Email from a tax professional working on the issues of GST and chronic care (see the Canada GST Service commentary to Excise Tax Act subsection 259(2.1) and to the definition of "facility supply" in subsection 259(1):

From: [redacted]
Subject: **RE: 83% Facility Supply Issues**
Date: February 14, 2012 6:15:19 PM EST (CA)
To: "David M. Sherman" <ds@davidsherman.ca>
1 Attachment, 32.5 KB Save

David, I have a few comments regarding the analysis I'd like to share with you and otherwise you are of course, free to do what you wish. Overall – the analysis of the words in the legislation is true enough but I'd like to share some information with you, if I may. I have been working on the issue of what constitutes 'activities engaged in by that person in the course of operating a public hospital' since 2000, and – in recent years – what the " meaning" of words like "active" , and "therapeutic health care" is in the context of this legislation… and extension of the 83% to chronic care provided by charities and NPO's since 2000. It seems on days that I've been dealing with a combination of "shape shifters" and CRA audit propagandists over this 12 year period. I only wish I *was* joking.

In terms of background, in 2000 through 2002 the Audit Directorate selected five hospital authorities in Canada – Victoria, Saskatoon, Winnipeg, Ottawa and Halifax for audit. A CRA auditor in Halifax – Ernie Harnett – had arrived upon a determined on the basis of exactly what – no one knows – that certain activities that were undertaken in hospitals in Canada were not *'activities engaged in by that person in the course of operating a public hospital.'*

The focus of the audit was to be to carve off "activities" and raise assessments on the basis of restricting the rebate to 50%. The approach to the five fortunate candidates selected for this exercise, was less than forthcoming. They were informed that CRA "Headquarters" – was on a national "information collection " exercise and led the five parties to believe this had all been cleared though earlier communications with their Provinces Departments of Health or Finance or both.

However, through our work with various hospital authorities throughout Canada– we were informed by ALL of the representatives of Provincial Ministers of Health and Finance in the jurisdictions within which the five audit candidates were situated - that no attempt was made by any of the audit personnel from Dobson's Audit Directorate "Headquarters" or any other CRA department to coordinate this "information exercise" with them. They, in fact, knew absolutely nothing about the "national initiative". In addition, in correspondence we had at the time with the Federal Minister of Health, Anne MacLellan via Heather Watson, Ministerial Assistant assigned to the Health portfolio, there was no awareness whatsoever of this particular initiative within the Federal Health Ministry whatsoever which was curious because at the time the tax assessments were being pulled together – Anne MacLellan was meeting with Provincial Ministers of Health, and Ministers of Finance in Vancouver, regarding federal and provincial responsibilities for the delivery of health care to Canadians.

Unknown to anyone -the audits of various health authorities targeted for the initiative were underway and in various stages of completion.

We were informed at the time (2002) by Bill Dobson that the CRA had the "full support" of the Canadian Healthcare Association (the "Association") for this initiative, however we had (and retain) several pieces of correspondence prepared by Ms. Sholzberg-Gray most notable of which is correspondence to then Minister of Revenue Elinor Caplan – that did not support Bill Dobson's vision of "support". The truth is that the Association was markedly opposed to the initiative from the outset, as it did not appear to be designed as an information collection process at all, but rather as an audit initiative designed to raise revenues.

Nevertheless, in spite of the storyline that the CRA was on an informaiton collection exercise, assessments for tax were identified and in two occasions – proposed assessments were levied in respect of a number of programs provided in hospitals. The key target for assessment was chronic care, or long term care, research and teaching (intern training/nurse training). The assessments argued that these (and other services such as addictions counseling; autism testing; various pre-natal & new born health programs ….) were not "*activities engaged in by that person in the course of operating a public hospital'* – the support offered to the assessed parties/proposed assessed parties was that this was the "opinion" of the auditor.

In no instance in the five hospital authorities we spoke with, met with and reviewed the results of, did the "research" undertaken by the CRA in their proposed re-assessments of what activities actually were involved in the operation of a public hospital, was there any consideration of Provincial legislation, (*Hospitals Act; Health Care Professions Act; Government Organization:* etc.,) regulations or even a passing investigation of the medical services provided by physicians, nurses or any health care service providers.

In correspondence written by Federal Minister of National Revenue (Elinor Caplan) in 2002 – the statement was made that no assessments will be finalized until a review by the Policy and Legislation Branch had been undertaken to determine whether the *current interpretation* reflected "*the reality of an evolving health care sector"* – however, someone in the Audit Directorate must not have received that memo because in at least two instances we are aware that proposed assessments were in fact issued.

However, once awareness of the CRA Audit Directorates mission became clear to Provincial Ministers of Health and Finance (i.e., to raise tax assessments), and the CRA was made aware of Elinor Caplans' letter – the assessments on these issues for the five hospital authorities were dropped.

Following that, some sincere and meaningful negotiations between Federal Finance and the provincial ministries of health occurred and as a result – section 259 was amended in the May 2005 federal budget. If you look at the 2006 Annual Report of the Canadian Health Care Association – page 2 – the comments by Sharon Scholzberg-Gray wherein she writes as President and CFO of the Canadian Health Care Association:

*"**During the year, I had the pleasure of making a number of representations to the federal government on key issues. I met with senior officials from the Canada Revenue Agency to discuss and clarify the issue of the 83% GST rebate for hospitals being extended to long term care and home and community services as well as the research activities of teaching institutions"** (page 2; 2006 Annual Report; Canadian Health Care Association)*

Clearly, Ms. Sholzberg-Gray, who *was intimately* involved in the negotiations with Finance (as were several Assistant Deputy Ministers of Finance for Health in provinces across Canada) was of the understanding the extended 83% rebate of GST was to be applied to "research activities" ***and "long term care***" – which were the very targets of the assessment initiative launched by the Audit Directorate. In any event, what she writes as President of the Canadian Health Care Association, in her closing summary of key issues addressed in the year ended, December 31, 2006 – a year and six (6) months after the legislation was introduced is that the amendments addressed health care services that were now eligible for the 83%. A copy of the Canadian Health Care Associations 2006 Annual Report is on the internet.

The Association of Canadian Academic Healthcare Organizations (ACAHO) was also of the same opinion – having been involved in the discussions. A letter posted to the ACAHO website written in June 2006, by the Honourable Carol Skelton, then Minister of National Revenue wrote to the Provincial and Territorial Ministers of Health addresses the application of the Goods and Service Tax ("GST") and the expanded 83% rebate entitlement. In her letter, the Minister stated:

"*The approach of the CRA is to ensure that the 83% percent rebate is **applied as broadly as possible** within the legislative framework of the Excise Tax Act*". A copy of that letter is available on the internet.

If the context of the submissions that were made to the House of Commons Standing Committee on Finance - throughout 2002 – 2004 are reviewed – such as the "*Reaching our Potential …Investing in the Health and Heath Care of Canadian"* it is clear the CHA and ACAHO were advocating 100% rebate – for health. The resultant expansion of the 83% to cover additional venues providing health care to Canadians funded by the Provinces was a compromise and designed to reflect in some small part – health care's evolution from acute care institutions.

