Diurnal Group

30 September 2021

Share Price	**58p**
CP Fair Value	**241p**

Market Cap (£m)	96
Net Cash (£m)	34
Enterprise Value (£m)	62

Country	UK
Code	DNL
Index	FTSE AIM

Source: Calvine Partners Research

Smart delivery

In pharmaceutical development, replacement therapies have generally been straightforward and commercially successful. This is unsurprising, we believe, given that replacing a missing enzyme/hormone usually fixes the underlying disease. For Diurnal, the focus has been on replacing cortisol in those patients who suffer from cortisol deficiency. Impressively, two products Alkindi and Efmody, have received approval in Europe and the UK, with roll out ongoing. Efmody is the more important product targeting the genetic disorder congenital adrenal hyperplasia (CAH) initially. While hydrocortisone replacement has been the mainstay of therapy, the emphasis has been on improving delivery to mimic cortisol's physiological release, which generally follows a circadian rhythm. CAH is problematic to treat because of the build-up of androgens overnight, which results in infertility, virilisation, osteopaenia and metabolic syndrome. Treatment requires supraphysiologic glucocorticoid dosing resulting in significant side effects and undertreatment as patients choose not to or cannot tolerate high glucocorticoid doses. Therefore, an ideal therapy for CAH would combine better circadian glucocorticoid delivery at nearer physiological dosing, effectively controlling overnight androgens and minimising the risk of adrenal crisis. The data so far indicate that Efmody fulfils many of these requirements suggesting future commercial success. Complementary approaches targeting CRF1 are in development elsewhere, specifically targeting high androgen production, which could further transform the lives of CAH sufferers.

Broader adrenal insufficiency franchise evident

While all eyes are on the European Efmody roll out, the key US market is also in sight with the US (and Japan) Phase 3 trial (CONnECT) design secured under the auspices of a Special Protocol Assessment (SPA) which should reduce risk. The more significant Adrenal insufficiency (AI) opportunity beckons with no overnight androgen complications, suggesting a more straightforward approach. A registration trial (CHAMPAIN) in Europe will soon be underway, promising greater operational leverage from 2023.

Managing commercial execution and pipeline delivery

Diurnal aspires to create a broad endocrinology (ex diabetes) franchise. DITEST, as an orally available native testosterone, promises greater convenience in the treatment of hypogonadism, with a streamlined US development pathway. A Capital Markets Day planned for later this year should provide more pipeline details on DITEST and novel therapies for hypothyroidism and Cushing's disease.

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Promising to transform the lives of CAH patients

CAH sufferers have challenges controlling their disease

Diurnal's approach to the treatment of cortisol deficiency has been to focus initially on the rare genetic disease congenital adrenal hyperplasia (CAH). CAH patients suffer from the usual cortisol deficiency manifestations, including fatigue, growth retardation, and potentially life-threatening adrenal crises. Adrenal crises are concerning and are usually associated with a stress event like an infection, particularly in children with CAH, where patients are more likely to suffer from higher rates of infections. Unfortunately, adrenal crises are difficult to predict, can be complicated by an inability to absorb glucocorticoids (nausea and vomiting), and are usually treated by using stress (high dose glucocorticoid) dosing.

Not just a straightforward replacement

Treatment of patients with CAH has traditionally involved replacement therapy with glucocorticoids to replace the lost cortisol. These treatments usually consist of hydrocortisone and more potent alternatives, including prednisolone and dexamethasone, in more challenging patients. Treating CAH is more complicated than a straightforward adrenal insufficiency replacement therapy because of excess overnight androgens in classical CAH patients caused by a mutation in 21-hydroxylase. Cortisol production is controlled by a feedback control loop, and the absence of 21-hydroxylase results in CAH patients producing too many of the precursors of cortisol, including damaging androgens. Inadequate control of androgens results in virilisation of females and infertility in both males and females.

Management of overnight androgen production is an additional challenge

For reasons unknown, although adrenal crises can be prevented by administering physiologic doses of hydrocortisone, the control of overnight androgens requires significantly higher doses. Long-term treatment with these supraphysiologic doses can result in growth retardation, low bone density, metabolic syndrome, and obesity. To make matters worse, administering glucocorticoids late at night to reduce androgen production is unnatural and results in additional issues, including insomnia and a greater metabolic impact.

