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Lucid Diagnostics

Third Quarterly Update Conference Call and Webcast

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PRESENTATION

Operator

Greetings, and welcome to Lucid Diagnostics' Third Quarterly Update Conference Call and Webcast.

As a reminder, this conference is being recorded.

It is now my pleasure to introduce your host, Mr. Adrian Miller, Vice President of Investor Relations. Thank you. You may begin.

Adrian Miller

Thank you, Operator. Good afternoon, everyone.

This is Adrian Miller, Vice President of Investor Relations at Lucid Diagnostics. Thank you for participating in today's business update call.

Joining me today on the call are Dr. Lishan Aklog, Chairman and Chief Executive Officer of Lucid Diagnostics, along with Dennis McGrath, Chief Financial Officer of Lucid Diagnostics.

The press release announcing our business update and financial results will be available shortly on Lucid's website. Please take a moment to read the disclaimer about the forward-looking statements in the press release. The business update press release and this conference call both include forward-looking

statements, and these forward-looking statements are subject to known and unknown risks and uncertainties that may cause actual results to differ materially from statements made.

Factors that could cause actual results to differ are described in the disclaimer and in our filings with the Securities and Exchange Commission. For a list and description of these and other important risks and uncertainties that may affect future operations, see Part I Item 1A entitled Risk Factors in Lucid's most recent annual report on Form 10-K filed with the SEC and any subsequent updates filed in the quarterly report on Form 10-Q and any subsequent Forms 8-K.

Except as required by law, Lucid disclaims any intentions or obligations to publicly update or revise any forward-looking statements to reflect changes in expectations or in events, conditions or circumstances on which these expectations may be based or that may affect the likelihood of actual results will differ from those contained in the forward-looking statements.

With that said, I would like to turn the call over to Lishan Aklog.

Dr. Aklog.

Lishan Aklog

Thank you, Adrian.

Thanks, everyone, and welcome to our quarterly call. I'd like to first start by thanking our long-term shareholders for their ongoing support and commitment.

As we discussed at our last quarterly call, we had some recent transformational milestones that we put behind us and the team is now for this past quarter and moving forward and just intensely focused on executing on our long-term strategy that we are very satisfied with the solid results that they've delivered over this past quarter and are really particularly proud that they did so well under budget for the quarter and the year as we can be able to keep a close eye on some cash preservation.

I will note that for the first time, we've changed the format here and moving from truly an audio conference call to a webcast. We did so in response to feedback, including one of our long-term patent investors suggested that this would be more useful and we look forward to ongoing feedback to make sure that we are providing the type of transparent communications that we have always aspired to.

Let me start with some quarterly highlights. EsoGuard testing volume has increased 28% sequentially quarter to quarter and 436% annually to 1,088 tests performed in the third quarter and we're happy that we've gratified that we've cleared that 1,000 tests per quarter milestone. We now have 13 with the test centers that are operating in 11 states and three more are due to open during this quarter.

The satellite LTC activity, a concept that we introduced on our last call and I'll describe more in detail later, has been increasing rapidly and now includes about 22% of the patients undergoing the EsoGuard testing.

Our laboratory LucidDx Labs, is operating independently with enhanced quality and efficiency metrics in our view. We're starting to receive payments and recognizing revenue on EsoGuard claims that were submitted under LucidDx Labs starting in August.

We have clinical utility studies to support private and public payer reimbursement that are underway. We completed the transfer of EsoCheck to a high volume manufacturer. As I mentioned, we're executing on

our growth strategy while continuing to focus on conserving cash and are running well ahead of our budget for both the full year and for this past quarter.

Recent introduction for those of you who are just learning about our Company. Lucid Diagnostics is a commercial stage cancer prevention medical diagnostic company. We're focused on early pre-cancer detection in the tens of millions of patients with gastroesophageal reflux disease or chronic heartburn who are at risk of developing highly lethal gastroesophageal cancer. Our mission is to prevent these deaths from these cancers and at risk patients with chronic heartburn.

