

Acadia Healthcare: Where Should the Next Growth Dollar Go?

Internal ID: S&F-STR-025

Topic: Growth Strategy, Mergers & Acquisitions, Operations Strategy

Industry: Health Care Facilities

Source: Strategy & Finance

Publication date: 5 October 2026

License: Not specified

Decision setting: October 3, 2026

Information cutoff: October 3, 2026, end of day U.S. Eastern

Acadia Healthcare had added 322 beds during the first half of 2026 and said it was still ramping occupancy at facilities opened in recent years. At the same time, its second-quarter same-facility revenue was nearly flat, even as admissions and patient days increased. Management lowered its fiscal 2026 capital-spending outlook and raised its operating-cash-flow forecast. The public data did not show whether newer sites were meeting their operating plans or what the next beds would cost to open and staff. [C1, MD&A pp. 24-30; C2, Ex. 99.1 pp. 1, 4]

Imagine you are advising Acadia on a hypothetical October capital-planning discussion. What rule should govern the next growth-capital tranche: add capacity through de novo or joint-venture facilities and existing-site expansions; concentrate on ramping recent openings and selectively adding beds at current facilities; or preserve more balance-sheet flexibility? The question is prospective. Acadia had not published a fiscal 2027 budget, a project pipeline, or a fixed cash ceiling, and it had not disclosed a labor or occupancy bottleneck.

A growing behavioral-health operator

Acadia is a holding company whose subsidiaries own and operate inpatient psychiatric, specialty, comprehensive treatment center (CTC), residential and outpatient facilities. At June 30, 2026, the network included 279 facilities and approximately 12,600 beds in 40 states and Puerto Rico. Its stated growth routes include existing-facility expansions, joint ventures, de novo facilities, acquisitions and expansion across the continuum of care. [C1, cover p. 1, Note 1 p. 5, MD&A p. 24]

In the first half, Acadia added 42 beds to existing facilities and 280 through one wholly owned and three joint-venture facilities; it also opened two CTCs. Management said it continued to ramp occupancy at facilities opened over the prior few years. The company did not report occupancy, staffed beds, contribution margin or capital cost for the recent-facility cohort. Licensed beds therefore cannot be read as staffed or occupied capacity, and the additions cannot be converted into a return estimate from the available disclosure. [C1, MD&A p. 24; C2, Ex. 99.1 pp. 1-3]

Q2 signals are mixed

Second-quarter revenue was \$865.8 million, down 0.4% from a year earlier. Acadia also presented 2.8% growth after removing specified prior-period state supplemental-payment amounts. Same-facility revenue declined 0.1%; patient days increased 0.8%, admissions rose 6.4%, and revenue per patient day declined 0.8%. Same-facility measures exclude facilities operating less than one year, acquisitions and disposals, and corporate general and administrative costs. They do not reveal the performance of newer openings. [C1, MD&A pp. 25-26; C2, Ex. 99.1 pp. 1-2]

The issuer's supplemental-payment disclosures do not reconcile cleanly. For Q2 2025, Acadia reported \$65.6 million of Tennessee program revenue, including \$48.7 million for prior-period services. In its H1 discussion, the 10-Q separately said \$65.6 million of H1 2025 program revenue included \$34.4 million for prior services. Do not combine these figures into a single normalized first-half bridge; the allocation remains unreconciled in the public disclosures. [C1, MD&A pp. 25, 27; C2, Ex. 99.1 p. 2]

Service-line performance also differed. Q2 acute-care revenue was \$494.6 million and reported flat; specialty revenue was \$133.5 million, down 8.4%; CTC revenue was \$141.2 million, flat; and residential treatment revenue was \$96.5 million, up 11.6%. The company attributed the specialty decline partly to Pennsylvania facilities and closures after Q2 2025. These consolidated service-line figures do not identify site-level returns or where incremental beds would be most productive. [C2, Ex. 99.1 pp. 2-3]

Capital and cash-flow outlook

First-half capital expenditures were \$115.1 million: \$34.9 million for routine or maintenance spending and \$80.2 million for expansion. In July, management reduced fiscal 2026 capex guidance from \$255-\$280 million to \$235-\$255 million and increased operating-cash-flow guidance from \$285-\$325 million to \$350-\$400 million. The company says the forecast excludes future acquisitions, transaction costs and nonrecurring legal-settlement expenses. These are management forecasts, not a disclosed fiscal 2027 commitment or a site-level project budget. [C1, cash-flow statement p. 4, MD&A pp. 29-30; C2, Ex. 99.1 p. 4]