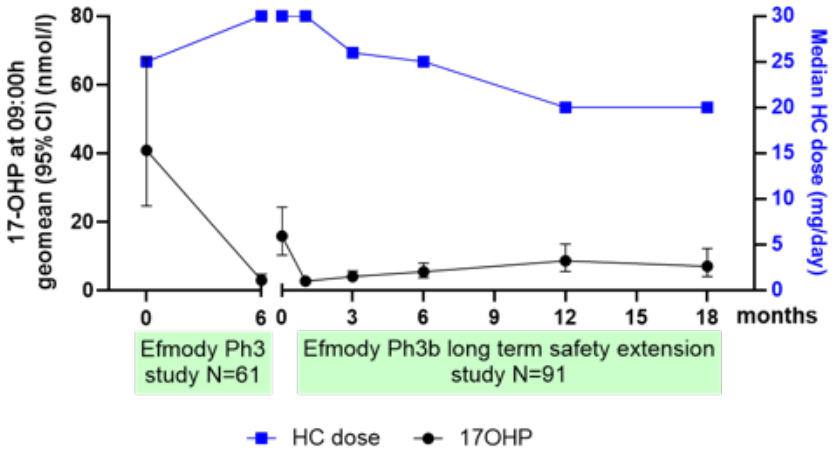
A balance between hyperandrogenism and hypercortisolism

The principal goal of CAH therapy is to provide control of overnight androgens at a low enough glucocorticoid dose to manage the symptoms of low cortisol and prevent adrenal crises. Diurnal's approach with Efmody is to deliver hydrocortisone in a manner that replicates the normal circadian rhythm. Traditional methods involve multiple dosing of immediate-release (IR) hydrocortisone, whereas Efmody offers a modified release profile taken twice daily in a toothbrush regimen. One of the key limitations of IR hydrocortisone therapy has been the inability to replicate the production of early morning cortisol required to prevent the overnight build-up of damaging androgens.

Intuitively, smarter delivery of hydrocortisone which better mimics the circadian release profile should lead to steroid-sparing. Examination of the data generated by Efmody in the European Phase 3 study has shown that Efmody does indeed deliver better

androgen control in adults, with a 33% reduction in glucocorticoid dose to cortisol replacement levels. Looking at the open-label extension study, we note that the CHMP assessment highlighted that at month 18 (interim readout), patients had experienced a median reduction in total daily dose of Efmody of 10mg (from 30-20mg) and that this "*…represents a clinically meaningful steroid-sparing in these participants*". A reduction in glucocorticoid dose to physiological levels should be sufficient, we believe, to satisfy the concerns of physicians, particularly given that using a lower dose could expose the patient to a higher risk of adrenal crises.

Efmody answers many of these concerns



Source: Adapted from Merke et al., JCEM 2021

Fertility is a big issue for classical CAH patients, in men and women, as a direct result of the production of excess androgens. In men, it can result in the development of benign testicular tumours (TARTs) and hypogonadism. In females, similar benign resting tumours (OARTs) appear to be rarer. At the same time, fertility rates are lower with those affected by poor hormonal control suffering from abnormal sexual development, amenorrhoea and irregular periods. Given that fertility represents one of the most significant long-term concerns in CAH patients, much emphasis has been placed on the ability of treatment to reduce androgens and improve fertility rates in CAH patients. From Efmody's perspective, the data are both reassuring and encouraging. In the Phase 3 study, 4 patients resumed menses (compared to only 1 on IR hydrocortisone) with 2 partner pregnancies that achieved full-term delivery. In addition, 1 of the patients experienced an increase in sperm count while receiving Efmody. This trend continued into the extension Phase of the study. Overall, across both studies, 8 patients receiving Efmody resumed menses (only 1 on IR hydrocortisone), while 4 partners and 3 patients achieved pregnancy (0 on IR hydrocortisone).

