Calvine Partners

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Diurnal Group

3 June 2021

Share Price	**69.5p**
CP Fair Value	**241p**

Market Cap (£m)	105
Net Cash (£m)	28
Enterprise Value (£m)	77

Country	UK
Code	DNL
Index	FTSE AIM

Source: Calvine Partners Research

Globalisation of the adrenal franchise

Formal approval of Efmody by the EMA for the treatment of the inherited Orphan disorder congenital adrenal hyperplasia (CAH) in patients aged 12 and over should be transformational for Diurnal. With an endocrinology-based salesforce already in place in major European markets, Efmody should deliver significant scale and operating leverage in this geography. We await the deliberations of the UK MHRA to flesh out European ambitions. Elsewhere, Efmody has been licensed to rare disease specialist Citrine Medicine for key Asian markets (ex Japan).

US is a key market for Diurnal

As a rare disease, CAH is highly tractable to a small specialised salesforce, especially in the more homogeneous US market. In common with other geographies, Orphan legislation seeks to promote development of treatments for rare diseases providing extended data protection (7 years) as well as regulatory help and financial inducements. Also, Orphan drugs in the US generally benefit from pricing power, and in this regard our price assumptions for Efmody are higher in the US than Europe. Additionally, Plenadren, a potentially competing modified release hydrocortisone is not available in the US. This leaves the market wide open for a hydrocortisone preparation which effectively mimics the circadian rhythm and provides control of excess androgens with the potential for steroid sparing compared to current supraphysiological glucocorticoid therapy. With funding secured, Diurnal will now progress the Phase 3 development of Efmody under its own steam. Given the recent positive EMA approval and the prospect of a Special Protocol Assessment from FDA, holding onto US rights suggests an attractive risk/reward profile for Diurnal as well as the added benefit of retaining the full margin and establishing a US platform.

Addison's disease indication still overlooked

While much of the emphasis in cortisol deficiency has been aimed at CAH, we have previously highlighted the importance of adrenal insufficiency opportunity where patients also suffer from low cortisol. Efmody also has Orphan drug designation in the US for AI and we are looking forward to Diurnal using the future CAH platform in the US to treat the broader and more lucrative AI patient population. Clinical development may well be more complex than Europe, but it is important to note that high androgen levels are not an issue for the Addison's disease patient and as a result, this is an indication where the CRF1 inhibitors are not relevant, and Diurnal could establish Efmody as the standard of care.

Dr Brian White
Partner
bw@calvinepartners.com

Andrew Keith
Partner
ak@calvinepartners.com

Plans for the adrenal franchise coming together

Pre-launch activities underway

Following a faltering start, the plans to create a global adrenal franchise based on cortisol replacement are now coming together. Efmody has received approval in Europe and pre-launch activities are underway. We await the deliberations of the UK MHRA (both on approval and Orphan drug status). In the US, Diurnal is awaiting the receipt of a Special Protocol Assessment (SPA) for Efmody for development in CAH and funding has now been secured to allow Diurnal to self-develop and ultimately self-market in this key geography.

Commercial base established already

Following the positive CHMP recommendation for Efmody, Diurnal is now in full swing as it prepares for its most important commercial launch to date. Although Diurnal's child-friendly hydrocortisone preparation Alkindi has been available in Europe for some time, our sales expectations are modest, but a commercial platform has been established. Following EMA approval we look forward to an expeditious rollout and fruitful reimbursement discussions, recognising however that these need to be completed on a country-by-country basis.

Limited number of key centres suggest low execution risk

Europe represents a relatively straightforward commercial opportunity for Diurnal, thanks not only to the existing commercial infrastructure but also because there are a limited number of key centres that treat CAH patients. Ultimately, the addition of Efmody should facilitate chronic treatment for patients suffering from low cortisol levels. Given the length of time that Alkindi has been in the main European markets, the salesforce should have gained a significant degree of familiarity with the endocrinology specialist physician community.

Consequently, Diurnal should be well placed to offer an appropriate treatment for those Efmody patients (aged 12 and over) transitioning through puberty and those currently receiving less effective glucocorticoid (GC) preparations.

Opening up the broader AI opportunity

As Diurnal seeks to build on its adrenal franchise in Europe, a successful regulatory outcome for Efmody in CAH has important implications for the larger adrenal insufficiency indication. As a line extension, clinical development should be relatively straightforward. The last remaining clinical hurdle comprises a comparator study versus an existing (Europe only) alternative modified-release hydrocortisone (Plenadren). The study which will start later in 2021 should allow the company to position Efmody optimally in the AI indication in Europe.

