INCOME TAX AND GST/HST CONSIDERATIONS FOR MULTI-PROFESSIONAL MEDICAL CLINICS

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Multi-professional medical clinics are common. In some cases, these clinics consist only of physicians while in other cases, the clinic is multi-disciplinary involving multiple health professionals including nurses, physiotherapists, dieticians, pharmacists and integrated diagnostic services. Further, a clinic may have a non-physician owner/manager, which leads to further tax and other legal considerations.

Such clinics may be structured in a variety of ways, including as a cost-sharing arrangement, a partnership, or a sole proprietorship. Further, there may be contracted physician associates engaged by the clinic to provide services.

Regulation of Medical Practice and Medical Professional Corporations

Each Canadian province and territory has a legislative and regulatory framework in place to govern the practice of medicine and the incorporation of medical professional corporations ("MPCs") which are permitted to carry on the practice of medicine. An examination of the laws and rules governing MPCs and the practice of medicine is beyond the scope of this paper, but for an overview of the history behind professional corporations in Canada, various structuring considerations respecting professional corporations in the western provinces and Ontario, and interprovincial taxation considerations for professionals practicing in multiple Canadian jurisdictions, see the paper written by Asma Gehlen, Nicholas Talarico and Crystal Taylor for the 2023 CTF Prairie Provinces Tax Conference[1].

The existence of this legislative and regulatory framework does not necessarily restrict the ownership of medical clinics themselves to physicians. A non-physician can own the business and administrative side of a medical clinic. Physicians must retain control over clinical matters such as diagnosis, treatment and medical records, but a non-physician business entity can provide management services to a physician or MPC. However, any structure must examine the legislative and regulatory framework applicable in that jurisdiction to confirm that what it intended is permitted within that framework.

It is important to determine how fees must be billed for insured services. All provinces/territories require billing to be done under the billing number of the physician who is providing the services, but some jurisdictions will permit payments to be redirected to a group, clinic or corporation or provide for group numbers to allow physicians to administratively associate themselves for billing purposes.

Income Tax Considerations

The Small Business Deduction

[1] A. Gehlen, N. Talarico and C. Taylor, "Professionals – Behind the Scenes on Ownership Structures and Operating Across Canada (2023), Canadian Tax Foundation, *2023 Prairie Provinces Tax Conference* 10:1

The key benefit of practicing medicine through an MPC is where the MPC is earning active business income that is eligible for the small business deduction ("SBD") under s. 125 of the ITA. To the extent that earnings are left in the MPC and not withdrawn for the physician's personal use (generally by way of dividend or salary/bonus), there is a significant opportunity to defer tax on the earnings that remain in the MPC.

If the SBD is available, the MPC will pay a lower corporate tax rate on the first approximately $500,000 of active business income. The rates and thresholds for the SBD vary between jurisdictions (combined rates range from 9% to 12.2%), but the tax deferral opportunity is substantial since personal marginal rates, particularly for high-earning physicians, are much higher (often in excess of 50% in the top tax bracket).

It should be noted that if an MPC earns significant passive income (meaning interest, dividends or rent) exceeding $50,000 in a year, the SBD threshold is reduced. For each $1 over $50,000 of passive income in a year, the SBD threshold is reduced by $5. However, even without the SBD, the higher general corporate income tax rate is approximately 27% (the exact rate depends on the jurisdiction), which is still much lower than personal income tax rates in the higher tax brackets.

The specified corporate income ("SCI") and specified partnership income ("SPI") rules in s. 125(7) of the ITA operate to prevent Canadian-controlled private corporations ("CCPCs") from accessing the SBD in certain circumstances. For purposes of this paper, it is assumed that MPCs are CCPCs.

Associated Corporations

Associated corporations share one SBD among them. Section 256 of the ITA sets out the rules with respect to the determination as to whether corporations are associated. A discussion of the association rules is beyond the scope of this paper.

Association among MPCs is not common due to restrictions on share ownership, but association can occur where a family member is included as a shareholder of an MPC if that family member owns shares in another corporation. Since the introduction of the tax on split income rules, it is less common for family members to be introduced as shareholders of an MPC but many existing corporations still include family members as shareholders.