Esophageal cancer is highly lethal and is becoming more prevalent, about 16,000 patients die every year, you can see on the far right there. We've had a 500% increase in the circumstances over the last few decades and it remains the second most lethal cancer with an 80% overall private mortality.

The key statistics on this slide, however, is that the staged one mortality rate of five years is 40%, unlike most other nearly all other common cancer like colon cancer and breast cancer where stage one diagnosis is actually a victory. Because of this, early pre-cancer detection is really necessary to prevent these deaths. Unfortunately, less than 5% of those who have been recommended for screening for over a decade have historically undergone endoscopy.

List of Lucid's products include two products EsoGuard, our esophageal DNA test and our EsoCheck cell collection device and they are the first and only commercially available tests capable of serving as a widespread screening tool to prevent these deaths through the early detection of the esophageal pre-cancer. In a sense, they are merely missing clinic to establishing a viable cancer prevention program for this particular type of cancer.

We're really excited and we have previously announced this that the society guidelines from the major Gastroenterology Society now recommend EsoCheck in conjunction with EsoGuard as an acceptable alternative to endoscopy, and the further updates also no longer consider having symptomatic heartburn as a mandatory prerequisite, which has significantly expanded the population of patients and candidates who are EsoGuard testing.

The commercial opportunity here is very, very large as I mentioned the target population because of the updated guidelines of now 30 million patients who represent patients who are at risk, who have chronic heartburn and are recommended for screening. I should note that this increase does not include the elimination of the need for GERD symptoms in the American Gastroenterology Association guidelines, but does reflect an expansion to include an unequivocal recommendation of limit.

Medicare payment has been established at $1,938, resulting in a very large multibillion dollar market opportunity and an over 90% estimated growth cross margin and volume.

Our sales strategy includes targeting primary care physicians at the specialties and institutions. The specialists include gastroenterologists, (inaudible) surgeons and doctors, as well as institutions, large practices, hospitals and so forth. These two channels are somewhat different and now when we talk to, small PCP practices, our goal is to get them to EsoGuard test.

However, with those specialties and institutions, we're looking to have them build an EsoGuard program, and by making the case that by bringing more patients with—detecting more patients with the esophageal pre-cancer, that will create downstream revenue opportunities for more endoscopy of patients pH monitoring another testing.

They also have somewhat different low counts. The PCP referred patients are sent to a one of our Lucid test centers where one of our Lucid nurse practitioners performs the EsoCheck cell collection procedure.

With the practices and institutions, there are two options. We have some practices and institutions where their own nurse and nurse practitioner or physician assistant performs the test after we have trained them. But as I mentioned at the beginning, we're also increasingly utilizing our own nurse practitioners who are able to perform the cell collection procedure at a particular practice, typically allocating a day or so where patients are teed up for that day. We had situations where up to a dozen patients have been set up for other practitioners to perform this test. We're looking forward to continuing to expand this.

We have established rigorous, (phon) robust compliance program around this, and there are a couple of states where we have some limitations, California and Florida being two, but we're figuring out ways to work around both the compliance and the regulation challenges in those states or satellite test centers.

Lucid test centers are current that we've established are not just physical locations where nurse practitioners could perform testing, but they also tend to be a sort of centers around which a lot of educational programs targeting patients as well as the physicians are centred.

The economics of our test centers are very attractive, as I've mentioned many times before. We won't go through all of the numbers today, but the bottom line is that we can cover the fixed cost of the personnel as well as the location by performing two reimburse procedures per week.

As I noted in the beginning, we continue to show steady growth in EsoGuard testing volume, 1,088 tests performed in the third quarter, which represents a 28% increase from the second quarter and a 435% increase from the third quarter of 2021. I've described this as a mid-throttle (phon) strategy where we are deploying sufficient resources to get good steady growth, but not going full throttle until we have more predictable reimbursement which we hope to see in the coming quarters.

