EVOLUTION CAPITAL

CYP | UPDATE REPORT | HEALTHCARE

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CYP-001 Phase 2 in aGvHD: A Guide to the Readout

Cynata Therapeutics Ltd.

Cynata has confirmed that the 100-day primary evaluation period is complete for the last participant enrolled in its Phase 2 trial of CYP-001 in high-risk acute graft-versus-host disease (aGvHD). Results expected June 2026.

Trial Design & Key Endpoints

The trial is a global, randomised, placebo-controlled trial of approximately 60 adults with newly diagnosed high-risk aGvHD. Participants receive corticosteroids plus either CYP-001 or placebo, with CYP-001 administered as two IV infusions on Day 0 and Day 7. The primary endpoint is Overall Response Rate (ORR) at Day 28. Key secondaries include complete response rate (CRR), durable ORR, overall survival, and event-free survival. Long-term follow-up continues out to two years.

Phase 1 Context

CYP-001 generated a striking Phase 1 signal (Kelly et al., *Nature Medicine*, 2024) in 15 steroid-refractory patients: 87% ORR and 53% CR at Day 100, with 60% two-year survival in a population where historical survival is below 20%. The Phase 1 was open-label, uncontrolled, and in steroid-refractory patients – a different population to the current first-line, high-risk Phase 2 – so the numbers cannot be directly extrapolated. But they establish biological plausibility and a clean safety baseline.

No Direct Benchmark Exists

This is the first randomised, placebo-controlled trial of an MSC therapy as a first-line add-on in adult high-risk aGvHD. Cynata's Phase 1 was uncontrolled and in a different population; Mesoblast's paediatric Phase 3 was single-arm and in children; the Osiris/Mesoblast Phase 3 was in second-line steroid-refractory patients using a manufacturing-compromised product; ruxolitinib's REACH trials were in a different treatment line with a different drug class. No existing dataset maps cleanly onto this trial. Results must therefore be assessed on their own terms, against the natural history of high-risk aGvHD on corticosteroids alone.

What We Want to See

We anchor expectations to a placebo arm Day 28 ORR of 45-50%, drawn from published high-risk aGvHD outcomes. A ≥20% delta for CYP-001 over placebo would constitute a clearly positive result; clinically meaningful and statistically achievable at this sample size. 10-15% would be ambiguous; <10% would be disappointing.

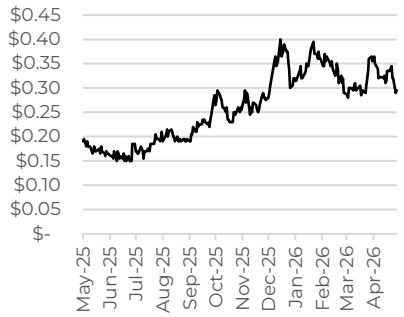
Beyond the primary, CRR is the most important secondary: a large CRR delta signals depth of response, which is what translates to durable survival benefit. Duration of response matters because ruxolitinib doesn't sustain responses well – if ≥70% of Day 28 responders remain in response at Day 100, it becomes a genuine point of differentiation. Day 100 overall survival is too early to read decisively; the meaningful signal will emerge from the two-year follow-up. Safety must replicate the clean Phase 1 profile.

Recommendation	**SPEC BUY**
Price Target	**$1.19**
Share Price	**$0.295**
TSR	**303%**

Company Profile

Market Cap	$81.8M
Enterprise Value	$78.7M
SOI (diluted)	254.5M
Free Float	86.8%
ADV (3-month)	$71k
52-Week Range	$0.14 - $0.435

Price Performance



%	1M	3M	12M
Absolute	-11.9%	-25.3%	48%
ASX/S&P200	-3.9%	-4.9%	2.6%

Company Overview

Cynata Therapeutics (ASX: CYP) is a clinical-stage Australian biotech developing Cymerus™, an iPSC-derived MSC platform designed to solve first-generation MSC constraints around donor variability, scalability, and CMC consistency. Its pipeline spans immunology, musculoskeletal, and wound care, led by CYP-001 in high-risk aGvHD (randomized Phase 2), CYP-004 in knee osteoarthritis (Phase 3), and CYP-006TK for diabetic foot ulcers (Phase 1 complete). The company follows a capital-efficient model with academic/strategic collaborators (e.g., University of Sydney, LUMC, Fujifilm).