Diurnal now has wherewithal to capitalise on US

Funding in place to progress CAH in the US and retain margin

Diurnal's recent fundraising activities have successfully bolstered the company's cash position by circa £20m. We believe that management has sought to secure the long-term margin for Diurnal emboldened by the recent successful approval for Efmody in Europe which has lowered the risk profile of conducting future

development for CAH in the US. While we have not been privy to discussion with FDA, we note the imminent receipt of a Special Protocol Assessment which should further de-risk the programme assuming that agreed clinical endpoints are achieved.

Awaiting details of the US Phase 3 trial design

Additionally, we suspect that the European clinical experience has been very helpful as Diurnal has sought to ensure that the design of the US Phase 3 study employs suitable and appropriate endpoints to meet US regulatory requirements. Looking at the clinical programme for tildacerfont, we note that both CAHmelia-203 (the androgen reduction study) and CAHmelia-204 (the GC reduction study) are of double-blind, placebo-controlled design which involves a 12 & 24 week treatment period respectively and a 58 & 52 week open-label extension period respectively. The primary endpoint in '203 is change in A4 to 12 weeks while the primary endpoint in '204 is change in GC at week 24. Many of the additional endpoints are looking at the impact on metabolism, bone turnover, body composition and BMD, likely associated with supraphysiological dosing of glucocorticoids. For crinercerfont, Phase 3 involves 24 weeks of treatment with a primary endpoint the reduction in GC followed by 12 months of active treatment.

Diurnal has secured Orphan drug designation for Efmody in broader AI indication

Retention of US commercial rights should bring not only the full margin for the CAH indication but also facilitate future development opportunities. We have previously highlighted the importance of the broader AI indication noting that Efmody also has Orphan drug designation for this indication. Consequently, launching Efmody into the broader AI patient population should deliver not only significant additional revenue but also substantial operating leverage.

Carving up the cortisol deficiency market

Cortisol replacement market large and lucrative

Diurnal has chosen to focus initially on disorders characterised by low cortisol levels as it establishes its adrenal franchise, effectively replacing lost cortisol with its pharmaceutical equivalent (hydrocortisone). Low cortisol is a characteristic of disorders of the hypothalamic-pituitary-adrenal (HPA) axis which results in primary, secondary and tertiary adrenal insufficiency. Primary AI affects the adrenal gland directly while secondary (and tertiary) AI affect the hypothalamus and pituitary. The clinical manifestation can be very different depending on the aetiology but nevertheless all are helped by replacing lost cortisol.

Challenging to optimise availability of cortisol to match normal circadian profile

The main goal of therapy in patients with AI is to prevent the occurrence of adrenal crises by replacing the lost hormones. Further complicating matters is that physiological release of cortisol follows a circadian secretion pattern. Unfortunately, this is far from straightforward with cortisol peaking overnight (before awakening) making it difficult to deliver glucocorticoid in a convenient dosing regimen.

Imperfectly mimicking circadian profile results in adverse consequences

Additionally, quality of life is significantly impaired in these patients as a result of the inability of conventional glucocorticoid preparations to effectively mimic physiological replacement. In CAH patients in particular, there are challenges in balancing the risk of hypercortisolism with hyperandrogenism with elevated androgen levels requiring administration of supraphysiological levels of glucocorticoid. In CAH patients this has presented an opportunity for the CRF1 inhibitors as well as smarter delivery of glucocorticoid.

Data to date suggests important role for Efmody in CAH

For Diurnal, clinical data have clearly shown that Efmody administration facilitates lower dosing of glucocorticoid. Given the continued requirement for glucocorticoid replacement therapy, even if the CRF1 approach is successful in steroid sparing, we believe that the benefits of circadian delivery should result in Efmody becoming the preferred glucocorticoid treatment option in the CAH indication. This, coupled with the observation that control of overnight androgens can also be achieved with adrenal replacement doses, further re-enforces the appeal of using Efmody for treating physicians, we believe.