The Department of Finance explained the ***intent*** of amended section 259 in the Backgrounder to the 2005 Budget as follows:

> *"In recent years, the restructuring by provinces and territories of the delivery of health care services has resulted in some services formerly provided by hospitals being performed by other non-profit institutions entitled to claim the lesser 50-per-cent rebate. In recognition that this restructuring might affect the application of the GST/HST rebate for health care, the 2003 budget announced a review of the rebate to assess and improve its application with respect to health care functions moved outside of hospitals."*

Supplementary Information released by the Department of Finance in conjunction with the announcement of the expanded rebate as part of the 2005 Budget, states:

"The proposed measure, which accommodates the significant variations in health care delivery models across the country, will expand the 83% rebate to eligible facilities and entities that belong to the following categories:

- *Ambulatory care hospitals, which currently do not qualify for the hospital rebate because they do not have in-patient beds, and day surgery clinics.*
- *Cancer clinics and other specialized clinics that provide care such as mental health or HIV programs.*
- *Community health centres.*
- ***Facilities that offer high-level therapeutic care**.*
- *Organizations that provide medical care to individuals in their homes.*
- *Regional health authorities that support the delivery of health care within their regions.*
- *Entities that provide ancillary support, such as laboratory and diagnostics services and centralized laundry and in-patient meal services, to health care facilities."*

This listing indicates the Department of Finance clearly intended for the expanded rebate to apply to more than acute care services such as those provided in an acute care hospital.

The amendments to section 259 included – new definitions for "ancillary supply" – the service of organizing and coordinating facility supplies, home medical supplies etc., "external supplier" – charities, NPO's or public institutions making ancillary supplies, facilities supplies or home medical supplies; "facility operator", =a charity or NPO pr public institution other than a hospital authority – operating s qualifying facility – "facility supplies" – including 259(1)(a)(iii) "in the case of chronic care" –

I believe the legislative "intent" of the amendments is clear - Charities and Not for Profit Organizations do not have physicians on staff in the same context or to the same extent as acute care hospitals – a fact that surely was not outside the scope of knowledge of the Department of Finance personnel when the legislative provisions were crafted, nor Parliamentarians when the legislation was passed – therefore – by providing for the 83% rebate to organizations that are NOT hospital authorities for "ancillary supplies" "home medical supplies" "facility supplies" and "external supplies" – clearly there was some intent to broaden the legislation in an attempt to capture the evolution of health care to venues outside the bricks and mortar of a public hospital operated by a hospital authority.

I want to add to this that in the Public Health Agency of Canada *Report of Continuing Care Organization and Terminology*, (1998) and an earlier 1992 document *Future Directions in Continuing Care* (both available on the internet) the following was stated:

> ***"Continuing Care is an amalgamation of diverse categories of service. These categories are integrated by an overall system of service delivery. Thus it is important to remember that continuing care is not a type of services by a system of service delivery."***

The report goes on to say:

> ***"It should be noted that in most jurisdictions, Chronic Care is now part of Long Term Care, and a distinction is no longer made between Chronic Care beds and Long Term Care beds."***

In 1998 the Public Health Agency of Canada found the use of the term "*long term care"* as an umbrella term to cover an array of services was rapidly becoming no longer relevant.

As early as 1992, and certainly by 1998, six provinces and one territory (BC, Alberta, Manitoba, Nova Scotia, PEI, Newfoundland, and the Northwest Territories) were using the term Continuing Care or complex care, as a descriptive term or as a concept, or organizing framework, for providing a continuum of services. Alberta Health and the Capital Health Authority used the term "Continuing Care" to refer to "facility services."

In the 2005 amendment - the term "*chronic care"* is used in the ETA in 2005 to describe a *type of care* that is ***eligible*** for the expanded 83% rebate. *.. "in the case of chronic care…"*

Chronic care (long term care) stands alone as a level of care that **should not be misconstrued** with "*intermediate nursing care*,*"* as described in the *Canada Health Act* of 1984. Long term care is ***not synonymous*** with *intermediate* nursing care or care previously provided in a "nursing home" - as the CRA auditors espouse. Chronic care is provided in auxiliary hospitals and in "qualifying facilities" funded to provide such care by provincial Departments of Health. This is recognized, supported and documented by many sources, including the Public Health Agency of Canada, which, in 1998 based on information collected from the provinces and territories noted the following:

> ***"Chronic Care Units/ Hospitals provide care provided to persons, who because of chronic illness and marked functional disability, require long term institutionalization care but do not require all of the resources of an acute, rehabilitation or psychiatric hospital. Twenty-four hour coverable by professional nursing staff and on-call physicians is provided, as well as care by professional staff from a variety of other health and social specialties. Only people who have been properly assessed and who are under a physician's care are admitted to chronic care facilities. Care may be provided in designated chronic care units in an acute care hospitals or in standalone chronic care hospitals, Care requirements are typically 2.5 hours of professional nursing care per day or more".[Public Health Agency of Canada: Report of Continuing Care Organization and Terminology; Marcus J. Hollander & Elizabeth R. Walker; 1998]***

Very interestingly the 1998 description of chronic care contained in the Public Health Agency of Canada document is remarkably similar to the criteria contained in the 2005 amendment to section 259 of the ETA. So – the question that arises is this: If the legislation was not intended to extend the 83% rebate to chronic care (i.e., ***long understood to be known as "long term care***",) why did the Department of Finance legislative drafters provide specifically for it in ss. 259(1)(a)(iii) and why did Parliament accept it as written?

In short - chronic, continuing, or complex care "long term care" is health care which requires twenty-four hour supervision by nursing staff; it requires that physicians be on call twenty-four hours a day; it requires admission to a facility on the order of a physician; it requires that the individual remain under the active care of a physician throughout the time they are in the facility; it requires that, on average, physicians make weekly rounds to see their patients; it requires medication reviews which occur on an ongoing and frequent basis; it requires the employment of a Medical Director who is a physician, or nurse practitioner; and in 2006 and beyond – and, in every province of Canada – it requires a minimum ***of 3.6 hours of direct care nursing and therapeutic health care hours per day. This level of 3.6 hours of direct care nursing and therapeutic health care service required for chronic care/continuing care/complex care (all of which are regulated and referred to as "long term care")*** is ***higher*** by 1.1 hours of direct care nursing care than was contemplated as the level constituting "***chronic care"*** levels in 1998, ***and higher than the 2.4 hours required in section 259.***

Subparagraphs (a)(i) and (a)(ii) of the definition of "facility supply" require that the exempt property made available or the exempt service rendered ***at*** the public hospital or qualifying facility, be part of a "***medically necessary process of health care" for the individual for the purpose of (1) maintaining health, (2) preventing disease, (3) diagnosing or treating an injury, illness or disability or, (4) providing palliative care.*** To the extent the exempt service of *any* medically necessary processes of health care are rendered to the individual for *any* of these purposes, this criteria is satisfied.

The assessment of what constitutes a "*medically necessary process of health care"* is, in Canada, at the sole discretion of, and within the jurisdiction of a physician or physicians, acting in the practice of medicine. Thank God that has not yet come up for discussion as to "meaning"….

An individuals' access to any government funded health service in Canada is controlled by the medical judgement of the physician, or in certain legislated circumstances, by a nurse practitioner. The objective of "*medical necessity"* is to separate what is necessary from what is optional or elective. Given an individual has been accurately diagnosed by a physician, or physicians, as suffering from multiple or various, co-morbities, diseases or illnesses, the question becomes: is it "necessary" for the maintenance of the individual's health for the conditions to be treated. The *diagnosis* of any condition requiring treatment does not automatically entail that the provincial health care plan has any obligation to pay for the health services or treatment. To be medically necessary, it is only required that a physician diagnose or deem that treatment is required for the individuals health to be maintained. The diagnosis of a condition and course of treatment does not mean a physician will be "performing" the processes of health care required. The position that unless the processes of health care are physically performed by a physician, the physician cannot be determined as "actively" involved in the medically necessary processes of health care delivered to an individual is not supported by the legislation or the Techncial Notes.

