Electromed (ELMD): Research Report

Breath easy, The drug isn't a threat.

Summary

Electromed came up in a screen of US micro-caps. It grows steadily at high margins, and has interesting debates around it, such as whether Insmed's new drug helps or hurts the vest. Revenue has risen every year for ten years, and by 10% or more in each of the last six (FY21 to FY26) [1, 2]. Electromed sells one product, the SmartVest airway clearance vest. It sells the vest directly to patients and bills their insurers, mostly Medicare and commercial plans. It is a well-run, debt-free business with a 78.5% gross margin and a return on capital above 20% [1]. However, it has no product advantage over three larger rivals and depends on one Medicare billing code. Furthermore, it is about to change chief executive. At $27.85 the shares trade well below what the cash flows are worth. Discounted at the 10-year Treasury yield [3], the base case is worth about $62 a share, and about $33 even in the bear case. With a 40% margin of safety the buy price is about $37, so my rating is a moderate buy.

Exhibit 1. Key numbers [1, 4]

Market data		FY26 results	
Share price	$27.85	Revenue	$73.8M, up 15.3%
Market value	$231M	Homecare revenue	$66.6M, up 16.3%
Net cash, no debt	$20.5M	Gross margin	78.5%
Enterprise value (diluted shares)	$219M	Operating margin	18.8%
P/E (FY26)	21.4x	Diluted EPS	$1.30
EV / EBIT	15.8x	Free cash flow	$8.4M
Free cash flow yield	3.6%	Return on invested capital	22.5%
2026 high and low	$23.01 to $47.40	Average homecare reps	58

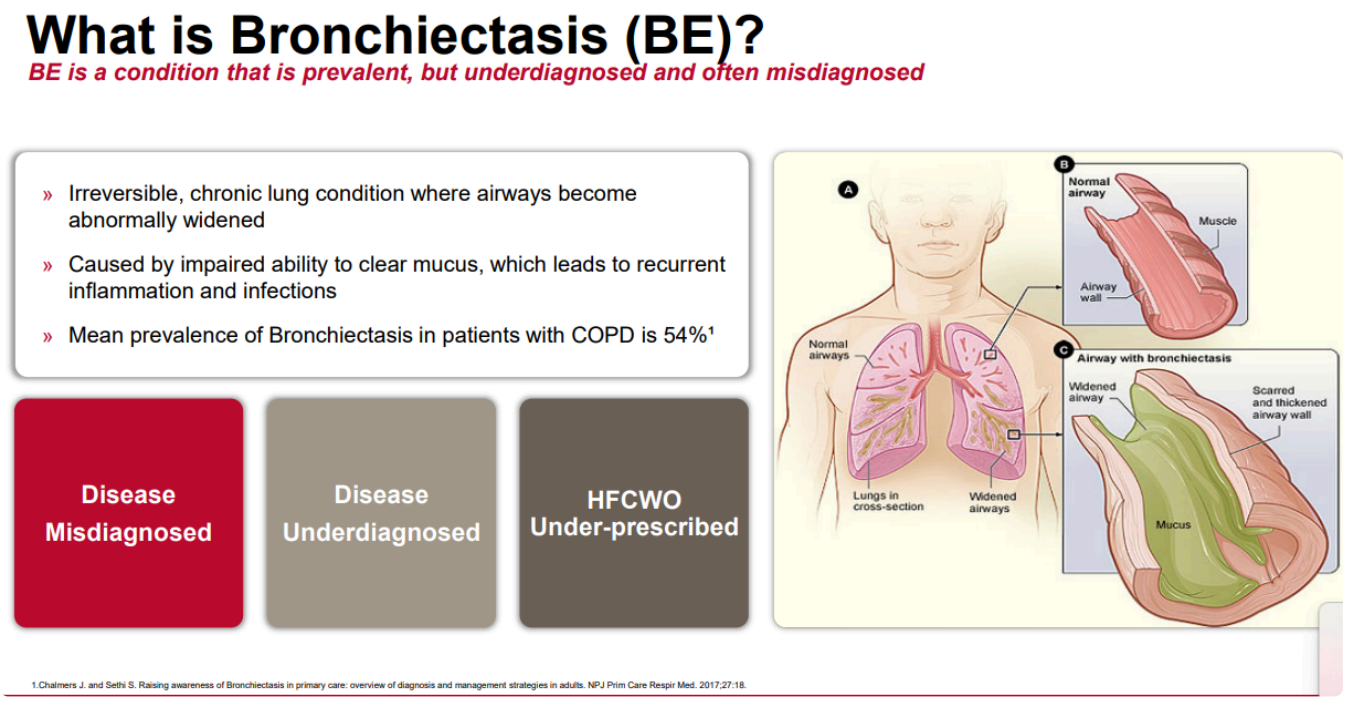
Exhibit 2. The five debates in one line each

Debate	My view	What would change my mind
1. Does Brinsupri, Insmed's new pill, replace the vest?	No, not over two to three years. The pill cuts flare-ups by about a fifth but does not clear mucus, and Medicare's vest criteria do not require trying it first. It brings more patients to a diagnosis.	Payers adding the pill as a step before the vest, vest referrals falling where the pill is prescribed most
2. How fast can it grow?	In line with management, below the analysts: about 10% in FY27, against management's "double-digit" and the analysts' 12.7%. The boost from Medicare rates and payer mix has gone, but Q4 FY26 still grew 15% on volume alone, and most of FY27's reps are already hired. The real question is whether 10% a year holds after FY27.	Revenue per rep falling below $1.05M as the new reps ramp up
3. Is there a moat?	A narrow one, a reimbursement and service operation that clinics get used to. No product or price advantage.	A portable vest from Electromed, or clinical evidence that singles out SmartVest
4. Are the receivables and accounting clean?	Yes. An SEC review in 2026 closed in one round; receivables more than a year old are under 2% of the total. The real estimate risk sits in how much revenue is booked up front.	Downward revisions to past revenue estimates
5. Management, succession and ownership	Strong operators are leaving or selling. The CEO retires in April 2027; the Chair, CEO and CFO sold at $34 to $38; an activist director is leaving the board.	A credible successor; insider buying

Management did not grant a meeting before publication: the company is in its quiet period before Q1 FY27 results, expected around 12 November 2026 [5].

1. What Electromed does

Electromed makes one product, the SmartVest, and sells most of it directly to patients at home. The vest is a high frequency chest wall oscillation (HFCWO) device: an inflatable garment, a hose and an air-pulse generator that shakes the chest to loosen mucus so the patient can cough it up. It is prescription-only and billed under a single Medicare code, E0483 [1].





The company was founded in 1992 in New Prague, Minnesota, listed in 2010 and trades on NYSE American. It had 197 employees at June 2026 and makes the vest at one site in Minnesota. Two models are sold: SmartVest SQL (2014) and SmartVest Clearway (introduced November 2022), whose generator weighs under 14 pounds. There is no battery-powered portable model [1, 2].

Who uses it. In FY26, 76% of qualified homecare referrals were for bronchiectasis, a chronic lung disease in which damaged airways fill with mucus. Neuromuscular conditions made up 19%, cystic fibrosis 3% and other conditions 2% [7].

How a sale works. A sales rep calls on pulmonology clinics. When a doctor prescribes, Electromed's reimbursement team collects the records and gets the insurer's approval. A contract respiratory therapist (about 167 nationally) delivers the vest and trains the patient at home. Electromed then bills the insurer itself. Medicare allows about $16,000 per vest; Medicaid and commercial plans allow roughly $8,000 to $15,000 [1]. Management has said each patient brings in "over $10,000", and its market-size formula uses about $10,500 per vest [6, 7].

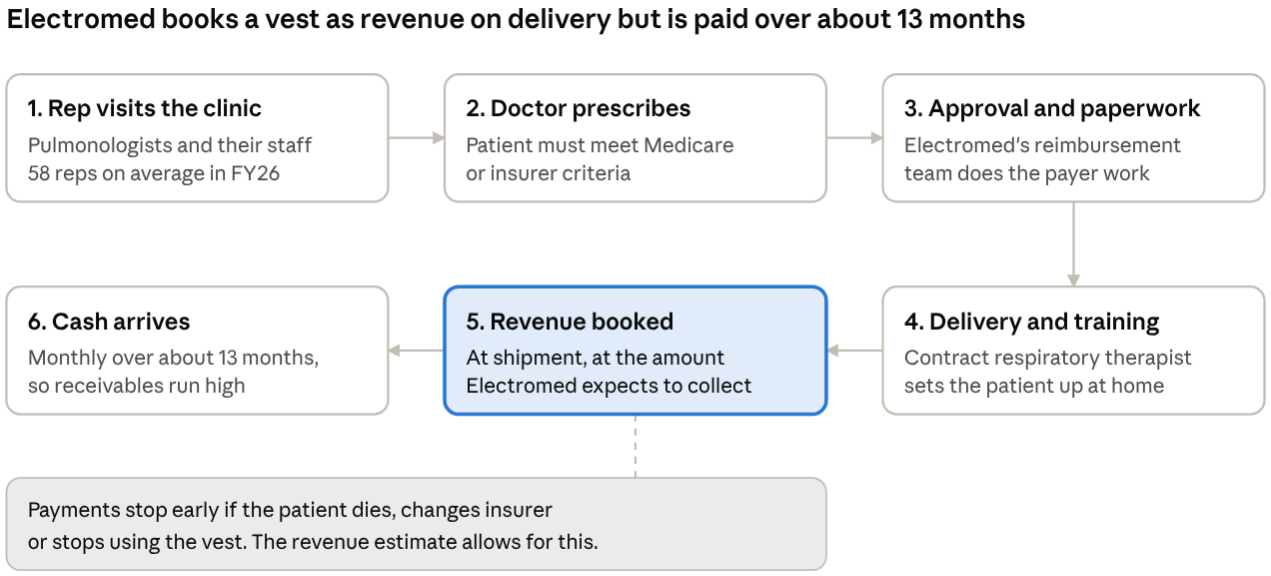


Exhibit 3. How a SmartVest sale becomes cash · FY26 10-K [1]; SEC correspondence, March 2026 [8]