Lack of Orphan status in EU puzzling but broader label helpful

CAH represents the initial focus for Diurnal and its development has focussed initially on delivering a paediatric friendly hydrocortisone preparation (Alkindi) as well as a preparation that best mimics cortisol's circadian release profile (Efmody). CAH is the prevalent genetic cause of primary AI and a result, neonates are screened to identify children with a mutation affecting the 21-hydroxlase. Clearly, neonatal screening significant aids diagnosis of at-risk patients. European and UK approval provides Diurnal with medicines which promise to provide lifelong therapy for CAH patients. The failure to gain Orphan drug status in Europe is clearly disappointing particularly given that Plenadren was afforded this status despite a lack of clinical data showing any benefit in this patient population. Nevertheless, our assumptions remain that Efmody should receive a price in Europe in line with Plenadren. It is worth noting offsetting some of this disappointment is the observation that CHMP provided Efmody with a broader label (age 12+) compared to our expectation of an adult only recommendation. As a result, Diurnal should be able to manage treatment using Efmody from an earlier age with a product that offers greater benefit over Alkindi and other conventional hydrocortisone preparations.

Comparison with Plenadren in Addison's disease should show benefit

Interestingly, Diurnal will compare Efmody with Plenadren in the larger AI indication. Clearly, this will be essential as Diurnal seeks to optimally position Efmody. However, given the decision by the EMA regarding Orphan status we suspect that success here should dismiss any lingering concerns regarding the additional benefit provided by Efmody. Compared to Efmody which offers delayed and sustained release of hydrocortisone Plenadren offers 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.

Orphan status in the US a key objective

While Plenadren is not available in the US, there are various glucocorticoid preparations used for the treatment of AI including CAH. As we have previously suggested, development of the CRF1 inhibitors (currently crinecerfont and tildacerfont) have raised awareness of the need for new approaches which effectively reduce the high androgen levels in CAH patients while reducing the need for supraphysiological levels of glucocorticoid.

Securing SPA a sensible approach to ensure study design appropriate

Efmody has Orphan drug designation for both CAH and AI in the US. While Diurnal had previously agreed a Phase 3 protocol for the US (with different endpoints to the EU study), this was paused following the failed EMA study to conserve cash. Fortunately, we suspect that management has learnt much from the outturn of the European Phase 3 study and has sought to secure a Special Protocol Assessment from FDA prior to starting the US Phase 3 study to ensure that the trial design is acceptable.

Looking forward to receipt of SPA

SPAs are an important feature of the US regulatory system facilitating agreement of a study protocol incorporating input and feedback from FDA. As a result, should the study drug perform as expected, and deliver a positive result at the requisite endpoints, regulatory risk should be significantly reduced – a welcome change from the uncertainty created by the failure of the European trial to deliver a positive result at the primary endpoint.

Awareness of CAH growing in the US

If the Phase 3 programme is successful, Diurnal should be in a position to establish its own sales and marketing function, if desired, in the US. Like many rare diseases CAH awareness is lower than many more common disorders. However, thanks to the efforts of neonatal screening, the efforts of advocacy groups (such as Living with CAH and CARES Foundation), CAH awareness is improving which should help facilitate the introduction of new approaches (such as Efmody).

Efmody should be complementary to CRF1 approach

While the development of the CRF1 inhibitors may have raised awareness of cortisol deficiency generally, we suspect that it may also have confused with respect to how future standard of care in CAH may develop should the CRF1 approach prove successful. We have previously stated our view that the main opportunity for the CRF1 inhibitors is for those patients who struggle to control their androgens with standard glucocorticoid therapy. We note, for example, that Spruce Biosciences is pursuing two patient populations (poorly and well-controlled), endeavouring to demonstrate that treatment can reduce the requirement for supraphysiological glucocorticoid treatment as well as reduce androgens generally.

No androgen build up but still important to replace cortisol and match circadian profile

AI, however, is a very different proposition with high androgen levels not a feature in these patients – often quite the opposite. Consequently, AI patients do not require supraphysiological doses of glucocorticoid to manage high overnight androgen levels. Nevertheless, there is still a clear need for a treatment that more

accurately mimics the circadian release pattern of cortisol to provide an improvement in both disease control (metabolic outcomes) and quality of life. Despite significant efforts to provide near to physiological dosing with existing glucocorticoid preparations, patients with AI still suffer from periods of hypo- and hypercortisolism both of which are clearly undesirable. Hypocortisolism runs the risk of adrenal crises (amongst others) while hypercortisolism can also result in fatigue, low libido and cognitive issues. Moreover, there remains significant inter and intra patient variability with no easy diagnostic means of ensuring that patients are adequately controlled.