Specified Corporate Income

The SCI rules are designed to avoid multiplication of the SBD through establishment of separate non-associated corporations to conduct separate aspects of a business.

Under the SCI rules, where a CCPC (an "**Earner**") earns income that would otherwise be active business income from providing property or services to another private corporation (the "**Payor**") and the Earner (or one of its shareholders) or a person who does not deal at arm's length with the Earner (or one of its shareholders) holds a direct or indirect interest in the Payor, the income is SCI and is not eligible for the SBD unless all or substantially all of the Earner's income for the year from an active business is from the provision of services or property to persons (other than the Payor) with which the Earner deals at arm's length, or partnerships with which the Earner

deals at arm's length (other than a partnership in which a person that does not deal at arm's length with the Earner holds a direct or indirect interest). However, it is possible for a Payor to assign to the Earner a portion of the Payor's unused SBD limit, allowing the Earner to regain access to the SBD on what would otherwise be ineligible SCI.

Consider the following example (note that tax rates are combined federal and provincial rates applicable in Manitoba). Dr. X owns 100% of the shares of Dr. X Medical Corporation ("MedicalCo") and Dr. X's spouse, Y, owns 100% of the shares of Y Management Ltd. ("ManagementCo"). MedicalCo and ManagementCo are not associated corporations under the ITA because a corporation that is 100% owned by one spouse is not associated with a corporation that is 100% owned by the other spouse. MedicalCo earns $1,000,000 annually (before any deduction for management fees). ManagementCo employs receptionists, leases clinic space and handles all billing and scheduling of patients. ManagementCo charges management fees to MedicalCo of $500,000 annually. Without the SCI rules, ManagementCo could claim the SBD on its management fee income (tax at 9% on $500,000) and MedicalCo could claim the SBC on its medical practice income (tax at 9% on $500,000). However, through application of the SCI rules because X and Y are related (within the meaning of s. 251 of the ITA) and therefore do not deal at arm's length, the management fee income earned by ManagementCo is SCI and ineligible for the SBD unless MedicalCo assigns all or a portion of its SBD to ManagementCo. The result is that $500,000 of active business income between MedicalCo and ManagementCo is eligible for the SBD and taxed at 9% and the balance of $500,000 will bear the higher corporate tax rate of 27%.

SCI is relevant to multi-professional medical clinics because these clinics may arrange their staffing, leasing and other administrative services through separate management corporations, the shares of which are owned by the various physicians. The fees paid by the MPCs to the management company may be SCI and therefore ineligible for the SBD.

Specified Partnership Income

SPI applies to corporate partners in partnerships and is aimed at preventing multiplication of the SBD, similarly to the SCI rules.

Prior to 2016, the SPI rules required corporations that were members of a partnership to share one SBD among them, preventing multiplication of the SBD among the corporate partners on income earned through the partnership. However, it was possible for separate non-partner corporations to be established to provide services to the partnership. The SPI rules did not prevent each such corporation from using its own separate SBD on that income. The SPI rules were expanded in 2016 to prevent this type of multiplication of the use of the SBD. Without the SPI rules as they currently exist, physicians operating in a partnership could each incorporate a corporation and have the partnership pay management fees to each physician's corporation, and each corporation could use its own separate SBD to pay 9% income tax on its first $500,000 of income annually.

SPI is active business income earned by a corporation from providing services or property to a partnership in which a shareholder of the corporation is a member of the partnership or not dealing at arm's length with a member of the partnership. It is important to note that the corporation does

not itself need to be a partner – it is sufficient that a shareholder of the corporation (or a person not dealing at arm's length with a shareholder of the corporation) is a partner.

For medical clinics, it is critical to consider whether the physicians involved are practicing in partnership, because if a partnership exists, the SPI rules are applicable and will significantly restrict access to the SBD by MPCs who are partners or who are owned by individual physician partners and providing services to the partnership.