About 95% of homecare revenue comes from instalment arrangements. Medicare and many other payers pay monthly for up to 13 months, then the patient owns the vest. Electromed books the expected total at shipment and collects it over the following year. This year the SEC sent a letter asking how the company estimates what it will actually collect. Electromed explained it uses historical payment and termination patterns, and said past adjustments to these estimates have been immaterial [1, 8].

Exhibit 4. Where the revenue comes from, FY26

By channel	Revenue	Share	Growth
Homecare (direct)	$66.6M	90.3%	+16.3%
Hospital	$3.4M	4.7%	+9.6%
Homecare distributor	$3.3M	4.5%	+12.7%
Other, including international	$0.4M	0.6%	-34.7%
Total	**$73.8M**	**100%**	**+15.3%**

Homecare by payer	Revenue	Share	Growth
Commercial	$31.9M	47.9%	+9.5%
Medicare	$25.7M	38.6%	+22.7%
Medicare Supplemental	$6.3M	9.5%	+21.3%
Medicaid	$1.4M	2.2%	+55.9%
Other	$1.2M	1.8%	+15.8%

Source: FY26 10-K, revenue note. Commercial includes Medicare Advantage and managed Medicaid plans (Q4 FY26 deck) [1, 7].

Two things stand out. First, Medicare grew more than twice as fast as commercial in FY26, so traditional Medicare and its supplemental plans rose from 45.7% to 48.1% of homecare revenue. Medicare pays the highest price per vest, so this shift lifted revenue per patient. Second, international sales are 0.6% of revenue and management has said international growth is not a focus [1, 6].

The sales machine. Electromed averaged 58 homecare reps in FY26 and ended the year with 64 direct reps, including two hospital liaisons. Each rep generated $1,145,000 of annualised homecare revenue, against a target of $1.0M to $1.1M. Contracts cover a reported 87% of insured lives (about 275 million people), after 40 new payer contracts in FY26. More than 45% of Q4 orders came through SmartOrder, its electronic prescribing tool, and those orders shipped about five days faster than faxed ones [1, 6, 7].

What it spends. People are the main cost. Payroll inside SG&A was $28.9M, 39% of revenue, against cost of goods of $15.8M. R&D was $1.3M, or 1.8% of revenue. Capex was $1.3M [1].

2. Market and competitors

The vest market is small, growing about 8% a year and shared by four suppliers, of which Electromed is the only independent one. Electromed sized it at about $245M in calendar 2024; its $66.6M of homecare revenue would be roughly a quarter of that. The FY26 10-K dropped the dollar figure but kept the 8% growth rate [1, 2].

How many patients there are depends on who you ask. Electromed's estimate of diagnosed US bronchiectasis patients has risen from 824,000 (November 2024 call) to 923,000 (August 2025 call) to about 1 million (FY26 10-K). The roughly 800,000 it calls untreated is what is left after about 16% use a vest. Insmed uses about 500,000. So a 16% vest penetration means 166,000 patients on Electromed's base but about 80,000 on Insmed's [1, 6, 7, 9].

Exhibit 5. Competing estimates of the patient pool [1, 7, 9, 10]

Source	Diagnosed US bronchiectasis patients	Other claims
Electromed, FY26 10-K and results release	About 1 million, growing about 12% a year	16% use a vest (about 166,000), leaving about 800,000 untreated; 4.1 million undiagnosed with COPD overlap; 35% managed by pulmonologists
Insmed, 2025 annual report and Q4 2025 call	About 500,000	Bronchiectasis may be present in 30% to over 50% of moderate-to-severe COPD patients

Electromed's estimates come from its own analysis of claims data. One of its directors, Joseph Galatowitsch, is a retired partner of Guidehouse, the consultancy behind the market study the company has cited which should be noted [7, 11].

The pool is being widened by someone else's money. Insmed is spending to find undiagnosed patients among the 32 million Americans with COPD or asthma, an effort it says is "being resourced like its own separate launch". Every new diagnosis is a potential vest patient. This is the strongest tailwind Electromed has, and it costs Electromed nothing [10].

Exhibit 6. The four suppliers [1, 12–15]

Supplier	Product	Owner since	How it sells	Notes
Electromed	SmartVest SQL, Clearway	Founded 1992	Direct to patient; bills insurers itself	Only listed pure play; homecare +15.2% in the June 2026 quarter
Baxter	The Vest	Hill-Rom bought Advanced Respiratory in 2003; Baxter bought Hillrom in 2021	Direct	Not reported separately
Philips	InCourage	Bought RespirTech in 2017	Direct	Not reported separately
Tactile Medical	AffloVest (battery-powered, portable)	Bought in 2021	Mostly through home equipment (DME) distributors	Claims category leadership; $12.1M of sales in Q2 2026, down 7%, after distributor overstocking; up 32% over 12 months

Insmed is not listed because it sells a drug, Brinsupri, not a vest. It is covered in Debate 1.

Tactile's numbers need care. It sells AffloVest to distributors at wholesale, so its revenue per patient is lower than Electromed's, and its 66% growth in Q4 2025 probably included distributors building stock. In Q2 2026 Tactile said several large distributors had been "carrying elevated AffloVest inventory" and cut its outlook for the line. Tactile launched a next-generation AffloVest in mid-2026, with lower weight, digital connectivity and better size adjustment. Electromed has no battery-powered vest to answer it [14, 15].

The guideline does not pick a winner. The first US bronchiectasis guideline (CHEST, 2026) makes a ***conditional recommendation for vests, with very low certainty of evidence,*** as one of four airway clearance options, and flags their cost. It makes a conditional recommendation for brensocatib (Brinsupri) with moderate certainty. Electromed's chief executive conceded the guideline is "not as definitive as we would like" [6, 16].

Exhibit 7. What buyers have paid [12, 13, 17]

Date	Target	Buyer	Price	Revenue at the time	Price to sales
Sep 2021	AffloVest	Tactile Medical	$80M cash plus $15.6M earn-out paid (up to $20M allowed)	About $17M	4.7x; 5.6x with the earn-out paid
May 2017	RespirTech	Philips	Not disclosed	About $50M expected for 2017	Unknown
Oct 2003	Advanced Respiratory	Hill-Rom	$83M plus up to $20M contingent	About $45M	1.8x; 2.3x with full contingent

Two deals 18 years apart are a thin base for valuation its only a range.

3. Financial record, FY16 to FY26

Revenue has grown every year for a decade, at 12.4% a year compounded. Profit did not follow until FY24: diluted EPS was $0.27 in FY16 and $0.26 in FY22, then rose to $1.30 in FY26 [1, 2].