Negative consequences from disturbance of circadian activity well established

There has long been a recognition of the inability of immediate release glucocorticoids to provide adequate control of the symptoms of cortisol deficiency in AI. This has been associated with the complex mechanism (the hypothalamus-pituitary-adrenal axis) which controls cortisol secretion. Cortisol is released by the adrenal glands in a circadian and ultradian rhythm. It has been well established, we believe, that this circadian coordination is essential not just to help regulate the wake sleep cycle but also more broadly for the attainment of normal physical and mental health. Disturbance of circadian activity on the other hand is associated with various adverse physiological, psychological, and clinical issues. These include an elevated risk of metabolic syndrome, diabetes and cardiovascular events. This is unsurprising we believe given that cortisol plays an important role in various physiological functions which are beyond the scope of this research but include metabolism, electrolyte balance and cognition, as well as in various key organ systems, such as the neuroendocrine and immune systems, as well as the reproductive, cardiovascular, and nervous systems.

Various efforts historically have fallen short

The importance of a glucocorticoid release profile which best mimics the circadian cycle has not been lost on the pharmaceutical industry, with efforts such as modified release (Plenadren) and subcutaneous infusion explored to satisfy these concerns. In particular, the observation that cortisol levels peak just before waking has provided significant challenges in optimising the release profile. While Addison's disease patients may not have the high androgen issue to deal with, the weight of the available evidence suggests that it is still important to ensure that glucocorticoid delivery is optimised. Indeed, we believe that endocrinologists understand the need to replicate circadian availability to best manage the consequences of AI.

Timelines broadly in line with alternative approaches in US

We have previously noted that the US CAH market remains a potentially very lucrative opportunity for Diurnal and one that should be tractable to a small endocrinology focussed sales force. Importantly, the addition of the Addison's disease indication in future would add revenue as well as significant operating leverage. We were therefore encouraged with the recent fundraising completed by Diurnal which has secured a further circa £20m to fund the completion of a US Phase 3 study. Assuming that an SPA is secured shortly and that studies can start in H2 2022, assuming

24 weeks of treatment followed by 52 weeks of an open-label extension, suggests a potential regulatory filing in H2 2023.

Risks

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

Diurnal has retained selected European rights to its adrenal disorder franchise, which brings commercialisation risks. We note that Diurnal has engaged the services of Ashfield, which has a successful track record in helping life science companies launch new products. Nevertheless, the pace of uptake is difficult to predict which could affect out forecasts although we recognise that market expectations for Alkindi are modest. Following Efmody launch in Europe our expectation is that Diurnal will benefit from the existing sales platform, with only incremental costs required to effect a successful launch.

We note that Diurnal is seeking to launch its products into what is largely 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 in this regard there is no equivalent product in the US 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. Diurnal has successfully raised funds to continue with its development plans and aid the launch of Efmody in Europe. Even with this near-term funding, our forecasts suggest that in order to progress its pipeline assets expeditiously, Diurnal may require additional funding.

Financial Model and Summary

Already established commercial presence should expedite Efmody's launch in Europe

Alkindi represents a modest opportunity for Diurnal in Europe, we believe. However, we would contend that while reimbursement has been predictably prolonged and the pandemic clearly hasn't helped, the awareness of Diurnal's efforts in treating low cortisol disorders and the establishment of a European commercial presence should help expedite the launch of Efmody – Diurnal's flagship treatment for low cortisol disorders.

US CAH market has the potential to be transformed with the development of both Efmody and potentially the CRF1 inhibitors

With formal EMA approval for Efmody in CAH and the funds raised to progress a US Phase 3 study in CAH, Diurnal is well placed to capitalise on the broader potential of its adrenal franchise, particularly as it pertains to the higher value-added product Efmody. Arguably, the US CAH treatment market has the potential to be transformed with the development of both Efmody and potentially also the CRF1 inhibitors crinacerfont and tildacerfont. While we recognise that the competitive noise has increased as a result of the efforts of Spruce and Neurocrine it is clear that even if this approach is successful in reducing androgens, the glucocorticoid component will still be required and optimised. Given that there is substantial evidence that glucocorticoid delivery should best mimic the normal diurnal rhythm, Efmody should become a well-established component of standard of care for CAH treatment in the US as well as in Europe in future treatment approaches. We also suspect that if successful, as we anticipate it will be, the outcome of the US Phase 3 study will further enhance Efmody's position in CAH treatment in this important geography.