Like this growth has been driven by a variety of factors, we have increased our personnel, as I'll show in the next slide. We've also dramatically improved our sales training and really data driven sales processes and we're now steadily as we grow in our team at developing increased experience. Although I will note that the median rep has only been in the field for a month or two and we look forward to continuing to extract improved performance from our existing team through increased experience in the field.

We are starting to track the testing volume by referral source and by operator. We're still optimizing the tracking and recording of both of these, and so these are generally rough numbers, but you can see that approximately half of the patients—just under half the patients right now are being referred by piece individual or small PCP practices and the remainder are coming from specialists or institutions.

As I noted earlier, the performance of the test is being done in a variety of settings, including our own nurse practitioners and LTC or the satellite LTC, as well as the physician practices, but the important thing to note and then the important trend from the last quarter on this slide is that 22% of the tests performed in the fourth quarter were in that satellite LTC model where our nurse practitioners are collocating with adequate physician practice to perform tests on patients I referred from that practice and we expect this to continue to—it's clearly making an impact now, and we expect it to be a growth driver moving forward.

This slide shows the expansion of our sales team. I've showed this in previous slides. You can see we were making good steady progression month to month at expanding our team. We have 37 sales professionals across the full spectrum of sales reps on the way to sales leadership. Our target where we intend to plateau for the near term is that 58. We would look to complete that by the end of this year, but likely we've set target by the early part of the first quarter of 2023.

Our plan, as we've described before is at that point to pause both the expansion of our sales team as well as the expansion of our test centers and continue through 2023 while we're establishing more predictable

reimbursement by allowing the team to continue to grow volume through the measures and the effects that I described earlier.

I previously mentioned, we now have Lucid test centers located in—we have 13 centers located in 11 states. You can see them here. A couple of notes, we did have a center in Seattle, which we paused as the regulatory hurdles with regard to managing nurse practitioner there. I became bit a cumbersome and we'll go back there at a different point, but we thought it would be better allocation of our resources elsewhere.

Since our last announcement, we added a center in Chicago, that's very much recent opening. You can see there in Illinois and we continue, as we described previously, we're shooting for an additional three centers by the end of this year, and we're on a good path to do so.

Let me talk a little bit about our laboratory operations. We're really quite proud of the progress that we've made. If you may recall, Lucid Diagnostics Lab or LucidDx Labs was live in February of this year and we've been gradually working our way and now I can probably say that we've transitioned to being fully independent with our own personal performing all aspects of the test and one in the laboratory.

You can see here that we've extracted substantial efficiencies. I won't go through all the details here, but I just thought I'd highlight a few, that our ability to extract the DNA from the sample as it arrives has improved in multiple parameters there. You can see by substantial amounts and we're actually garnering more DNA per sample, which has an impact on the performance of the test and even very somewhat obscure aspect of the test by self like conversion phase, which is a critical step that has been incredibly time consuming and costly.

You can see that the team in just a couple of months has dramatically decreased the time and resources that go into that, and that bodes well for our decreasing the overall cost, and there are opportunities to continue to extract efficiencies and cost savings through a variety of needs, including automation. The team is also from a really important patient and physician phasing point of view has been able to get the turnaround times down. You can see when we took over the lab, times increased as there were some growing pains in the early couple of months. But now we've decreased the turnaround time to six days, which is a record for us.

I'll talk a little bit about our reimbursement strategy and where we are with that. If you look at the upper left, you can see that our payer mix for the balance of test that are performed to date skew heavily towards private payers, with Medicare and Medicaid only representing about 11%. That is really important as we look at the near-term opportunities for securing reimbursement from private payers versus Medicare and as it relates to the local coverage determination for Medicare.

A quick update on that, really we do have a lot of news. The Multi X group, which is reviewing the local coverage determination comments that occurred in the second quarter of the year that included us and about a dozen other entities that commented on a draft of foundational LCD. They are still working on that on it that. We haven't heard any response to that.

Although we did have a call with them, but we weren't allowed to talk about the local coverage determination, but we did have a call with the team to discuss our plan for collecting the type of clinical utility data that will be required to translate a final foundational LCD into an actual coverage of tribulation for EsoGuard at the appropriate time, and those conversations were quite fruitful and productive.

