorally in patients with metastatic renal cell carcinoma.

SECONDARY OBJECTIVES

» To evaluate the immune response by measuring a panel of immunologic parameters in blood, including determining the amount of tumor-specific T-cells with ELISPOT technique.

» To evaluate the immune response to INTUVAX® by examination of the immunohistology of the renal tumor post nephrectomy.

» To increase the understanding of the working mechanism of INTUVAX® by evaluating different inflammatory/immunological parameters.

» To evaluate tumor response by CT evaluation of the metastases 3 months post nephrectomy.

» To evaluate potential auto- and allo-immunization.

» To assess tumor response by calculating the number of new metastases by CT evaluation 3 months post nephrectomy.

» To evaluate the patients' general condition and general performance by measuring the change in body weight and ECOG three months post nephrectomy vs. baseline.

» To study the overall survival for the patients.

The first patient to be treated with INTUVAX® in the ongoing clinical trial in renal cell carcinoma.

RESULTS

Despite the limited number of patients, data indicates that INTUVAX® induces a tumor-specific immunization which appears to inhibit the growth rate of tumor metastases and thus prolong survival. Preliminary data indicates that subsequent additional treatment with tyrosine kinase inhibitors (TKIs) may accentuate the anti-tumor effect in a synergistic manner. This synergy may well come from some TKIs, particularly sunitinib, having the ability to "open up" the tumor to vaccine-induced cytotoxic T-cells via a well-documented mechanism that down-regulates the immunosuppressive environment of the tumor tissue.

INTUVAX (5-20 million activated allogeneic dendritic cells) were injected intra-tumorally on two occasions two weeks apart before nephrectomy.

SAFETY PROFILE

The safety profile was excellent. Side effects that could potentially be related to vaccination consisted mainly of transient fever (5 patients). No clinical or laboratory signs of autoimmunity were observed in any patient.

IMMUNE RESPONSE

Nine of the eleven evaluated patients exhibited an increased number of tumor-specific and IFN-gamma-producing lymphocytes (so-called ELISPOT) when comparing prior values with values obtained one week after the second vaccination.

A massive infiltration of CD8+ T-cells was detected in five of the 12 removed renal tumors which, as far as the Company is aware, is the most intense and general intratumoral infiltration of CD8+ T-cells that has ever been reported in any human solid tumor. Two other patients showed a relatively sharp intratumoral infiltration of CD8+ T-cells.

EFFECT ON TUMOR SIZE AND METASTASES

According to a press release on September 12, 2014: No initial objective tumor regression (according to so-called RECIST criteria) was observed in any patient. Three out of four patients that so far have received subsequent treatment with tyrosine kinase inhibitors (TKIs) (3, 4, 9 and 17 months after vaccination), do in fact show an ongoing partial regression. One of these patients had substantial sarkomatoid malignant transformation of the removed primary tumor. Another patient who developed four brain metastases four months after treatment with INTUVAX, has now responded with a complete regression of two brain metastases and extensive regression (> 60%) of the two remaining brain metastases six months after initiation of sunitinib treatment. These two cases of tumor regression following subsequent treatment with sunitinib are surprising since mRCC patients with brain metastases or extensive sarkomatoid tumor transformation almost never respond with tumor regression during sunitinib treatment.

According to a press release on June 2, 2014: Two patients showed a late-going clinical response, without additional therapy, despite initial slow progress. One patient showed an ongoing stable disease that lasted for more than six months after a previous slow tumor growth for 15 months. Another patient who also did not receive any additional therapy exhibited an ongoing late partial tumor regression (> 40%) that started after 16 months of very slow tumor progression.

SURVIVAL

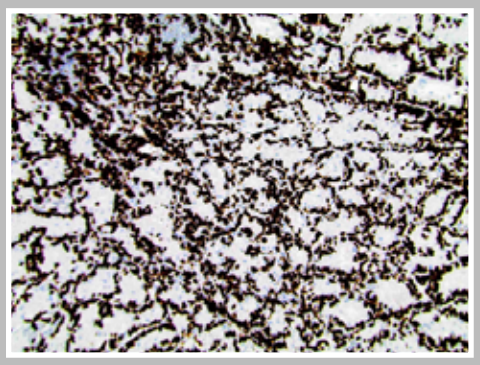
The median survival in the subset of five patients who were initially classified as high-risk patients has now passed 18 months. Two of these patients, one of which is still alive, have achieved a survival of more than two years. This should be compared with the expected median survival of nine months of the current standard treatment for this patient category, i.e. the tyrosine kinase inhibitor sunitinib. It's worth noting that none of the high-risk patients in the INTUVAX study received tyrosine kinase inhibitors during the first nine months after vaccination.

The median survival (from diagnosis) for the group of patients with poor prognosis (Heng criteria) and extensive sarkomatoid tumor transformation (n = 3, one patient received sunitinib for 3 months after vaccination) was 7.5 months, which is a good result in comparison to the most recently published data on median survival (from diagnosis) of three months in this subgroup of patients with very poor prognosis.

In patients with sarkomatoid tumor transformation (n = 6), a tendency of prolonged survival has been observed in patients who have shown a massive intratumoral infiltration of CD8 + T-cells; the survival of 2 patients with mild to moderate intratumoral infiltration of CD8+ T cells was 3.0 months and 6.0 months respectively, and the survival of 4 patients with massive intratumoral infiltration of CD8+ T cells was 5.0 months in one patient, while 3 patients are still alive 15 months (sunitinib was administered after 9 months), 19 months and 25 months after starting therapy. The expected median survival for these patients receiving standard therapy is 8 months after starting therapy.

The figure below shows tissue samples from a treated patient. The darker areas indicate infiltration of activated immune cells (T-cells) in the corresponding surrounding tissue (lighter areas). The upper left image shows a tissue sample from an un-treated tumor, compared with a treated tumor (upper right). The lower left image shows infiltration in a metastasis in the same patient, compared with surrounding tissue in the kidney. The lower right image shows an image of the same kidney as the one displayed in the upper right image, but from an area which is not attacked by cancer, i.e. healthy tissue. The absence of infiltrated T-cells in the lower right image indicates that the T-cells in the upper right image are tumor specific.

Un-treated tumor



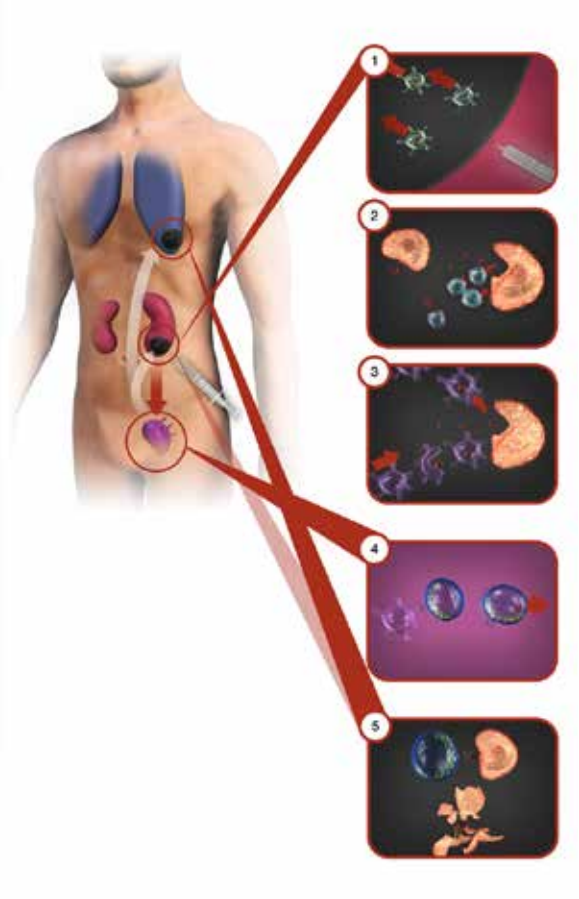
Treated tumor

Metastasis in scalp

Treated tumor, normal kidney tissue

CONCLUSION

The results indicate that intratumoral injection of pre-activated allogeneic DCs is safe and can elicit a systemic CTL-mediated anti-tumor response that may prolong the survival of mRCC patients. Preliminary data from patients who subsequently received additional therapy with TKI, also indicates a synergistic effect between treatment with INTUVAX and subsequent treatment with TKI. A fully funded phase II study is currently being planned, and the work is in its final phase.



1. ALLOGENEIC DCS ARE INJECTED INTRATUMORALLY.

2. NK-CELLS ARE RECRUITED TO THE TUMOR WHERE THEY INDUCE AN NK-CELL-MEDIATED TUMOR CELL DEATH, THUS RELEASING TUMOR ANTIGENS READY FOR UPTAKE BY ANTIGEN-PRESENTING CELLS SUCH AS DCS.

3. AUTOLOGOUS DCS ARE RECRUITED TO THE TUMOR WHERE THEY ENGULF TUMOR ANTIGENS AND MIGRATE TO THE DRAINING LYMPH NODES.

4. DCS PRESENT TUMOR ANTIGENS TO NAIVE T-CELLS WHO SUBSEQUENTLY BECOME TUMOR-SPECIFIC CYTOTOXIC T-LYMPHOCYTES (CTLS).

5. CTLS SCAN THE BODY FOR CANCER AND ATTACK TUMOR CELLS IN THE KIDNEY AND IN LUNG METASTASES.

Description of INTUVAX®' mechanism of action.

The figure above shows that INTUVAX® creates an inflammation in the tumor that will attract NK-cells (for release of autologous tumor antigens) and autologous DCs for uptake of autologous antigens. Thus, what Immunicum expects to accomplish through a standardized vaccine is to load patients own DCs with their own tumor antigens in vivo, thus in a way offering patients an individualized treatment. This makes it a unique concept.