The determination of *"medical necessity"* has nothing to do with who is responsible for paying for the treatment and from that perspective, the *Canada Health Act* of 1984 sheds no light as to the meaning of terms selected for the construction of the legislation that is section 259 of the ETA,

as amended in 2005. "*Medical necessity*" is the assessment of a condition by physicians, licensed to practice medicine or, in certain instances, nurse practitioners.

The College of Physicians and Surgeons of the provinces regulate the practice of medicine. The privilege of self-regulation is granted through the various *Health Professions Act* ("HPA"). Thus, if the assessment of a physician licensed to practice medicine deems a course of treatment necessary for the health of an individual to be maintained, that treatment is by virtue of that assessment – "medically necessary".

The definition of "facility supply" in section 259 provides that the medically necessary ***processes of health care*** must be undertaken in whole or in part at the public hospital or qualifying facility and that the process be ***"reasonably expected"*** to take place (1) under the active direction or (2) supervision, or with the (3) active involvement, of a physician acting in the course of the practice of medicine (or by a nurse practitioner in certain circumstances or a prescribed person in prescribed circumstances).

"*Processes of health care"* as a term or phrase is not defined in the ETA. However, the *Government Organization Act*, *Health Services Restricted Activities*, of most provinces define the term "*health service"* is defined as a service provided to an individual:

(i) ***to protect, promote or maintain their health***.

(ii) to prevent illness,

(iii) to diagnose, treat or rehabilitate them, or

(iv) to take care of the health needs of the ill, disabled, injured or dying.

Every province has a similar definition in their respective equivalent legislation.

Individuals are admitted to long term care facilities across Canada only on the order of a physician – this is the law. They are admitted under the authority of provincial departments of Health – based on their level of acuity (which must demand 24/7 nursing supervision, 3.6 hrs of direct care nursing and therapeutic health care services. The are admitted for the purpose of maintaining health; the treatment of chronic and progressive disease, the treatment of chronic illness and chronic disabilities, and to ensure their health needs are met when they are dying. Every province has similar assessment processes – whether they use the Regina Risk of Institutionalization Tool ("RRIT") - the Inter RAI tool – or other processes – the point is , these assessments are used to assess the individuals level of acuity prior to admission and the level of health care they will require. The assessment must be completed prior to admission to any chronic care, or residential care facility in any province in Canada (I have researched the admissions processes and levels of required acuity for admission to long term care throughout the country). Individuals are admitted to a chronic care, complex care or continuing care facility based on a high degree of urgency, and admitted clients must require 24 hour nursing supervision and continuous professional health care that cannot be met by community resources, including severe behavioural problems, moderate to severe cognitive problems, physical dependence with medical needs requiring daily nursing care and/or clinically complex medical conditions.

Use of these tools includes an assessment of the individual's functional, cognitive, health and psychosocial needs including the ability/inability to perform daily living activities. The inability to perform activities of daily living in complex/continuing/chronic care settings is as a result of physical inability as well as, in 85% of patients/residents, their having moderate to severe cognitive impairments. These cognitive impairments care range from an inability to follow a three-step command to losing the ability to understand language, recognize family, recognize what a toilet is, or even remember how to eat. The legislation provides that there is a "reasonable expectation" the processes of health care (medically necessary processes of health care) will take place under the active direction, supervision or with the involvement of a physician -

The meaning of the term "*reasonable*" or "*reasonably expected*" is not provided the ETA, however, "a *reasonable expectation* is something less than an occurrence or action that is a

"*required",* and refers to provisions or actions that are *appropriate for the particular circumstances.*

Where the Courts *have* dealt with the meaning of "*reasonable",* the circumstances of the situation are examined. For example, the "*reasonable expectation"* of a profit does not mean the making of profit is a mandatory requirement, it means there must be indicators present that would allow a reasonable anticipation that a profit *may* be made.

That the legislation provides for a "*reasonable expectation"* the processes of health care take place under the "*active direction, or supervision, or with the active involvement of a physician,"* or where warranted by geographic circumstances, a nurse practitioner means the legislation provides there is ***no requirement,*** under the terms written, for these processes to be *performed by* or *delivered to* the individual *by* the physician.

The "required or reasonably expected to require" conditions associated with "in the case of chronic care" come into play for a RN to be onsite; a physician to be on call or available to attend at; the individual being subject to "medical management and receive a range of therapeutic health care service" and the not less than 2.4 hours a day requirements for the 'therapeutic health care services". I am of the position that if these conditions were mean to be "required" –as in absolutely non-negotiable conditions – why then was the condition of required modified by " required or reasonably expected to require". If something is required – it is not 'reasonable expected to be required". Something is either "required" or it is "not required". Something that is 'reasonably expected to require' means that there is a reasonable expectation that something is required – but it is not "required". I do not concur these conditions are categorically "required". But – regardless – these criteria are ALL 100% satisfied in the confines of long term care in every province of Canada. Long term care is not "intermediate nursing care" and so there is no trouble for any long term care organization satisfying these conditions….. "*in whole or in part".* No assessments that have been levied to date have been on any of these conditions. Rather – the basis for the hundreds of thousands of dollars in assessments in the context of chronic care (long term care whether ether in a public hospital operated by a hospital authority or by a charity or NPA – is the following:

> ***"One of the eligibility requirements for the Facility Operator Rebate requires active direction or supervision of a physician. The legislation requires that a physician actively be involved in the course of the practice of medicine as a part of a medically necessary process of health care for the individual for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, or for the purpose of palliative health care rendered in a public hospital or qualifying facility. In your case these services are required to be performed by a physician."[lifted from actual audit assessment]***

This statement clearly neglects or overlooks that the legislation as written by Finance and passed by Parliament, requires only that the processes be ***reasonably expected*** to take place with the *active involvement*, *supervision or direction of a physician*. The legislation does not provide that these processes either take place with a physician ***present,*** or that they be ***performed*** by a physician. The only requirement of this sentence is that there is a "reasonable expectation" for the processes to take place with the active involvement, or under the direction of, or supervision by, a physician. The examples provided in the Technical Notes to the definition of "facility supply" support this understanding

It is our view as well that the phrase "reasonably expected" to take place under the "active direction", "supervision" or "with the active involvement" of a physician is further defined by the parameters of what the *"action"* is directed to in this provision – which is – the action of a physician ***"acting in the course of the practise of medicine****".*

With reference to the *Health Professions Act* "in their ***Practice of Medicine,*** physicians …do one or more of the following: (all provinces are essentially if not virtually, the same)

(a) assess the physical, mental and psychosocial condition of individuals to establish a diagnosis
(b) assist individuals to make informed choices about medical and surgical treatment
(c) treat physician, mental and psychosocial conditions
(d) promote wellness, injury avoidance, disease prevention and cure through research and education
(e) engage in research, education and administration with respect to health, and
(f) provide restricted activities authorized by the regulations.