On the private payer side, you see that we are steadily working our way through from the lower hanging fruit, which are the secondary PPOs are from preferred payroll organizations through increasing lives covered all the way to national plans. The key factor, and we continue to have ongoing discussions with

private payers with medical directors and so forth, remains as with the Medicare side with collecting clinical utility data, and I'll talk a little bit more about that later. But our plan to do so we've been vetting that through both retired and existing medical directors of multiple plans, and we believe we're in a position to start collecting that data in a way that we should start being able to start securing the plan further down on this chart here, and it's security networks for that.

Claim processes, as we discussed last quarter, we just completed in August the transition to our new revenue cycle management partner, which is the entity that submits claims on our behalf and then goes through the entire claims, a process including a variety of adjudications and so forth, ultimately, leading to payment or denial. That process was launched in August of this year, beginning part of August, and we have several thousand claims that we have been holding. These are claims that started all the way back to February when we took over the laboratory clear certificate and we're able for the first time to theoretically build on our own behalf, and we did start through filling once the revenues cycle management partner was in place in August.

We are to this and how it works just a little bit of a primer on that at once we build taken the payer private pay directly, and the direct payment can be out of network as a percentage of charge of bill typically so out of network rate, or if we're in that work on that particular payer paid at a contract to create. If the payment is denied, there is an opportunity to appeal and to secure payment after the appeal before or final denial. This process is important obviously for securing payment, but it's also extremely important for the entire reimbursement process. I've described as many times that in order to actually have meaningful conversations with the larger payers, you actually have to generate a claims history where claims are being submitted, denied, paid, appealed and so forth, and we were looking forward to starting to now that we have all the elements in place starting to build up those claims history. We can start having a substantive conversations to be in their work on these various plans that are shown on the slide.

We did, as I said, we started submitting these payments in the second quarter. We did start to see some payments. They include a few in network payments, but the majority of them are out of network payments that were worthy payer paid us typically at a 50% to 60% standard part of network benefit rate, resulting in payments of about $1,200 to $1,300, which is gratifying because these payments do reflect the full list price that we charge the payer.

We don't really have enough data yet to know what percentage of the claims submitted will get paid, and we need another couple of quarters to get a better picture of that, but we look forward to tracking that closely over the next couple of quarters to give you a better sense as to how we'll do from out of network payments as we are waiting going in network and securing the network contracts.

As I've mentioned several times, the key factor for our securing reimbursement is establishing clinical utility. If you look at the clinical studies that are currently active, we've talked about this over several quarters that we substantially shifted our own internal resources from the performance studies that we had launched earlier, B1 and B2, two clinical utility studies but I won't go through these in detail, but these are coming along.

We are starting to enroll patients in them. We have at the retrospective study from the NYU that has 700s of patients that should start generating data quite soon and we're hopeful by the mid-part of next year to have substantial meaningful amount of corporate utility that to engage private payers on.

As I mentioned previously, we made the strategic decision to pause the screening portion of the performance studies of the E1 study until such time that we have better predictability and, frankly, an improved asset. Since we transferred the test to our personnel, we have been making significant strides with regard to improving the asset itself, and so we're going to keep that on hold for now. We're continuing to enrol in the case control study and expect to do so for the next couple of quarters, and once

we close that out, that will be a nice piece of performing data that will supplement the excellent data that we currently have from the Science Translational Medicine Paper from a couple of years ago.

As I mentioned again, even for this study, we're benefiting from the fact that we have delayed things a bit for cost control and cash preparation purposes because we're continuing to improve the asset and will be subjecting the samples collected to the best version of the assets.

There are a lot of other studies out there. On the far right, you can see that other investigators are initiating, whether they'd be ongoing national cancer institute studies, American (inaudible) Society, DA and others, and we're really excited as those studies continue to enroll and generate positive data from these.