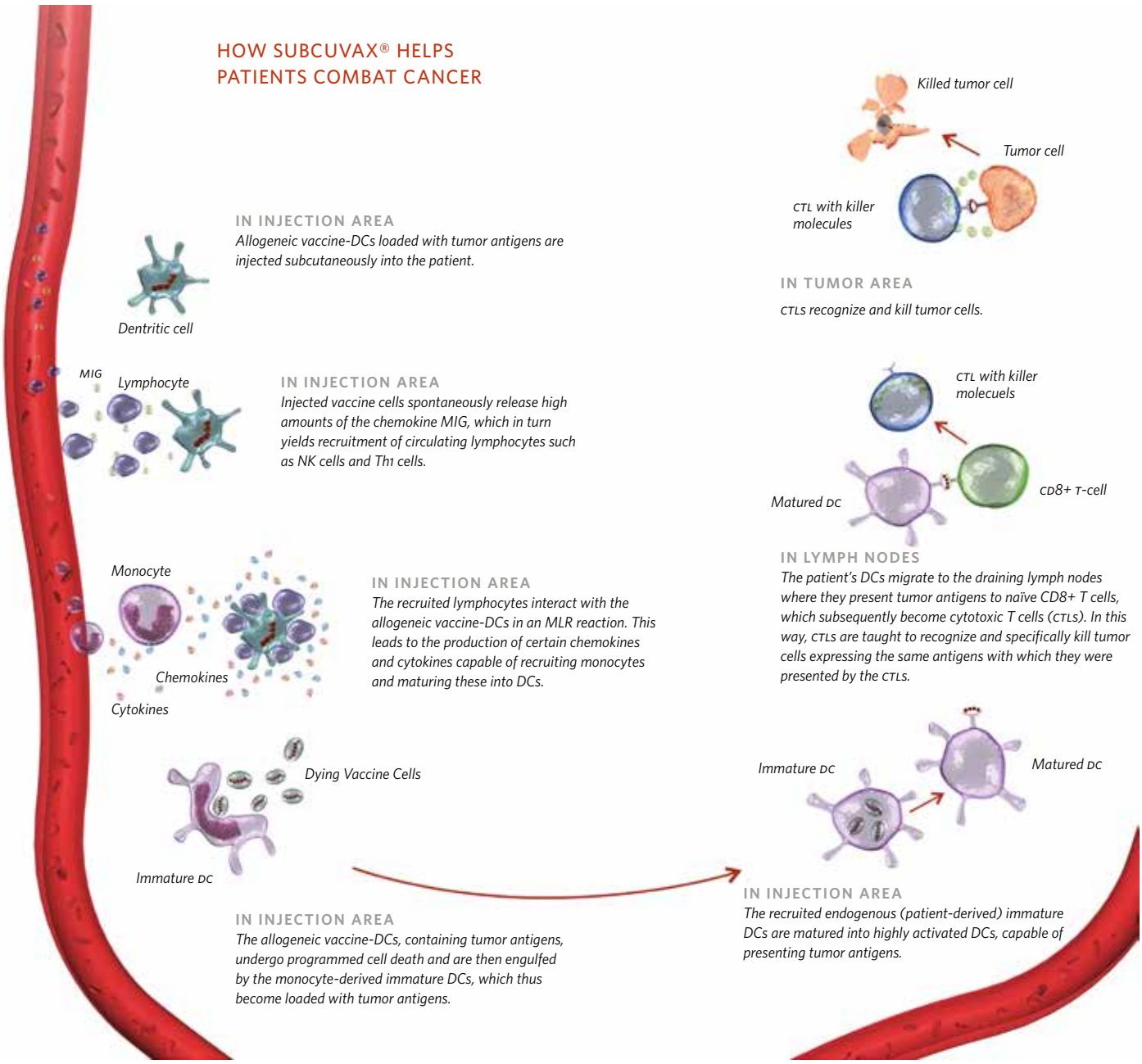
SUBCUVAX®

During organ transplantation, the accompanying dendritic cells from the donor are what triggers the inflammatory process that leads to the specific immune system of the host eventually trying to reject the transplanted organ, which is what Immunicum makes use of for the development of its cancer vaccines. By also using the rejection process as an immune booster for immunization against concurrently injected tumor antigens, significant anti-tumor responses have been demonstrated in rat cancer models.

The following is a description of SUBCUVAX®' expected mechanism of action (see figure on next page): Dendritic cells from healthy donors (allogeneic DCs) are loaded with tumor-specific antigens in vitro and treated with activating factors. Since the vaccine cells can be loaded with different types of antigens, it is possible to tailor the vaccines for the treatment of all types of cancers. Immunicum takes advantage of the fact that DCs can be activated to produce high levels of NK, NKT and T-cell recruiting chemokines in a sustained fashion (*Gustafsson et al, Cancer Research, 2008*).

If the injected DCs are allogeneic, the interaction between these injected DCs and recruited lymphocytes will further create a highly inflammatory local environment (corresponding to an allogeneic mixed leucocyte reaction/MLR) at the vaccination site, containing several inflammatory mediators that are capable of recruiting the patients' own monocytes and subsequently also capable of maturing these into highly activated DCs (*Wallgren et al, Scand J Immunol, 2005*). The patients' recruited DCs will then engulf the invading allogeneic vaccine cells and in this way become loaded with tumor-specific antigens.

Thus, the inflammation induced by the allogeneic DCs is used to recruit, activate, and load the patients' own (autologous) DCs with tumor antigens in vivo (in human) instead of artificially in vitro, which would otherwise be necessary. This "natural" activation is expected to optimally prepare the patients' own DCs for migration to the draining lymph nodes where they can trigger the immune system against tumor antigens.



Promising SUBCUVAX® preclinical studies in animal

SUBCUVAX® has been evaluated in preclinical studies and the results are promising. The initial studies were performed in vitro with allogeneic DCs and set the foundation for Immunicum's first patent application in 2002. Data from the study was published in Scandinavian Journal of Immunology (62, pp. 234–242) and shows that DCs mixed with immune cells from another individual will induce an immune response which leads to the production of inflammatory substances that can recruit and activate DCs in the "host" in test tube. The patent covers the use of both allogeneic DCs and allogeneic monocytes as vaccine cells.

Following the successful in vitro-studies, Immunicum moved on to perform studies in animal models. Rats were injected subcutaneously (under the skin) with a breast cancer cell line and were vaccinated in both prophylactic and therapeutic settings. Activated allogeneic monocytes or monocyte-derived allogeneic DCs were loaded with apoptotic tumor cells and subsequently used as vaccine cells. Prophylactic vaccinations reduced tumor take from 80% in non-vaccinated rats to 20% in vaccinated rats. This immunity was long-lasting since re-challenge of tumor rejecting rats with tumor cells 6 weeks later failed to induce any tumor growth. In the therapeutic setting all rats developed tumors, but tumor growth was significantly reduced in rats given tumor-loaded and activated allogeneic monocytes ($p<0.05$) or monocyte-derived DCs ($p<0.001$). Data was published in the scientific journal Cancer Immunology and Immunotherapy (2008, 57 suppl1, p10). See picture on the next page.

A total of 20 rats were injected with cancer cells. Shortly thereafter, half the group was vaccinated and 12 days later the tumors were extracted. The above image shows the extracted tumors for the vaccinated group (right side), compared to the tumor size of the non-vaccinated group (left side).

THE CD70 PLATFORM

It is now well established that the immune system has cells, particularly CD8+ cytotoxic T-lymphocytes (CTLs), that can recognize and potentially kill tumor cells. Nevertheless, a major problem is that these T-cells are either not induced or only weakly induced. There are different ways of using immunotherapy to enhance the efficacy of T-cells to fight cancer, where adoptive immunotherapy is a treatment strategy in which T-cells derived from cancer patients are activated and expanded in vitro and re-infused into the patient with the purpose of killing tumor cells.

Adoptive immunotherapy is one of the most promising areas in the development of new cancer treatments. The method basically means that immune cells are taken from the patient with cancer and processed with a chimeric antigen receptor (CAR) so that they can recognize and kill cancer cells, then be expanded in vitro, and finally re-injected into the body. The prestigious scientific journal Science named immunotherapy for cancer the scientific breakthrough of the year in 2013, which is largely a consequence of the rapid development of adoptive immunotherapies.

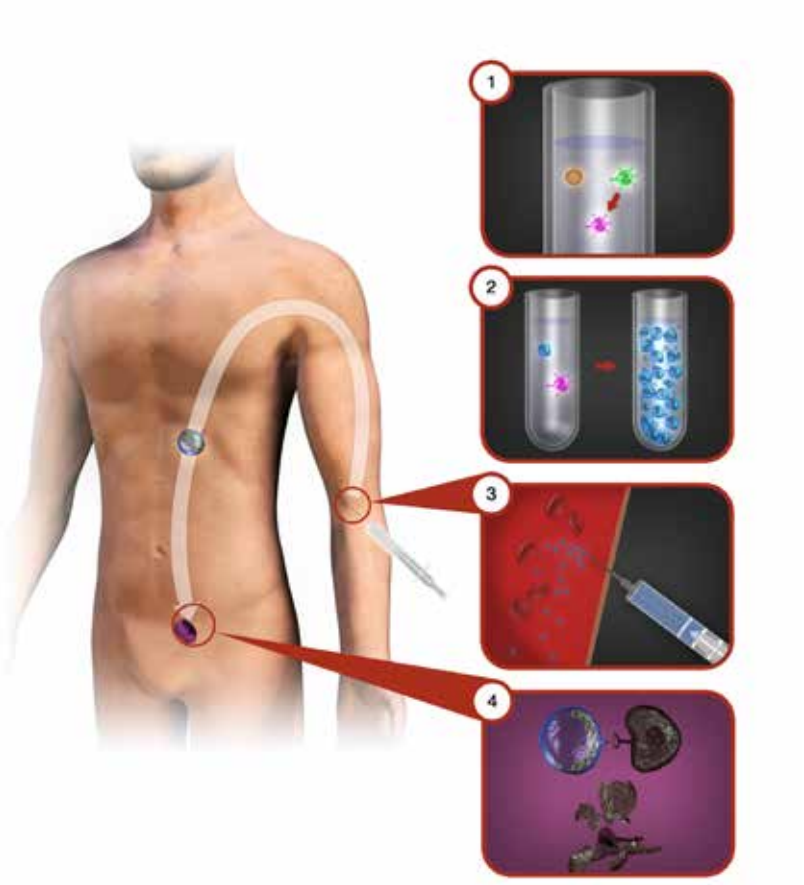
Preclinical experiments have shown that immune cells (T-cells) that are processed and expanded in vitro using Immunicum's CD70 platform have a much better viability in the immunosuppressive environment of solid tumors than what can be achieved using currently available methods (Molecular Therapy - Methods & Clinical Development (2014) 1, 14001; doi: 10.1038 / mtm.2014.1; published online March 5, 2014). Established expansion protocols generate propagated T-cells that normally cannot survive in solid tumors, which is also the reason why today, various kinds of blood cancer

are treated with adoptive immunotherapy. Immunicum's CD70 platform can facilitate the development of effective adoptive immunotherapy drugs for the treatment of various types of solid tumors.