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Coverage:

Initiation Report *28/01/2026*

Financial Summary

VALUATION DETAILS	
Share Price (A$)	$0.295
Market Cap (A$m)	81.7M
Enterprise Value (A$m)	78.7M
Fair Value/Share (A$)	$1.19

STATEMENTS (A$m)	FY25	FY26E	FY27E	FY28E	FY29E
Income Statement					
Revenue	2.11	0.00	13.50	33.75	4.29
EBITDA	-9.11	-11.75	1.65	21.90	-9.78
EBIT	-9.39	-12.03	1.37	21.62	-10.06
Net Income	-9.39	-12.03	0.96	15.13	-10.06
Balance Sheet					
Cash & Cash Equivalents	5.05	2.06	15.09	26.62	21.65
Inventory	0.00	0.00	0.00	0.00	0.28
Receivables	0.10	0.00	2.22	5.55	0.71
Other Assets	2.04	1.82	1.89	2.41	2.27
Total Assets	7.20	3.88	19.19	34.58	24.92
Total Debt	0.00	0.00	0.00	0.00	0.00
Other Liabilities	1.22	0.28	0.29	0.29	0.44
Total Liabilities	1.22	0.28	0.29	0.29	0.44
Shareholders' Equity	5.98	3.60	18.91	34.29	24.48
Cash Flow Statement					
Net Income	-9.39	-12.03	0.96	15.13	-10.06
Add: D&A	0.28	0.28	0.28	0.28	0.28
Less: Change in NWC	0.13	-0.84	-2.21	-3.32	4.71
Cash Flow from Operations	-8.72	-12.34	-0.73	12.34	-4.82
Cash Flow from Investing	-0.05	-0.05	-0.35	-0.80	-0.15
Equity Raised (net)	7.61	9.40	14.10	0.00	0.00
Less: Dividends Paid	0.00	0.00	0.00	0.00	0.00
Cash Flow from Financing	7.61	9.40	14.10	0.00	0.00
Unlevered Free Cash Flow	-8.77	-12.39	-1.08	11.54	-4.97

PER SHARE DATA	FY25	FY26E	FY27E	FY28E	FY29E
Shares Out (dil., m)	226.0	257.7	305.3	305.3	305.3
Normalised EPS (A$)	-0.04	-0.05	0.00	0.05	-0.03
Dividends (A$/share)	0.00	0.00	0.00	0.00	0.00
Payout	0%	0%	0%	0%	0%
Franking	0%	0%	0%	0%	0%

RATIOS	FY25	FY26E	FY27E	FY28E	FY29E
Liquidity					
Current Ratio	4.4	8.0	61.2	110.9	52.0
Quick Ratio	4.2	7.3	60.5	110.2	50.9
Solvency					
Debt to Equity	0.00	0.00	0.00	0.00	0.00
Equity to Assets	0.83	0.93	0.99	0.98	0.98
Profitability					
ROA	-120.5%	-217.1%	8.3%	56.3%	-33.8%
ROE	-142.3%	-251.1%	8.5%	56.9%	-34.2%
EBITDA Margin	-431.1%	0.0%	12.2%	64.9%	-227.9%
NPAT Margin	-444.5%	0.0%	7.1%	44.8%	-234.5%
Growth					
Revenue	0.0%	0.0%	0.0%	150.0%	-87.3%
EBITDA	-3.8%	29.0%	114.0%	1231%	-144.7%
Underlying NPAT	-3.6%	28.1%	107.9%	1483%	-166.5%
EPS	0.0%	0.0%	0.0%	1408%	-163.3%
Valuation					
P/E	N/A	-22.3	317.1	23.5	-35.3
EV/Revenue	N/A	N/A	22.1	8.8	69.6
EV/EBITDA	N/A	N/A	181.6	13.6	N/A
Dividend Yield	0.0%	0.0%	0.0%	0.0%	0.0%