Finally, and before handing it over to Dennis, just a quick comment about our manufacturing. This was a long process. Want to commend our team for completing, but it's a very technical process of transferring and manufacturing form of our EsoCheck. So collection device to a high volume manufacturer at coastline, but manufacture the device that began there in October of this year just last month of this kind of a company that headquartered in San Diego with plants in T1 and Mexico, will have a median impact by moving to the high volume provider of decreasing our per unit manufacturing cost of EsoCheck by about 60% and also the capacity with just the initial line will go to about 20,000 units a year, but what's really important with regard to this transfer is that we have fully scalable capacity at this facility by we can just add additional lines as demand dictates upward of million devices a year. Really, really unlimited for the near term.

With that, I'll pass it on to Dennis to talk about our financials.

Dennis McGrath

Thanks, Lishan, and good evening, everyone.

Our summary financial results for the third quarter were reported in our press release that was published earlier today, and on the next three slides I'll emphasize a few key highlights from the quarter, but I encourage you to consider those remarks in the context of the full disclosures covered in our quarterly report on Form 10-Q that was filed with the SEC earlier today and is also available on our website.

You see the balance sheet in front of us, cash between the quarters sequentially decreased by $5.7 million. Our vendor payables decreased by $2.2 million when considering not only accounts payable that's reflected there, but other recurring accrued expenses. It is offset by inner company debt to the current company PAVmed of $4.2 million increase. However, both boards have agreed that that could be settled up in stock in the coming weeks.

We have a committed equity facility as you're aware of the $50 million of possibility of stock issuances. We did during the quarter record $1.8 million of proceeds, most of which we had already reported to you as part of our update in August. Our shares outstanding included unvested restricted stock awards as of today is 39.1 million shares. We are now S3 eligible as previewed with you previously and similar to what we have done at PAVmed, the Lucid Board considers it's good governance to have a shelf registration with the embedded ATM on file with the SEC, and we plan to do so in due course.

You see our P&L in front of us. Slide 20 here compares this year's third quarter to last year's third quarter on certain key items. I'll trust you'll review the information of my comments in light of the cautionary disclosure that's probably hard to read on the slide, but at the bottom of the slide, and provides supplemental information, particularly about non-GAAP information.

The revenue for the quarter reflects 39 tests at an average payment rate of $1,945 per test. The rate is slightly higher than the Medicare rate of $1,938 as we received one payment closer to ASD of $2,499 than the Medicare rate and that skewed things slightly higher. The prior year reflects the fixed monthly fee received from the third party lab that we used before setting up our own lab earlier this year.

Just a comment on revenue recognition that's consistent with our past discussions. The key determinant in revenue recognition is the probability of collection for the vast majority of patient out of network claim submissions. This means revenue recognition occurs when the claim is actually collected versus when the patient report is invoiced and submitted for reimbursement.

As you'll see in our 10-Q, this is called variable consideration in the jargon of GAAP's ASC 606 for revenue recognition guidelines, and presently there is insufficient predictive data to recognize revenue when invoiced. That will occur in time as contracts start to come on board and the probability of what we invoice gets collected, we will shift to recognizing revenue when it is invoiced.

Our GAAP and our non-GAAP loss for the third quarter of this year is fairly flat sequentially. Our non-GAAP loss per share is $0.28 for the third quarter and was also a loss of $0.28 per share in the previous quarter in the second quarter.

On Slide 21 is a graphic illustration of our operating expenses presented in detail in our press release. The total non-GAAP Opex was relatively flat sequentially. The cost of revenue primarily consists of EsoCheck devices, lab supplies, and fixed lab facility costs, and is now being presented in our 10-Q as an operating expense, consistent with the practices of other diagnostic companies.

Sales and marketing was relatively flat sequentially and G&A decreased by 35%, primarily related to the allocation of almost a million dollars of lab costs in the prior quarter. As you'll recall, there was no revenue recognized in that quarter, and therefore the typical cost of revenue type expenses are required to be reclassified in the G&A. Then R&D, consistent with Lishan's comments already, decreased sequentially by 22%.

With that, Operator, let's open it up for questions.