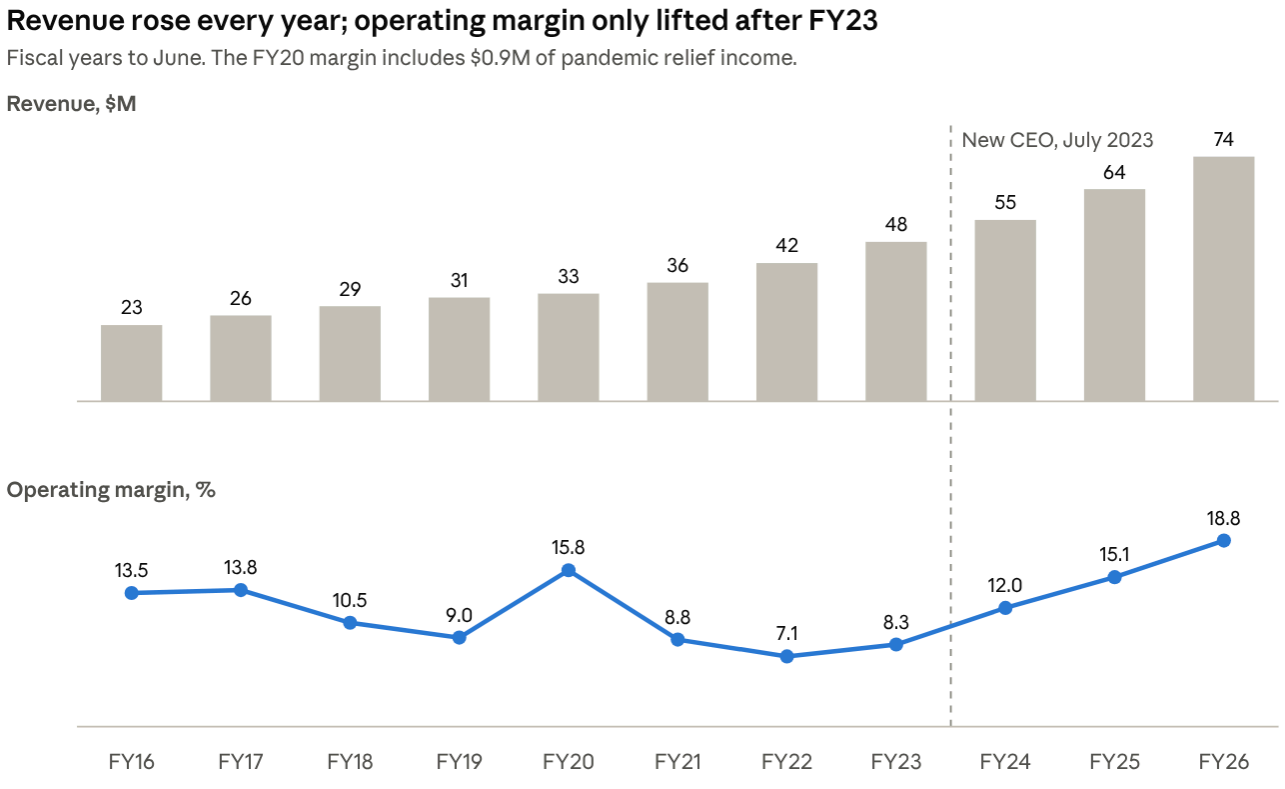


Exhibit 8. Revenue and operating margin, FY16 to FY26 · 10-Ks FY2017 to FY2026 [1, 2]

Over FY25 and FY26, higher net revenue per approval added about $3.4M of revenue, nearly all of which fell to profit; that is close to half of the $7.3M rise in operating income over the two years [1, 8].

How much further can the margin go? The margin rose from 8.3% in FY23 to 18.8% in FY26, well above the 13% to 16% the company earned in its good years before. Three things drove it. Revenue grew by half, so fixed costs were spread more thinly. After years of hiring ahead of demand, management switched to harvesting that investment. And rising Medicare rates and more Medicare patients added revenue at almost no extra cost. Scale will keep helping, but less each year. By my estimate, overheads fell from about 31% of revenue to 20% over FY23 to FY26, and at 10% growth they would fall only to about 14% by FY31. The other two drivers have mostly run their course. The price boost has nearly gone, and new reps add cost months before they add sales. Payroll is already 39% of revenue and grows with every rep hired. I expect about a point of margin a year at most, and only if reps become more productive, which the FY27 guidance does not assume [1, 2].

Exhibit 9. Cash conversion, FY22 to FY26 ($M)

	FY22	FY23	FY24	FY25	FY26
Net income	2.3	3.2	5.2	7.5	11.3
Operating cash flow	-0.7	1.3	9.1	11.4	9.7
Operating cash flow / net income	-0.30	0.42	1.76	1.51	0.86
Capex	1.5	1.7	0.4	0.3	1.3
Free cash flow	-2.2	-0.4	8.7	11.1	8.4
Stock-based compensation	1.0	0.7	1.7	3.1	2.7
Share buybacks	1.4	0.2	0.3	10.0	3.9
Receivables and contract assets, days of revenue	187	187	160	147	153
Return on invested capital	6.9%	8.6%	11.7%	16.1%	22.5%

Source: 10-Ks FY2022 to FY2026 [1, 2].

Cash flow is lumpy because receivables swing. In FY22 and FY23, receivables and contract assets grew by $7.2M and operating cash flow was close to zero. In FY24 and FY25 they stabilised and cash flow exceeded profit. In FY26 they grew 20.2% against revenue growth of 15.3%, and cash flow fell to 86% of net income. Over ten years, free cash flow added up to 83% of net income [1, 2]. Debate 4 looks deeper at receivables.

Capital allocation. No debt since FY19, no dividend, no acquisitions. From FY21 to FY26 the company spent $16.9M buying back 911,000 shares, yet shares outstanding fell by only about 202,000; most of the buybacks absorbed shares issued to employees. Buybacks were well timed in FY25 (an average of about $20) and almost stopped after December 2025 as the price rose (about $0.15M in January to March 2026, none in April to June). The share count fell by 79,078 between 19 August and 16 September 2026, which suggests buying resumed after the price fell. The board approved $5.0M of buybacks in March

2025, used up by June 2025, and a further $10.0M in September 2025, of which $3.9M was used by June 2026. That leaves about $6.1M, roughly 2.6% of the company at today's price. A $10M credit line with BMO, with nothing drawn at June 2026, matures in December 2026 [1, 11, 18, 19].

Stock compensation is high for the company's size: $2.7M in FY26, 3.7% of revenue and 24% of net income. Free cash flow after it was $5.6M [1].

Debate 1. Is Brinsupri a complement or substitute?

My view: mostly a complement in the medium term. The drug and the vest act on different problems, the drug barely improved symptoms over placebo in its trial, and Medicare's vest rules do not require patients to try the drug first. What could change this is insurers deciding that two expensive treatments are one too many.

What Brinsupri is. Brinsupri (brensocatib) is Insmed's once-daily pill for non-cystic fibrosis bronchiectasis, approved by the FDA in August 2025 for patients aged 12 and over. It blocks an enzyme (DPP1) that drives inflammation in the airways. It does not loosen or remove mucus. Electromed's chief executive puts its cost at about **$85,000** per patient per year, and Insmed guides to discounts in the "mid- to high 20s" percent in 2026 [6, 10, 20].

The launch has been fast. Sales were $207.9M in Q1 2026 and $309.2M in Q2, and Insmed raised its 2026 guidance to $1.25B to $1.40B, about 20 times Electromed's homecare revenue. New patient starts were about 11,550 in August to December 2025, 7,800 in Q1 2026 and 7,000 in Q2 2026. Insmed expects about 7,000 a quarter for the rest of 2026, from more than 6,300 prescribers [10, 21].

Exhibit 10. What the drug did in its main trial (ASPEN, 52 weeks)

Measure	Placebo	10 mg	25 mg
Patients	563	583	575
Flare-ups per patient per year	1.29	1.02	1.04
Reduction against placebo		21%	19%
Patients with no flare-up in the year	40.3%	48.5%	48.5%
Severe flare-ups per patient per year	0.19	0.14	0.14
Lung function (FEV1) change, mL	-62	-50	-24

Measure	Placebo	10 mg	25 mg
Respiratory symptom score, gain over placebo			About 3.8 points at 25 mg (2.0 at 10 mg), against 8 points regarded as clinically meaningful

Source: FDA label, Table 3 [20]; Chalmers et al. and supplementary appendix [22]. Adults needed at least two flare-ups in the prior year to enrol.

Three points matter for Electromed. First, the drug reduced flare-ups by about a fifth, not to zero, more than half of treated patients still had at least one in the year. Second, the gain on the respiratory symptom score was 3.8 points over placebo at 25 mg (2.0 at 10 mg), under half the 8 points regarded as meaningful. The trial did not measure sputum, but daily symptoms improved little more than on placebo. Third, the trial did not record whether patients used airway clearance, and it is not a subgroup. Nobody has trial data on how the two treatments interact [22].

Exhibit 11. Medicare's vest criteria, and where the drug touches them

Medicare requires (LCD L33785)	Does the drug change it?
A CT-confirmed bronchiectasis diagnosis	No. Insmed's diagnosis campaign should increase the number of qualifying patients
Daily productive cough for at least 6 continuous months, or	Little. ASPEN showed a small symptom effect
More than 2 flare-ups a year needing antibiotics	Yes, at the margin. A patient going from 3 flare-ups to 2 could drop below the threshold.
Well-documented failure of standard treatments to mobilise retained secretions	No. The drug does not mobilise secretions, so under the current wording it cannot be a required first step.

Source: DME contractors' physician letter summarising LCD L33785 and policy article A52494 (October 2024) [23].

Exhibit 12. The launch so far, side by side

Calendar quarter	Electromed fiscal quarter	Electromed homecare growth	Brinsupri new patients
Jul to Sep 2025	Q1 FY26	+12.7%	Launch in August; about 11,550 from August to December

Calendar quarter	Electromed fiscal quarter	Electromed homecare growth	Brinsupri new patients
Oct to Dec 2025	Q2 FY26	+18.4%	(included above)
Jan to Mar 2026	Q3 FY26	+18.6%	About 7,800
Apr to Jun 2026	Q4 FY26	+15.2%	About 7,000

Growth rates are year on year. Sources: Electromed 10-Qs and 10-K [1, 24]; Insmed [10, 21].