The Company conducted several successful in vitro studies between 2009 and 2011. In a publication entitled "Allogeneic lymphocyte-licensed DCs expand T-cells with improved anti-tumor activity and resistance to oxidative stress and immunosuppressive factors" which in March 2014 was published in the american journal Molecular Therapy Methods & Clinical Development (published by Nature Publishing Group in collaboration with the American Society of Gene & Cell Therapy), Professor Essand's research group at the Department of Immunology, Genetics and Pathology, Uppsala University, compares Immunicum's patent pending expansion protocol called CD70-CD3 with established expansion protocols.

The article shows that T-cells expanded with Immunicum's protocol, in comparison to established protocols have better viability, better ability to kill tumor cells in the test tube, and better ability to restart expansion upon contact with tumor cells when the cells are subjected to immunosuppressive factors that reflect the "hostile" tumor environment.

The development of the CD70-concept is currently carried out in collaboration with Professor Magnus Essands research group at the Department of Immunology, Genetics and Pathology, Rudbeck Laboratory, Uppsala University.



1. ALLOREACTIVE T-CELLS ARE MIXED WITH ALLOGENEIC DCS, WHICH INDUCES AN EXPRESSION OF CD70 ON THESE DCS.
2. TRANSFECTED T-CELLS ARE MIXED WITH ALLOGENEIC DCS THAT EXPRESS CD70, WHICH EXPANDS T-CELLS AND IMPROVES THEIR SURVIVAL FUNCTION.
3. EXPANDED T-CELLS ARE INJECTED INTO THE BLOODSTREAM.
4. T-CELLS ATTACK AND KILL CANCER CELLS.

The CD70 concept is currently in a preclinical phase.

Market Overview

THE GLOBAL MARKET

According to Global Data, the global cancer vaccine market was worth around $3.5 billion in the year 2010 in the seven major markets - the US, France, Germany, Spain, England, Italy and Japan (Cancer Vaccines – Pipeline Assessment and Market Forecasts to 2018). By the year 2020, this number is expected to have risen to $9 billion due to the introduction of new therapeutic cancer vaccines and an increasing number of cancer patients. In May 2013, an analyst at US Bank Citigroup predicted that the market for cell therapies for cancer will be valued at $35 billion per annum, and that cancer vaccines will be part of 60% of all cancer treatments in 10 years (today it's 3%). Howard Liang and Seamus Fernandez also predict that within 10 years, 50% of all cancer treatment will involve immunotherapy. According to the WHO, the number of new cases of cancer could increase by 50% until 2020, which would correspond to 15 million new cases.

MARKET OVERVIEW - RENAL CELL CARCINOMA (RCC) AND LIVER CANCER

By using Immunicum's cancer vaccine INTUVAX®, it is possible treat all solid tumors that can be accessed through intratumoral injection. The Company has decided to initially focus on metastatic RCC and is about to complete plans for a phase II clinical trial in this indication. A clinical phase I/II trial in liver cancer is also in progress. The potential market is considerable. Some examples of tumors that are suitable for treatment include those in the kidney, liver, breast, lung, prostate, pancreas, thyroid, cartilage or soft tissue (sarcoma). Lung cancer is the world's most frequent type of cancer with about 1.6 million new cases every year. Breast cancer is the second most frequent one, with about 1.4 million new cases every year. Even liver cancer (appr 0.75 million/year) and prostate cancer (appr. 0.9 million/year) are common (GLOBOCAN, WHO, 2008). The WHO estimates that liver cancer will be the world's most frequent cancer indication by 2020 since Hepatitis B – which is widespread in Asia – often leads to liver cancer, and is expected to increase even more.

THE RCC MARKET

Approximately 273,000 new cases of RCC are diagnosed worldwide each year, representing approximately two percent of all cancers. GlobalData estimates that the global RCC market was worth $1.3 billion in 2009 and is forecast to grow at a Compound Annual Growth Rate (CAGR) of 13.9% to reach $3.8 billion by 2017. (Renal Cell Carcinoma (RCC) Therapeutics – Pipeline Assessment and Market Forecasts to 2017, 2010). This high growth forecast is primarily attributed to population growth and high diagnosis rates.

In addition, the RCC market will continue to be driven by the strong pipeline landscape of first-in-class drugs with better survival rates, safety and efficacy profiles.

According to GlobalData, the global RCC market in 2009 was made up of mainly six products, so-called directed therapies (tyrosine kinase inhibitors) - Avastin (bevacizumab), Sutent (sunitinib), Nexavar (sorafenib), Afinitor (everolimus), Votrient (pazopanib) and Torisel (temsirolimus). Even though new drugs have managed to grab significant market share (sales of Sutent reached 1.2 billion USD in 2011 for three indications, RCC being the largest one) (Pfizer, annual report 2011), these therapies are often costly and have serious side effects, and the therapeutic effect is often of short duration (the survival gain is on average 5-6 months). These products have considerable side effects but for many patients there are no alternatives to these therapies, which can, in fact, provide some disease relief. The market has a relatively large unsatisfied demand due to the limited efficacy and safety profiles of current products. Hence, there are considerable opportunities for new competitors to gain market share and a large potential for products such as INTUVAX®, which are based on new technology, with few or no side effects. The total annual cost of treatment for current therapies falls in the range $38,000 - $124,000, but a new competitor with a superior therapy could easily charge more. Nor should cancer vaccines be considered only substitutes to conventional treatments, but also potential complements. In general, directed therapies are thought to have reached their potential as "stand-alone products", where Sutent has shown the longest median survival of 26.4 months.

Before the approval of directed therapies, IL-2 was used as a treatment, with mixed results. Due to serious side effects, however, the treatment has only been applied to a limited number of patients, and today, IL-2 has been removed from current guidelines as a recommended treatment. The four major competing products in phase III as identified by Immunicum (in collaboration with Arthur D. Little) are three immunotherapies (ima-901 from Immatics Biotechnologies, ags-003 from Argos Therapeutics and Nivolumab from Bristol-Myers Squibb) and one directed therapy (Cabozantinib from Exelixis). Neither of these products is expected to revolutionize the renal cell cancer treatment (see the table on the next page for a more comprehensive summary and analysis).

Immunicum primarily wants to compete on better efficacy, but INTUVAX® also has potential advantages because of its ability to lessen the patient's side effects and provide better general health during treatment and thereby increase the possibility for the patient to return to a normal life. This way, the treatment can bring values from other perspectives: for society, health care services, insurance companies and the patient's social environment.

RENAL CELL CARCINOMA – COMPETITIVE POSITION ANALYSIS

	TREATMENT	MECHANISM / DELIVERY / INDICATION	EFFICACY			TOXICITY		COST		COMMENTS
			PFS / OS[1] (MONTHS)		SCORE	SELECTED TOX DATA[2]	SCORE	PRICE/ TREATM.[3]	SCORE	
			CONTROL	DRUG						
ON MARKET	***Sutent (standard of care)***	Tyrosine kinase inhibitor / Oral / 1st line	Interferon OS: 21.8 PFS: 5	OS: 26.4 PFS: 11		Diarrhea 3/4: 9% Fatigue 3/4: 11% Hypert. 3/4: 12% Hand foot 3/4: 9%		$70k (daily doses)		» Sunitinib is the preferred choice among targeted therapies and the standard for comparisons » Severe toxiticities exist (Pazopanib may replace Sutent as standard due to lower toxicity)
	IL-2	Interleukin (cytokine) / injection / mRCC	Interferon alfa: 1%	Complete response: 6-7%		Very severe toxicities, exceeding sutent		~$25k (daily, 5 days, 2x/month)		» High-dose IL-2 is the only therapy with a durable but small, complete response » Few patients eligable, costly monitoring needed
NEW TREATMENTS IN DEVELOPMENT	***AGS-003 + Sutent***	Aut. Vaccine / intradermally / 1st line mRCC	Historic OS: 15 Sutent OS: 26.4	OS: 30.2 PFS: 11.2		No reported grade 3/4 toxicities		$88k (8 inj./year)		» AGS-003 had only 21 patients in phase II but clear clinical benefit and low toxicity » Cost likely high, complexity similar to Provenge
	Nivolumab	Anti PD-1 / Intravenous / 2nd line mRCC	No phase II data KOL interview: 4-5 mths improved OS		?	14% of phase I patients had some grade 3/4 toxicity		$65k (26 inj./year)		» Lack of data on clinical benefit but KOL optimism » Some severe toxicities exist but lower than Sutent
	IMA-901 + GM-CSF + Sutent	Immunostimulant / Intradermal / 1st line mRCC	Historic 2nd line TKIs:16.4 & 17.8	2nd line data from phase II. OS: 19.8		5.9% of phase II patients had some grade 3/4 toxicity		$85k (17 inj./year)		» Only tried in 2nd line after Sutent with 3-4 mths improvement – unclear effect in 1st line » Some toxicities and likely high cost
	INTUVAX	Allogeneic DC vaccine / Intratumoral / 1st line mRCC	Historic OS (Heng): about 9	Ongoing mOS at 15 (July 2014): 5 poor prognosis patients	**TBD**	Initial phase I/II data suggest toxicity is not severe	?	Allogeneic donor blood, 2 inj		» Phase I/II data indicate potential for clear clinical benefit and a well tolerated vaccine » Cost profile is beneficial with few injections and mass production potential

Ability to adress unmet need: = *Very high* = *High* = *Medium* = *Low* = *Very low*

Source: Datamonitor, clinicaltrials.gov, Citeline, publications on clincal trial outcomes, Interviews, Immunicum management, Arthur D. Little analysis

Note:
1) Progression free survival or overall survival (depending on availability).
2) Grade 3 or 4 occurrences (i.e. severe or life-threatening)
3) Actual or estimated price per dose multiplied by #doses over 1st year. Cost score weighs in other costs in handling the therapy.

THE LIVER CANCER MARKET

Liver cancer is the 6th most frequently diagnosed form of cancer in the world. The disease is especially common in Asia and even though less common in Europe and the U.S., it is still the third most deadly form of cancer even here. The limited spread of liver cancer in the West presents the opportunity for novel treatment alternatives to obtain Orphan Drug Designation (ODD) status in strategic markets (the U.S., Europe and Japan) while at the same time, there is still a great potential in other markets. More than half of the world's liver cancer patients are found in China, where approximately 400,000 patients are diagnosed every year. The incidence in the world's largest drug markets (the U.S., France, Germany, Italy, Spain, the UK and Japan) is 88,000 cases per year and growing (Stakeholder Opinions: Hepatocellular Cancer, Datamonitor 2010).

