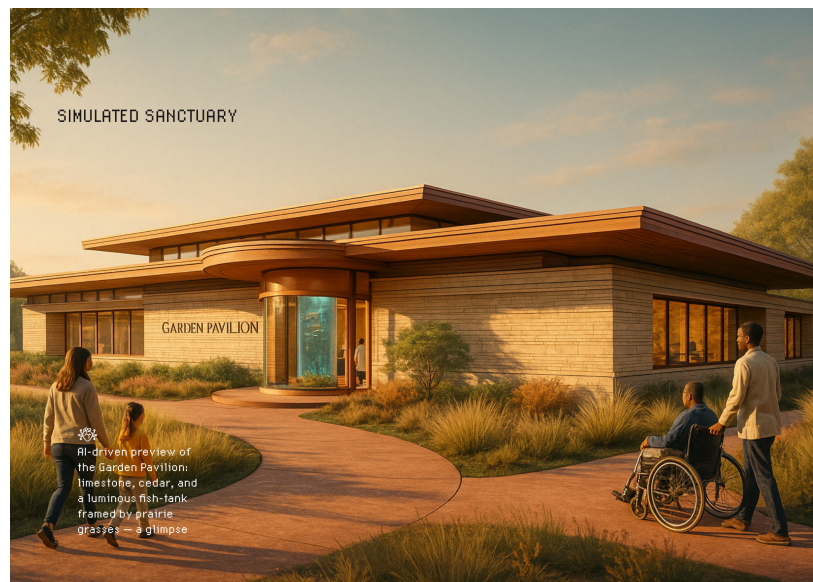


South Florida Special Care Dental Clinic

A place to receive ordinary dental care

A case for support and feasibility review

Version 2.6 | Edward R. Kirsh, DDS | September 2026



Garden Pavillon concept study, July 2025. The drawings communicate design intent only; final architecture, clinical scope, permissions, and specifications remain subject to Phase 0 review.

"This clinic is the practice I have wanted to build my whole career-the place where I can finally tell these patients and their families: come here, and come back every six months, like everyone else does." - Edward R. Kirsh, DDS

The proposal



Garden Pavillon concept study: a single-level, accessible clinic organized around generous circulation. Illustrative only; Phase 0 will determine the site-specific program.

We propose an independent nonprofit dental clinic serving people of any age whose medical, physical, or cognitive condition makes ordinary dental care unworkable.

The clinic would combine four capabilities that rarely exist together:

1. **Accessible dental treatment rooms.** Patients could walk in, transfer with assistance, or remain safely in their own wheelchairs.
2. **Unhurried special-care appointments.** The schedule would allow the additional time needed for positioning, communication, medical review, treatment, and room turnover.
3. **Appropriately permitted office-based sedation.** Nitrous oxide, oral sedation, and IV moderate sedation could be provided when clinically appropriate by qualified professionals in an equipped, inspected treatment environment.
4. **Clinicians trained for medically complex patients.** Recruitment and clinical standards would emphasize hospital dentistry, special care dentistry, and the judgment required to know which patients can

be treated safely in the clinic and which require a hospital or qualified outpatient facility.

The clinic is not intended to reproduce a hospital operating room. Patients whose condition or treatment needs require general anesthesia or hospital-level medical support would be treated through formal relationships with hospitals or qualified outpatient facilities. Dentists treating patients at those facilities would obtain the credentials and privileges required by each institution.

Office-based deep sedation would not be promised as an opening service. It could be considered only after review by the board, clinical advisory committee, legal counsel, insurers, and applicable regulators, and only with the required permit holder, facility, personnel, monitoring, recovery, and emergency capabilities.

Why an ordinary dental office cannot simply accommodate these patients



Garden Pavillon concept study: a universal bay and wide circulation illustrate the additional space required for adaptive care.

The first obstacle is physical. A conventional operatory is designed around a dental chair fixed in the center of a small room. Once cabinetry and equipment are installed, there may be no safe turning or working space for a wheelchair, transfer device, caregiver, and clinical team.