Efmody should become a substantial component of CAH standard of care

Efmody should be able to secure a similar price to Plenadren and Alkindi in Europe without Orphan drug status

We sense that the lack of Orphan drug status in Europe has elicited concerns. Although it may have blunted some pricing expectations, we still expect Efmody to secure a similar price to Plenadren (and Alkindi). The lack of additional exclusivity shouldn't be an issue given that there appears to be no competing product in clinical development at this time. Importantly, Orphan pricing in the US remains a real possibility suggesting upside to forecasts should Efmody deliver a positive Phase 3 result and secure Orphan drug status in the US. We note also the suggestion that the US study should be sufficient for Japanese approval and presumably for Orphan drug status there too.

Orphan pricing in US suggests upside to forecasts

Efmody in Addison's disease is more straightforward and targets a significantly larger market

Finally, as Diurnal seeks to fully exploit its Efmody franchise in the US, a Phase 2 study in Addison's disease) is scheduled to begin in 2022. This is a very attractive market opportunity where Efmody also has Orphan drug designation. Arguably this represents a more straightforward cortisol replacement market with no overnight androgens to control and no supraphysiological doses (or CRF1 inhibitors) required. The combination of both CAH and Addison's suggests a total market opportunity of $3bn compared to our peak sales forecast of £700m.

Adrenal franchise sales (£m)	2021E	2022E	2023E	2024E	2025E	2026E	2027E	2028E
Alkindi sales US	0.48	1.01	1.96	2.73	4.25	5.31	5.52	5.75
Alkindi sales EU	2.44	6.92	9.60	9.99	10.39	10.81	11.25	11.70
Efmody sales US	-	-	-		9.17	41.06	85.98	103.21
Efmody sales EU	-	9.67	29.58	109.94	172.98	300.57	326.56	363.67
Adrenal franchise sales	2.48	17.60	41.15	122.65	196.79	357.74	429.31	484.33
Adrenal franchise sales unrisked	**4.82**	**17.60**	**41.15**	**132.78**	**210.52**	**393.20**	**482.40**	**547.05**

Source: Calvine Partners Research

Diurnal Income Statement (£m)												
Year to June	**2019A**	**2020A**	**2021E**	**2022E**	**2023E**	**2024E**	**2025E**	**2026E**	**2027E**	**2028E**	**2029E**	**2030E**
Sales	**1.04**	**6.31**	**2.48**	**17.60**	**41.15**	**126.32**	**196.79**	**357.74**	**429.31**	**484.33**	**568.07**	**608.27**
COGS	(0.22)	(0.67)	(0.74)	(4.40)	(8.23)	(25.26)	(39.36)	(71.55)	(85.86)	(96.87)	(113.61)	(121.65)
Gross profit	**0.82**	**5.65**	**1.74**	**13.20**	**32.92**	**101.06**	**157.44**	**286.19**	**343.45**	**387.47**	**454.45**	**486.62**
gross margin	78.5%	89.4%	70.0%	75.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
SG&A	(6.66)	(7.04)	(9.80)	(10.03)	(13.17)	(18.95)	(33.46)	(57.24)	(68.69)	(72.65)	(85.21)	(91.24)
R&D	(8.69)	(4.63)	(10.21)	(20.23)	(24.28)	(27.79)	(29.52)	(35.77)	(42.93)	(48.43)	(56.81)	(60.83)
Other operating income	0.00	0.63	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Operating profit	**(14.53)**	**(5.39)**	**(18.27)**	**(17.07)**	**(4.53)**	**54.32**	**94.46**	**193.18**	**231.83**	**266.38**	**312.44**	**334.55**
Finance income	0.13	0.11	0.15	0.27	0.10	0.07	0.47	1.20	2.65	4.41	6.45	8.83
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)**	**(18.12)**	**(16.80)**	**(4.42)**	**54.39**	**94.93**	**194.38**	**234.48**	**270.79**	**318.88**	**343.38**
Tax	2.11	1.21	0.00	0.00	1.11	(13.60)	(23.73)	(48.59)	(58.62)	(67.70)	(79.72)	(85.84)
Net income	**(12.29)**	**(4.07)**	**(18.12)**	**(16.80)**	**(3.32)**	**40.79**	**71.20**	**145.78**	**175.86**	**203.10**	**239.16**	**257.53**
EPS Basic (p)	-19.70	-4.30	-12.52	-10.00	-1.98	24.29	42.40	86.81	104.72	120.94	142.42	153.36
EPS Diluted (p)	**-19.70**	**-4.30**	**-12.52**	**-10.00**	**-1.98**	**24.29**	**42.40**	**86.81**	**104.72**	**120.94**	**142.42**	**153.36**