Electromed's homecare growth accelerated during the first nine months of the launch. The Q4 slowdown to 15.2% is the first data point a bear will point to. I do not think one quarter proves anything: Electromed has said referrals historically dip in July to September (Q1 FY23 call), and Q4 FY26 also faced a tough comparison with price and payer-mix gains that stopped (Debate 2) [6].

The case that it substitutes.

1. **Payers.** A Medicare patient on both treatments costs roughly $60,000 to $64,000 a year for the drug after Insmed's discounts, plus about $16,000 once for the vest. An insurer could require patients to try the drug before approving a vest, or tighten the vest criteria. This is the route I worry about most. So far none has: in October 2026 the published vest policies of UnitedHealthcare, Aetna, Cigna, Anthem and Humana did not mention Brinsupri or require any drug first [10, 25].
2. **Doctors' habits.** A pulmonologist who has a new pill may try it first and revisit the vest only if the patient keeps coughing. That would delay vest referrals rather than end them.
3. **The flare-up route.** Some patients qualify for a vest on flare-ups rather than cough. Fewer flare-ups means fewer of them qualify [23].
4. **Mid-rental drop-outs.** If drug-treated patients stop using the vest during the 13-month rental, Medicare stops paying, and Electromed would have to cut its revenue estimates. This would show up in the accounts before it shows up in referrals.

The case that it complements.

1. **Different jobs.** The drug treats inflammation whilst the vest moves mucus. The trial tested the drug on top of patients' existing care, and their symptoms changed little [22]. Insmed's own patient brochure lists "difficulty clearing mucus" as a separate driver of the disease, says the pill targets inflammation, and tells patients to take it "as appropriate with your existing bronchiectasis treatment routine" [31].

2. **More diagnoses.** Insmed is paying to find undiagnosed patients, and every new diagnosis is a candidate for airway clearance [10].
3. **Cheap by comparison.** A vest is a one-off cost of $8,000 to $16,000. The drug costs more than that every year [1, 6].
4. **The rules.** Medicare's criteria require failure of secretion-clearing treatments, which the drug is not [23].

Management calls the drug "a tailwind" that raises awareness. Insmed has not mentioned airway clearance once in three earnings calls or in its 2026 patient brochure [6, 10, 31].

What would change my mind: a commercial insurer or the Medicare contractors adding the drug as a step before the vest, Electromed reporting weaker referrals in regions where Brinsupri is prescribed most; or downward revisions to Electromed's revenue estimates on existing rentals.

Debate 2. How fast can it grow?

Over five years, about 10% a year looks achievable, but not the 15% to 17% of FY25 and FY26. Homecare revenue is the number of reps multiplied by what each one sells, and both are under pressure in FY27. Hiring keeps slipping and new reps take months to reach full sales. Furthermore, the boost from higher prices has gone. However, management has beaten its own sales-per-rep target in each of the last two years [1, 6].

The analysts are more optimistic still. Their consensus for FY27 is about $83M of revenue, up 12.7%, which is above even my bull case of 12% [26]. Reaching it needs about 65 reps each selling FY26's $1.145M from early in the year, the top of management's guidance, with no slowdown from new hires.

Part of the productivity story was price. In March 2026 the SEC asked Electromed to split homecare growth into volume and price. The answer showed that in FY25, $2.0M of the $7.8M increase came from "higher net revenues per approval": an annual Medicare rate increase and a shift towards payers that pay more. That price-and-mix share fell to 15% of the increase in FY26, and on my arithmetic to almost nothing in Q4 FY26 [1, 8].

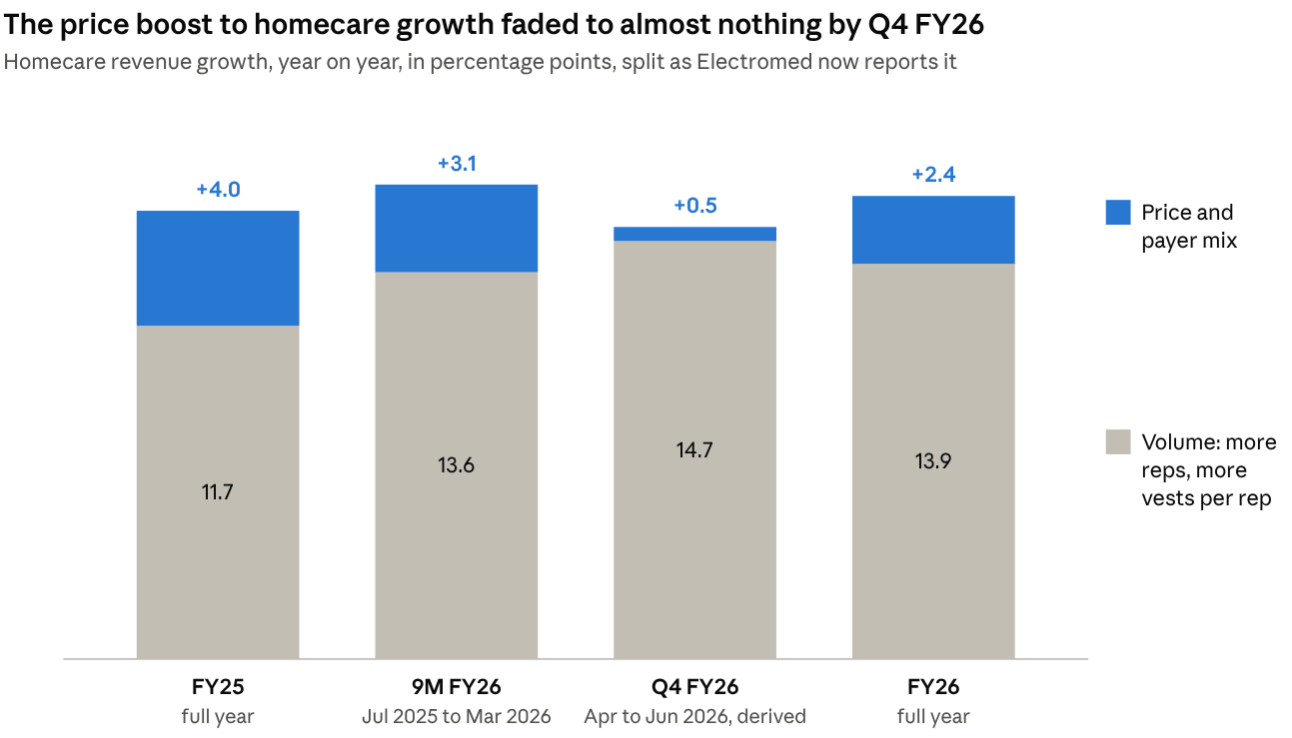


Exhibit 13. Homecare growth split into volume and price · Electromed letter to the SEC (FY25) [8]; Q3 FY26 10-Q [24]; FY26 10-K [1]. Q4 FY26 = FY26 less nine months, my derivation from rounded figures

The Q4 figure is a subtraction of two rounded company numbers, so treat it as approximate. Medicare's share of homecare revenue, including supplemental plans, rose from 45.7% to 48.1% over FY26 (Exhibit 4), and it cannot rise that fast for ever. From here, growth must come almost entirely from more patients [1].

Exhibit 14. Reps and what each one sells [1, 2, 6, 7]

Fiscal year	Homecare reps (average)	Reps at year-end	Homecare revenue per rep	Company target	Homecare growth
FY23	not compared	46	$945,000	$850,000 to $950,000	+15.6%
FY25	54	55	$1,058,000	$900,000 to $1.0M	+15.7%
FY26	58	64 direct, incl. 2 hospital liaisons	$1,145,000	$1.0M to $1.1M	+16.3%
FY27 guidance		67 territories, incl. 2 liaisons		$1.05M to $1.15M	"Double-digit" total revenue growth

Hiring keeps slipping. Management missed its rep targets three times and re-dated them rather than withdrawing them: 57 reps slipped from Q2 to Q3 FY25 and the year ended at 55. Headcount rose by six in Q4 to 64 at June 2026; the CEO said many of the new reps joined in June and will "take some time to ramp up" [6].

Three things support about 10% a year: diagnoses growing about 12% a year, Insmed's awareness spending, and more territories. However some things cut against it. The best territories are filled first. Reps call on pulmonologists, who see only about 35% of patients. And price increases are now limited to Medicare's annual inflation update [1, 7].

What would change my mind: revenue per rep below $1.05M in the first half of FY27, which would mean the new reps are ramping more slowly than I assume. Q1 FY27 results, due around 12 November, are the first read; management has said referrals historically dip in July to September (Q1 FY23 call) [6].

Debate 3. Is there a moat?

A narrow one

Electromed is winning share because it is easier to work with and not because its vest is better. That can be copied, and the company spends too little on R&D to build a product lead.

The products are close substitutes. All four suppliers' vests are billed under the same Medicare code, E0483, at the same allowable price. The 2026 CHEST guideline does not distinguish between brands and grades the evidence for vests as very low. Electromed's own annual report admits that insurers, under pressure to cut costs, are becoming more sensitive to price. In practice, the insurers decide what a vest is worth, and no supplier can charge more [1, 16].