First-half operating cash flow was \$223.6 million, compared with \$145.0 million in the prior-year period. Management attributed the increase primarily to insurance proceeds for the 2019 Securities Litigation, higher receipts from state supplemental-payment programs and working-capital or other-liability changes. The company did not quantify each driver in that explanation. The first-half total is not a recurring cash-generation run rate. [C1, MD&A p. 29]

At June 30, cash was \$171.3 million and \$669.8 million was available under the \$1.0 billion revolving facility. Net leverage under the credit agreement was 4.1x, and Acadia reported covenant compliance. The maximum leverage covenant was 5.0x, with a step-up to 5.5x for a four-quarter period after a qualifying material acquisition, available up to three times under the agreement. Credit-agreement leverage is a contractual measure; revolver availability is not cash. These disclosures make balance-sheet flexibility relevant but do not establish a binding constraint. [C1, Note 12 p. 13, MD&A p. 30; C2, Ex. 99.1 p. 3]

Costs and uncertainty

Medicaid represented 62.4% of Q2 revenue. Acadia discussed possible effects of federal and state changes to Medicaid coverage and payment arrangements. Management did not expect an initial material impact from work requirements, primarily because many patients it serves are exempt, while also warning that the law could negatively affect performance. This is a management expectation, not a measured outcome or facility-level sensitivity analysis. [C1, MD&A pp. 23-24, 28]

Q2 operating expenses included a \$28.6 million unfavorable professional-liability and general-liability (PLGL) reserve adjustment for expected settlements of certain 2025 policy-year claims. The adjustment was an expense included in reported Adjusted EBITDA; the filing did not identify it as a cash payment or quantify payment timing. It is separate from other pending legal matters. [C1, MD&A pp. 26-27; C2, Ex. 99.1 pp. 1-2]

On September 25, the company disclosed a proposed settlement of shareholder derivative actions. The proposed terms included a \$12 million payment to Acadia by defendants' insurance carriers, \$4.75 million of fees and expenses payable by Acadia, and governance reforms. The court had preliminarily approved the proposal, but a hearing was scheduled for December 10; the settlement was not final at the cutoff. The proposed insurer payment and company-paid fees should be kept separate, not netted or treated as current operating cash. [C4, Ex. 99.1 §§V.1, V.4, printed pp. 11-12]

Separately, CTC subsidiary Fashion Valley faced a May 12 jury verdict of \$35 million compensatory and \$70 million punitive damages in a former-employee retaliation case. Acadia said the parent was not a party, denied the claims, considered the award far above comparable-case precedent, and planned post-trial motions and an appeal. The verdict was disputed and unresolved at the cutoff. No cash payment or insurance recovery was disclosed. [C1, Note 8, pp. 11-12]

The decision

What policy should Acadia use for its next growth-capital tranche? Consider three paths:

1. **Continue expansion:** maintain a growth posture through de novo and joint-venture facilities and existing-site bed additions, subject to project-level evidence.
2. **Prioritize ramp and selective additions:** emphasize occupancy and operating progress at recent openings, then add capacity at existing sites where evidence supports it.
3. **Preserve balance-sheet flexibility:** make fewer new commitments while reimbursement, cash-flow and facility-level economics become clearer.

The alternatives may be combined or sequenced. Recommend a decision rule and evidence gates, not an invented dollar allocation. Acadia had not disclosed facility-level occupancy, staffed beds, project capex, ramp curves, JV economics, site contribution margins, a corporate return hurdle or a fiscal 2027 capital budget.

Discussion questions

- What do admissions, patient days and revenue per patient day show-and what remains unknown about utilization and returns?
- How should you treat the unreconciled state supplemental-payment allocations?

- What additional site and cohort data would distinguish new-capacity performance from same-facility trends?
- How should the revised capex and cash-flow outlook inform the decision without becoming a project budget or cash ceiling?
- What evidence would cause you to continue, pause or redirect commitments?

Source notes

- **C1:** Acadia Healthcare Company, Inc., Q2 2026 Form 10-Q, filed July 28, 2026; accession 0001193125-26-321076. [SEC filing](#)
- **C2:** Acadia Q2 2026 results Form 8-K and furnished exhibits, filed July 28, 2026; accession 0001437749-26-024693. [SEC filing](#)
- **C4:** Acadia Sept. 25, 2026 Form 8-K and proposed settlement exhibits; accession 0001437749-26-031225. [SEC filing](#)