Of all the forms of liver cancer, 85% is of type HCC (Hepatocellular carcinoma) and this is the indication in which Immunicum is conducting a clinical trial. The disease is often symptom free and few appropriate biomarkers are available. That is why a large part of the patients (appr 50% in Europe and the U.S., and 73% in Japan) progress so far that few treatment alternatives remain: Only 20-30% of patients globally are diagnosed early enough to be eligible for surgery. Surgery and preferably transplantation of a new liver is usually the first treatment alternative when chemotherapy and other standard treatments prove ineffective for HCC because of adverse side effects on the healthy liver and other organs. Even for surgical treatment, however, the recurrence is considerable and surpasses 70% after 5 years.

Limiting factors for the market potential include better diagnostics, which would allow more patients to be treated early with surgery. An expanded vaccination program for hepatitis is mentioned as a competing treatment alternative, since viral infections of type hepatitis A and B are the primary reason for the large prevalence in Asia. Still, neither of these factors is expected to significantly influence the patient population in the immediate future. For example, a vaccination program for hepatitis B would probably affect the number of patients in 2020 (there is yet no active vaccine for hepatitis C). – by which year the WHO expects liver cancer to have become the world's most frequent cancer disease.

The competitive landscape for liver cancer resembles that for renal cell carcinoma. Since 2006, the new drug Nexavar has entered the market, (Sorafenib, Bayer Healtchcare), with proven clinical effect. Nexavar (Sorafenib) is active against receptors and enzymes that are important for tumor cell growth, and is used in cases where surgical treatment is not possible. Even though Nexavar has limited effect on survival (appr 12 weeks), the lack of alternatives makes it useful. Nexavar sales in 2008 were 840 million USD for two approved indications (including renal cell carcinoma).

In addition to being a treatment for growing patient populations, new therapies are expected to make a contribution by having higher efficacy and less severe side effects. One target for new therapies is to reduce the number of recurrences post surgery, or to delay recurrence. Nexavar is being evaluated for administration to patients directly, post surgery. The new therapies that have reached late clinical phase for liver cancer are mostly drugs that are aimed at specific molecular targets, similar to the function of Nexavar. Immunicum together with Arthur D. Little have identified 4 competitors in addition to Nexavar, and they are listed in the table on the next page. However, there still remains a great need for more effective alternatives. (Stakeholder Opinions: Hepatocellular Cancer, Datamonitor 2010).

HEPATOCELLULAR CARCINOMA – COMPETITIVE POSITION ANALYSIS

	TREATMENT	MECHANISM / DELIVERY / INDICATION	EFFICACY			TOXICITY		COST		COMMENTS
			PFS / OS[1] (MONTHS)		SCORE	SELECTED TOX DATA[2]	SCORE	PRICE/ TREATM.[3]	SCORE	
			CONTROL	DRUG						
ON MARKET	*Nexavar / sorafenib*	TKI / Oral / 1st line adv. mHCC	Placebo	Improved OS: 2.8 PFS: 2.7		Pivotal trial events: Diarrhea 3/4 : 10% Hand foot 3/4: 8% Rash 3/4: 1%		$102k (2 daily doses)		» The only drug currently approved has limited clinical benefit and some severe toxicities
	ADI-Peg 20	Cytotoxic / Intra-muscular injection / 2nd line adv. or metastatic	-	Improved OS: 7.3 PFS: 1.8		Anemia 3/4: 1.5% Fatigue 3/4: 1.5% Hyperuricemia 3/4: 5.6%		$52k (weekly doses)		» Targets 2nd linte but limited data on efficacy in this setting as phase II patients were often untreated » Low toxicity, weekly hospital injections adds cost
NEW TREATMENTS IN DEVELOPMENT	*Stivarga*	TKI / Oral / 2nd line adv or metastatic	-	TTP: 4.5		Grade 3/4 toxicities: 5%		$111k (daily doses)		» Approved for other indications but only 36 patients in phase II so efficacy is very uncertain » Low toxicity and oral admin
	Muparfostat	Heparanase inhibitor / Injection / Adjuvant, early stage HCC	PFS at 48 weeks: 50%	PFS at 48 weeks: 63%		Grade 3/4 toxicities: 4%		$73k (daily doses)		» Has showed clinical benefit in a 172 patient trial in adjuvant setting where no treatment is available » Low toxicity but daily injection is inconvenient and potentially costly
	Ramucirumab	TKI / Intravenous / 2nd line adv or metastatic	-	1st line trial: PFS: 4		Fatigue 3/4: 10% GI bleeding 3/4: 7% Hypertension 3/4: 12%		$70k (every 2 weeks)		» Phase II data only for 1st line » Severe toxicities exist, inconvenient and costly administration
	INTUVAX	Allogeneic DC vaccine / Intra-tumoral / 1st line mRCC	-	-	**TBD**	-	**TBD**	Allogeneic donor blood, 3 inj		» Phase I/II initiated Q4 2013

Ability to adress unmet need: = *Very high* = *High* = *Medium* = *Low* = *Very low*

Source: Datamonitor, clinicaltrials.gov, Citeline, publications on clincal trial outcomes, Interviews, Immunicum management, Arthur D. Little analysis

Note:
1) Progression free survival or overall survival (depending on availability).
2) Grade 3 or 4 occurrences (i.e. severe or life-threatening)
3) Actual or estimated price per dose multiplied by #doses over 1st year. Cost score weighs in other costs in handling the therapy.

THERAPEUTIC CANCER VACCINE COMPETITIVE LANDSCAPE

The following section is largely based on information taken from Datamonitor's report "Pipeline insight: Therapeutic Cancer Vaccines" from 2009.

Therapeutic cancer vaccines can be divided into two principal categories: personalized vaccines and standardized (or 'off-the-shelf') vaccines. Standardized vaccines account for the majority (96 vaccines, i.e. 68%) of all therapeutic cancer vaccines in clinical development. In theory, personalized vaccines are highly attractive from a clinical point of view. These vaccines are potentially applicable to a broad range of patients since they can be tailored to the antigenic profile of each individual patient. This therefore negates the problem of heterogeneous tumor antigen expression, which can limit response rates to standardized vaccines based on a narrow range of antigens (Kalinski et al., 2009).

The discovery of the dendritic cell and its vital role in all specific immune responses was awarded the Nobel Prize in Medicine in 2011.

From a commercial point of view, however, there are several significant drawbacks associated with personalized therapeutic cancer vaccines. Mass-scale production, storage, and distribution of personalized vaccines present a great challenge, even for the most capable of companies, and could greatly reduce profitability in comparison to the more straightforward standardized vaccines (Kalinski et al., 2009).

Antigen-based vaccines account for 37 (26%) of all therapeutic cancer vaccines in clinical development, making this the most common class of technology platform in the therapeutic cancer vaccines pipeline. This partly reflects the relative ease of production of antigen-based vaccines compared to other more technically challenging classes of technologies such as antigen-presenting cell (APC) vaccines. Immunicum is unique in the sense that it develops an APC vaccine that can be produced at a large scale, in contrast to competing APC vaccines.

The number of APC vaccines in clinical development has more than doubled since 2006 and this is now the second most common technology platform in the therapeutic cancer vaccines clinical pipeline. As personalized vaccines, APC vaccines require a high level of technical expertise to develop, making the barriers to successful commercialization of this class of vaccine high (again, note that Immunicum is alone in developing an APC vaccine which is not personalized, but which still retains the benefits of personalized vaccines). Nevertheless, US market approval for Provenge (sipuleucel-T; Dendreon) in 2010 and recent advances in the understanding of APC-based vaccine approaches (Kalinski et al., 2009) appear to have stimulated interest in this class of vaccine. In fact, the Nobel Prize in Medicine 2011 was awarded to the discoverer of the dendritic cell, the most efficient APC known today.

Organization

BOARD OF DIRECTORS

AGNETA EDBERG

SCHAIRMAN OF THE BOARD
SHARES 27 000
STOCK OPTIONS 150 000
UNDERLYING SHARES 75 000

Alumna from Stockholm School of Economics, Biomedical Analyst
Born 1956

Currently Nordic CEO of Mylan and Chairman of the Board of AISAB. Agneta Edberg has held leading positions at Pfizer, Pharmacia, Orion, Cederroth International and Cilag. She has held positions on the boards of Hansen AB, Cityakuten AB, Stockholm Heart Center AB, LinkMed AB, Fastum AB and served as chairman of the boards of BioResonator AB, Health Solutions AB and the VINNExcellence Project BioMatCell.

ALEX KARLSSON-PARRA

BOARD MEMBER, FOUNDER/INNOVATOR & CHIEF SCIENTIFIC OFFICER
SHARES 702 726 (incl. related parties)
STOCK OPTIONS 150 000
UNDERLYING SHARES 75 000
M.D., Ph. D., Associate Professor of Clinical Immunology
Born 1950

Over 20 years of experience from work within the field of transplantation immunology and former chairman of the Swedish Expert Committee in Clinical Immunology. Previously Chief Physician at Regional Hospital Haugesund and Associate Professor of Clinical Immunology, Sahlgrenska University Hospital.

BENGT FURBERG

BOARD MEMBER, CHAIRMAN OF THE SAB
SHARES 2 000
STOCK OPTIONS 225 000
UNDERLYING SHARES 112 500

M.D., Ph. D., Associate Professor of Clinical Physiology
Born 1941

Bengt Furberg is an expert in clinical trials and has written several books and scientific articles within the field. He spent 10 years as Medical Director at GlaxoWellcome in Sweden and was also part of the company's management team in addition to being member of the corporate group's Medical Board and Safety Board. Bengt Furberg is also a member of the Board of Directors of BrainCool. He is also the chairman of the Education Committee, section for Clinical Trials in the Swedish Academy for Pharmaceutical Sciences.

PER-OLOF GUNNESSON

BOARD MEMBER,
CHIEF FINANCIAL OFFICER
SHARES 3 000
STOCK OPTIONS 150 000
UNDERLYING SHARES 75 000
B. Sc. Business and Administration
Born 1945

Per-Olof Gunnesson has a B. Sc. in Business and Administration and brings more than 40 years of experience from the pharmaceutical industry, including 27 years at the Astra Group where he held several leading positions. He has extensive experience from research intensive companies as well as marketing.