Fertility is a big problem

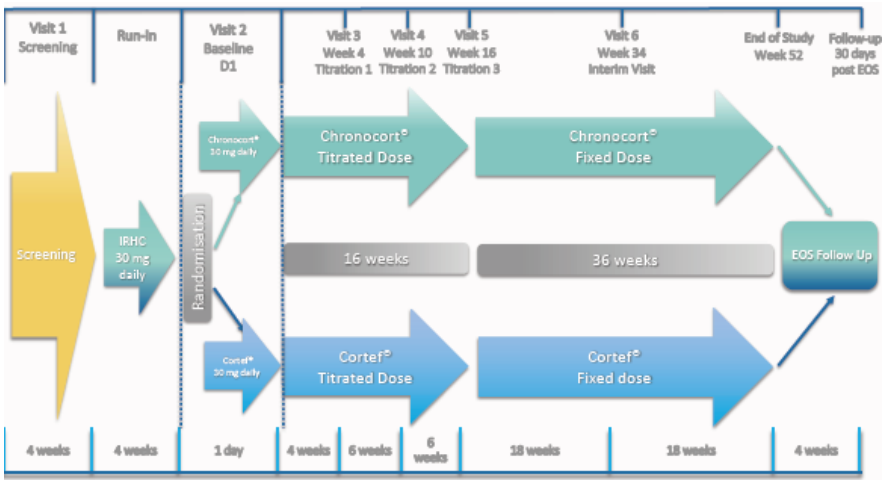
In summary, we believe that the data to date are supportive of the role of Efmody as an important new treatment approach, reflecting the significance of mimicking the circadian release of cortisol to improve the control of overnight androgens. These include better

Efmody's profile should reassure regulators and endocrinologists

control of the androgen precursor 17-OHP, improvements in fertility, and reduced adrenal crises. We also note that Efmody is not associated with decreased bone mineral density and offers better compliance. Importantly, this has also resulted in a decrease in glucocorticoid requirement to those required for adrenal insufficiency, which should satisfy the prevailing concerns held by endocrinologists regarding glucocorticoid overuse in these patients.

SPA provides reassurance on the adequacy of the Phase 3 trial

Following receipt of a Special Protocol Assessment (SPA) from FDA, details of the design of the US (and Japan) Phase 3 (CONnECT) Efmody study suggests that much has been learned from Diurnal's pioneering efforts. This is a double-blind 52-week study, where the primary endpoint is a biochemical responder analysis versus IR hydrocortisone in a non-inferiority design. Secondary endpoints should also provide important information comparing Efmody with IR hydrocortisone with respect to key measures, including steroid-sparing, fertility, body weight, and quality of life measures.



Source: Company presentation

Other approaches beckon in CAH

Potential to block and replace

The desire to improve the lives of patients with CAH has gathered significant momentum lately, especially in the US. In particular, the CRF1 inhibitors crinecerfont and tildacerfont offer alternative and complementary approaches to reducing the build-up of overnight androgens in CAH patients. Essentially, CRF1 inhibition potentially compartmentalises treatment, reducing overnight androgen build-up so that cortisol replacement requires only physiological levels of glucocorticoids such as hydrocortisone to prevent the risk of adrenal crises. The appeal is obvious, as traditional supraphysiologic levels of glucocorticoid are associated with significant long-term complications. Effectively, the expectation is that eliminating the high androgen concern reduces treatment to adrenal insufficiency. If successful, such an approach could also reduce the need for laboratory testing and improve fertility (reduction in TARTs).

Not all Phase 3 trial designs are the same

That said, the approach followed by Spruce with tildacerfont is materially different from that of both Neurocrine with crinecerfont and Diurnal with Efmody. Spruce has divided the CAH patient population into those who are poorly controlled or well controlled. Those who are well controlled are receiving high doses of glucocorticoid, while those who are poorly controlled are receiving sub-optimal dosing and likely cannot tolerate supraphysiologic doses. We suspect that this reflects the heterogeneity of the disease, recognising that it is a personal choice whether to accept the long-term consequences of high androgens or high glucocorticoids. As a result, tildacerfont is progressing through steroid-sparing as well as glucocorticoid reducing Phase 3 studies.

Efmody may be all that many patients require

These are clearly promising times for patients with CAH with multiple therapeutic approaches in late-stage development. Unfortunately, none of the Phase 3 programmes underway (tildacerfont and crinecerfont) or planned (Efmody US Phase 3) have sought to evaluate the combination of CRF1 inhibition with better-tailored glucocorticoid treatment. Intuitively, the combination of a therapy that reduces overnight androgens alone (CRF1 inhibition) and Efmody, which best mimics the circadian release of cortisol, suggests the optimal treatment for most CAH patients. Intriguingly, the data so far suggests that in many patients, Efmody alone may be sufficient in controlling overnight androgen production as well as the risk of adrenal crises. At the same time, however, we recognise that a lower dose of glucocorticoid administered chronically must be beneficial, which suggests a role for both approaches.