Trial Design Recap

The Phase 2 trial (NCT05643638) is a global, randomised, placebo-controlled study of CYP-001 plus corticosteroids versus placebo plus corticosteroids in adults with newly diagnosed high-risk aGvHD. CYP-001 is administered as two intravenous infusions (on Day 0 and Day 7). The primary evaluation period extends to 100 days from the first dose, with long-term follow-up continuing out to two years.

The trial targeted approximately 60 patients and is being conducted across multiple sites in the US, Australia, and Turkey. The trial is fully blinded, with an unblinded pharmacist preparing and masking the study drug at each site to preserve blinding for investigators, patients, and assessing staff. This is an important design feature given the subjective elements of aGvHD staging assessment.

Two design features are critical to understanding this readout. First, this trial positions CYP-001 as a first-line add-on therapy in high-risk patients; not as a salvage therapy in steroid-refractory disease (which was the setting for the Phase 1 trial). Patients enrolled are earlier in their disease course but carry a high probability of steroid failure based on clinical severity or biomarker risk stratification. Restricting enrolment to high-risk patients also reduces disease heterogeneity, which is important in a relatively small trial where baseline imbalance between arms could otherwise obscure a true treatment effect. Second, the inclusion of a concurrent placebo arm with corticosteroid backbone provides a clean control for measuring the incremental benefit of CYP-001 — something absent from both Cynata's open-label Phase 1 and Mesoblast's single-arm paediatric Phase 3.

How Responses Are Measured

Acute GvHD is a multi-organ disease, and response is determined by a structured comparison of organ involvement at each trial visit against baseline. aGvHD is staged across three target organs: skin, liver, and gastrointestinal tract. Each organ is assigned a stage from 0 (no involvement) to 4 (severe involvement) based on predefined clinical criteria — body surface area affected for skin; total bilirubin level for liver; stool volume or number of bowel movements for GI. An algorithm then converts these individual organ stages into an overall clinical grade from I (mild) to IV (life-threatening), based on the most severely affected organ.

Importantly, a single patient does not necessarily have all three organs involved. In many cases, the aGvHD presentation is driven by severe involvement of just one or two organs, with the other organ(s) at stage 0. This is relevant for interpreting partial response rates, as improvement in the driving organ can constitute a meaningful clinical response even if the other organs were never affected.

Response assessments are conducted at scheduled patient visits through the primary evaluation period. At each visit, the current organ stages are compared against baseline to determine response:

- **Complete response (CR):** all signs and symptoms of aGvHD have resolved across all organs (all organ stages return to 0).
- **Partial response (PR):** improvement by at least one stage in at least one organ, with no worsening in any other organ.
- **Overall response (OR):** CR or PR, measured without the patient requiring additional systemic therapies for earlier progression, mixed response, or non-response.

The staging assessments have inherent subjectivity, particularly for GI involvement, where stool volume can be influenced by oral intake, antibiotics, and other factors. The blinded placebo-controlled design mitigates this: the same assessment subjectivity

applies to both arms, so any systematic bias affects both equally and cancels out in the between-arm comparison.

Why There Are No Direct Comparators

Cynata's own Phase 1 (n=15) was conducted in steroid-refractory patients (grades II–IV), an entirely different population to the high-risk first-line patients in the Phase 2. The 87% overall response rate and 53% complete response rate at Day 100 from the Phase 1 cannot be directly extrapolated to this trial. The Phase 1 was also open-label and uncontrolled. Elsewhere:

- **Mesoblast's Ryoncil paediatric Phase 3 (n=54)** enrolled children with steroid-refractory aGvHD and was a single-arm study with no placebo control. The 70% Day 28 ORR was achieved in a paediatric population, which has different disease biology and treatment responsiveness to adults. This trial cannot serve as a benchmark for Cynata's adult, placebo-controlled, first-line study.