With reference to the *Standards of Practice* enforceable under the *Health Professions Act,* and which are complementary to the *Canadian Medical Association Code of Ethics,* the *practice of*

medicine includes:

(i) working as part of a multi-disciplinary medical care teams;
(i.e., Standard 3 (4) *When working in a team setting a physician must document clearly his or her contribution to the patient care*; and
(ii) recording, documenting diagnosis, treatments, investigations, consultations with other regulated health care service providers, prescribing medications etc., (i.e., Standard 20 (4) *A patient record must contain enough information for another physician or other regulated health care provider to be sufficiently informed of the care being provided including:*

(a) clinical notes
(b) laboratory and imaging reports
(c) pathology reports
(d) referral letters and consultation reports
(e) hospital summaries and
(f) surgical notes

The practice of medicine also requires the physician to:
(5) document current medications, allergies and drug sensitivity; document findings on physician examination, or diagnosis; document treatments advised and provided; document medications prescribed (if any, and where prescribed, the name of the medication, the dosage, and frequency); document investigations ordered and reviewed; documentation of any instructions, precautions, orders, advice; and, (11)In the practice of medicine, a physician is required to keep an accounting of the date services were provided to any person, a description of the service rendered and the fee charged.

Any and all of the above constitute actions of a physician "*acting in the course of the practice of medicine"* and are assigned a specific billing code under the provincial medical billing processes.

As well, in considering the *grammatical construction* of subparagraph 259(1)(a)(ii) of "facility supply", there must be a reasonable expectation of *only one of the terms* (a)"active direction", (b) "active supervision" OR (c)"active involvement" must apply for this condition to be met.

The example provided by the Minister in the *Technical Notes* supports that the involvement, direction, or supervision of a physician in a health care process can indeed be "active" without the presence of the physician and certainly occurs without the necessity of the physician physically performing the processes.

Example 3 in the *Technical Notes* to the definition of "facility supply" provides the Ministers guidance as to the meaning of "active involvement, supervision, or active direction".

In the example provided by the Minister, a qualifying *not for profit* organization makes a supply of a health care process to an individual suffering from chronic kidney disease. In the example, the individual attends the facility, a number of hours during the day or evening, several times a week. The service is provided by a person that is *not a physician.* The service has been ordered by a physician, who is "*actively involved in monitoring the individual's condition". In this example provided, the physician orders the process and monitors the condition – all of which occur without the physician being in the physical presence of the individual, as is, in satisfaction of the condition of a reasonable expectation of the active direction, supervision or involvement of a physician.*

Based on the Ministers example contained in the *Technical Notes,* the action of the physician in *ordering the treatment* and "*monitoring the individual's condition*" satisfies (a)(ii) of the definition – the "active direction", "active involvement", or "supervision" of a physician.

This example provided by the Minister is noteworthy because (a) the physician is specifically noted in the example as ***not being physically present,*** when the medically necessary procedure is performed, nor does the example illustrate that a physician must perform the process for the condition to be satisfied. The procedure is ordered by the physician, the individual's condition is monitored, yet the conclusion made is that the physicians' involvement is "active". In the Ministers example, who it is that performs the medical procedure is not relevant to the determination of whether the physician's direction, supervision or involvement in the process is "active." Thus, we find it strange "shape-shifting" on the Minister part to now (2011) insist that the Minister cannot now insist in their assessments on these charities and there drastically underpaid health care staff that – a physician must physically perform the health care processes for the condition of active direction, supervision or involvement to be met.

See also – the October 2, 2008 Ruling Letter issued to *Baptist Housing Care Homes Society*, a long term care facility – wherein the (#77030), the Minister states:

"Therefore, while the quarterly review of a care plan and the ordering of medication or diagnostic procedures by a physician for a resident at the Facilities may be part of a medically necessary process of health care for the resident, physician involvement in the process whether it is through direction, supervision or actual involvement, must be ***reasonably expected to be active*** *in order for any exempt supply made by the Society as part of that process to constitute a facility supply."*

The Minister concludes in this Ruling that:

"Based on the facts set out above, we rule that the Society is a facility operator entitled to claim the 83% rebate of non-creditable tax charged, as defined on subsection 259(1) on its acquisitions to the extent that the Society intends to consume, use or supply property or services in activities engaged in by the Society in the course of operating the Facilities for use in making facility supplies, or of making facility supplies."

The same position is espoused by the Minister in the May 20, 2009 Ruling letter (#87244). Other Ruling letters provide that facility supplies are indeed made, and the active involvement condition is met, in lesser circumstances, or circumstances where the facts do not differ from any other long term care operator. For example, in Ruling # 110323 dated August 4, 2010 the Minister addresses health care services provided by a not for profit organization, including general physician assessment, health consultation and counseling, health advice and instruction, family planning, pre-natal classes and baby support and immunization. The services are rendered by physicians, nurses, a nurse practitioner, chiropodists, social workers, community workers and a dietician. The Centre also provides health promotion and illness prevention services to individuals, groups and the community, and s involved in a variety of teaching and research activities. The health care services are provided by the staff at the Centre whose members include (but are not limited to) physicians, nurses, a nurse practitioner, and other health care workers. However in this ruling response the Minister recognizes in this case …..

> "*…it is clear that physicians are reasonably expected to be involved in the processes of health care for patients. Accordingly, to the extent that the health care services provided as the centre are exempt supplies that are part of a medically necessary process of health care for the individual for purposes described in paragraph 259(1)(a) of the definition of "facility supply" an are rendered under the active direction or supervision or with the active involvement of a physician, they will meet the requirements of subparagraphs 259(1)(a)(1) and 259(1)(1)(ii) and will constitute facility supplies".*

The ***only supplies*** made by the not for profit organization in this case the Minister does not recognize as medically necessary processes of health care for individuals as taking place with the active involvement of a physician are supplies made in the course of research activities, nutrition education programs, cooking classes, exercise programs and community wellness and health promotion workshops. This Ruling is significant because the medically necessary processes of health care provided in this not for profit Centre require lesser "involvement" or supervision, or direction than those provided in any chronic care, continuing care or complex care facility.

Also - Ruling # 86383 dated February 15, 2007 wherein a charity, that is not a public hospital, offers beds which provide assistance and support to individuals in need of "*ongoing nursing care and personal assistance".*

In this Ruling, the Minister recognizes that the charity provides *"care of individuals who have been assessed as being no longer able to live independently as they need ongoing medical support and assistance with the activities of daily living."* Residents in these facilities have heavy, multiple, complex health care needs. Physicians with "*active privileges issue and review diagnostic, therapeutic and maintenance orders for resident and complete and maintain a comprehensive medical record. They set up treatment plans to address the individual needs involving nursing management, clinical dieticians and therapy to be provided."* They perform a number of procedures in the care centres. Members of the nursing staff (registered nurses, psychiatric nurses, licensed practical nurses and health care aides) are on duty in these facilities 24 hours a day. Based on these facts, the Minister rules the charity meets the definition of a facility operator as defined in subsection 259(1) of the ETA and as a facility operator is entitled to claim an 83% rebate for its non-creditable tax charged to the extent that it makes facility supplies in these facilities. What is particularly relevant in the Ministers position in this ruling is the Minister recognizes that nursing services provided to an individual that is no longer able to live independently, that requires ongoing medical support and assistance with *activities of daily living* includes the services provided by qualified health care aides.

The average number of co-morbidities (chronic illnesses; diseases; conditions) of the individual admitted to a chronic care facility is five (5). The average life expectancy of an individual in long

term care facilities is 12 to 18 months. In excess of 30% to 45% of individuals admitted to long term care die each year. Long term care facilities operated by the province, or funded by the province – provide individuals with complex, medically necessary health care services, end of life health care services, and palliative care, because they are chronically ill and diseased. Given that ***only individuals*** with several co-morbities, chronic disease and illnesses, resulting in high acuity, and complex health care requirements such that the average life expectancy of individuals admitted is less than 18 months – it's hard to imagine that the active involvement of a physician would not be "*reasonably expected",* and in any event – it is from the research I've conducted - *required by provincial legislation*, regulation and standards in every province. Individuals admitted to such facilities are admitted because the chronic care facility is the only alternative, apart from an acute care hospital, equipped to provide the "medically necessary processes of health care" necessary for the maintenance of the individual's health – these are not intermediate nursing homes – they are chronic care or long term care health care facilities.