MARTIN LINDSTRÖM

BOARD MEMBER
SHARES 2 712 685
(LOGGEN INVEST AB)
STOCK OPTIONS 150 000
UNDERLYING SHARES 75 000
M. Sc., Civil Engineering, B. Sc., Business and Administration
Born 1980

Martin Lindström has an M.Sc. in Civil Engineering and a B. Sc. in Business and Administration. He represents the main owner Loggen Invest AB and since 2008 has shown a strong commitment to helping Immunicum's products reach cancer patients and he has contributed to the board of directors' work through his competence from the fields of economics and law, as well as through his genuine interest in Immunicum's business.

SVEN ANDRÉASSON

BOARD MEMBER
SHARES 44 534
STOCK OPTIONS 0
UNDERLYING SHARES 0
B. Sc. Business and Administration with a diploma from the Stockholm School of Economics
Born 1952

Sven Andréasson has a B. Sc. in Business and Administration from the Stockholm School of Economics and has long experience of the international biotech pharmaceutical industries, including serving as CEO of Active Biotech AB (publ) and several other Swedish, British, Belgian, French and German companies, mainly within Pharmacia Corporation. Sven Andréasson has also held the position of CEO of the BioPharma division within KabiVitrum. He is currently Senior Vice President for Novavax Inc. (US) and chairman of the board of Cantargia AB (Sv) and a board member of Erytech SA (Fr), Immunicum AB (publ Sv) and Cellastra Inc. (US).

SCIENTIFIC ADVISORY BOARD

CHAIRMAN: BENGT FURBERG

BENGT ANDERSSON

MEMBER OF THE BOARD, FOUNDER/INNOVATOR
SHARES 541 939
STOCK OPTIONS 150 000
UNDERLYING SHARES 75 000
M.D., Ph. D. Associate Professor of Clinical Immunology, Sahlgrenska University Hospital. Born 1952

Over 20 years of experience from work within the field of infection immunology. Bengt's competence is unique when it comes to the development and evaluation of methods for monitoring the immune response in different types of immunotherapy. Since 2007: Associate Professor of Clinical Immunology, Dept. of Clinical Immunology and Transfusion Medicine, Div. of Laboratory Medicine, Sahlgrenska University Hospital, Gothenburg.

ROLF KIESSLING

MEMBER OF THE SAB
SHARES 0
STOCK OPTIONS 0
UNDERLYING SHARES 0

M.D., Ph. D. Professor of Experimental Oncology, Karolinska Institutet.
Born 1948

Rolf Kiessling is a professor of Experimental Oncology at Karolinska Institutet since 1995 and has a part-time position as Chief Physician at Radiumhemmet, Karolinska hospital. R.K. has published more than 200 publications in peer reviewed journals and has a broad scientific expertise the field of experimental and clinical immunology. Among his earliest achievements, he discovered and named the NK-cell during the mid 70s, a discovery for which he was awarded "Anders Jahres medicinska pris for yngre forskare" 1985 and "Erik Fehrnströms pris" 1989. A more recent research focus of his group has been the area of immunotherapy of cancer where his group is carrying out investigator initiated clinical trials on cancer patients and also performing basic research in preclinical animal models.

ROGER HENRIKSSON

MEMBER OF THE SAB
SHARES 0
STOCK OPTIONS 0
UNDERLYING SHARES 0

M.D., Ph. D. Professor of Experimental Oncology
Born 1953

Roger Henriksson is professor of experimental oncology and Chief Physician, Medical Oncology and Radiotherapy since 1994. He has also served as Senior Medical Director (adviser) at Astra Zeneca, globally, part time since 2000. Roger Henriksson has over 270 publications in peer reviewed journals, including publications in all phases of drug development. Current scientific positions include Head/Deputy Head of the Dept of Radiation Sciences, Chairman of the National (Nordic 2001) Group for Treatment of CNS Tumors, Member of the Scientific Advisory Board for the Swedish Cancer Society, Board Member of the National Group for Treatment of Lung cancer.

CURT FURBERG

MEMBER OF THE SAB
SHARES 0
STOCK OPTIONS 0
UNDERLYING SHARES 0

M.D., Ph. D., Professor of Public Health Sciences
Born 1936

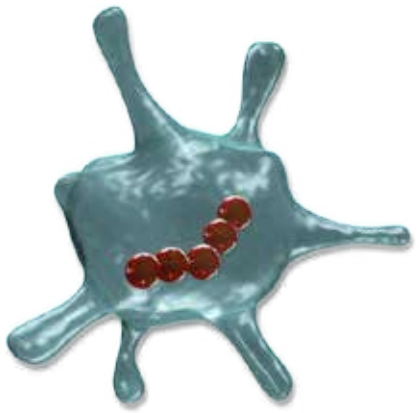
Curt Furberg is an internationally recognized cardiovascular epidemiologist with expertise in clinical trials and public health. He co-authored the first text on clinical trials methodology entitled "Fundamentals of Clinical Trials". He is also the co-author of a new text, "Data Monitoring in Clinical Trials. A Case Studies Approach", and has published more than 400 articles. As a strong proponent for evidence-based medicine, his public health background provides a strong foundation for his views on drug evaluation and patient safety. He has served on the FDA Advisory Committee on Drug Safety and Risk Management and testified before Congress.

DAN MAGNUSSON

MEMBER OF THE SAB
SHARES 27 450
STOCK OPTIONS 75 000
UNDERLYING SHARES 37 500

M. Sc. Pharmacy, Economy
Born 1945

Dan Magnusson has broad experience from pharmaceutical industry production and from acting as Qualified Person. Previous experiences include working as International Marketing Manager for Astra/Hässle for the international launch of Losec.



MANAGEMENT

JAMAL EL-MOSLEH
CHIEF EXECUTIVE OFFICER
SHARES 450 000
STOCK OPTIONS 150 000
UNDERLYING SHARES 75 000
M. Sc., Industrial Engineering and Management, Innovation and Entrepreneurship
Born 1981

Jamal El-Mosleh is a graduate from Chalmers University of Technology (Industrial Engineering and Management) and Chalmers/GIBBS (Innovation and Entrepreneurship). He previously worked as a management consultant and as a project manager for a biotech startup. Jamal holds the position as CEO of Immunicum since 2007.

HENRIK ELOFSSON
CHIEF OPERATING OFFICER
SHARES 4 288
STOCK OPTIONS 0
UNDERLYING SHARES 0

M. Med. Sc. in Medical Biology, M. Sc. Innovation and Entrepreneurship
Born 1982

Henrik Elofsson studied medical biology at the University of Linköping and has an additional diploma from Chalmers Bioscience Business School. He comes from Arterion where he worked as vice president in charge of R&D and the establishment of new production processes, and where he was also a member of the board of directors. He has also worked as a consultant to several innovation projects in addition to serving as coach of several business developers within Life Sciences.

ALEX KARLSSON-PARRA
CHIEF SCIENTIFIC OFFICER
See *Board of Directors* above.

PER-OLOF GUNNESSON
CHIEF FINANCIAL OFFICER
See *Board of Directors* above.

ORGANIZATION

To operate cost-effectively and with flexibility, Immunicum has chosen to work with a reduced staff and instead bring in external expertise through partnerships with qualified and experienced consultants and experts in various fields including production, and preclinical and clinical development. The Company has its own Scientific Advisory Board. Today, Immunicum's organization consist of 6 employees, including the CEO.

Milestones reached

YEAR	MILESTONES	FINANCING
2008	» Financing round #1 secured.	APPR 5 MSEK
	» Grants secured.	
	» Scientific Advisory Board (SAB) is established.	
	» Winning Venture Cup.	
2009	» CD70-cancer is developed and a patent application is submitted.	
	» The COMBIG platform is developed and successful in vitro-studies are completed.	
2010	» Financing round #2 secured.	6 MSEK
	» A major grant from VINNOVA.	3.5 MSEK
	» COMBIG patent application is submitted.	
	» Successful INTUVAX® proof-of concept study in rat is completed.	
	» Professor Rolf Kiessling joins the SAB and Agneta Edberg joins as Chairman of the Board.	
2011	» Successful INTUVAX® toxstudy and biodistribution study are completed.	
	» Medical Products Agency approves clinical trial in RCC.	
	» EPO grants patent protection for INTUVAX® och SUBCUVAX®.	
	» CD70-Viral and AntiCD3 are developed and patent applications are submitted.	
2012	» Financing round #3 secured.	APPR 6.3 MSEK
	» A clinical phase I/II trial in RCC is initiated.	
2013	» Financing round #4 secured.	APPR 30.2 MSEK
	» The Immunicum share begins trading on NASDAQ OMX First North.	
	» Immunicum is granted approval to start a clinical phase I/II trial in primary liver cancer.	
	» The last patient in the ongoing clinical phase I/II trial in metastatic renal cell carcinoma is given the final dose.	
	» Immunicum receives a grant from VINNOVA for optimization of the production process.	
	» A clinical phase I/II trial in primary liver cancer starts.	
2014	» Immunicum publishes promising data for the Company's CD70 technology for adoptive immunotherapy. The results indicate a robust method for expanding tumor-specific T-cells with increased viability, compared to established expansion protocols.	
	» Immunicum presents the final phase I/II report with positive safety data and promising survival data in the treatment of metastatic renal cancer.	
	» Immunicum conducts a directed new share issue.	APPR 56 MSEK
	» Rights issue conducted.	APPR 44 MSEK
	» Acquisition of adenovirus vector.	