- **The Osiris/Mesoblast Phase 3 (n=260)** was randomised and placebo-controlled, but enrolled steroid-refractory patients receiving second-line therapy, not first-line. Moreover, it used a first-generation, donor-derived MSC product with acknowledged manufacturing inconsistencies. The trial failed (58% MSC vs. 54% placebo Day 28 ORR), but the product quality issues make it an unreliable comparator for a consistently manufactured iPSC-derived product.

- **Ruxolitinib trials (REACH1/REACH2)** studied a JAK1/2 inhibitor in the steroid-refractory second-line setting with a different mechanism of action, patient population, and treatment context. Ruxolitinib's Day 28 ORR of ~55–62% in SR-aGvHD provides a general sense of what is achievable in this disease, but cannot be used to set expectations for a first-line MSC add-on trial.

- **First-line ruxolitinib + steroids data** exists from a Chinese Phase 3 trial, which showed significantly improved ORR for the combination versus steroids alone in intermediate/high-risk aGvHD. However, this trial used a pharmacologically distinct agent (a small-molecule JAK inhibitor) with a completely different mechanism to an MSC therapy. Cross-class comparisons are not analytically valid.

Endpoint-by-Endpoint Framework

The following section outlines each endpoint, why it matters, and what levels of response we would consider indicative of a strong efficacy signal. Our framework is anchored against what is known about the natural history of high-risk aGvHD on corticosteroid therapy and the general performance characteristics of agents that have advanced in this indication.

1. Overall Response Rate at Day 28 (Primary)

ORR at Day 28 is defined as the proportion of participants achieving a complete or partial response, without the need for additional systemic therapies. Day 28 ORR is the standard primary endpoint in aGvHD trials due to its established correlation with downstream survival outcomes.

Drawing on published outcomes data for high-risk aGvHD patients on first-line corticosteroid therapy – including the 44% Day 28 response rate reported in Minnesota high-risk patients and control arm data from the Chinese ruxolitinib + steroids Phase 3 – we expect the placebo (steroids-only) arm to deliver a Day 28 ORR in the range of 45-50%. This is a meaningful baseline: steroids do work in a substantial proportion of patients, and the CYP-001 arm must demonstrate clear improvement on top of this.

Against that backdrop, our interpretation of possible CYP-001 arm outcomes is as follows:

Delta vs Placebo (CYP-001 arm ORR)	Signal Strength	Interpretation
≥25% (≥70–75% CYP-001)	**Strongly Positive**	Exceptional signal. Would strongly support advancement to a registrational trial and likely trigger significant re-rating of the stock.
~15% (~60–70% CYP-001)	**Clearly Positive**	Clinically meaningful and statistically achievable in a ~60-patient trial. Confirms MSC modality delivers incremental benefit over steroids alone and materially de-risks the program.
10-15% (~55-69% CYP-001)	**Baseline / Ambiguous**	Directionally positive but may not reach statistical significance. Not a failure, but secondary endpoints (CRR, durability) become critical to the narrative.
<10% (<60% CYP-001)	**Disappointing**	No meaningful separation from placebo. Would materially impair the near-term investment case and shift focus to the SCUlpTOR Phase 3 OA readout.

2. Complete Response Rate at Day 100

Complete response – the complete resolution of all aGvHD signs and symptoms across every affected organ – is the highest-quality efficacy signal. CR rates are more predictive of durable survival than overall response, which includes partial responses that may be transient. In Cynata's Phase 1, 53% of steroid-refractory patients achieved CR by Day 100.