Operator

Thank you. Our first question is from the line of Mike Matson with Needham and Company. Please proceed with your question.

Mike Matson

Yes, thanks. Hi.

I guess just doing some rough math on the test centers and some of the numbers you guys gave, I think that it's about 240 tests of the 1,088 were at the test centers that spot you have 13 centers that's about by my math, 18 to 19 per center in the quarter, about 1.5 per week. Does that sound right, and maybe you can just comment on kind of what you've seen at the centers that are, I know some of them are newer? Maybe the ones that have been running longer, what kind of volumes you've seen there on a weekly or monthly basis?

Lishan Aklog

Let me make a couple comments on them, Mike, and then I'll let Dennis to chime in.

One thing is I did give one to give a caveat that the numbers on that slide is a pie chart was but those were still kind of improving our sort of tracking ability to understand test that come through ultimately to the lab who the referring physician was and who actually performed the procedure. We're trying to capture that.

I see, we haven't actually broken that down, and I'd be a little bit careful to sort of confirm your extrapolation there, and I'll ask Dennis to chime in if you'd like. But you didn't know one thing, which is that we had test centers in Arizona that have been in place for over a year that are quite a bit busier than we have some that have just been getting off the ground as we've accelerated growth in over the last couple of months.

I don't think yet to have the kind of data which I think you're seeking, which is sort of what is the productivity of the center, but I just again want to remind you and everyone that is not sort of a set like a same-store concept. The test centers are just like the bottoming lab. They're just where the tests are performed. Ultimately, I do think the more useful information which I think will capture some of the trends that you're trying to seek here, Mike, is the breakdown between primary care physician referrals and referrals coming from institutions that are trying to build their own program, and right now that number has been bouncing between about 50-50 between the two of them.

I do want to be cautious in terms of not to get ahead of ourselves in terms of the kinds of extrapolations for looking for. But hopefully qualitatively that gives you a bit of a sense.

Dennis, did you want anything to that?

Dennis McGrath

Yes, I would say that although that math is probably something that all of us want to ultimately do the chunkiness of, yet percentage doesn't lead to the predictive value that's needed for future forecasting of what these test centers can result, some because of the newness of how long some have been operating, but we're still pretty early in the game to be able to put trend lines to that.

(Multiple speakers).

Lishan Aklog

One of challenges, I will just add to that, Mike, that that we even have some locations where we have specialty practices. We have a gastroenterological practice that's building their own test program, but it's more convenient for them if they have a Lucid test center in the vicinity is more convenient for them to send those patients to our test center. We're still kind of grappling in sort of a three dimensional matrix here about who the operators is, who the referral is, where it's actually being performed to try to capture that data in a way that's useful to understand more of the underlying substantive issues here with going to referral patterns and so forth.

Mike Matson

Okay. Thanks. I mean, the volume number looks pretty good, the 1,088. Just wondering, the backlog you obviously have gone a fair number. I don't know what the number is up on my head, but test to date to just started doing them and a lot of them obviously haven't been paid for but, yet at least so, do you have any feel for—have any of them got to the point where, it is sort of a right off where you got to that when you put that little flow chart up there where you kind of got that final denial stage, or are all of them still kind of potentially that I can see?

Lishan Aklog

Just to give you a sense about how early we are in this process. So you're right, if you kind of total the number of tests that have been performed, you include Q3, Q2 and I believe then the right of half of Q1. Here you're talking several that over 2,000 tests and tests have been performed in claims that need to be—that have been or need to be submitted and work their way through the process. As you mentioned, that process just started in August. We're just starting to see an initial trickle of payments and an initial denial.

I don't believe we've seen any final denial that we are quite sure we haven't because that would be quite early, for a claim that was submitted in August. We've got, as I said, we've been paid on a few, in the second quarter. Test claims that were submitted in August got paid before the end of September, but the majority of them are still working their way through the system. We don't have really a numerator, much less of the development, on the number that would lead to final denial that will take us a reasonable period of time to find that way.