In any event – the assessments are being levied on the basis that a physician has to be physically "performing" any processes of health care delivered to a person in a long term care or chronic care facility doesn't stick – the CRA Audit Directorate is hedging their bets with the following add on "reason" as to why they do not qualify:

> ***"Another eligibility requirement is that the individual be subject to medical management and receive a range of health care series, including registered nursing care, throughout the process for a significant portion of each calendar day or part during which the individual stays at the public hospital or qualifying facility. In order to meet this requirement we would need evidence to show that each of your residents receives at least 2.4 hours of therapeutic health care services each day. We are unable to comment on whether or not you meet this requirement because the definition of therapeutic health care services is still under review. <u>We are still waiting for direction from our Headquarters in response to our request on this issue."[lifted from actual audit assessment letter] –</u>***

So – even though they may not have any idea whether the health care services provided to resident or patients in the chronic care setting is 'therapeutic" or not – because they have not been provided with "guidance" as to the "meaning" of that phrase – they "know" *(maybe psychically?) that they are not – and are levying assessments anyway – on those that have applied for the 83% rebate.

The crux of this issue is whether the services of qualified health care aides should be "included" in the calculation of the minimum 2.4 hours of therapeutic health care services. The CRA is of the view that health care aides spend time wheeling around, flipping theme over, taking them to the toilet, bathing them and "reminding them" to take their pills. The CRA believe these activities have "***no therapeutic value, regardless of the level of care".***

It is difficult to fathom just how lacking in knowledge the Audit Directorate is in having determined – or arriving upon the conclusion that someone that has been categorized or assessed as medically presenting level of physical, cognitive, and behavioural acuity at a level high enough that their health care needs can only be met in a long term care facility – who would, as a result - require daily wound and ulcer dressing changes, regular medications to be provided for any multiple of chronic diseases, illnesses or conditions, and regular monitoring of medication effects – to find that assistance with repositioning of the body, feeding and bowel care has "no therapeutic" value. According to the Minister, any assistance with repositioning the body, bowel care and incontinence care and assistance with feeding have no "therapeutic" value even where an individual has been assessed with extremely limited or reduced physical functionality, requiring regular mediation, monitoring of medication and daily application of topical cream. I am 100% certain –based on the interviews I have done with physicians – including the Medical Directors of several hospitals that if the CRA can find a single physician who would *agree with them , that* that repositioning the body to alleviate the occurrence of pressure sores, bowel care and incontinence care, and feeding do NOT constitute medically necessary processes of health care to their patients in a chronic care/long term care facility – that physician is obviously wanted on war crimes somewhere.

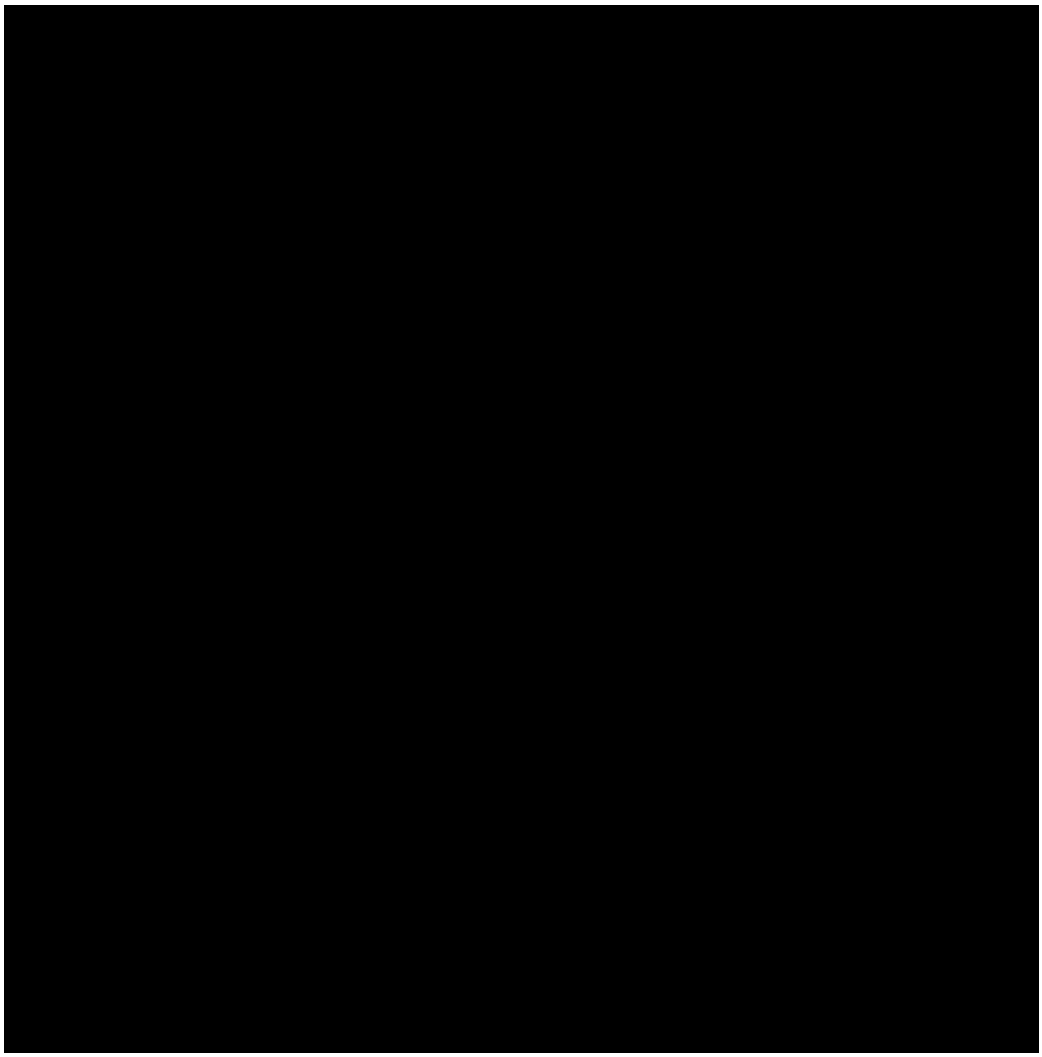
And, while the assessments continue to pour in – the CRA is now seeking the input from the provinces – as to the meaning of "therapeutic health care" – and other funding and acuity assessment related information. We are aware that a "questionnaire" were sent out by Policy and Legislation – we do not know whether on their own behalf or behalf of the Audit Directorate – seeking support for the assessments. The questionnaire were sent mostly to inter-governmental departmental personnel – not to the Departments of Health –where some meaningful information might be collected ….here is what the CRA is asking – I am also including a copy of the "questionnaire" for you to read.

Obviously, the rule of law, as described by the McRuer report on civil rights – fails to resonate with the Audit Directorate. There are two parts to the rule – the first being that it requires governance by relatively clear rules enacted or prescribed by duly constituted authority not "*the*

uncertain and crooked cord of discretion" . The tax every person is bound to pay ought to be certain, and not arbitrary. The Carter commission has stated that uncertain law is retroactive law: "Obscure law creates uncertainty and when the law cannot readily be determined it is impossible for the individual to know what is required. In effect, uncertain law is retroactive law, because the effect of the law is known only after the event. Uncertain law penalizes those anxious to obey it, and eventually creates contempt for the law. "

This is about as "arbitrary" as it gets …….