We would flag CRR as potentially the most important secondary signal in this readout. A large delta in CRR between CYP-001 and placebo is clinically meaningful even if the ORR delta is more modest, because it indicates CYP-001 is driving deeper, higher-quality responses than steroids alone, not just marginally more partial responses. A CRR of, say, 35% in the CYP-001 arm versus 15% in placebo (a 20pp delta) would constitute a robust signal of response depth, supporting the thesis that CYP-001 is achieving meaningful immunological reset rather than symptomatic suppression.

Conversely, a low CRR (≤20%) in the CYP-001 arm even alongside a reasonable ORR would suggest that CYP-001 is producing shallow responses, which may not translate to meaningful survival benefit.

3. Duration of Response (Day 28 to Day 100)

Durability of response – whether patients who respond at Day 28 maintain that response out to Day 100 – is arguably the most clinically differentiating endpoint in this readout. Ruxolitinib, the current second-line standard of care, does not sustain partial and complete responses well; many patients who respond early subsequently relapse. This is a recognised limitation of JAK inhibition in aGvHD and represents a genuine unmet need in the treatment paradigm.

In Cynata's Phase 1, the published long-term follow-up data show that responses were durable: no patients who survived to 12 months still had active acute GvHD. Replicating durable responses in the Phase 2 would be a major point of differentiation from ruxolitinib and would validate the immunomodulatory durability of the Cymerus MSC platform.

We would view a durable ORR – defined as Day 28 responders maintaining response at both Day 60 and Day 100 – where ≥70% of Day 28 responders sustain response through Day 100 as indicative of a durable treatment effect. Conversely, if the Day 100 ORR is substantially lower than Day 28 ORR, this would indicate fading responses and materially weaken the case for a registrational trial. We also note that even responses sustained for only a few months have clinical value in a disease where early mortality is high: patients who survive the acute phase have markedly better long-term prognosis.

4. Overall Survival

Day 100 overall survival (OS) is the ultimate clinimetric in aGvHD, but this Phase 2 trial (~60 patients) is almost certainly not powered to detect a statistically significant survival difference between arms. Day 100 is also a short window for assessing survival in this indication: mortality continues to accrue well beyond 100 days from infections, organ damage, and disease relapse.

We would view a directional improvement in OS favouring the CYP-001 arm as supportive evidence but would not expect statistical significance at Day 100. A visually clear Kaplan-Meier separation (e.g., 10–15 percentage points at Day 100) would strengthen the thesis. The more definitive survival signal will emerge from the longer-term follow-up, which continues out to two years post-first-dose. Investors should not over-weight Day 100 OS in the top-line readout as it is simply too early.

5. Safety Profile

While not an efficacy endpoint, safety data will be scrutinised as closely as the efficacy results. Cynata's Phase 1 reported no treatment-related serious adverse events across 15 patients: an exceptional safety profile that will now be tested in a larger, controlled setting.

We note that infection rates require careful interpretation. aGvHD patients are profoundly immunosuppressed by both the transplant conditioning and steroid therapy, so high infection rates are expected in both arms. The key question is whether the CYP-001 arm shows comparable or lower infection rates versus placebo. Comparable or lower infection rates in the treatment arm would confirm that MSC-mediated immunomodulation is not adding to immunosuppressive burden – a critical point of differentiation from JAK inhibitors like ruxolitinib, which carry significant infection and cytopenia risk.

Summary: What We Want to See

Endpoint	Strong Signal	Key Consideration
ORR Day 28 (Primary)	≥20pp delta vs placebo (expected placebo 45–50%)	The delta matters more than the absolute number. ≥20pp = clearly positive. <10pp = disappointing. 10-19pp = ambiguous, needs support from secondaries.
CRR Day 100	Large delta (e.g., ~20pp) vs placebo	Potentially the most important secondary endpoint. A large CRR delta is meaningful even if the ORR delta is modest – signals depth of response, not just incidence.
Duration of Response (D28→D100)	≥70% of D28 responders still responding at D100	Key differentiator vs ruxolitinib, which does not sustain responses well. Phase 1 showed strong response durability.
Overall Survival	Directional improvement; KM separation	Day 100 is too early for OS. Real signal will come in the 2-year follow-up data.
Safety	No treatment-related SAEs; comparable or lower infection rates vs placebo	Must maintain the clean Phase 1 safety profile in a controlled setting. Differentiation from ruxolitinib on infection and cytopenia risk would be a key narrative.