Yet Electromed is gaining share. Its homecare revenue grew 16.3% in FY26, about twice the 8% market growth it estimates. In the June 2026 quarter its homecare sales rose 15.2% while AffloVest fell 7%, though AffloVest's fall was partly distributor destocking. Gross margin of 78.5% and return on invested capital of 22.5% say something is working [1, 14, 15].

Medicare's own data agree on size. In calendar 2024 Electromed billed 24.3% of traditional Medicare's $104M of vest spending, more than any other supplier. Philips (RespirTech) had 19.2%, Baxter (The Vest) 13.3%, and distributors, through which AffloVest is sold, 43.3%. Medicare allowed the three manufacturers and the largest distributor about the same $1,180 a month, which confirms that no one has pricing power. [27].

The clinic's routine. A pulmonology clinic that sends a prescription to Electromed gets the paperwork, the insurer approval, the delivery and the training handled. Electromed can do this because it has its own reimbursement team, agreements with insurers that cover 87% of insured Americans, an online ordering system (SmartOrder) and about 167

contract respiratory therapists who deliver the vests. Once a clinic has a routine that works, it has little reason to switch. Clinic staff decide as much as the doctor, and they value rep presence, turnaround time and ease of ordering [1].

Exhibit 15. Moat scorecard [1, 2, 16]

Source of advantage	Present?	Evidence
Product or technology	Weak	Clearway is a good product, but no battery-powered portable model; R&D is $1.3M a year (1.8% of revenue); stopped renewing patents outside the US and Mexico in 2025
Clinical evidence	No	Company-sponsored and retrospective studies only; guideline grades vest evidence very low
Scale or cost	No	Smaller than Baxter and Philips; makes the vest at one site
Pricing power	No	One billing code; payers set the price
Service clinics prefer	Yes	Handles the paperwork, insurer approval and delivery for the clinic; agreements with insurers covering 87% of insured Americans, with 40 new payer contracts in FY26; online ordering. Homecare grew about 16% in FY26, roughly twice the market, with no product advantage
Regulatory shelter	Shared	E0483 is outside Medicare competitive bidding, which protects price for all four suppliers

Who could neutralise it. Baxter and Philips already sell direct and could invest in service. Tactile could win through the distributor channel, where a portable, lighter AffloVest now has a fresh launch. A payer could change the rules for everyone, for example by adding E0483 to competitive bidding or prior authorisation; CMS added Tactile's other product category to the prior authorisation list in 2026 [28].

What I would want management to do. Three things would widen the moat. Fund an independent randomised trial in bronchiectasis that includes patients on brensocatib; it would address the weakest point in the case for vests. Add a portable vest by licence, partnership or a small acquisition. And extend the sales effort beyond pulmonology, through hospital discharge (the two liaisons are a start) and primary care. None is in the current plan, and the chief executive is leaving.

Debate 4. Are the receivables and accounting clean?

YES

Receivables are high because Medicare pays over 13 months. Electromeds judgement of how much revenue it books at shipment has held up.

The SEC looked and closed the file. In March 2026 the SEC's Division of Corporation Finance reviewed the financial statements in the FY25 10-K and asked three questions. Electromed answered within ten days, promised more disclosure, and the SEC closed its review on 1 April 2026 with no further comments [8].

Exhibit 16. What the SEC asked and what the answers revealed [8]

SEC question	Electromed's answer
How much homecare growth came from volume and how much from price?	FY25: $5.8M volume, $2.0M price, from Medicare's annual rate rise and a richer payer mix
Show the bad-debt allowance and receivables more than a year old	Allowance $45,000 with no write-offs; receivables over a year old $931,000 (Jun 2024), $430,000 (Jun 2025), $484,000 (Dec 2025)
Explain the judgements behind "variable consideration"	About 96% of FY25 homecare revenue was under capped instalments; estimates use approval rates, payment timing, termination history and patient data

Exhibit 17. Receivables in detail [1, 8, 24]

	Jun 2024	Jun 2025	Mar 2026	Jun 2026
Receivables, net ($M)	23.3	24.7	28.3	29.8
Of which more than a year old ($000)	931	430	473	514
More than a year old, % of receivables	4.0%	1.7%	1.7%	1.7%
Allowance for credit losses ($000)	45	45	45	45
Accrued insurance recoupments ($000)	467	602	850	970

Receivables rose 20.2% in FY26 against revenue growth of 15.3%, taking them from 147 to 153 days of revenue. That is still well below the 187 days of FY22 and FY23. The old-debt figure stayed flat at 1.7% of the total, so the growth is new business moving through

Medicare's 13-month cycle, which itself grew faster than other payers [1].

Receivables more than a year old more than halved during FY25, from $931,000 in June 2024 to $430,000 in June 2025, with no write-offs against the bad-debt allowance. The filings do not say whether the fall came from collecting old claims or from cutting their expected value through revenue estimates. I find this very odd. That is a question for management [1, 8].

One smaller item is rising faster than sales. Insurance recoupments roughly doubled from $467,000 in June 2024 to $970,000 in June 2026, while revenue grew about 35%. At about 1.3% of revenue the amount is small, but the trend is worth a question to management [1, 24].

Risk to note. Electromed books each vest at the total it expects to collect over the rental. If more patients die, change insurer or stop using the vest before month 13, it collects less, and has to cut revenue. The company says payment trends "have remained relatively consistent over the past five years" and that revisions to past estimates were immaterial in FY25 and FY26. The auditor treats this estimate as a critical audit matter. It is also the channel through which any Brinsupri effect on existing patients would appear first [1].

Other accounting points, none serious.

- **Tax rate.** FY26's 21.3% rate compares with 26.7% in FY25, which was inflated by a non-deductible officer pay charge that did not recur; R&D credits also helped. Stock-compensation deductions still cut the FY26 rate by 4.5 points, a benefit that shrinks if the share price falls [1, 2].
- **No non-GAAP adjustments.** Management sometimes calls items "one-time" on calls, but adjusts nothing in the reported figures [6].
- **Related-party supplier.** Electromed bought $2.27M of goods in FY26 from a supplier connected to Stephen Craney, a 7.2% shareholder; about $7.9M over FY21 to FY26. It is disclosed and pre-dates the current CEO, but it is about 14% of cost of revenue [1, 11].
- **History.** A 2021 data breach led to a class action, settled in July 2023 [2].

Debate 5. Management, succession and ownership

The operators did a good job and are leaving or selling. That is a negative signal and it raises the odds of a strategy change.

The record under Jim Cunniff (CEO since July 2023) is strong on numbers. Operating margin rose from 8.3% to 18.8% and revenue from $48.1M to $73.8M in three years. Every company-wide revenue, margin and productivity target with a due date was met. The misses were on hiring and hospital sales [1, 2].

Exhibit 18. Promises made under Cunniff and what happened

Outcome	Count	Promises
Kept	8	Double-digit growth with operating leverage in FY25 and FY26; revenue per rep above target in FY25 and FY26; "as many as 61 territories" (62 by May 2026); gross margin "mid-70s or better"; new CRM and manufacturing upgrade on time
Partly kept	3	Five more reps in the second half of FY24 (got four); "strong operating cash flow" in FY26 (fell to $9.7M); registry paper (accepted, later than promised)
Missed	4	Rep targets for September 2023, November 2023 and FY25 (57 reps, re-dated, ended at 55); hospital growth of "20% plus" in FY26 (+9.6%)
Pending	4	FY27 revenue per rep of $1.05M to $1.15M; 67 territories; double-digit FY27 growth; $10M buyback ($3.9M used)

Source: earnings calls, FY23 to FY26 [6].

Succession. Cunniff told the board on 25 August 2026 that he will retire on or about 2 April 2027 and leave the board. A search firm is looking for a successor; none is named. The Chair, Kathleen Skarvan, ran the company before him and now describes herself as retired. The shares fell more than 18% after the announcement, which came with slower Q4 growth [7, 11, 29].

A new chief executive usually brings a new plan. That could mean a bigger hiring push, an acquisition ("acquisition opportunities" is a stated growth pillar), or a sale of the company. Change-of-control terms exist: the CEO would receive one year's salary plus 100% of target bonus, and the CFO 1.5 times salary plus 150% of bonus with accelerated vesting, if either is dismissed within 12 months of a sale [7, 11].

Exhibit 19. Insider and large-holder sales since 2024 (no purchases are recorded) [30]

Date	Seller	Shares	Price	Value (est.)	Notes
Nov 2024	Kathleen Skarvan, Chair	150,000	About $28	$4.2M	Took her below 5%
Dec 2024 to Feb 2025	Summers Value Partners (Andrew Summers, director)	214,509	$27.30 to $30.80	$6.1M	Fell below 5% on 20 Feb 2025, to 4.0%

Date	Seller	Shares	Price	Value (est.)	Notes
Feb 2025	Kathleen Skarvan	76,583	$29.15 to $33.08	$2.3M	Exercised 40,000 options at $1.80; sales described as "diversification"
Sep 2025	SVP Deal Fund (Summers)	65,714	$23.68 to $26.62	$1.6M	Deal fund sold out; Summers and his main fund still hold about 3.4%
May 2026	Kathleen Skarvan	40,000	$34.36 to $37.33	$1.4M	Exercised options at $3.82
Jun 2026	Brad Nagel, CFO	11,801	$36.34 to $37.11	$0.43M	Option exercise and sale
Jun 2026	Jim Cunniff, CEO	9,700	$36.25 to $37.77	$0.36M	Eleven weeks before the retirement notice

The FY26 10-Qs and 10-K report no trading plans adopted by officers in Q2 to Q4 FY26 [1, 24].