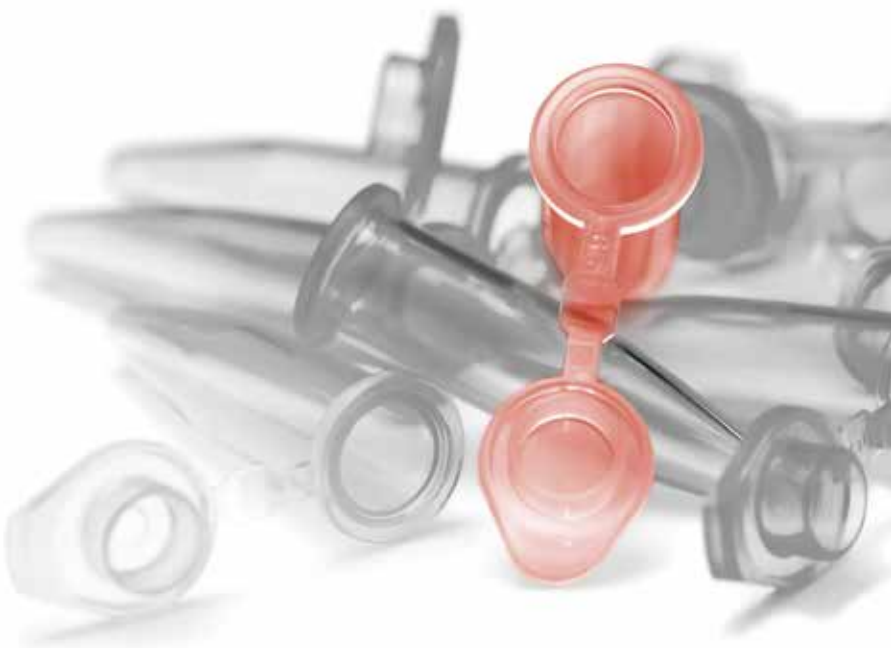
The share and ownership structure

DEVELOPMENT SHARE CAPITAL

DATE	EVENT	NUMBER OF SHARES	SHARE CAPITAL
July 12, 2002	Share register created	9 600	240 000
September 18, 2003	Directed new share issue of 26,250 SEK (1,050 new B-shares)	+1 050	+26 250
December 8, 2004	Directed new share issue of 50,625 SEK (2,025 new B-shares)	+2 025	+50 625
May 3, 2007	Directed new share issue of 185,625 SEK (7,425 new B-shares)	+7 425	+185 625
April 10, 2008	Directed new share issue of 171,600 SEK (6,864 new B-shares)	+6 864	+171 600
May 6, 2008	Directed new share issue of 13,900 SEK (556 new B-shares)	+556	+13 900
April 2, 2009	Decrease in share capital of 555,425 SEK through cancellation of 22,217 shares	-22 217	-555 425
April 2, 2009	Conversion of all shares to Ordinary shares		
May 14, 2010	Directed new share issue of 33,150 SEK (1,326 new Ordinary shares)	+1 326	+33 150
February 13, 2012	Directed new share issue of 15,000 SEK (600 new Ordinary shares)	+600	+15 000
September 7, 2012	7,221,771 new shares, split ratio 1000:1	+7 221 771	
September 7, 2012	Capitalization issue of 319,275 SEK (12,771,000 new Ordinary shares)	+12 771 000	+319 275
February 22, 2013	Reverse split 2:1	-10 000 000	
March 26, 2013	New share issue without preferential rights of 133,750 SEK (2,675,000 new Ordinary shares).	+ 2 675 000	+133 750
March 28, 2013	Directed new share issue of 55,000 SEK (1,100,000 new Ordinary shares)	+1 100 000	+55 000
April 2, 2014	Directed new share issue of 175,000 SEK (3,500,000 new Ordinary shares).	+3 500 000	+175 000
June 3, 2014	Rights issue of 137,750 SEK (2,755,000 new Ordinary shares).	+ 2 755 000	+137 750
	SUM	20 030 000	1 001 500

THE TEN MAJOR SHAREHOLDERS OF IMMUNICUM AT SEPTEMBER 30, 2014

OWNER	NUMBEROF SHARES	CAPITAL/ VOTES (%)
Loggen Invest AB	2,712,685	13.5%
Holger Blomstrand Byggnads AB	2,380,309	11.9%
Swedbank Robur Fonder	1,250,000	6.2%
Försäkringsaktiebolaget, Avanza Pension	963,747	4.8%
Stiftelsen Chalmers Innovation	827,416	4.1%
Alex Karlsson-Parra including related parties	702,726	3.5%
Nordnet Pensionsförsäkringar	587,273	2.9%
Bengt Andersson	541,939	2.7%
LMK stiftelsen	450,000	2.2%
Jamal El-Mosleh	450,000	2.2%
Total, ten largest shareholders	**10,866,095**	**54.2%**
All other shareholders	9,163,905	45.8%
Total	**20,030,000**	**100.0%**



Management report

The Board of Directors and the Chief Executive Officer of Immunicum AB, Org. no 556629-1786, hereby submit the annual accounts for the July 1, 2013 – June 30, 2014 financial year.

BUSINESS DESCRIPTION

Immunicum develops therapeutic cancer vaccines. The main product is based on white blood cells from healthy donors, so-called allogeneic dendritic cells. The discoverer of the vital role of the dendritic cell in all specific immune responses was awarded the Nobel Prize in Medicine in 2011.

Immunicum will continually conduct clinical trials in order to validate vaccine efficacy in humans in various cancer indications. A clinical trial in patients with metastatic renal cell carcinoma was concluded during the financial year. A clinical trial in primary liver cancer is on going.

A larger, phase II, clinical trial in patients with metastatic renal cell carcinoma will begin early 2015.

FINANCIAL OVERVIEW

RESULTS

Profit/loss after financial items was -16.2 MSEK (-6.9). The number of shares at end of period was 20,030,000 (13,775,000). Profit/loss per share was -0.81 SEK (-0.50) calculated before and after dilution.

Operating expenses were 17.2 MSEK (7.0). The increased costs are according to plan and are mainly due to the expanded clinical program.

FINANCIAL SITUATION AND LIQUIDITY

Immunicum's cash and cash equivalents at the end of the financial year were 107.8 MSEK (25.6). Total equity at end of period was 100.2 MSEK (24.6) and the equity/assets ratio was 92% (92). Equity per share was 5.00 SEK (1.78).

SIGNIFICANT EVENTS DURING THE FINANCIAL YEAR

- On July 1, 2013 the MPA approved the Company's application to initiate a clinical trial in primary liver cancer (HCC I/II).
- In August 2013 Immunicum reported that the last patient of the clinical trial in metastatic renal cell cancer had received the final dose of INTUVAX.
- At the 2013 AGM, Sven Andréasson was elected member of Immunicum's Board of Directors.
- In December, Immunicum's CSO, Alex Karlsson-Parra, presented positive phase I/II data on renal cell cancer at Informa's Immunotherapy conference in Brussels.
- On March 6, 2014, positive preclinical data for the CD70 platform was published in the American journal "Molecular Therapy – Methods & Clinical Development", which is published by Nature Publishing Group in collaboration with the "American Society of Gene & Cell Therapy".
- In March, the USPTO approved Immunicum's patent application regarding protection of the Company's core technology.
- On March 31, the final report was submitted to the MPA with positive data on renal cell carcinoma (RCC I/II).

» In May, Immunicum reported promising preliminary regression data regarding supplementary treatment with tyrosine kinase inhibitors and continued positive survival data from the completed phase I/II study in renal cancer.

» The Company presented phase I/II data on renal cell cancer at the world's largest cancer conference ASCO (American Society of Clinical Oncology), held early June 2014.

» On April 2, 2014, a directed share issue brought the company 56 million SEK before issue costs.

» On June 3, the Company announced that it had completed an oversubscribed rights issue which raised 44 million SEK before issue costs.

SIGNIFICANT EVENTS AFTER THE END OF THE FINANCIAL YEAR

» As a part of building Immunicum's organization, Alex Karlsson-Parra (CSO and one of the company's founders) became a full-time employee on July 1, 2014.

» Total expenditure for conducting the two share issues in April and June was 8.3 million SEK. A larger portion, 5.5 million SEK, was paid in August, and therefore does not affect the Company's cash and cash equivalents at end of the financial year.

» In early September, Alex Karlsson-Parra presented positive follow-up data from the phase I/II study in renal cancer at SMI's cancer vaccine conference in London.

» On October 27, Immunicum acquired the patent rights to an adenovirus vector for oncolytic therapy and for further development of SUBCUVAX.

RESEARCH AND DEVELOPMENT

The focus of product development is to validate the effect of the different vaccine concepts in human, but Immunicum also carries out tests in order to optimize the production process. Immunicum has a research collaboration with Professor Magnus Essand at Uppsala University Hospital regarding the CD70 platform and the vector technology.

BOARD OF DIRECTORS' PROPOSED APPROPRIATIONS OF THE COMPANY'S PROFIT OR LOSS

	Amounts in SEK
Funds at the disposal of the Annual General Meeting:	
Share premium reserve	134 355 491
Profit/loss brought forward	- 18 940 635
Profit/loss for the year	-16 175 036
Total	**99 239 820**
The Board of Directors propose that available funds:	
Carried forward	99 239 820
Total	**99 239 820**

As for the company's earnings and financial position, please refer to the financial statements and accompanying notes.

Financial summary

INCOME STATEMENT	2013/2014	2012/2013	2011/2012	2010/2011	2009/2010
Income	560 000	1 473	5 134	12 328	5 006
Operating expenses	-17 211 957	-6 974 772	-4 310 500	-3 060 358	-2 868 349
Operating profit/loss	**-16 651 957**	**-6 973 299**	**-4 305 366**	**-3 048 030**	**-2 863 343**
Net financial income	476 921	85 325	64 475	43 861	23 720
Profit/loss before tax	**-16 175 036**	**-6 887 974**	**-4 240 891**	**-3 004 169**	**-2 839 623**
Tax	-	-	-	-	-
Profit/loss for the year	**-16 175 036**	**-6 887 974**	**-4 240 891**	**-3 004 169**	**-2 839 623**

BALANCE SHEET	2014-06-30	2013-06-30	2012-06-30	2011-06-30	2010-06-30
Tangible fixed assets	347 313	95 184	57 206	8 935	11 550
Financial fixed assets	1 000	1 000	1 000	1 000	-
Other current assets	1 346 131	992 214	270 035	336 010	103 104
Cash and cash equivalents	107 840 568	25 607 241	5 750 558	4 317 205	6 318 269
Assets	**109 535 012**	**26 695 640**	**6 078 799**	**4 663 150**	**6 432 923**
Equity	100 241 320	24 604 113	4 431 491	2 336 381	5 340 550
Non-current liabilities	850 000	850 000	850 000	850 000	850 000
Current liabilities	8 443 692	1 241 527	797 309	1 476 769	242 373
Equity and liabilities	**109 535 012**	**26 695 640**	**6 078 800**	**4 663 150**	**6 432 923**

SUMMARY CASH FLOW STATEMENT	2013/2014	2012/2013	2011/2012	2010/2011	2009/2010
Cash flow from operating activities	-9 280 851	-7 146 028	-4 845 068	-2 000 064	-2 845 982
Cash flow from investing activities	-298 065	-57 886	-57 579	-1 000	-13 075
Cash flow from financing activities	91 812 243	27 060 597	6 336 000	-	6 278 361
Change in cash and cash equivalents	82 233 327	19 856 683	1 433 353	-2 001 064	3 419 304
Cash and cash equivalents at beginning of year	25 607 241	5 750 558	4 317 205	6 318 269	2 898 965
Cash and cash equivalents at year-end	**107 840 568**	**25 607 241**	**5 750 558**	**4 317 205**	**6 318 269**