Larger AI indication on track

AI is a much more straightforward proposition

While treatment of CAH requires a balance between hyperandrogenism and hypercortisolism, patients with adrenal insufficiency (AI) not caused by a defect in 21-hydroxylase do not experience problems with excess androgens – often quite the opposite. Cortisol replacement is much more straightforward, although there remain clear benefits in mimicking the body's circadian delivery. As a result, we believe that Efmody is well placed to provide a best-in-class approach to the treatment of AI. The importance of a glucocorticoid release profile that best mimics the circadian cycle has already met with some success with subcutaneous infusion providing encouraging results – if not convenience. In particular, the observation that cortisol levels peak just before waking has provided significant challenges in optimising the release profile. While AI patients may not have high androgens, it is still important to ensure optimal glucocorticoid delivery.

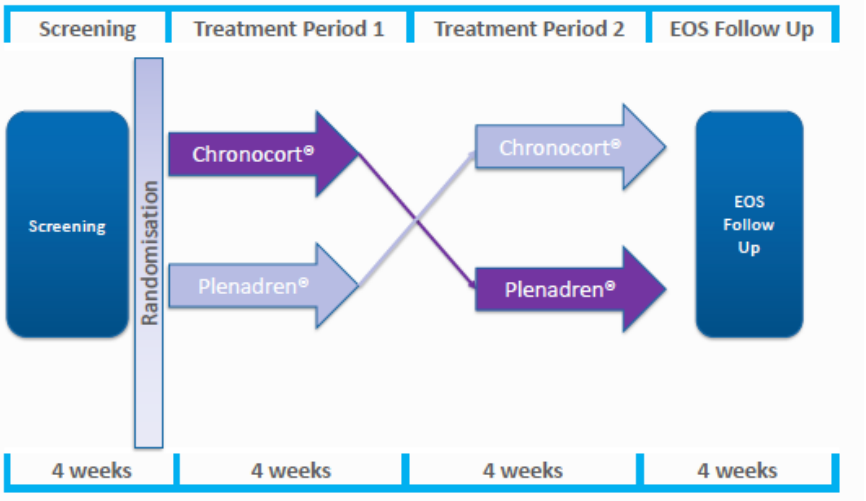
Plenadren in Europe but not in the US

The market is currently dominated by immediate release glucocorticoids and Plenadren (in Europe), a modified release hydrocortisone product. There are no competing modified-release alternatives in the US, and we look forward to the US AI programme progressing after the Phase 3 CAH trial is completed.

The orphan drug designation for Plenadren expires in Europe in November 2021. As Diurnal seeks to position Efmody in the AI

indication optimally, it has revealed the design of the Phase 2 CHAMPAIN study. This registration study assesses the ability of Efmody to deliver higher concentrations of once-daily Plenadren in the morning (primary endpoint). Secondary endpoints include the usual AI endpoints such as fatigue and quality of life and looking at the response to therapy with respect to cortisol levels in the morning reaching a predefined level (>140 nmol/l).

CHAMPAIN study looks to provide superiority claim



Source: Company presentation

Not all modified release profiles are the same

It is probably helpful at this stage to highlight the differences between Efmody and Plenadren. Compared to Efmody, which offers delayed and sustained release of hydrocortisone, Plenadren provides an immediate release outer layer and an extended-release inner core which facilitates once-daily dosing. Its release profile approximates (rather than mimics) the physiological release profile of cortisol, providing adequate daytime control but less so overnight control of androgens. Consequently, we believe there is a good prospect of Efmody delivering a positive superiority result versus Plenadren from CHAMPAIN.

Operationally, the continuing roll out of the adrenal franchise should drive operating leverage with Efmody firstly in CAH and then in AI, sold through a similarly sized promotional force throughout Europe.

Endocrinology pipeline diversifying the adrenal portfolio

Replacement therapies are generally low risk

Smart replacement therapy has been a feature of the drug development efforts at Diurnal, epitomised by the ability of Efmody to provide a replacement therapy that is best tailored to the needs of patients with CAH and adrenal insufficiency.

This low-risk approach to developing new therapies has continued with DITEST, the only orally available testosterone replacement therapy to treat classical hypogonadism, which does not require patients to eat a high-fat meal.