The second obstacle is time. A conventional practice depends on relatively short appointments. Special-care dentistry may require additional time to position a patient safely, review medical risks, communicate with a patient or decision-maker, manage anxiety or movement, and disinfect a larger set of surfaces and equipment.

The third obstacle is clinical preparation. Equipment makes access possible; it does not make treatment safe. Clinicians must understand how conditions such as respiratory compromise, seizure disorders, anticoagulation, aspiration risk, autonomic dysreflexia, immunosuppression, and polypharmacy affect dental treatment.

The clinic therefore begins with a different operating premise: the room, schedule, equipment, and clinical team are designed around the patient rather than asking the patient to fit an ordinary practice.

What care would look like



Garden Pavillon concept study: light, visibility, and a calm treatment environment. Equipment and configuration remain subject to clinical and regulatory review.

Most patients would receive routine preventive and restorative dentistry while awake. Some would benefit from communication support, desensitization visits, additional positioning assistance, nitrous oxide, or oral sedation. Appropriately selected patients could receive IV moderate sedation under the required professional permit and facility protocols.

The initial clinical pathway would be straightforward:

Level of need	Expected setting
Routine care with accessible positioning and communication support	Clinic
Nitrous oxide, oral sedation, or appropriately permitted IV moderate sedation	Clinic

Level of need	Expected setting
Deep sedation or general anesthesia requiring higher-acuity support	Affiliated hospital or qualified outpatient facility

The final scope of office-based sedation would be approved only after the feasibility phase establishes the applicable Florida requirements, staffing model, emergency protocols, insurance coverage, referral arrangements, and financial implications.

A source of training and continuing education



Garden Pavillon concept study: an approachable clinical environment that can support patient care, practitioner training, and continuing education.

The clinic's primary obligation would be excellent, dependable care for its own patients. It would also serve as a source of training and continuing education for dental practitioners in the community.

That supporting role could include:

- Continuing education for dentists and dental teams
- Observational or supervised clinical experience when staffing and patient care allow
- Practical training that helps general dentists incorporate appropriate special-needs patients into their daily practices

The clinic would make this education available as a community resource. Because participation will depend on practitioner interest, the plan does not assume a fixed number of participants or rely on training revenue in the base case.

What success would mean

The present financial model estimates that a five-operatory pilot could serve approximately 1,900 people annually by Year 3. This is a planning estimate to be validated during feasibility, not a promise made in advance of evidence. No practitioner-training target is assumed.

The board would adopt a public impact scorecard before opening. Proposed measures include:

- People establishing an ongoing source of dental care
- Median time from referral to first completed treatment
- Percentage of patients completing a comprehensive treatment plan
- Percentage maintained on an appropriate recall schedule
- Emergency dental episodes and hospital referrals
- Teeth preserved rather than extracted where clinically measurable
- Patients successfully treated with the least intensive appropriate sedation
- Patient and caregiver experience
- Training, continuing education, and practitioner support provided to the community
- Cost per person served and philanthropic cost per person served

Results would be reported to the founding benefactor and published annually. The pilot's larger purpose is to create credible clinical, operating, and financial evidence that can support future replication.

A disciplined first step



Garden Pavillon concept study. Phase 0 will translate this design language into a feasible site, room program, and capital budget.

The immediate request is not to fund construction. It is to determine, professionally and independently, whether the clinic should be built and under what conditions.

Founding feasibility commitment: \$250,000

This initial commitment would fund a defined Phase 0 process. Before larger capital is requested, it would produce:

1. An incorporated nonprofit organization or approved fiscal-sponsorship structure
2. An independent governing board and clinical advisory committee
3. A professional feasibility and local-demand study
4. A documented referral pipeline and community-partner assessment
5. Validation of payer mix, collection assumptions, and contracted reimbursement
6. A board-approved scope for office-based sedation
7. Hospital and outpatient referral and credentialing pathways
8. A site comparison and preliminary letter of intent
9. A validated lease-versus-acquisition recommendation
10. Updated capital, operating, fundraising, and implementation plans

The result would be a clear go, revise, or stop decision. If the evidence does not support proceeding, no construction commitment would be sought.