KEY RATIOS	2014-06-30	2013-06-30	2012-06-30	2011-06-30	2010-06-30
Liquid ratio (%)	1293%	2142%	755%	315%	265%
Equity/assets ratio (%)	92%	92%	73%	50%	83%
Dividend	-	-	-	-	-

Financial definitions
Liquid ratio: Current assets divided by current liabilities
Equity/assets ratio: Equity as a percentage of total assets

Income statement

Amounts in SEK	*Note*	*2013-07-01 - 2014-06-30*	*2012-07-01 - 2013-06-30*
Other operating income		560 000	1 473
		560 000	**1 473**
OPERATING EXPENSES			
Other external costs	*1, 2*	-13 033 603	-4 453 698
Personnel costs	*2*	-4 111 316	-2 501 167
Depreciation of tangible fixed assets	*3*	-45 936	-19 908
Other operating expenses		-21 102	-
Operating profit/loss		**-16 651 957**	**-6 973 299**
PROFIT/LOSS FROM FINANCIAL ITEMS			
Interest income and similar items		504 157	118 102
Interest expenses and similar items		-27 236	-32 777
Profit/loss after financial items		**-16 175 036**	**-6 887 974**
PROFIT/LOSS BEFORE TAX		**-16 175 036**	**-6 887 974**
Taxes		-	-
PROFIT/LOSS FOR THE YEAR		**-16 175 036**	**-6 887 974**

Balance sheet

AMOUNTS IN SEK

ASSETS	*Note*	*2014-06-30*	*2013-06-30*
FIXED ASSETS			
TANGIBLE FIXED ASSETS			
Equipment	*3, 4*	347 313	95 184
Total tangible fixed assets		**347 313**	**95 184**
FINANCIAL FIXED ASSETS			
Other investments held as fixed assets		1 000	1 000
Total fixed assets		**348 313**	**96 184**
CURRENT ASSETS			
Other receivables		718 919	859 839
Prepaid expenses and accrued income	*5*	627 212	132 376
Total current receivables		**1 346 131**	**992 215**
Cash and bank balances	*6*	107 840 568	25 607 241
Total current assets		**109 186 699**	**26 599 456**
TOTAL ASSETS		**109 535 012**	**26 695 640**

Balance sheet

AMOUNTS IN SEK

EQUITY AND LIABILITIES	*Note*	*2014-06-30*	*2013-06-30*
EQUITY	*7*		
Restricted equity			
Share capital		1 001 500	688 750
Total restricted equity		**1 001 500**	**688 750**
Non-restricted equity			
Share premium reserve	*8*	134 355 491	42 855 998
Profit or loss brought forward		-18 940 635	-12 052 661
Profit/loss for the year		-16 175 036	-6 887 974
Total non-restricted equity		**99 239 820**	**23 915 363**
Total equity		**100 241 320**	**24 604 113**
NON-CURRENT LIABILITIES			
Other liabilities to financial institutions	*9*	850 000	850 000
CURRENT LIABILITIES			
Accounts payable		1 022 884	387 522
Other liabilities		167 709	157 241
Accrued expenses and deferred income	*10*	7 253 099	696 764
Total current liabilities		**8 443 692**	**1 241 527**
Total liabilities		**9 293 692**	**2 091 527**
TOTAL EQUITY AND LIABILITIES		**109 535 012**	**26 695 640**
Pledged assets and contingent liabilities	*6*	314 400	NONE
Contingent liabilities		NONE	NONE

Cash Flow Analysis

INDIRECT METHOD

OPERATING ACTIVITIES	*2013/2014*	*2012/2013*
Operating profit/loss before financial items	-16 651 957	-6 973 299
Depreciation/amortization	45 936	19 908
Interest received	504 157	118 102
Interest paid	-27 236	-32 777
Cash flow from operating activities before changes in working capital	**-16 129 100**	**-6 868 066**
CHANGES IN WORKING CAPITAL		
Increase/decrease in accounts receivable	-	-
Increase/decrease in other current receivables	-353 916	-722 180
Increase/decrease in accounts payable	635 362	306 025
Increase/decrease in other current liabilities	6 566 803	138 193
Total changes in working capital	**6 848 249**	**-277 962**
Cash flow from operating activities	**-9 280 851**	**-7 146 028**
INVESTING ACTIVITIES		
Investments in intangible fixed assets	-	-
Investments in tangible fixed assets	-298 065	-57 886
Investments in other financial non-current assets	-	-
Cash flow from investing activities	**-298 065**	**-57 886**
FINANCING ACTIVITIES		
New share issue	91 812 243	27 060 597
Borrowings	-	-
Cash flow from financing activities	**91 812 243**	**27 060 597**
Cash flow for the year	82 233 327	19 856 683
Cash and cash equivalents at beginning of year	25 607 241	5 750 558
CASH EQUIVALENTS AT THE END OF THE PERIOD	107 840 568	25 607 241

Accounting principles & comments to the accounts

Amounts in SEK unless stated otherwise

GENERAL ACCOUNTING PRINCIPLES

The annual report has been prepared in accordance with the Swedish Annual Accounts Act and the general advice and guidelines of the Swedish Accounting Standards Board. The accounting principles remain unchanged as compared with the previous year.

REVENUE RECOGNITION

Income is reported in accordance with BFNAR 2003:3 Revenue.

VALUATION PRINCIPLES, ETC.

Assets, provisions and liabilities are valued at acquisition cost, unless stated otherwise below.

CAPITALISED EXPENDITURE FOR RESEARCH AND DEVELOPMENT WORK

Starting from the financial year 2012/2013, the Company implemented a changed accounting principle regarding when development expenses are capitalized. Henceforth, development expenses are not capitalized until a drug development project has entered PHASE III. Thereafter, the above mentioned expenses will be reported as costs in the Income statement until the new criteria for capitalization have been met.

The change in accounting principle implied that capitalized development costs from previous years were removed from the balance sheet and equity was reduced by a corresponding amount.

RECEIVABLES

Receivables are reported at acquisition cost less any write-down.

TANGIBLE FIXED ASSETS

Tangible fixed assets are valued at acquisition cost less accumulated depreciation and any write-down.

Depreciation according to plan is based on the original acquisition costs less estimated residual value. Depreciation takes place on a straight-line basis over the estimated useful life of the asset.

Fixed assets	*% per year*
Tangible fixed assets:	
- Equipment	20

CASH FLOW ANALYSIS

The cash flow statement has been prepared using the indirect method. The reported cash flow includes only those transactions that results in receipts or payments.

Notes

NOTE 1 FEES TO AUDITORS

	2013-07-01-2014-06-30	2012-07-01-2013-06-30
Audit assignment	120 000	66 550
Auditing activities other than the audit assignment	190 000	191 800
Total	**310 000**	**258 350**

NOTE 2 EMPLOYEES AND PERSONNEL COSTS

AVERAGE NUMBER OF EMPLOYEES	2013-07-01-2014-06-30	2012-07-01-2013-06-30
Men	3	3
Women	2	1
Total	**5**	**4**

SALARIES, OTHER REMUNERATION AND SOCIAL SECURITY CONTRIBUTIONS	2013-07-01-2014-06-30	2012-07-01-2013-06-30
Board of Directors and CEO	1 743 249	1 271 161
Other employees	1 590 975	944 052
Total	**3 334 224**	**2 215 213**
Social security contributions	989 928	745 439
(of which pension costs SEK 49,993, previous year SEK 23,975)		
Total	**4 324 152**	**2 960 652**

The CEO was paid a total of 1,323,708 SEK (871,161 SEK) in salary and remuneration during the year. In addition to the fixed monthly salary, the CEO is paid a variable salary component conditioned on the achievement of specific performance goals. The variable salary component is determined by the Chairman of the Board. During the financial year, a total variable salary component of 247,500 SEK (100,000) was paid to the CEO. The CEO has a notice period of 6 months. No agreements exist covering severance pay to employees.

BOARD OF DIRECTORS

As resolved at the December 2013 AGM, the Board of Directors receive a total yearly remuneration of 425,000 SEK, of which 100,000 SEK is paid to the Chairman. The remuneration to board members Agneta Edberg, Sven Andréasson and Per-Olof Gunnesson has been paid to their respective companies. During the financial year, board member Bengt Furberg was paid 6,000 SEK (12,000) in consulting fees; and Per-Olof Gunnesson was paid 187,350 SEK (39,200) in consulting fees for his work as CFO. The compensation level for their work is set at commercial conditions.

NOTE 3 DEPRECIATION OF TANGIBLE FIXED ASSETS

	2013-07-01-2014-06-30	2012-07-01-2013-06-30
Equipment	45 936	19 908
Total	**45 936**	**19 908**

NOTE 4 EQUIPMENT, TOOLS, FIXTURES AND FITTINGS

	2013-07-01-2014-06-30	*2012-07-01-2013-06-30*
Accumulated acquisition costs:		
- At the beginning of the year	128 540	70 654
- New acquisitions	298 065	57 886
	426 605	**128 540**
Accumulated depreciation according to plan:		
- At the beginning of the year	-33 356	-13 448
- Depreciation according to plan for the year	-45 936	-19 908
	-79 292	-33 356
Carrying amount at year-end	**347 313**	**95 184**

NOTE 5 PREPAID EXPENSES AND ACCRUED INCOME

	2013-07-01-2014-06-30	*2012-07-01-2013-06-30*
Interest income, bank	278 477	80 956
Other prepaid expenses	348 735	51 420
Total	**627 212**	**132 376**

NOTE 6 CASH AND BANK

	2014-06-30	*2013-06-30*
Pre-approved credit	50 000	50 000

The company has provided security for bank guarantee by pledging bank deposits of 314,400 SEK.