Current TRT preparations suffer from several limitations

While testosterone replacement therapy (TRT) has been used since the 1950s, due to the poor bioavailability of oral testosterone, the market has been dominated by topical formulations and injectable products. However, compliance rates with injectable and gel formulations remain poor, with switching between products commonplace. In addition, administration of injectable products can be painful, while topical formulations are associated with skin reactions and transference to women and children (hence a Black Box warning of virilisation). While oral formulations of testosterone have been available for some time outside the US, until the approval of Jatenzo (testosterone undecanoate), the only US-approved oral product was a 17-alpha-alkyl preparation methyltestosterone (Android) which has been associated with significant liver toxicity and as a result has not been widely used.

DITEST well positioned

DITEST is a native testosterone that has been formulated for oral administration but designed to provide normal physiological levels of testosterone irrespective of the need for food. Potentially, DITEST should overcome some of the limitations associated with the current TRT profile of testosterone undecanoate. In a Phase 1 study, Diurnal confirmed the differentiated nature of DITEST compared to testosterone undecanoate.

Streamlined development pathway

Importantly, discussions with the FDA have confirmed that DITEST can be developed using the branded generic pathway (505(b)(2)). This means that clinical development can be streamlined. The 505(b)(2) pathway is associated with significantly lower costs and risks than traditional drug development. As a result, Diurnal has progressed DITEST using its own resources, although a partner will ultimately be required, we suspect. Effectively, Diurnal (along with a commercial partner) can take advantage of data previously provided by other testosterone-based products as it seeks to provide a regulatory package that fulfils the Agency's requirement that DITEST is safe and efficacious.

Clear need for better oral products

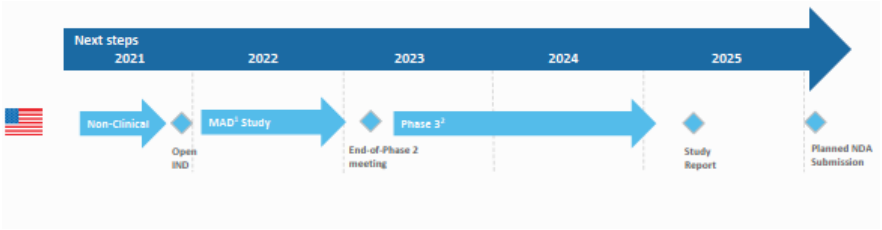
TRT is a significant market opportunity, with approximately 6% of US males affected by low testosterone levels (approx. 4-5 million men). There is a very clear need for oral products with fewer limitations that are more convenient than topical or injectable products.

DITEST profile and clearer regulatory backdrop should help attract partners when required

TRT represents a fragmented market with no clear leadership, and we sense that this is a highly promotionally sensitive therapeutic area. Since the approval of Jatenzo, originator Clarus has expended significant resources to maximise awareness (including direct to consumer advertising). Although the efforts to raise awareness generally should be helpful to DITEST when approved (likely in the 2025/26 timeframe), the resource required is possibly beyond the capabilities of Diurnal alone.

Indeed, given the challenges faced in diagnosis, concerns over abuse, and the significantly higher prescribing of TRT in the US over Europe, we believe that a development partner with relevant experience will be required to ensure optimal positioning and drive uptake in the appropriate patient populations. We think that Diurnal

should be able to deliver a suitable commercial development partner, particularly given the well-defined, low-risk pathway agreed with FDA, plus the positive Phase I data. An IND application later in 2021 should facilitate DITEST entering US clinical development with a Phase 1 multiple ascending dose study in early 2022. We suspect that the earliest Diurnal can achieve a satisfactory partnering agreement would be post DITEST Type B (end of Phase 2) meeting with FDA in the 2023 timeframe. Diurnal's timing could be helped by the regulatory actions that have effectively limited the target population to patients with hypogonadism, specifically those with structural issues.



Source: Company presentation

Offering significant upside to our model and valuation

DITEST sits outside of our financial model and valuation. Still, we believe it could deliver global peak sales of over $1bn should the requisite label be approved and the appropriate commercial partner is secured. There is little read-across from the ongoing Jatenzo launch in the key US market as these remain relatively early days. However, the roll out of Jatenzo does reflect some of the challenges faced in launching a new therapy in a market dominated by primarily topical and injectable generic TRTs despite their limitations. We also note that Clarus is guiding towards ultimately achieving a low double-digit share of the US TRT market, with each point of share comprising $33m in sales. As highlighted previously, the regulatory pathway for Jatenzo (now approved) and Tlando (tentative approval) may have been chequered but much has been learnt from a regulatory perspective which should reduce any concerns from potential DITEST partners.