> *Below is the e-mail message sent ot the Provincial contacts by GST/HST Excise – Rulings Directorate -*
> *"Good morning,*
> *As mentioned in our earlier e-mails, section 259 of the Excise Tax Act was amended in 2005 to extend the existing 83% rebate of the GST/HST available to hospital authorities to non-profit publicly funded organizations providing health care services similar to those traditionally provided in hospitals. A number of interpretative questions have arisen over the years with respect to the eligibility of certain persons to claim this rebate. While many questions have been resolved, others remain under active consideration by the Canada Revenue Agency. We are presently gathering information to better understand the delivery models for long-term care and high level therapeutic care provided outside of public hospitals in order to determine which persons are eligible to claim this rebate with respect to specific types of activities and services.*
> *The attached consultation document contains background information on this rebate and asks a series of questions related to the delivery of care to individuals in residential care facilities in your province. We would appreciate receiving your responses by March 31, 2012."*



GST/HST Extended Health Care Rebate - Finance Officials Tax Committee Consultation

Canada Revenue Agency
Excise and GST/HST Rulings Directorate

January 2012

BACKGROUND

Under the goods and services tax and harmonized sales tax ("GST/HST"), many supplies made by public service bodies are exempt. This means that, although these entities do not charge GST/HST on their exempt supplies, they cannot recover the GST/HST paid or payable on purchases related to these supplies in the same manner that businesses making taxable supplies can, i.e., through input tax credits. Instead, under section 259 of the *Excise Tax Act* ("ETA") and the *Public Service Body Rebate (GST/HST) Regulations*, public service bodies are generally entitled to claim a partial rebate of the GST/HST paid or payable by them on their purchases.

Since the introduction of the GST/HST, hospital authorities have been entitled to claim an 83% rebate of the GST and the federal part of the HST paid or payable in respect of property or services to the extent that the property or services are intended for consumption, use or supply in the course of operating a public hospital[1]. However, the restructuring of health care delivery by the provinces and territories has resulted in some health care services formerly provided by hospital authorities being performed by other not-for-profit organizations that are generally entitled to a lesser rebate of GST/HST.

Effective January 1, 2005, section 259 of the ETA was amended to provide, in part, that eligible facilities and entities are entitled to claim an 83% rebate of the GST and the federal part of the HST paid or payable in respect of property or services to the extent that the property or services are intended for consumption, use or supply in the course of operating a qualifying facility, or in making facility supplies, ancillary supplies or home medical supplies, as these terms are defined in the ETA. This "extended health care" rebate was introduced to extend the existing 83% rebate of the GST and the federal part of the HST available to hospital authorities to non-profit publicly-funded organizations providing health care services similar to those traditionally provided in hospitals[2].

Following the introduction of the extended health care rebate, a variety of interpretative questions have arisen with respect to the eligibility of various entities to claim this rebate, as well as with respect to the types of activities or services that qualify. Many of these interpretative questions have been resolved, while others remain under active consideration by the Canada Revenue Agency ("CRA").

During the June 21, 2011 Finance Officials Tax Committee meeting, the CRA committed to developing interpretative policy guidelines to assist taxpayers in determining their eligibility to claim the extended health care rebate and agreed to consult with interested provincial officials regarding their respective health care delivery models, with the goal of obtaining information that would assist the CRA in developing these guidelines.

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[1] A rebate of the provincial part of the HST may also be available to a hospital authority resident in a participating province. The rebate rates are: 58% in British Columbia, 83% in Nova Scotia and 87% in Ontario.

[2] A similar rebate of the provincial part of the HST may also be available to eligible entities resident in a participating province. The rebate rates are: 58% in British Columbia, 50% in New Brunswick and Nova Scotia and 87% in Ontario.

One of the issues currently being considered by the CRA is the application of the definition of "facility supply" in subsection 259(1) of the ETA to facilities in which long-term care or high-level therapeutic care is provided. As indicated above, certain eligible entities may be entitled to claim an 83% rebate of the GST and the federal part of the HST paid or payable in respect of property or services (as well as a parallel rebate of the provincial part of the HST) to the extent that the property or services are intended for consumption, use or supply in the course of making facility supplies.

As part of the consultation process, the CRA is interested in gathering additional information regarding the provincial delivery models for long-term care and high-level therapeutic care provided outside of public hospitals in order to better understand the type of care provided in such facilities and to consider the extent to which the entities that operate these facilities are making facility supplies. For your reference, the definition of "facility supply" that appears in subsection 259(1) of the ETA is attached to this document as Appendix 1.

The CRA is also interested in obtaining information with respect to each *category* of care that includes the provision of health care services in an institutional setting in conjunction with overnight accommodation and that, in terms of the severity or acuity of the resident/patient's condition, falls between acute or hospital care and, for example, assisted or supportive living provided to seniors.

In addition, the CRA is interested in gathering specific information about the *classifications* assigned to residents or patients within each category of long-term or high-level therapeutic care, as well as information pertaining to the *specific assessment criteria* used to assess the severity or acuity of a resident or patient's condition for purposes of classifying the resident or patient within each category or determining the level of funding to be granted to the facilities who provide long-term care or high-level therapeutic care.

For purposes of the consultation between the CRA and the provinces, the CRA is using the terms long-term care and high-level therapeutic care in a general sense to refer to categories of care in which an individual stays overnight at a care facility and receives a range of health care services, including professional nursing services, as well as meals, laundry and housekeeping services. The term "high-level therapeutic care" was selected, in part, because this term was used by the Department of Finance in the *Budget 2005: Budget Plan* document to describe one of the categories of eligible facilities and entities to which the extended health care rebate was intended to apply. The relevant text from the *Budget 2005: Budget Plan* document is attached as Appendix 2.

To facilitate the consultation between the CRA and the interested provincial officials, and to gather specific information related to the delivery models for long-term care and high-level therapeutic care in each province, the CRA has prepared the attached list of questions. In addition, Appendix 3 to this document contains two examples designed to illustrate the scope of the CRA's enquiry.

QUESTIONS

Categories of care

i. In the context of long-term care or high-level therapeutic care, is there a system in which the delivery of care is divided into different categories (e.g., in terms of acuity)? Please describe the system, considering the questions below.

ii. What are the categories of long-term care or high-level therapeutic care in the Province, and what types of facilities are there in the Province that render the type of care in each category?

- What are the categories of care that include the provision of overnight accommodation and that fall between acute or hospital care and, for example, assisted or supportive living provided to seniors?
  - Examples of care categories may include: sub-acute care, complex care, chronic care, long-term care, continuing care, extended care, etc.
  - Examples of facilities may include: hospitals or auxiliary hospitals, complex care facilities, long-term care facilities, nursing homes, etc.
- Are certain categories of long-term care or high-level therapeutic care only available in certain types of facilities? Are certain facilities limited to providing only the type of care that falls within specific categories of care?
- How is palliative care categorized within the provincial health care system?
- How is convalescent or rehabilitative care categorized within the provincial health care system?
- What documentation (legislation, policy, procedures manuals, etc.) is available to describe these various categories of care?

iii. Does the Province provide funding to facilities that is directed towards specific programs that relate to a higher level of care than is typically provided to the residents or patients in that particular facility, or towards specific procedures or treatments rendered to an individual?