Mike Matson

Yes. Okay. That makes sense. I guess I forgot how early it was in the process. The ones that have been paid what are those all coming from a single insurer? Are they coming, have you gotten actually gotten to be able to get paid from multiple insurers at this point?

Lishan Aklog

Yes. It's from multiple insurers. We don't have the numbers yet. Again, it wouldn't really be meaningful to give you the numbers yet, but no. no, it's not a single pair. We were getting them and as I mentioned, the most gratifying thing is that they're respecting the list price, not even the Medicare price, but the list of targets that we submit and are paying that at a standard kind of 50% to 60% out of network payment with an average payment around $1,200 to $1,300. Yes, but I think we really need a little bit of time to see how that holds in terms of the price, in terms of the number of payers that are paying out of network and, frankly, ultimately for the near term, a useful metric that we're really looking forward to get our head around, which is the percentage of the total plan submitted that eventually they get paid out a network, that'll be an important number for us in the near term as we're trying to walk down a long-term contracts in (inaudible).

Mike Matson

Okay, great. Thank you.

Lishan Aklog

Thank you.

Operator

Thank you. Our next question is from the line of Ross Osborn with Cantor Fitzgerald. Please proceed with your question.

Lishan Aklog

Good evening, Ross.

Ross Osborn

Hi, guys. Congrats on the progress.

Starting off, just given last quarter's update that guidelines now include women. Can you describe how the female population performed during the quarter and how you plan to drive awareness going forward?

Lishan Aklog

We don't have a breakdown by gender yet, but I think qualitatively we're seeing men and women and sort of the proportions that you might see. I don't have a number to report to you, but we'll get a couple of things that we're noting again, do your qualitative that we are getting patients that are consistent with sort of guidelines.

We're not we're not getting the patients where someone's referring a 15-year old without—a 21-year old without GERD that we consider far removed from qualifying for guidelines. It really does appear that the patients who qualify based on the respectful guidelines is our typical patient, which again bodes well for us in our conversations with the payers, as they're seeing patients who where they believe it's not medically indicated based on guidelines would be difficult. I don't have hard numbers for you, but I think the ratio between men and women is consistent with what we would expect from the broader population.

Ross Osborn

Okay. Now that makes sense. Again I was thinking about next year as you continue to expand geographically, do you expect any staffing headwinds with getting nursing practitioners in your testing centers, and if so, what are you doing to mitigate these risks ahead of broader commercialization?

Lishan Aklog

I'm glad you asked that question. It has a good opportunity for me to reiterate what our plan actually is.

Our plan is not to continue to grow the test centers, the nurse practitioner group or the sales team through the year. Our plan previously articulated was to get to a level by the end of this year with 16 test centers and nurse practitioners sufficient to cover those test centers as well as 58 sales personnel. Those 58 target will leak a bit into the first quarter of next year, but that we maintain that as sort of our plan; and in the context of our kind of strategic assessment and cash preservation mode, we believe that we'll be able to continue to show steady kind of mid-throttle test volume growth with that team as they get more experience in the field and become individually more productive.

We may reassess that into the year depending on sort of how some of these numbers play out with regard to reimbursement about a network payments and so forth. We're not ruling out the possibility that we could pivot from that stance; but given our current stance where we're very much focused on resource utilization and cash preparation, we're looking to keep those plateau.

Now, we still have a ways to go on both of those. The answer to your question is that, I think I said this before, we've been very gratified despite the challenges with the workforce labor shortages and workforce limitations and our ability to recruit both nurse practitioners and sales personnel. That always takes time. It takes time to interview. We're very picky. We have a very fair robust process. We don't just require people without a very extensive process where they interviewed literally half a dozen people or more. It takes time, but we've been able to secure high caliber candidates that will work, and that's true awesome guess.

Ross Osborn

Sounds great. Thank you for taking my questions.

Lishan Aklog

Thanks, Ross.

Operator

Thank you. Our next question is from the line of Kyle Mikson with Canaccord. Please proceed with your question.

Lishan Aklog

Hi, Kyle.