Risks

The principal risks associated with Diurnal are primarily clinical and commercial. Clinical trials of novel drugs can be associated with risk of failure and delays, and we note that the COVID-19 pandemic has resulted in delays in enrolment in clinical trials in general.

Diurnal has retained European rights to its adrenal disorder franchise, which brings commercialisation risks. The pace of uptake is difficult to predict, which could affect our forecasts, although we recognise that market expectations for Alkindi are modest. Following Efmody launch in Europe, we expect that Diurnal will benefit from the existing sales platform, with only incremental costs required to secure a successful launch.

Following Efmody commercialisation in Europe, Diurnal is seeking to launch its products into what is essentially a generic market environment. We have assumed a price for Efmody that is consistent with the European price of Plenadren – a once-daily formulation of hydrocortisone which looks to be a reasonable proxy. We note that there is no equivalent product in the US in this regard and have assumed that Efmody is priced at a premium. With Diurnal also now retaining US rights, we look forward to the company securing a price which reflects its orphan status.

With Diurnal looking to partner several of its products in the US, including DITEST, there is an associated partnering risk.

As a development stage company, Diurnal is currently a loss-making enterprise. Nevertheless, Diurnal has successfully raised funds to continue with its pipeline development ambitions and aid the launch of Alkindi and Efmody in Europe.

Financial Model and Summary

Efmody is a transformational treatment for CAH

The past few years at Diurnal have been characterised by the creation of a commercial infrastructure in Europe to sell Alkindi initially, but more in preparation for the launch of Efmody as a transformational therapy for the treatment of CAH in adolescents and adults. Undoubtedly, experience with reimbursement and the launch of Alkindi in Europe should aid Diurnal as it seeks reimbursement for Efmody and ensures a timely roll out despite the ongoing pandemic. News so far has been encouraging, with important markets including the UK and Germany and Austria providing reassuring feedback concerning pricing. In addition, a modified-release hydrocortisone treatment that mimics the circadian release of cortisol, best manages the threat of overnight androgen build-up, and allows a reduction in glucocorticoid dose to replacement levels should be well received by endocrinologists.

Efmody early launch progress reassuring

Despite the usual prolonged reimbursement negotiations, Europe should provide a helpful environment for the launch of Efmody with a limited number of key endocrinology centres, which should be familiar to Diurnal from the launch of Alkindi. Efmody is a significantly more important product introduction (than Alkindi) and should be even better received. Longer-term, the Phase 2 registration trial comparing Efmody to once-daily Plenadren should not only lead to optimal positioning in the more significant AI indication, but it should also deliver clear superiority for Efmody's hydrocortisone delivery in general.

Efmody should become an essential part of the standard of care

The US is an important market for Diurnal, not just for Efmody but also for its endocrinology ambitions generally. Ultimately, given the efforts of Diurnal and other approaches, treatment of CAH in the US could be transformed if Efmody and therapies such as tildacerfont and crinecerfont seeking to reduce the build-up of overnight androgens are approved. Given that there is substantial evidence that glucocorticoid delivery should best mimic the normal circadian rhythm and Efmody also has shown potential for glucocorticoid sparing, it should become a well-established component of standard of care for CAH treatment in the US, Japan and Europe.

Capital Markets Day beckons

Thankfully, Diurnal is now well funded, allowing the company to launch Efmody in Europe and the UK and continue its development in the US for CAH and Europe for AI. Additionally, mainly behind the scenes, the broader endocrinology pipeline has progressed during the year with a streamlined and truncated development pathway secured for DITEST. We look forward to further details being revealed at the Capital Markets Day later in the year.

AI is a more straightforward opportunity

Finally, as Diurnal seeks to fully exploit its Efmody franchise in the US, a Phase II study in AI will begin in 2023. This is a very attractive market opportunity where Efmody also has orphan drug designation. AI represents a purer cortisol replacement opportunity with no overnight androgens to worry about, so no supraphysiological glucocorticoid dosing (or CRF1 inhibitors) required. The combination of CAH and Addison's suggests a total

market opportunity of $3bn compared to our peak sales forecast of £700m.