Source: Calvine Partners Research

Diurnal Cash Flow (£m)						
Year to June	**2019A**	**2020A**	**2021E**	**2022E**	**2023E**	**2024E**
Net income	(12.29)	(4.07)	(18.12)	(16.80)	(3.32)	40.79
Licensing income received as non-cash		(1.04)				
Fair value adjustment to investments		(0.63)				
Dep/Amort/Impair	0.02	0.03	0.01	0.01	0.01	0.02
Share- based payment	0.83	0.84	0.84	0.84	0.84	0.84
Net Fx gain	(0.01)	(0.36)				
Financial income	(0.13)	(0.11)	(0.15)	(0.27)	(0.10)	(0.07)
Financial expense	0.00	0.00	0.00	0.00	0.00	0.00
Tax	(2.11)	(1.21)	0.00	0.00	(1.11)	13.60
(Increase) in receivables	1.36	0.12	0.04	(0.15)	(0.24)	(0.85)
Increase in payables	(3.14)	0.07	0.07	0.15	0.15	0.68
(Increase) in inventories	(0.55)	(0.57)	0.05	(0.73)	(0.77)	(0.88)
Interest paid	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Tax paid/ received	2.28	2.12	0.00	0.00	1.11	(13.60)
CFO	(13.74)	(4.81)	(17.27)	(16.95)	(3.42)	40.54
PP&E	(0.03)	(0.01)	(0.01)	(0.01)	(0.08)	(0.10)
R&D capitalised	(0.04)	(0.04)				
Investments	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Interest received	0.13	0.11	0.15	0.27	0.10	0.07
CFI	0.07	0.07	0.15	0.26	0.02	(0.03)
Net proceeds from issuance of share capital	5.53	10.67	28.95	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	28.95	0.00	0.00	0.00
Increase in cash	(8.15)	5.93	11.83	(16.69)	(3.40)	40.51
Cash brought forward	**17.28**	**9.14**	**15.07**	**26.90**	**10.20**	**6.80**
Fx		0.36				
Cash EOP	**9.14**	**15.07**	**26.90**	**10.20**	**6.80**	**47.31**

Source: Calvine Partners Research

Diurnal Balance Sheet (£m) Year to June	2019A	2020A	2021E	2022E	2023E	2024E
Intangible assets	0.05	0.08	0.01	0.01	0.01	0.01
PP&E	0.03	0.02	0.02	0.02	0.10	0.17
Inv held at fair value through P&L		1.67	1.67	1.67		
Non-current assets	0.08	1.77	1.69	1.69	0.10	0.18
Trade and other receivables	3.56	2.53	0.02	0.18	0.41	1.26
Inventory	0.67	1.24	0.15	0.88	1.65	2.53
Financial assets	0.00	0.00	0.00	0.00	0.00	0.00
Cash & Cash equivalents	9.15	15.43	26.90	10.21	6.81	47.31
Current assets	13.38	19.21	27.07	11.26	8.86	51.10
Total Assets	**13.46**	**20.98**	**28.76**	**12.96**	**8.97**	**51.28**
Loans and borrowings	0.00	0.00	0.00	0.00	0.00	0.00
Trade and other payables	(2.50)	(2.56)	0.03	0.18	0.33	1.01
Current liabilities	(2.50)	(2.56)	0.03	0.18	0.33	1.01
Loans and borrowings	0.00	0.00	0.00	0.00	0.00	0.00
Trade and other payables	(0.02)	(0.04)	(0.05)			
Non-current liabilities	(0.02)	(0.04)	(0.05)	0.00	0.00	0.00
Total Liabilities	**(2.52)**	**(2.59)**	**(0.02)**	**0.18**	**0.33**	**1.01**
Share capital	4.23	6.08	6.28	6.28	6.28	6.28
Share premium	42.15	50.97	79.07	79.07	79.07	79.07
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)	(53.34)	(69.64)	(72.46)	(31.17)
Total equity	**10.94**	**18.39**	**29.06**	**12.76**	**9.94**	**51.24**

Source: Calvine Partners Research

Disclosures

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