There are 2 ways to read this. The bear reading, the two holders with the best view of the business, the former CEO and an activist who sat on the board, sold near today's price, and the current officers sold at $34 to $38. The defence, Skarvan's remaining stake is mostly cheap options and she is retired, a fund trimming a long-held winner is normal, and the officers' sales were small. Neither side can point to an insider buying.

Exhibit 20. Who owns the company [11, 30]

Holder	Stake	Notes
Stephen Craney	7.2%	Individual; connected to a related-party supplier
George Winn	6.0%	Individual; 6.1% at 30 September 2024 (13G/A filed November 2024), mostly held through a family partnership
Jim Cunniff, CEO	3.6%	307,335 shares, of which 162,255 are options
Andrew Summers, director	About 3.4%	Not standing for re-election on 13 November 2026
GAMCO, Gabelli and Teton	2.3%	Active investors
Hunter Associates	1.9%	Aggregator data
Lazard	1.1%	Aggregator data

Holder	Stake	Notes
Directors and officers together	11.0%	Including options
Vanguard	Not comparable	Vanguard Group now files 0% because, after a January 2026 realignment, its subsidiaries report separately; this is not a sale

Dilution. Staff and directors hold options over 544,315 shares, about 6.6% of the company, and all are well in the money. On 13 November shareholders vote on a new employee share plan of up to 750,000 shares (9%), on top of 721,444 shares still available under the existing plan. Share-based pay equalled 24% of FY26 profit. Buybacks have mostly just kept pace: about 78% of the shares bought back since FY21 only replaced shares issued to staff [1, 11].

Pay is reasonable but short-term. Cunniff earned $1.81M in FY26. The annual bonus pays on revenue growth and operating profit against the prior year, which rewards hiring and growth but says nothing about returns on capital or the share price. His FY27 salary is $562,432 with a 50% bonus target [11].

Valuation

At $27.85 Electromed trades well below what its cash flows are worth, but above where its peers trade. Discounted at the 10-year Treasury yield, the base-case cash flows are worth about $62 a share; with a 40% margin of safety the buy price is about $37. Peer EV/EBIT gives about $24 a share (I don't think this method is appropriate), and Electromed's own past EV/EBIT $30 to $37.

Common inputs: 8.61 million diluted shares (8,287,085 outstanding at 16 September 2026 plus in-the-money options by the treasury method); net cash $20.45M at 30 June 2026; no debt. Cash is at June and the share count at September; if the 79,078-share fall reflects buybacks, cash is about $2M lower, worth about $0.25 a share. DCF values are as at 30 June 2026 [1, 11].

Discounted cash flow

Exhibit 21. DCF assumptions

	Bear	Base	Bull
FY27 revenue growth	4%	10%	12%
FY28 to FY31 revenue growth	5%	10%	14%
FY32 to FY36 revenue growth	3.5%	6%	8%
Operating margin by FY31 (from 18.8%)	14%	19.5%	23%
Story	Brinsupri and payers trim vest demand; new reps produce less	FY27 guidance met, then reps and diagnosis growth carry it	Hiring catches up, productivity at the top of the range, operating leverage

Why these growth rates.

FY27 is built from management's own targets: 62 to 65 homecare reps each selling $1.05M to $1.15M gives homecare growth of about −2% to +12%. The base case of 10% assumes the 62 homecare reps, rising to about 64 on average, sell close to FY26's $1.145M each. That is above the middle of the guidance range, but management has beaten its sales-per-rep target in each of the last two years, and Q4 FY26 homecare still grew about 15% on volume alone. It is in line with management's "double-digit" target and below the analysts' 12.7%. The bear case of 4% assumes hiring slips and new reps sell less. The bull case of 12% assumes every rep is hired early and sells at the top of the target [1, 6, 7].

FY28 to FY31 start from the vest market, which grows about 8% a year. The base case of 10% adds about a point from Medicare's annual rate rise, which applies to roughly half of homecare, and about a point from a few new reps a year. It sits below the 12.4% ten-year average because the price-and-mix boost of FY25 and FY26 has gone. The bear case of 5% means losing share to Brinsupri, the portable AffloVest or stalled hiring, close to FY20's 4%, the weakest year of the decade. The bull case of 14% means FY25 and FY26's 15% to 17% roughly continuing [1, 2].

FY32 to FY36 move each case halfway towards the 2% long-run rate, roughly inflation, because the best territories are filled first and pulmonologists see only about 35% of patients. As a check, the base case lifts Electromed's share of the US homecare vest market from about 24% today to 26% by FY31; the bear case implies 21% and the bull case 31% [2].

How this compares with the analysts. Consensus FY27 revenue of about $83M (+12.7%) is above my bull case of 12% and my base case of $81.2M (+10%). The two published price targets, Lake Street's $47 and a second at $50, equal about 24x the operating profit those forecasts imply (my estimate), the multiple the shares reached at the June 2026 year-end. My base case is more cautious on growth but gives a higher value, about $62, because it discounts at the Treasury rate rather than applying a market multiple [26].

All cases: 25% tax; working capital absorbs 35% of each year's revenue increase (over FY22 to FY26 it absorbed about 30% in total, but about 60% in FY26 alone, when receivables, prepaid costs and a tax receivable all rose); capex exceeds depreciation by 0.5% of revenue; 2% growth after FY36. Stock compensation is treated as a cost because it sits inside operating income. I discount at the 10-year US Treasury yield, 5.21% on 13 October 2026, and allow for risk through a 40% margin of safety on the price paid rather than through a higher discount rate. A 40% margin suits a single-product micro-cap with a narrow moat [1, 2, 3].

Exhibit 22. DCF value and buy price at the 10-year Treasury yield [E]

	Bear	Base	Bull
DCF value at 5.21% (10-year Treasury, 13 Oct 2026; 2% long-run growth)	$32.97	**$61.76**	$91.32
Buy price after a 40% margin of safety	$19.78	**$37.06**	$54.79

In the base case, revenue reaches $81.2M in FY27 and $118.8M in FY31, operating income $15.4M and $23.2M, and free cash flow $8.5M and $13.0M. Long-run growth of 1.5% to 2.5% gives a base case of $56 to $70.

What the price implies. Using the same 5.21% discount rate and 2% long-run growth, $27.85 is what the shares are worth if revenue shrinks about 3% a year for the next five years at today's 18.8% margin. Electromed has grown every year for a decade, so the price assumes far less than even the bear case.

Multiples

Exhibit 23. Electromed against listed peers (peer prices at 2 October 2026; InfuSystem at 25 September)

Company	EV / sales	EV / EBITDA	EV / EBIT	P/E	Forward P/E	Operating margin	3-year revenue growth forecast
Electromed, at $27.85	2.97x	14.7x	15.8x	21.4x	19.0x	18.8%	11.8%

Company	EV / sales	EV / EBITDA	EV / EBIT	P/E	Forward P/E	Operating margin	3-year revenue growth forecast
Tactile Medical (TCMD)	1.27x	10.7x	12.7x	20.5x	18.4x	10.0%	9.5%
Viemed Healthcare (VMD)	1.16x	6.3x	13.7x	25.3x	18.4x	8.5%	14.0%
InfuSystem (INFU)	1.93x	11.4x	24.6x	31.7x	26.3x	7.9%	4.6%
Peer median	1.27x	10.7x	13.7x	25.3x	18.4x	8.5%	9.5%

Source: StockAnalysis (aggregator) [4]; Electromed multiples are my calculations. Tactile is the only direct competitor; Viemed and InfuSystem share the home-equipment, insurance-billed model. Inogen is excluded as loss-making.

I use EV/EBIT, because P/E is skewed by cash and tax. Electromed holds $20.5M of net cash, about 9% of its market value, and its tax rate fell from 26.7% to 21.3% in FY26. EV/EBITDA flatters Viemed and InfuSystem, which rent out equipment fleets and so carry heavy depreciation; Viemed is 6.3x EBITDA but 13.7x EBIT. EV/sales ignores margins, and Electromed's are more than double the peer median. EV/EBIT also matches the DCF, which is built on operating income with stock pay counted as a cost. Peer medians give about $21 a share on EV/EBITDA, $24 on EV/EBIT and $33 on P/E. **Its weakness is that it ignores growth, and Electromed's forecast 11.8% a year against 9.5% for the peers arguably deserves a premium [1, 4].**

Exhibit 24. Electromed's own valuation multiples at each fiscal year-end

	FY22	FY23	FY24	FY25	FY26	Five-year median	Today, at $27.85
Market value ($M)	82	92	130	184	350		231
P/E	35.6x	29.0x	25.3x	24.5x	31.0x	29.0x	**21.4x**
EV / EBIT	24.3x	21.2x	18.0x	17.1x	24.0x	21.2x	**15.8x**
EV / EBITDA	20.1x	18.4x	16.0x	15.3x	22.5x	18.4x	**14.7x**
EV / sales	1.74x	1.77x	2.16x	2.64x	4.52x	2.16x	**2.97x**

Source: StockAnalysis ratios at fiscal year-ends (30 June) [4]; today's figures are my calculations at $27.85.