NOTE 7 EQUITY

	Share capital	*Statutory reserve*	*Share premium reserve*	*Profit or loss brought forward*	*Profit/loss for the year*	*Total*
EQUITY JUNE 30, 2012 adjusted according to new accounting principle	180 725	85 875	16 217 551	-7 811 770	-4 240 891	4 431 490
Opening balance July 1, 2012	180 725	85 875	16 217 551	-7 811 770	-4 240 891	4 431 490
Capitalization issue	319 275	-85 875	-233 400			
New share issue	188 750		26 871 847			27 060 597
Transfer of profit/loss from previous year				-4 240 891	4 240 891	
Profit/loss for the year					-6 887 974	-6 887 974

EQUITY JUNE 30, 2013	688 750	-	42 855 998	-12 052 661	-6 887 974	24 604 113
Opening balance July 1, 2013	688 750	-	42 855 998	-12 052 661	-6 887 974	24 604 113
New share issue*	312 750		91 499 493			91 812 243
Transfer of profit/loss from previous year				-6 887 974	6 887 974	
Profit/loss for the year					-16 175 036	-16 175 036
EQUITY JUNE 30, 2014	1 001 500	-	134 355 491	-18 940 635	-16 175 036	100 241 320

* During 2013/2013, transaction costs directly related to the new share issue amounted to 8,267,757 SEK. These are reported under equity as a deduction after the proceeds of the share issue.

NOTE 8 INCENTIVE PROGRAM

The December 19, 2012 Annual General Meeting decided to issue a total of a maximum of 1,350,000 stock options to be distributed to the CEO and members of the Board of Directors and Scientific Advisory Board. Upon full exercise of all stock options, the Company's share capital will increase by a maximum of 33,750 SEK, corresponding to a dilution effect of just over 3%. 1,200,000 of the stock options have been sold at market rates. The proceeds, a total of 252,000 SEK, have been recorded in the share premium reserve.

Allotment date	*Expiry date*	*Participants*	*Exercise price SEK*	*Outstanding options on July 1*	*Issued*	*Exercised*	*Expired*	*Outstanding options on June 30*
3/1-2013	31/3-2016	9	24	1 200 000	0	0	0	1 200 000

The options may be exercised to subscribe for new shares in the Company during the period from March 1 to March 31, 2016. Two options entitle the holder to subscribe for one new share at a subscription price of SEK 24 per share.

NOTE 9 OTHER LIABILITIES TO CREDIT INSTITUTIONS

The Company has previously received financing in the form of conditional credits from Region Västra Götaland amounting to 850,000 SEK. The terms of repayment for these loans comprise 5% of potential future income. The reimbursement is based on five (5) percent of the year's accumulated income, according to above terms, with the addition of interest at the reference rate set by the Riksbank for the calendar half-year in question, plus an additional 2 (two) percent units.

NOTE 10 ACCRUED EXPENSES AND DEFERRED INCOME

	2013-07-01-2014-06-30	*2012-07-01-2013-06-30*
Accrued vacation pay	251 729	86 821
Accrued research and development costs	1 000 000	210 617
Accrued issue costs	5 467 757	-
Other accrued expenses	533 613	399 326
Total	**7 253 099**	**696 764**

Signatures

GOTHENBURG, October 29, 2014

Agneta Edberg
CHAIRMAN

Bengt Furberg
BOARD MEMBER

Martin Lindström
BOARD MEMBER

Per-Olof Gunnesson
BOARD MEMBER

Alex Karlsson-Parra
BOARD MEMBER

Sven Andréasson
BOARD MEMBER

Jamal El-Mosleh
CEO

AUDITOR'S ENDORSEMENT

The auditor's report has been submitted on November 3, 2014
Öhrlings PricewaterhouseCoopers AB

Gunnar Källhed
AUTHORIZED PUBLIC AUDITOR

Bengt Kron
AUTHORIZED PUBLIC AUDITOR

Auditor's report

To the annual meeting of the shareholders of Immunicum AB (publ), corporate identity number 556629-1786

REPORT ON THE ANNUAL ACCOUNTS

We have audited the annual accounts of Immunicum AB (publ) for the financial year July 1, 2013 - June 30, 2014. The annual accounts of the Company are included in the printed version of this document on pages 34–48.

RESPONSIBILITIES OF THE BOARD OF DIRECTORS AND THE CHIEF EXECUTIVE OFFICE FOR THE ANNUAL ACCOUNTS

The Board of Directors and the Chief Executive Officer are responsible for the preparation and fair presentation of these annual accounts in accordance with the Annual Accounts Act, and for such internal control as the Board of Directors and the Chief Executive Officer determine is necessary to enable the preparation of annual accounts that are free from material misstatement, whether due to fraud or error.

AUDITOR'S RESPONSIBILITY

Our responsibility is to express an opinion on these annual accounts based on our audit. We conducted our audit in accordance with International Standards on Auditing and generally accepted auditing standards in Sweden. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the annual accounts are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the annual accounts. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the annual accounts, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the company's preparation and fair presentation of the annual accounts in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the company's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board of Directors and the Chief Executive Officer, as well as evaluating the overall presentation of the annual accounts. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

OPINIONS

In our opinion, the annual accounts have been prepared in accordance with the Annual Accounts Act and present fairly, in all material respects, the financial position of Immunicum AB (publ) as of 30 June 2014 and of its financial performance and its cash flows for the year then ended in accordance with the Annual Accounts Act. The statutory administration report is consistent with the other parts of the annual accounts. We therefore recommend that the annual meeting of shareholders adopt the income statement and balance sheet.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

In addition to our audit of the annual accounts, we have examined the proposed appropriations of the company's profit or loss and the administration of the Board of Directors and the Managing Director of Immunicum AB (publ) for the financial year July 1, 2013 - June 30, 2014.

RESPONSIBILITIES OF THE BOARD OF DIRECTORS AND THE MANAGING DIRECTOR

The Board of Directors is responsible for the proposal for appropriations of the company's profit or loss, and the Board of Directors and the Managing Director are responsible for administration under the Companies Act.

AUDITOR'S RESPONSIBILITY

Our responsibility is to express an opinion with reasonable assurance on the proposed appropriations of the company's profit or loss and on the administration based on our audit. We conducted the audit in accordance with generally accepted auditing standards in Sweden.

As a basis for our opinion on the Board of Directors' proposed appropriations of the company's profit or loss, we examined whether the proposal is in accordance with the Companies Act.

As a basis for our opinion concerning discharge from liability, in addition to our audit of the annual accounts, we examined significant decisions, actions taken and circumstances of the company in order to determine whether any member of the Board of Directors or the Managing Director is liable to the company. We also examined whether any member of the Board of Directors or the Managing Director has, in any other way, acted in contravention of the Companies Act, the Annual Accounts Act or the Articles of Association.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

OPINIONS

We recommend to the annual meeting of shareholders that the profit be appropriated in accordance with the proposal in the statutory administration report and that the members of the Board of Directors and the Managing Director be discharged from liability for the financial year.

Gothenburg, November 3, 2014
Öhrlings PricewaterhouseCoopers AB

GUNNAR KÄLLHED
AUTHORIZED PUBLIC AUDITOR

BENGT KRON
AUTHORIZED PUBLIC AUDITOR

Articles of Association

§ 1 COMPANY NAME
The registered name of the Company is IMMUNICUM AB (publ). The Company is a public company (publ).

§ 2 REGISTERED OFFICE
The Board of Directors shall have its registered office in the municipality of Göteborg in the district of Västra Götaland, Sweden.

§ 3 BUSINESS PURPOSE
The Company shall engage in research, development, marketing and sales of pharmaceutical drugs and activities related thereto.

§ 4 SHARE CAPITAL
The Company's share capital shall amount to not less than SEK 500,000 and not more than SEK 2,000,000.

§ 5 NUMBER OF SHARES
The Company shall have not less than 10,000,000 shares and not more than 40,000,000 shares.

§ 6 BOARD OF DIRECTORS
The Board of Directors shall consist of three to eight members, with zero to three deputies. The Board of Directors is elected at the Annual General Meeting for the time up until the conclusion of the next general meeting.

§ 7 AUDITORS
For the purpose of examining the Company's annual report and financial accounts, as well as the management of the Chief Executive Officer and the Board of Directors, an authorized auditor is to be elected at the Annual General Meeting for the time up until the conclusion of the next Annual General Meeting.

§ 8 NOTICE
Notice of a General Meeting of Shareholders shall be made in the form of an announcement in the Official Gazette (Post och Inrikes Tidningar) and at the Company´s website. Announcement to the effect that notice convening a General Meeting has been issued shall be published in Dagens Industri. Notice to convene an annual general meeting of shareholders and an extraordinary general meeting of shareholders where the amendment of the articles of association shall be resolved upon shall be issued not earlier than six and not later than four weeks before the meeting. Notice to convene other extraordinary general meetings of shareholders shall be issued not earlier than six and not later than three weeks before the meeting.

§ 9 PARTICIPATION IN SHAREHOLDERS' MEETING
Shareholders recorded in the register of shareholders are entitled to participate at meetings as set out in Chapter 7 Section 28 paragraph 3 of the Companies Act (2005:551) and shall register their names not later than the day stipulated in the notice to attend the General Meeting. The latter day may not be a Sunday, other Swedish public holiday, Saturday, Midsummer's Eve, Christmas Eve or New Year's Eve and may not occur earlier than on the fifth weekday (Saturdays included) before the meeting.

§ 10 ANNUAL GENERAL MEETING
The following matters shall be dealt with at the Annual General Meeting:

1. Election of a chairman of the meeting.
2. Preparation and approval of the voting list.
3. Presentation and approval of the agenda.
4. Election of one (1) or two (2) persons to approve the minutes of the meeting.
5. Determination of whether the meeting was duly convened.
6. Presentation of the submitted annual report and the auditors' report and, where applicable, the consolidated financial statements and the auditors' report for the group.
7. Resolutions regarding:
   a) the adoption of the income statement and the balance sheet and, where applicable, the consolidated income statement and the consolidated balance sheet.
   b) allocation of the Company's profits or losses in accordance with the adopted balance sheet.
   c) discharge of the members of the board and the Chief Executive Officer from liability.
8. Determination of fees for members of the board of directors and auditors.
9. Election of board members and auditors, and where applicable, deputy auditors.
10. Other matters as set out in the Swedish Companies Act or in the Company's articles of association.

§ 11 FINANCIAL YEAR
The Company's financial year shall comprise July 1 - June 30.

§ 12 CENTRAL SECURITIES DEPOSITORY CLAUSE
The Company's shares shall be registered with a record day register according to the Financial Instruments Act (SFS 1998:1479).

Annual General Meeting and reporting dates

Financial calendar

» Interim report Q1: **November 18, 2014**

» Interim report Q2: **February 20, 2015**

» Interim report Q3: **May 21, 2015**

» Year end report 14/15: **September 18, 2015**

» Annual report 14/15: **November 6, 2015**

Annual General Meeting

» The AGM of Immunicum AB will be held on **December 3, 2014**

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