A clearly positive phase 2 readout would achieve several things simultaneously. It would validate CYP-001's efficacy in a controlled setting for the first time, confirming that the Phase 1 signal was real and not an artefact of an open-label design. It would produce the first controlled evidence for any MSC therapy as a first-line add-on in adult aGvHD, establishing CYP-001 as the clinical leader in a space where Mesoblast has paediatric approval but no adult controlled data. And it would de-risk the Cymerus iPSC platform

more broadly, supporting the thesis that manufacturing consistency resolves the historical failures of donor-derived MSC programs.

Key Risks

Clinical Risk: OA

The Phase 3 SCUlpTOR trial remains the most consequential binary risk in the portfolio. OA pain trials are notoriously difficult to de-risk due to the placebo effect, which has historically produced high response rates in control arms and obscured treatment benefit. The competitive graveyard is instructive: Lorecivivint (Biosplice) failed to consistently demonstrate symptomatic benefit alongside structural signals in Phase 3; Sprifermin achieved structural success but failed on pain; Lutikizumab (AbbVie) failed to show WOMAC pain or synovitis improvement. A failure to meet the primary endpoints for pain and function in SCUlpTOR would fundamentally break the investment thesis, eliminating the majority of the valuation upside derived from the mass-market OA program.

Clinical Risk: aGvHD

The Phase 2 trial in high-risk aGvHD is the more imminent catalyst and carries a distinct risk profile. The trial is first-of-its-kind: no randomised, placebo-controlled trial of an MSC therapy as a first-line add-on in adult high-risk aGvHD has been completed, meaning there are no direct benchmarks against which to calibrate expectations. The Phase 1 signal (87% ORR, 53% CR at Day 100) was generated in an uncontrolled, open-label setting in a different patient population (steroid-refractory), and may not translate cleanly. A failure to demonstrate a meaningful Day 28 ORR delta over placebo would remove the near-term validation catalyst and delay the path to registrational trials, shifting the full weight of the platform validation story onto SCUlpTOR. It would also undermine the thesis that manufacturing consistency alone resolves the historical failures of donor-derived MSC programs.

Commercial Risk

Our valuation model heavily relies on Cynata securing a strategic licensing partner to fund late-stage development and commercialisation for CYP-004. As a small-cap biotech, the company lacks the balance sheet to independently commercialise a mass-market drug in the US or EU, making a partnership essential for value realisation. The post-deal evolution of Mesoblast/Grünenthal (milestones reclassified as repayable following MPC-06-ID's US Phase 3 failure) and Takeda's 2024 withdrawal of Alofisel after a confirmatory Phase 3 miss illustrate that buyers have become more disciplined on risk even for approved or near-approved regenerative assets. If Cynata fails to secure a partner, or is forced to accept unfavourable terms such as royalty rates below our 10% base case, the intrinsic value of the CYP-004 asset would be materially impaired.