- For example, does the Province have certain higher-needs funding envelopes or programs in which a facility may obtain additional funding to the extent that its residents or patients require a level of care that is higher than is typically found in that facility, or in which additional funding is granted to a facility in respect of certain procedures (such as feeding tubes, dialysis, etc.)?

iv. To what extent can the categories of long-term care or high-level therapeutic care in the Province be compared to the categories that exist in other provinces?

- In developing the categories of long-term care or high-level therapeutic care that exist in the Province, did the Province consider and/or adopt the system of categorization of another province (or provinces)? If so, which one(s)?

- How is the system of categorization that exists in the Province (i.e., the categories of care) similar to the system that was considered in the other province(s), and how is it different?

- In what ways are the categories of care in the Province similar to those that *currently* exist in other provinces and in what ways do they differ?
    - For example, to your knowledge, do any other provinces use the same system of categorization, or a similar system of categorization that provides for comparable categories of care?
- Do the categories of care that exist in the Province encompass care that is similar, in terms of complexity or acuity, or in terms of the nature of the care provided (e.g., complex , rehabilitative, convalescent, etc.), to categories that exist in another province?

Classification assigned to individuals

i. Within each category of long-term care or high-level therapeutic care, are there specific classifications assigned to individuals who receive care, based on the extent of the individual's care needs and/or the acuity of the individual's condition? Please describe the system, considering the questions that follow.

- Examples of classifications may include an alphabetic classification (e.g., A-G, IC), a numerical score (e.g., .75, 1.0) or a care "level" assigned to an individual based on the individual's care needs or the acuity of the individual's condition.
- What documentation is available to describe these classifications in detail?

ii. Are these specific classifications used to determine the type of facility in which an individual will be placed?

- For example, do certain types of facilities only accept residents or patients that fall within certain classifications?

iii. To what extent can the specific classifications assigned to individuals be compared to the classifications that exist in other provinces?

- For example, to your knowledge, do any other provinces use the same specific classifications, or a similar system of classification?

iv. Page 5 to the Guide to Statistics Canada's *Residential Care Facilities Survey – 2008-2009* describes the different types of care provided in residential care facilities depending on the characteristics of the residents. See web link below

http://www.statcan.gc.ca/imdb-bmdi/document/3210_D1_T1_V13-eng.pdf

Appendix 1 to this Guide provides a list of provincial equivalences of type of care.

Please indicate the extent to which these classifications reflect the classifications of the levels of care provided to individuals in residential care facilities in the Province.

Please indicate how the Province distinguishes between Type II and Type III care levels in terms of the funding provided to the facilities.

2004/2005 categories and classifications

i. How do the current categories of long-term care or high-level therapeutic care, and the current classifications assigned to individuals, compare to those that were in place in 2004/2005 when the GST/HST extended health care rebate was introduced?

- What are the categories of care and corresponding classifications that existed in 2004/2005 and, in terms of the level of care provided and the severity or acuity of an individual's condition, how does each category or classification relate to the categories that exist today?
- For example, if in 2004/2005 an individual was determined to be in a particular category, such as sub-acute or complex care, and was assigned a specific classification, what category and classification would apply today?

Specific assessment criteria

i. What specific assessment criteria are used by the organization responsible for assessing and/or evaluating the severity or acuity of an individual's condition in order to determine to which category of care and classification the individual will be assigned?

- What documentation (legislation, policy, procedures manuals, etc.) is available to describe the specific assessment criteria in detail?

ii. Do the specific assessment criteria used to assess or evaluate an individual's condition or to assign the corresponding classifications to individuals distinguish, in terms of the intensity or level of care required by the individual, between behavioural or cognitive health issues and physical health issues?

iii. Upon referral to a facility that provides long-term care or high-level therapeutic care, what specific criteria are considered, on an ongoing basis, in determining the acuity or severity of an individual's condition?

- For example, for purposes of funding or allocation of budgeted care hours, what data does a facility have to maintain or submit to the Province (or other organization) to demonstrate the level of care it is providing to individuals?

Therapeutic health care services

i. Does the Province have a formal or working definition of the terms "therapy", "treatment", "therapeutic" or "therapeutic health care service"?

- Where applicable, what are these definitions and where can they be found?
- Are the definitions of these terms communicated through legislation, policy, guidelines or similar documents?
- Does the communication between the Province and a facility (e.g., funding documents, documents related to the assessment/classification and referral of individuals) make reference to these terms?

ii. Does the communication between the Province and the facility (e.g., funding documents, or documents that relate to the assessment/classification and referral of individuals) distinguish between health care services and services of assistance with activities of daily living?

- For example, do these documents contain a distinct category (or categories) of services that are considered to be therapy, therapeutic health care services or similar health care services that is separate from a category of services related to activities of daily living?

iii. Does the Province distinguish (e.g., in relation to the assessment of the acuity of an individual's condition or the allocation of budgeted care hours) between a service of *assistance* with an activity of daily living and a service in which the entire activity of daily living is performed for the person?

Information systems

i. Does the Province require that long-term or high-level therapeutic care facilities use a particular software program or case-mix classification system, such as the *interRAI MDS / RUG* system, that captures the level of care being provided at the facility and/or the acuity of an individual's condition?

- Which types of facilities are required to use these systems? How long have these facilities been required to use these systems (i.e., how long have these reporting requirements been in place)?
- What information is available (e.g., manuals, guidelines, etc.) to describe the software program or case-mix classification system in detail?

APPENDIX 1

Subsection 259(1) of the ETA: "facility supply"

"facility supply" means an exempt supply (other than a prescribed supply) of property or a service in respect of which

(a) the property is made available, or the service is rendered, to an individual at a public hospital or qualifying facility as part of a medically necessary process of health care for the individual for the purpose of maintaining health, preventing disease, diagnosing or treating an injury, illness or disability or providing palliative health care, which process

(i) is undertaken in whole or in part at the public hospital or qualifying facility,

(ii) is reasonably expected to take place under the active direction or supervision, or with the active involvement, of

(A) a physician acting in the course of the practise of medicine,

(B) a midwife acting in the course of the practise of midwifery,

(C) if a physician is not readily accessible in the geographic area in which the process takes place, a nurse practitioner acting in the course of the practise of a nurse practitioner, or

(D) a prescribed person acting in prescribed circumstances, and

(iii) in the case of chronic care that requires the individual to stay overnight at the public hospital or qualifying facility, requires or is reasonably expected to require that

(A) a registered nurse be at the public hospital or qualifying facility at all times when the individual is at the public hospital or qualifying facility,

(B) a physician or, if a physician is not readily accessible in the geographic area in which the process takes place, a nurse practitioner, be at, or be on-call to attend at, the public hospital or qualifying facility at all times when the individual is at the public hospital or qualifying facility,

(C) throughout the process, the individual be subject to medical management and receive a range of therapeutic health care services that includes registered nursing care, and

(D) it not be the case that all or substantially all of each calendar day or part during which the individual stays at the public hospital or qualifying facility is time during which the individual does not receive therapeutic health care services referred to in clause (C), and

(b) if the supplier does not operate the public hospital or qualifying facility, an amount, other than a nominal amount, is paid or payable as medical funding to the supplier.

APPENDIX 2

2005 Budget: Budget Plan
Annex 8 - *Tax Measures: Supplementary Information*

GST/HST Health Care Rebate

Under the goods and services tax and harmonized sales tax (GST/HST), most supplies made by public sector bodies are exempt. This means that these entities do not charge GST/HST on their exempt supplies, but they cannot recover the GST/HST paid in respect of their purchases related to these supplies by way of input tax credits in the way that businesses making taxable sales can. The public sector body rebate system entitles public sector bodies to claim rebates of the otherwise unrecoverable tax on their inputs. Under this system, hospitals are entitled to a rebate of 83 per cent of the GST and the federal component of the HST that they pay on their purchases used to provide exempt health care supplies, while charities and government-funded non-profit organizations are entitled to a 50-per-cent rebate.