Proposed Phase 0 budget

Use	Planning allocation
Independent feasibility, market, and referral analysis	\$55,000
Healthcare, nonprofit, and regulatory counsel	\$40,000
Site, architectural, and engineering assessment	\$35,000
Financial-model validation and payer research	\$25,000
Nonprofit formation, fiscal sponsorship, insurance, and governance	\$20,000
Interim project management and clinical planning	\$60,000
Contingency	\$15,000
Total	\$250,000

The final allocations would be approved by the independent board and documented in the restricted-gift agreement.

Governance before growth

The clinic would be governed independently from its founder. A majority-independent board would include experience in finance, nonprofit governance, healthcare, clinical dentistry, and the disability community.

Before capital is committed, the organization would adopt conflict-of-interest, compensation, gift-acceptance, financial-control, and clinical-quality policies. Material expenditures would require documented approval and, where appropriate, competitive proposals.

The model includes an operating allowance for leadership, but no compensation is promised to the founder or any individual. The base case assumes **\$0 in pre-opening leadership compensation**; any payment before opening requires separate approval by the independent board using comparability data and conflict-of-interest procedures. The board would determine:

- The organizational structure and division of responsibilities
- Whether executive and clinical leadership are combined or separate
- The timing and scope of each position

- Market-based compensation using appropriate comparability data
- Performance expectations and annual review

Any founder considered for a paid role would disclose the conflict, leave the discussion, abstain, and meet the same accountability standards as any other executive.

Financial candor

Special-care dentistry costs more to deliver than conventional dentistry because appointments are longer, staffing is more intensive, and reimbursement does not reflect the full cost of care.

The current planning model estimates that, by Year 3, fees earned from patient care could cover approximately 55 percent of operating expenses. Annual grants and community fundraising could increase total operating coverage to approximately 78 percent, leaving a structural gap of approximately \$557,000 under the current leased-facility scenario.

These figures are intentionally presented as estimates requiring validation. The most consequential assumptions include the actual patient and payer mix, collections under a sliding scale, reimbursement terms, achievable appointment volume, staffing requirements, and the final scope of sedation services.

The feasibility phase would test those assumptions before a facility commitment is made. Future benefactor materials would distinguish clearly among:

- Earned-income coverage
- Annual philanthropic support raised by the organization
- The remaining structural funding gap

The long-term objective is not to claim that fees alone will support the clinic. It is to establish a transparent, diversified model in which earned revenue, annual philanthropy, institutional grants, in-kind support, and potentially an endowment collectively sustain the mission.

Protection of the founding commitment

The restricted-gift agreement for Phase 0 should provide that:

- Funds may be used only for the approved feasibility scope and budget.
- Progress and expenditures are reported at agreed intervals.

- Material changes require board approval and notice to the benefactor.
- Professional findings are provided directly to the board.
- No construction or property commitment is authorized by the Phase 0 gift alone.
- Uncommitted funds are returnable if the board decides not to proceed, subject to the final agreement.

The founding benefactor may be offered appropriate recognition, anonymity, or an advisory relationship. Governance authority, fiduciary responsibility, clinical judgment, and compensation decisions would remain with the independent board.

The invitation

This project begins with a modest but consequential question:

Can South Florida create a sustainable place where patients with disabilities and medical complexity receive continuing dental care before preventable disease becomes a crisis?

The clinical need is visible. The proposed solution is practical. What remains is to test local demand, operating assumptions, regulatory requirements, partnerships, and site economics with professional independence.

The requested \$250,000 founding feasibility commitment would answer those questions before substantially greater capital is placed at risk.

The next step is a working conversation-not a request for an immediate decision. We welcome the prospective benefactor and their advisors to examine the concept, challenge its assumptions, and help shape a disciplined feasibility process.