Adrenal franchise progressing well

These are exciting times for Diurnal. It now has two licensed products in Europe, which should serve the continuum of adrenal insufficiency, particularly for CAH patients. Plans for the US are now in place, and we look forward to Efmody delivering on its promise in CAH and the broader AI indication. The company has the resources to progress DITEST, and the pipeline behind is beginning to emerge, highlighting management's ambition to create an expansive endocrinology franchise.

Diurnal Adrenal Franchise sales (£m)

	2021E	2022E	2023E	2024E	2025E	2026E	2027E	2028E
Alkindi sales US	-	1.01	1.96	2.73	4.25	5.31	5.52	5.75
Alkindi sales EU	-	3.46	7.20	9.99	10.39	10.81	11.25	11.70
Efmody sales US	-	-	-		-	11.13	38.58	71.68
Efmody sales EU	-	6.04	24.65	109.94	172.98	300.57	326.56	363.67
Adrenal franchise sales	2.35	10.51	33.82	122.65	187.63	327.81	381.92	452.80
Adrenal franchise sales unrisked	**2.35**	**10.51**	**33.82**	**127.88**	**198.30**	**353.29**	**419.20**	**505.00**

Source: Calvine Partners Research

Diurnal Group Income Statement (£m)

Year to June	2019A	2020A	2021A	2022E	2023E	2024E	2025E	2026E	2027E	2028E	2029E	2030E
Sales	**1.04**	**6.31**	**4.37**	**10.51**	**33.82**	**122.65**	**187.63**	**327.81**	**381.92**	**452.80**	**510.80**	**608.27**
COGS	(0.22)	(0.67)	(0.78)	(2.63)	(6.76)	(24.53)	(37.53)	(65.56)	(76.38)	(90.56)	(102.16)	(121.65)
Gross profit	**0.82**	**5.65**	**3.59**	**7.88**	**27.05**	**98.12**	**150.10**	**262.25**	**305.53**	**362.24**	**408.64**	**486.62**
gross margin	78.5%	89.4%	82.2%	75.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
SG&A	(6.66)	(7.04)	(8.29)	(9.25)	(11.84)	(18.40)	(30.02)	(42.62)	(42.01)	(54.34)	(61.30)	(85.16)
R&D	(8.69)	(4.63)	(6.92)	(18.50)	(22.32)	(26.98)	(30.96)	(32.78)	(38.19)	(45.28)	(51.08)	(60.83)
Other operating income	0.00	0.63	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Operating profit	**(14.53)**	**(5.39)**	**(11.60)**	**(19.86)**	**(7.10)**	**52.74**	**89.12**	**186.85**	**225.33**	**262.62**	**296.26**	**340.63**
Finance income	0.13	0.11	0.06	0.34	0.18	0.12	0.48	1.14	2.54	4.25	6.18	8.33
Finance expense	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PBT	**(14.40)**	**(5.28)**	**(11.54)**	**(19.53)**	**(6.92)**	**52.86**	**89.60**	**187.99**	**227.87**	**266.87**	**302.45**	**348.97**
Tax	2.11	1.21	1.49	1.49	1.73	(13.21)	(22.40)	(47.00)	(56.97)	(66.72)	(75.61)	(87.24)
Net income	**(12.29)**	**(4.07)**	**(10.05)**	**(18.04)**	**(5.19)**	**39.64**	**67.20**	**140.99**	**170.90**	**200.15**	**226.83**	**261.73**
EPS Basic (p)	-19.70	-4.30	-7.33	-10.74	-3.09	23.61	40.02	83.96	101.77	119.19	135.08	155.85
EPS Diluted (p)	**-19.70**	**-4.30**	**-7.33**	**-10.74**	**-3.09**	**23.61**	**40.02**	**83.96**	**101.77**	**119.19**	**135.08**	**155.85**

Source: Calvine Partners Research

Diurnal Group Cash Flow (£m)