In recent years, the restructuring by provinces and territories of the delivery of health care services has resulted in some services formerly provided by hospitals being performed by other non-profit institutions entitled to claim the lesser 50-per-cent rebate. In recognition that this restructuring might affect the application of the GST/HST rebate for health care, the 2003 budget announced a review of the rebate to assess and improve its application with respect to health care functions moved outside of hospitals.

Further to extensive consultations with provincial and territorial health and finance authorities, the budget proposes to extend, effective January 1, 2005, the application of the 83-per-cent rebate to eligible charities and non-profit organizations that provide health care services similar to those traditionally performed in hospitals. Under this proposal:

- Provincially recognized and funded non-profit public health care facilities established and operated for the medical or surgical treatment of individuals will become eligible for an 83-per-cent rebate of the otherwise unrecoverable GST and federal component of the HST paid on purchases related to their exempt health care operations.

- Government-funded charities and non-profit organizations that supply ancillary support services to hospitals and eligible health care facilities will also be able to claim an 83-per-cent rebate, as will those that provide therapeutic home care services or palliative care to individuals in their homes.

The proposed measure, which accommodates the significant variations in health care delivery models across the country, will expand the 83-per-cent rebate to eligible facilities and entities that belong to the following categories:

- Ambulatory care hospitals, which currently do not qualify for the hospital rebate because they do not have in-patient beds, and day surgery clinics.

- Cancer clinics and other specialized clinics that provide care such as mental health or HIV programs.

- Community health centres.

- Facilities that offer high-level therapeutic care.

- Organizations that provide medical care to individuals in their homes.

- Regional health authorities that support the delivery of health care within their regions.

- Entities that provide ancillary support, such as laboratory and diagnostic services and centralized laundry and in-patient meal services, to health care facilities.

Eligible entities that incur substantially all of their GST/HST during a rebate claim period on goods and services for use in respect of the medical or surgical treatment of individuals and/or the supply of ancillary support services will qualify for the 83-per-cent rebate in respect of the GST and the federal component of the HST that they incur during that period.

Entities that do not meet the "all or substantially all" threshold described above will be eligible to receive the 83-per-cent rebate to the extent that the GST/HST they pay relates to purchases used in fulfilling their medical mission. Thus, a community health and social service centre that is responsible for the provision of both health and social services to the public but does not meet the "all or substantially all" test will qualify for the 83-per-cent rebate to the extent that the GST/HST it incurs during a claim period relates to goods and services for use in the provision of health care services.

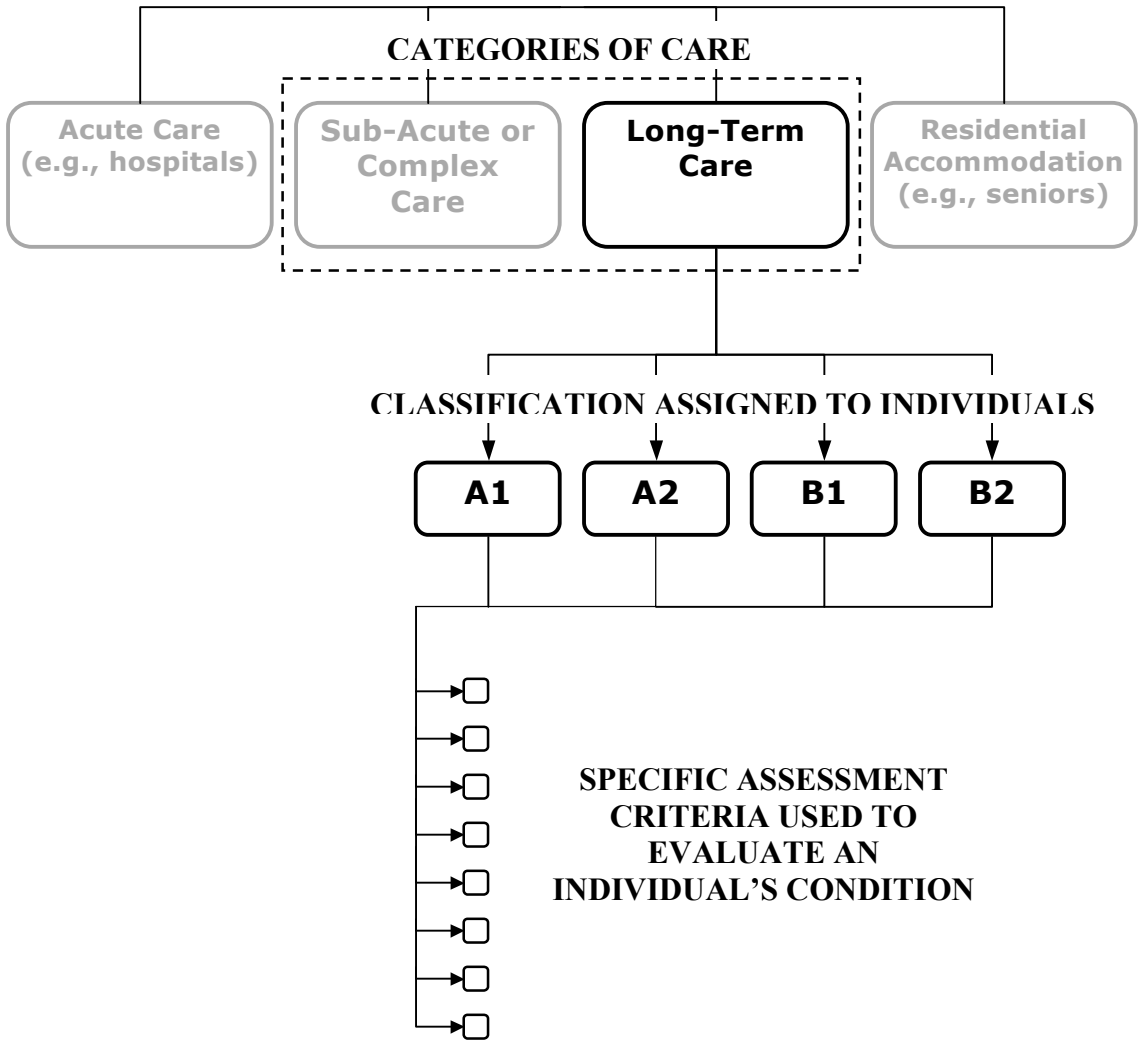
As a result of the proposal to expand the application of the 83-per-cent rebate, new remittance rates for eligible facilities and entities will be required under the Streamlined Accounting (GST/HST) Regulations, which provide small businesses and public service bodies optional simplified methods of calculating their GST/HST remittances. The new remittance rates will be the same as the current remittance rates for hospital authorities. The new rates will ensure that the appropriate amount of tax is remitted. It is proposed that these new remittance rates apply to reporting periods that end after 2004. However, they will not apply to a reporting period that includes January 1, 2005 in respect of a supply for which consideration was paid or became payable before that date.

Each HST province determines the rate of rebate for the provincial component of the HST with respect to entities in the HST provinces affected by this proposal.

Source: http://www.fin.gc.ca/budget05/bp/bptoc-eng.asp

APPENDIX 3

Example: Long-Term Care



APPENDIX 3 (cont'd)

Example: Sub-Acute or Complex Care