Alex

Hi, this is Alex (Inaudible) for Kyle Mikson.

Lishan Aklog

Hi, Alex.

Alex

Hi. Great quarter, guys. Just had a couple of questions for you.

I guess a good place to start would be on the new high volume manufacturer coastline, I was wondering if you could dive into this a little bit. More specifically, were you feeling a bit capacity constrained before, or is this more so just a pre-emptive measure prior to ramping up the business and this potentially becoming an issue in the future. Thank you.

Lishan Aklog

It's absolutely the latter. We were just planning ahead. We knew it take a while. It took about a year, honestly, there were a variety of delays. It's not a trivial thing to take a small batch manufacturer line and move it towards to a high volume manufacturer where these lines are easily reproducible and you could rapidly escalate a capacity over time.

Our team, led by Catherine Howard, do a great job of working their way through that, but it was all anticipatory. We haven't shut down the small volume manufacturing, because it's always a good idea to have dual sourcing because of a variety of—you never know what issues can arise, but this is just planning ahead for a future volume.

Alex

Got it. I know this is looking a little bit short for our ahead, but just thinking about 2023, can you provide us any color on, like possibly like a revenue breakdown by customer type or any trends that you're seeing at the end of this year, possibly that could be going into next year, it would be helpful. Thank you.

Lishan Aklog

I think the only trends, and I'll let Dennis to answer, the only trends are really the ones we talked about were clearly are getting some out of network payments. We're getting paid at that 50% to 60% through the $1200, $1500 dollar level. Here we're working through generating claims histories.

We're getting good quarter-on-quarter mid-throttle growth, but translating that into sort of predictable revenue projections, it was going to take us several more quarters. We can get a sense as to what are out of network, what portion of the claim submitted will get paid out of network and how we're progressing with regard to using our clinical utility data to secure in network contracts.

I'm quite sure Dennis will concur with some just leaving it at that. I don't think we have anything more we can provide.

Dennis McGrath

No, that's exactly right to predict the value is what we're striving for, and we just don't have that as of yet.

Alex

Got it. Thank you very much.

Lishan Aklog

Great. Thanks, Alex.

Operator

Thank you. Our next question is from the line of Ed Woo with Ascendiant Capital. Please proceed with your question.

Edward Woo

Yes, congratulations on all the progress.

Have you noticed any significant either increases or decreases in either nurse practitioners or medical supplies or any input costs or office space? Thank you.

Lishan Aklog

Yes. Inflationary pressures, no, inflation is out there, I think, we've generally had both whether sales reps or the bulk of our team are to be a well-paid professionals; but certainly in terms of our budgeting and our targeted expenses for personnel; or even for supplies, we've had supply chain issues which we've described before where we've had to work around challenges with regard to supply chain; but in terms of the—from a cost point of view, they are there, but it hasn't had a significant impact on our business with moving forward.

Dennis, would you agree with that?

Dennis McGrath

Yes, I agree. And the inflationary pressure for the delivery side of our test centers is not as sensitive, given the margin level of the next patient coming in the door in that test. Even if salaries or rents did creep up as a percentage of the total revenue opportunity for us, it's still a small portion.

Edward Woo

Great. Well, thank you for answering my questions, and I wish you guys good luck. Thank you.

Lishan Aklog

Thanks, Ed.

Dennis McGrath

Ed Woo, I thank you.

Lishan Aklog

Operator, do you have any more questions?

Operator

There are no further questions at this time.

Lishan Aklog

Okay. With that, I'd like to thank all of you for taking the time and listening to our update today. Hopefully, you found the webcast portion of this useful and informative. We look forward to any feedback that you might have and we look forward to having you keep up with abreast with our progress through our news releases and periodic calls such as this.

Also feel free to reach out to us, sign up for email alerts, either Investor Relations website and on social media as well, and you can always contact us through Adrian Miller, our VP of Investor Relations, at akm@PAVmed.com.

Thank you again, and have a great evening.

Operator

This concludes today's teleconference. You may disconnect your lines at this time. Thank you for your participation.