Year to June	2019A	2020A	2021A	2022E	2023E	2024E
Net income	(12.29)	(4.07)	(10.05)	(18.04)	(5.19)	39.64
Licensing income received as non-cash		(1.04)				
Fair value adjustment to investments		(0.63)	(0.02)			
Dep/Amort/Impair	0.02	0.03	0.02	0.05	0.05	0.16
Share- based payment	0.83	0.84	0.47	0.84	0.84	0.84
Net Fx gain	(0.01)	(0.36)	0.11			
Financial income	(0.13)	(0.11)	(0.06)	(0.34)	(0.18)	(0.12)
Financial expense	0.00	0.00	0.00	0.00	0.00	0.00
Tax	(2.11)	(1.21)	(1.49)	0.00	(1.73)	13.21
(Increase) in receivables	1.36	0.12	(2.10)	0.81	(0.75)	(2.75)
Increase in payables	(3.14)	0.07	1.64	0.22	0.02	(0.25)
(Increase) in inventories	(0.55)	(0.57)	(0.38)	0.05	(0.45)	(0.42)
Interest paid	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Tax paid/ received	2.28	2.12	1.20	0.00	1.73	(13.21)
CFO	(13.74)	(4.81)	(10.66)	(16.41)	(5.67)	37.11
PP&E	(0.03)	(0.01)	(0.14)	(0.05)	(0.62)	(0.75)
R&D capitalised	(0.04)	(0.04)	(0.03)			
Investments	**0.00**	**0.00**	**0.71**	**0.00**	**0.00**	**0.00**
Interest received	0.13	0.11	0.06	0.34	0.18	0.12
CFI	0.07	0.07	0.61	0.29	(0.45)	(0.63)
Net proceeds from issuance of share capital	5.53	10.67	28.76	0.00	0.00	0.00
Repayment of borrowings	0.00	0.00	0.00	0.00	0.00	0.00
Net proceeds from new borrowings	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
CFF	5.53	10.67	28.76	0.00	0.00	0.00
Increase in cash	(8.15)	5.93	18.71	(16.12)	(6.11)	36.48
Cash brought forward	**17.28**	**9.14**	**15.07**	**34.04**	**17.92**	**11.80**
Fx		0.36				
Cash EOP	**9.14**	**15.07**	**34.04**	**17.92**	**11.80**	**48.28**

Source: Calvine Partners Research

Diurnal Group Balance Sheet (£m)

Year to June	2019A	2020A	2021A	2022E	2023E	2024E
Intangible assets	0.05	0.08	0.09	0.09	0.10	0.10
PP&E	0.03	0.02	0.15	0.15	0.72	1.30
Inv held at fair value through P&L		1.67	0.00	0.00		
Non-current assets	0.08	1.77	0.24	0.24	0.82	1.40
Trade and other receivables	3.56	2.53	3.43	2.63	3.38	6.13
Inventory	0.67	1.24	1.63	1.58	2.03	2.45
Inv held at fair value through P&L			1.49	0.00	0.00	0.00
Financial assets	0.00	0.00	0.97			
Cash & Cash equivalents	9.15	15.43	34.04	17.92	11.80	48.28
Current assets	13.38	19.21	41.55	22.12	17.21	56.87
Total Assets	**13.46**	**20.98**	**41.79**	**22.36**	**18.03**	**58.27**
Loans and borrowings	0.00	0.00	0.00	0.00	0.00	0.00
Trade and other payables	(2.50)	(2.56)	(4.16)	(4.00)	(3.92)	(4.17)
Current liabilities	(2.50)	(2.56)	(4.16)	(4.00)	(3.92)	(4.17)
Loans and borrowings	0.00	0.00	0.00	0.00	0.00	0.00
Trade and other payables	(0.02)	(0.04)	(0.06)			
Non-current liabilities	(0.02)	(0.04)	(0.06)	0.00	0.00	0.00
Total Liabilities	**(2.52)**	**(2.59)**	**(4.23)**	**(4.00)**	**(3.92)**	**(4.17)**
Share capital	4.23	6.08	8.40	8.40	8.40	8.40
Share premium	42.15	50.97	77.41	77.41	77.41	77.41
Consolidation reserve	(2.94)	(2.94)	(2.94)	(2.94)	(2.94)	(2.94)
Other reserve	0.00	0.00	0.00	0.00	0.00	0.00
Retained earnings	(32.49)	(35.72)	(45.30)	(62.84)	(67.53)	(27.39)
Total equity	**10.94**	**18.39**	**37.56**	**20.03**	**15.33**	**55.48**

Source: Calvine Partners Research

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