Regulatory & Manufacturing Risk

Cynata's iPSC-based Cymerus platform theoretically solves the batch consistency issues that plague donor-derived cell therapies. However, the FDA has not yet approved any iPSC-derived therapeutic, placing Cynata in the position of regulatory pioneer with the attendant first-mover disadvantage. This risk has meaningfully moderated over recent months: in February 2026, Japan's MHLW granted conditional and time-limited approval to two iPSC-derived therapies: Cuorips' ReHeart (cardiomyocyte sheet for heart failure) and Sumitomo/Racthera's Amchepry (dopaminergic neural progenitors for Parkinson's disease). These approvals were granted under Japan's accelerated framework (small-scale safety data with presumed efficacy), not through the more stringent FDA or EMA pathways, so they do not directly de-risk Cynata's US regulatory path. They do, however, remove the argument that no regulator anywhere has ever approved an iPSC-derived therapy as a class. The FDA has historically been cautious with cell therapies — Mesoblast received two Complete Response Letters for Ryoncil (2020 and 2023) on potency assay and CMC grounds before securing approval in December 2024. Similar CRL risk applies to CYP-001, and could produce material delays even with positive clinical data.

Funding Risk

Cynata remains a pre-revenue, loss-making enterprise with a finite cash runway relative to its clinical ambitions. Our model explicitly incorporates a material balance sheet strengthening via two assumed equity raises (A$10m in FY26 and A$15m in FY27) to bridge the catalyst window and support regulatory progression. We have modelled these at prevailing market prices. The primary mitigant to dilution risk is the execution of a DFU licensing deal providing non-dilutive upfront cash, or a strategic partnership for CYP-004, but neither is guaranteed on commercially acceptable terms.

Competitive Risk

Mesoblast's Ryoncil is currently approved only for paediatric SR-aGvHD, leaving the adult market (>90% of transplant patients) commercially open. However, this window is not permanent. In November 2025, Mesoblast announced a collaboration with the NIH-funded Blood and Marrow Transplant Clinical Trials Network (BMT CTN) to run a pivotal adult trial of Ryoncil as part of first-line regimen in severe SR-aGvHD. If Mesoblast secures adult approval ahead of Cynata, the commercial window narrows significantly. Ryoncil already has seven years of orphan drug exclusivity for paediatric SR-aGvHD, and label expansion into adults would benefit from established commercial infrastructure and prescriber familiarity. Ruxolitinib (Jakafi) also remains the entrenched second-line standard of care with an Incyte commercial machine behind it, and combination or sequencing dynamics in the treatment paradigm remain unresolved.

Trial Execution Risk

A risk specific to the imminent Phase 2 aGvHD readout is baseline imbalance between arms. aGvHD is a heterogeneous disease driven by variable organ involvement (skin, liver, GI), severity grade, and underlying haematological condition. In a trial of approximately 60 patients, random chance can produce meaningful imbalances in disease severity, donor type, or transplant conditioning regimen between the CYP-001 and placebo arms. The high-risk inclusion criteria partially mitigate this by restricting heterogeneity, but a modest baseline imbalance could obscure a real treatment effect or inflate an apparent one.

Evolution Capital Ratings System

Recommendation Structure	• **Buy:** The stock is expected to generate a total return of >10% over a 12-month horizon. For stocks classified as 'Speculative', a total return of >30% is expected. • **Hold:** The stock is expected to generate a total return between -10% and +10% over a 12-month horizon. • **Sell:** The stock is expected to generate a total return of <-10% over a 12-month horizon.
Risk Qualifier	• **Speculative ('Spec'):** This qualifier is applied to stocks that bear significantly above-average risk. These can be pre-cash flow companies with nil or prospective operations, companies with only forecast cash flows, and/or those with a stressed balance sheet. Investments in these stocks may carry a high level of capital risk and the potential for material loss.
Other Ratings	• **Under Review (UR):** The rating and price target have been temporarily suppressed due to market events or other short-term reasons to allow the analyst to more fully consider their view. • **Suspended (S):** Coverage of the stock has been suspended due to market events or other reasons that make coverage impracticable. The previous rating and price target should no longer be relied upon. • **Not Covered (NC):** Evolution Capital does not cover this company and provides no investment view.

Expected total return represents the upside or downside differential between the current share price and the price target, plus the expected next 12-month dividend yield for the company. Price targets are based on a 12-month time frame.

Disclaimer & Disclosures

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