Discussion materials available upon request

- Detailed business plan and clinical model
- Three-year financial model with adjustable assumptions
- Population and appointment-capacity framework
- Preliminary facility and accessibility concepts
- Proposed feasibility scope and restricted-gift structure

Planning draft for private discussion. Financial, legal, credentialing, anesthesia, licensure, and facility assumptions remain subject to independent professional review and board approval.

Seeing the clinic

The concept is easier to understand when the building, treatment environment, and adaptive equipment are seen together. These images show the intended experience rather than a finalized architectural or equipment specification.



Arrival lounge: generous circulation, caregiver space, and a calming focal point.



Single-level organization: clear movement between arrival, treatment, recovery, and support spaces.



Universal treatment bay: room for mobility equipment, staff, and safe positioning.



Sensory-considerate environment: controlled light, sound, and visual complexity.

Garden Pavillon concept study, July 2025. Illustrative design language only.

What accessibility changes in practice

For some patients, access depends on eliminating a difficult or unsafe transfer. A larger universal bay, mobile delivery equipment, and wheelchair-positioning technology allow the clinical team to work around the patient while preserving dignity and safety.



Reference equipment: a wheelchair tilt platform can position some patients without transferring them to a conventional dental chair.

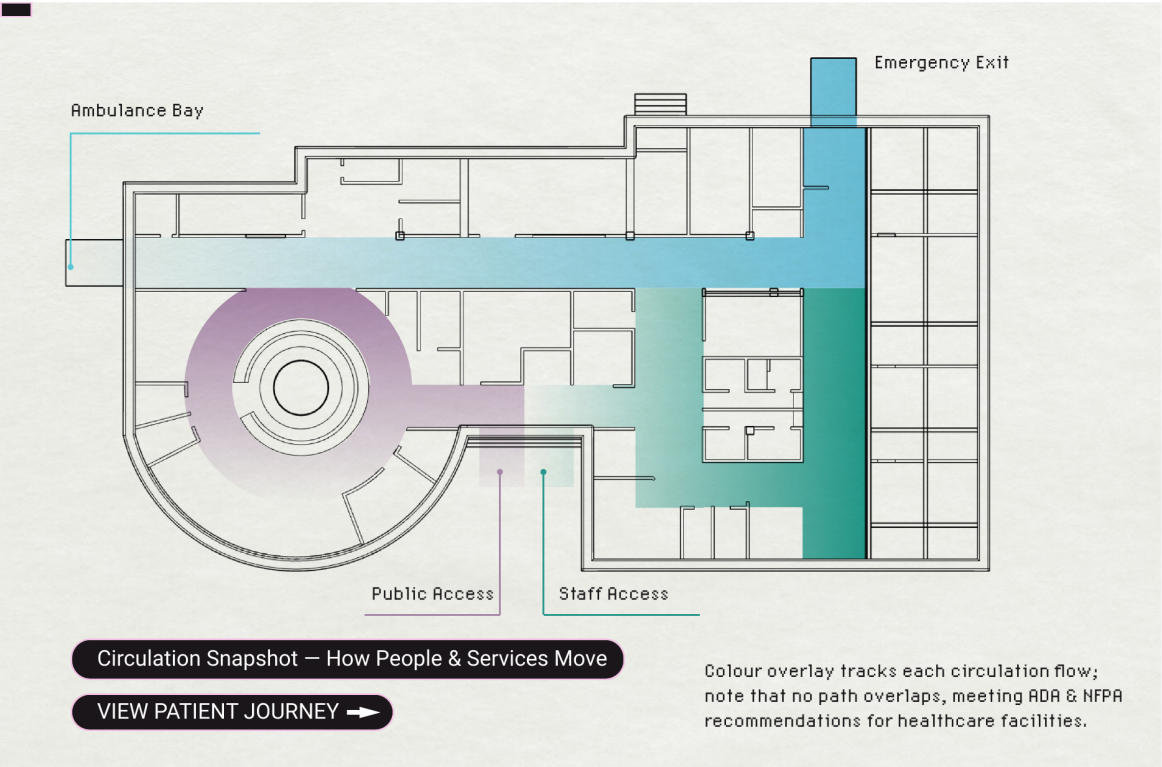


Reference care setting: mobile dental equipment can bring treatment to a patient who remains safely supported in a wheelchair.