On profit, Electromed is the cheapest it has been in five years. Today's P/E of 21.4x and EV/EBIT of 15.8x are below every year-end from FY22 to FY26. On sales it is not cheap: EV/sales of 2.97x is above every year except FY26, because margins have more than doubled since FY22. The FY22 and FY23 P/Es also flatter history, since earnings were depressed in those years. The highest year-end multiple came in June 2026, when the shares ended FY26 at $42.30 and 24x EBIT, just before guidance pointed to slower growth.

Back at the five-year median EV/EBIT of 21.2x the shares would be worth about $37; at the lowest, 17.1x, about $30. Those multiples were paid while growth was accelerating, so a full return to them is not a given [4].

Verdict

Buy. Intrinsic value about $62 a share. With a 40% margin of safety the buy price is about $37; at $27.85 the shares trade 55% below base-case value.

I discount the cash flows at the risk-free rate, and allow for risk through the price paid. For a single-product micro-cap with a narrow moat I think a 40% margin of safety is appropriate. Peer and own multiples are cross-checks.

Exhibit 25. Intrinsic value, buy price and cross-checks

	Value per share
DCF at 5.21%, base case (bear $32.97, bull $91.32)	**$61.76**
Buy price after a 40% margin of safety	**$37.06**
Cross-check: peer median EV/EBIT (13.7x) - see reasoning above for why I don't think this measure is accurate.	$24.46
Cross-check: Electromed's lowest year-end EV/EBIT, FY22 to FY26 (17.1x)	$29.94
Cross-check: Electromed's median year-end EV/EBIT, FY22 to FY26 (21.2x)	$36.55
Share price, 13 October 2026 (15.8x EV/EBIT)	$27.85

The buy price is 60% of DCF value. The cross-checks apply the EV/EBIT multiples in Exhibits 23 and 24 to FY26 operating income of $13.9M, plus net cash. All values are per diluted share (8.61 million) with net cash of $20.45M.

Why Buy. Even the bear case, with growth slowing to about 5% and margins falling to 14%, is worth $33, above today's price. This is a profitable, debt-free business growing around 10% a year in a market that someone else is paying to expand. **Its EV/EBIT of 15.8x is the lowest in five years. The SEC review removed one accounting worry. And with the CEO leaving, a sale of the company is a real option.**

Concerns. Near term, FY27 guidance points to slower growth, the price-and-mix tailwind has gone, a new chief executive must keep up the execution, and insiders have sold about $16.4M of stock since November 2024 without buying [7, 30].

Exhibit 26. What a buyer might pay

Basis	Multiple	Value per share
Tactile's AffloVest deal, 2021	4.7x sales (5.6x with the earn-out paid)	$42.66 to $50.36
A typical takeover premium on today's price	30% to 50%	$36.21 to $41.78
Hill-Rom's Advanced Respiratory deal, 2003	1.8x sales (2.3x with full contingent)	$17.80 to $22.09

Source: Exhibit 7 deal multiples [12, 17] applied to FY26 revenue of $73.8M, plus net cash of $20.45M, per diluted share. The 30% to 50% premium range is my assumption.

Takeout potential. A sale is a real possibility, but not my base case. The timing fits: the chief executive retires around 2 April 2027, so the board must choose between a new leader and a buyer, and change-of-control terms for the CEO and CFO are already in place. Electromed is a small, single-product, debt-free business with a 78.5% gross margin in a market of only four suppliers, and at 15.8x EV/EBIT it is the cheapest it has been in five years. The obvious buyer is Tactile, which already paid 4.7x to 5.6x sales for AffloVest and sells mainly through distributors, so Electromed's direct reimbursement model would complement it. Against that, Electromed has been independent since 1992, there is no sign of a sale process, and management talks about buying, not selling. A deal with Baxter or Philips would cut the market from four suppliers to three and would likely face antitrust scrutiny [7, 11].

Potential price. A buyer paying the AffloVest multiple would value Electromed at about $43 to $50 a share; a typical 30% to 50% premium on today's price gives $36 to $42. The 2003 deal's 1.8x to 2.3x sales would be below today's price, but that was a much smaller business 23 years ago. My estimate of a realistic takeover price is about $40 to $45 a share.

Risks

All of the risks below matter. Some come from outside the company: payers, Medicare and competing products could change how many vests are prescribed or what each one earns. Others come from inside it: slower growth as new reps ramp up, and a new chief executive who has to keep up the execution. Any one of them could cut the cash flows the valuation rests on, or keep the shares priced like their peers rather than closer to their cash-flow value.

Exhibit 27. Risks and their early warning signs [1, 25, 28]

Risk	Severity	Likelihood	First place it would show
Payers require Brinsupri before a vest	High	Low	Commercial insurers' medical policies for E0483, Electromed commentary on denials
Vests added to Medicare competitive bidding or prior authorisation	High	Low	CMS annual list updates; DME contractor notices (CMS did this to Tactile's lymphedema pumps in 2026)
Federal health-budget cuts	Medium	Low	Medicare fee schedule; the 2025 budget law's Medicaid changes, which the 10-K flags
Weak CEO successor or strategy drift	Medium	Medium	The appointment announcement; first 100-day plan
FY27 growth below 5%	Medium	Medium	Revenue per rep below $1.05M; average reps not rising above 62
Portable AffloVest takes referrals	Medium	Medium	Tactile's AffloVest growth recovering in late 2026 while Electromed slows
Plant or supplier disruption	Medium	Low	One manufacturing site; a related-party supplier is about 14% of cost of revenue
Cuts to past revenue estimates	Medium	Low	Prior-period revisions in the 10-Q revenue note
Dilution from the ESPP and options	Low	High	750,000-share ESPP vote on 13 November 2026

Catalysts and what to watch

The next six months decide most of this thesis: two quarters of FY27 results, a new chief executive and the first Brinsupri data that could show an effect on vests.

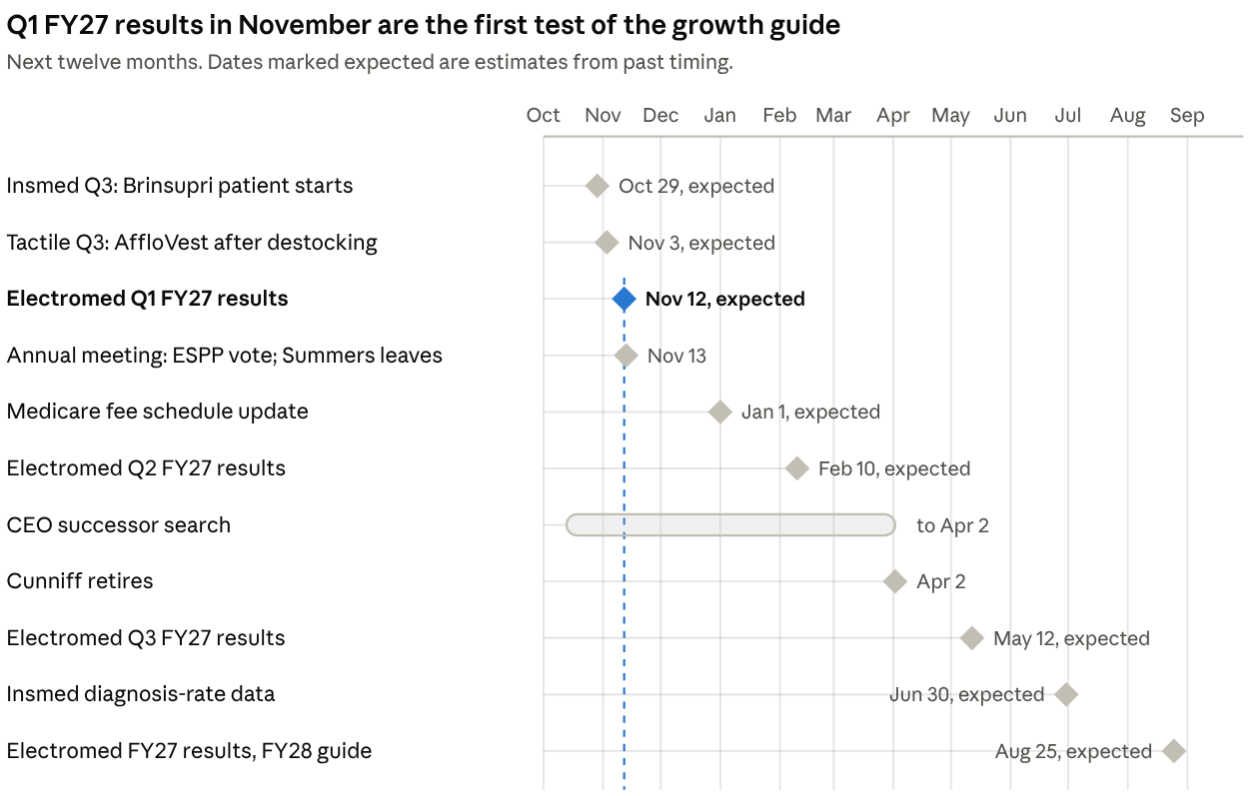


Exhibit 28. Catalyst calendar · annual meeting and retirement dates from the 2026 proxy [11] and 8-K [7]; other dates estimated from past timing

What to look for at each.

- **Q1 FY27 results.** Homecare growth and its split between volume and price; average reps against 62; revenue per rep against $1.05M to $1.15M; receivables more than a year old; how many shares were bought back after the price fell. Management has said referrals historically dip in July to September, so judge it against Q1 FY26's 12.7% homecare growth [6].
- **Insmed's Q3.** Whether new patient starts hold at about 7,000 a quarter and whether Insmed mentions airway clearance for the first time [10].
- **Tactile's Q3.** Whether AffloVest returns to growth after distributor destocking, which Tactile expects to last through Q3 before ordering normalises in Q4. A strong recovery would mean the portable vest is taking share [15].
- **The annual meeting.** The vote on the 750,000-share employee share purchase plan, and the board shrinking to seven as Andrew Summers leaves [11].
- **The successor.** Background, ownership requirement and first stated priorities. A buyer-friendly appointment, or a plan to acquire, would change the valuation range.
- **Medicare's January fee update.** It sets the price for the year; any change to the E0483 policy or prior-authorisation lists would matter more than the rate itself.

Appendix A. Channel-check plan

No primary research has been done for this report. The Brinsupri question will be answered in clinics before it shows in Electromed's filings, so this is the work I would do next. About 30 conversations over three to four weeks would be enough.

Exhibit 29. Who to call and what to ask

Who	What to ask	What would worry me
Lung specialists at busy bronchiectasis clinics, including heavy Brinsupri prescribers	Do you prescribe the drug and a vest together? Has the drug changed when, or whether, you prescribe a vest? Which vest brand do you use, and why?	"I try the pill first and see" becoming common
Clinic nurses and staff who place vest orders	Which supplier is easiest to work with? How long from order to delivery? Any change in denials this year?	Electromed losing its service edge; AffloVest gaining through local distributors
Respiratory therapists who set patients up at home (Electromed's contractors and others)	Are patients on Brinsupri still using their vests? Has early return or drop-out changed?	Drug-treated patients stopping vests mid-rental
Former Electromed sales reps and reimbursement staff	How long does a new rep take to reach full productivity? How good are the newest territories? Why do reps leave?	Ramp times longer than a year; high turnover
Respiratory home equipment distributors	How is the new AffloVest selling? Is distributor inventory back to normal?	A strong AffloVest recovery in late 2026
The analysts covering the stock (Lake Street, B. Riley, Titan Partners, Freedom Broker)	What do your models assume for FY27 reps and productivity?	Consensus above my 10%

Alongside the calls, three desk checks:

- **The top 10 insurers' published vest policies.** Do any mention brensocatib, require prior authorisation or add steps? Any step-therapy language would worry me. A first check in October 2026 found that none of the five largest insurers mentions Brinsupri [25].

- **Patient groups and forums, such as the Bronchiectasis and NTM Association (ongoing).** Do patients use both treatments, or stop the vest after starting the drug? Patients describing the drug as a replacement would worry me.
- **Medicare's public data on equipment spending by supplier, filtered to code E0483** (data.cms.gov). Calendar 2024 is done (Debate 3); earlier years would show whether Electromed's share is rising [27].

Note on the analysts: Kyle Bauser, who covered Electromed at Roth Capital, appeared on the August 2026 earnings call as an analyst at Titan Partners [6].

Appendix B. Questions for management

I asked for a call with management in October 2026. The company's investor relations firm, ICR, declined because Electromed is in its quiet period before Q1 FY27 results, and offered a call after them. These are the questions I would ask. All concern strategy and public information [5].

Brinsupri

1. Do you see any difference in vest referrals or approvals between practices that prescribe Brinsupri heavily and those that do not?
2. Have any commercial insurers asked for a trial of the drug before approving a vest?
3. Have early terminations of capped rentals changed since August 2025?

Market size

4. Your estimate of diagnosed US bronchiectasis patients rose from 824,000 (November 2024) to 923,000 (August 2025) to about 1 million (FY26 10-K). How much is new diagnosis, and how much is a change in method or claims coding?
5. Insmed uses about 500,000 diagnosed patients. Why the gap, and which figure should investors use for the vest?
6. Of the roughly 800,000 untreated patients, how many would meet Medicare's coverage criteria for a vest?
7. Why did the FY26 10-K drop the $245M market estimate, and is the 8% market growth measured in units or dollars, including price?
8. You estimated your share at about 19% in 2022, while Medicare's 2024 data puts you at 24% of traditional Medicare vest spending. What is your share today, and is it rising faster with Medicare than with commercial payers?

Growth

9. How long does a new rep take to reach $1M of annual revenue, and how productive are the territories added in FY26 compared with older ones?

10. Why guide revenue per rep below FY26's $1,145,000 while also guiding to double-digit growth?
11. What share of FY26 referrals came from outside pulmonology, and what do the two hospital liaisons add?
12. How much did price and payer mix add to homecare growth in Q4 FY26, and how much does FY27 guidance assume?
13. Hospital revenue grew 9.6% in FY26 against a target of "20% plus". What held it back, and what is the FY27 target?

Payers and accounting

14. How do you set the expected termination rate in the revenue estimate, and how often is it updated?
15. Receivables more than a year old fell from $931,000 to $430,000 in FY25 with no write-offs. How much was collected, and how much was removed by lowering the revenue estimate?
16. The amount you set aside for insurers taking back past payments rose every quarter in FY26, from $602,000 to $970,000. Which insurers are doing this, and why? Does it come out of revenue? And why does the 10-K still say payment patterns have been consistent?
17. The FY26 10-K shows "Other" revenue of $421,000, down 34.7%, and international sales of $421,000, up from $248,000. Are these the same line, and what is in each?
18. What share of revenue comes from Medicaid, and how exposed is it to the 2025 budget law changes flagged in the 10-K?

Product and moat

19. Is a battery-powered portable vest on the roadmap, and would you consider a licence or acquisition to get one?
20. Would the board fund an independent randomised trial of HFCWO in bronchiectasis, including patients on brensocatib?

Succession and capital

21. What profile is the board looking for in the next chief executive, and will the new CEO be required to own shares?
22. What is the board looking to acquire?
23. Why is a 750,000-share employee share purchase plan needed alongside 721,444 shares still available under the 2023 plan?

Appendix C. Data tables and sources

Data cut-off: 13 October 2026. Fiscal years end 30 June.

Exhibit 30. Ten-year financial summary ($M unless stated)

	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26
Revenue	23.0	25.9	28.7	31.3	32.5	35.8	41.7	48.1	54.7	64.0	73.8
Revenue growth		12%	11%	9%	4%	10%	17%	15%	14%	17%	15%
Gross margin	77.7%	79.5%	79.6%	76.2%	77.6%	76.4%	75.5%	76.0%	76.3%	78.1%	78.5%
Operating income	3.1	3.6	3.0	2.8	5.1	3.1	3.0	4.0	6.6	9.7	13.9
Operating margin	13.5%	13.8%	10.5%	9.0%	15.8%	8.8%	7.1%	8.3%	12.0%	15.1%	18.8%
Net income	2.2	2.2	1.9	2.0	4.2	2.4	2.3	3.2	5.2	7.5	11.3
Diluted EPS ($)	0.27	0.26	0.22	0.23	0.47	0.27	0.26	0.36	0.58	0.85	1.30
Diluted shares (M)	8.25	8.46	8.62	8.63	8.83	8.91	8.77	8.70	8.87	8.91	8.69
Operating cash flow	2.2	1.2	2.4	2.6	4.2	3.1	-0.7	1.3	9.1	11.4	9.7
Free cash flow	1.6	0.5	1.9	1.2	3.2	2.6	-2.2	-0.4	8.7	11.1	8.4
Stock-based compensation	0.2	0.5	0.9	0.9	0.9	1.0	1.0	0.7	1.7	3.1	2.7
Buybacks	0	0	0	0	0	1.1	1.4	0.2	0.3	10.0	3.9
Cash at year-end	5.1	5.6	7.5	7.8	10.5	11.9	8.2	7.4	16.1	15.3	20.5
Debt	1.2	1.1	1.1	0	0	0	0	0	0	0	0

Source: each year's 10-K as first reported [1, 2]. FY18 was later restated for the new revenue standard; FY20 operating income includes $0.9M of pandemic relief income.

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Numbers in square brackets refer to this list. Figures without a number are my own calculations or estimates.

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