Equipment photographs are reference images supplied for planning discussion. Manufacturer, configuration, clinical suitability, licensing, and publication permissions must be confirmed before purchase or public use.

A patient journey with less friction

A special-care clinic needs more than accessible rooms. The route through the building should reduce confusion, avoid unnecessary transfers, and leave enough space for patients, caregivers, equipment, and the clinical team to move safely.



Conceptual circulation study. Routes, room locations, emergency access, and all code requirements remain subject to feasibility review and final architectural design.

Public arrival A clear route from entrance to reception and treatment.	Clinical movement Generous circulation for wheelchairs, caregivers, mobile equipment, and staff.	Safety planning Distinct staff, service, and emergency pathways to be tested during feasibility.
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Inside the adaptive treatment environment

These perspectives help translate the care model into physical space: adaptable bays, room around mobility equipment, clear sightlines, and sufficient working clearance for clinicians and caregivers.



Conceptual treatment-bay study. Equipment, bay count, sedation capability, and room configuration are illustrative and will be established through clinical, regulatory, and architectural review.



Conceptual overall plan showing the relationship between arrival, support, and treatment areas. It is not a final building program or construction plan.

Financial and feasibility summary

The current model is a planning tool, not a promise of performance. Its purpose is to expose the assumptions that Phase 0 must test before a facility commitment is made.

Planning measure	Year 1	Year 2	Year 3
People served	463	1,361	1,898
Earned revenue	\$382,012	\$939,886	\$1,423,298
Annual fundraising	\$260,000	\$430,000	\$600,000
Operating expense	\$1,499,076	\$2,070,887	\$2,579,955
Earned-income coverage	25%	45%	55%
Coverage after fundraising	43%	66%	78%
Remaining structural gap	\$857,064	\$701,000	\$556,657

The first commitment

The immediate opportunity is a restricted \$250,000 feasibility commitment. Construction and property acquisition are outside this initial authorization. The board will approve the final Phase 0 budget and will receive the professional findings directly.

Questions Phase 0 must answer

- How many patients can be documented through local referral partners, and how quickly can the first 250 be enrolled?
- Which services can be provided safely and sustainably in the clinic, including the precise scope of IV moderate and deep sedation?
- Which patients should be referred to hospitals or qualified outpatient facilities, and what credentials and privileges will treating dentists require?
- What are the actual payer mix, contracted rates, patient collections, appointment lengths, and staffing requirements?
- Should the pilot lease or acquire a facility, and what site-specific capital budget follows from that choice?

Supporting model

A separate Excel workbook accompanies this document. It contains the adjustable assumptions, procedure-level revenue model, startup budget, three-year operating projections, funding milestones, and sensitivity analysis. An independent accountant should review it during Phase 0.

Clinical and legal note

Florida anesthesia requirements arise principally under section 466.017, Florida Statutes, and Chapter 64B5-14, Florida Administrative Code. Deep sedation and general anesthesia share a permit category and require specific personnel, equipment, monitoring, recovery, and emergency capabilities. The final clinical scope must be established with Florida healthcare counsel, the Board of Dentistry, insurers, qualified anesthesia professionals, and the governing board.



Garden Pavillon concept study: barrier-free circulation and a universal treatment bay. Illustrative only; final use and permissions must be confirmed.

Review materials and sources

Detailed sources and assumptions are maintained in the accompanying financial model and original technical plan. Principal authorities and evidence categories include:

- Florida Statutes section 466.017 and Florida Administrative Code Chapter 64B5-14 (dental anesthesia and sedation).
- Florida Medicaid dental coverage and contracted-plan reimbursement schedules.
- Medicare dental exclusions and medically necessary dental-service rules.
- U.S. Census Bureau and CDC disability prevalence data.
- MACPAC analysis of dental access for adults with intellectual and developmental disabilities.
- Comparable special-care dental programs, construction benchmarks, staffing benchmarks, and equipment estimates.

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