Partnerships vs. Cost Sharing Arrangements

Physicians in a multi-professional clinic may intend to be part of a cost-sharing arrangement and not to be operating in partnership, in order to preserve access to their individual SBDs. However, the factual reality is what matters and simply calling something a cost-sharing arrangement will not necessarily make it so.

A cost sharing arrangement is an agency relationship involving reimbursement of shared expenses and a written cost sharing agreement. MPCs share overhead costs (including rent, employee wages, overhead expenses, and capital and lease costs for certain furniture, equipment and medical instruments), but they maintain separate billings, retain their own profits, and avoid pooling income. If an arrangement is in fact a cost sharing arrangement, each participating MPC will retain its own separate SBD that can be applied to its billings. However, if the members of the arrangement are not careful, they run the risk that they could be seen as constituting a partnership. This is particularly the case where the MPCs market their services together (for example, under the name of one clinic), and/or operate under a centralized clinic governance structure that uses equipment in common and jointly employs professional or clerical staff. In a cost sharing arrangement, expenses should be allocated based on reasonable methodologies and tied to actual expenses. Expenses may be allocated based on space, time of use, or percentage of billings. In short, the MPCs involved should be sharing costs only and not profits. It is critical that revenues not be pooled since even if CRA were to allege a business is being carried together, it would not be with a view to a common profit, which as discussed below could tip the arrangement into being a partnership.

In a cost sharing arrangement involving agency, a particular MPC may act as the agent for the cost sharing group, or various MPCs may incur particular expenses as agent for the others in the group. The cost sharing agreement will allocate liabilities such as rent, salaries, benefits, and severance. All MPCs are involved in major expenditure decisions and employees understand that their employers are all of the MPCs. Even if each MPC periodically deposits funds into a pooled bank account that is used only to pay expenses, as long as no business revenues are deposited into that account the arrangement should qualify as a cost sharing arrangement.

A cost sharing arrangement may involve a separate corporation ("ClinicCo") that facilitates the clinic arrangements and overhead as an agent for the various MPCs, but caution should be exercised in this arrangement. Each MPC is responsible for their share of those expenses and reimburses ClinicCo. However, to the extent that ClinicCo is performing services for the MPCs, or being reimbursed for its own expenditures that are not incurred as agent for the MPCs, GST/HST may be applicable.

The term “partnership” is not defined in the ITA or the ETA. As a result, the question of whether a partnership exists is a question of mixed fact and law and is to be determined according to the law of the applicable province or territory. In general, a partnership exists where two or more persons join together to carry on a business in common with a view to profit. A partnership may exist in the absence of a written agreement between the parties. Refer to CRA GST/HST Memorandum 14-9-1, Partnerships – Determining the Existence of a Partnership[2] for CRA commentary on this matter.

Factors that may lead to a determination that a partnership exists include pooling of revenues into one account with subsequent division of profits among physicians, joint control of clinic operations through collective voting, advertising and marketing as a single group or clinic rather than as separate practices, and the ability for one physician to bind the others through contract.

In addition to being conscious of the various factual circumstances that may give rise to a cost sharing arrangement or a partnership, it is important to have appropriate written agreements in place that align with the factual reality.

Employees

The employer in a multi-physician clinic may be an individual physician, an MPC, a management company, a partnership, or a group of physicians/MPCs through a cost-sharing arrangement. This determination is fact-specific.

A centralized staffing arrangement where one entity hires all receptionists, administrators, nurses, and managers, and allocates cost among the physicians/MPCs, while common and administratively more efficient, requires appropriate documentation to confirm responsibilities and will give rise to GST/HST considerations.

If the clinic is structured as a cost sharing arrangement, one physician may be the employer with expenses reimbursed by other physicians in the clinic, or there may be a separate entity who hires the employees and is reimbursed by the various physicians. If the arrangement is truly a cost sharing arrangement, the employees are employed by each of the physicians who are part of the arrangement and documentation should reflect that fact. An agreement between them will be important to confirm allocation of cost and responsibility. However, it is necessary to consider whether a cost sharing group can engage employees jointly without being said to be a partnership. It may be that such a group could rely on the fact that revenues and profits are kept completely separate among them, such that they are not carrying on “business in common with a view to profit”.

If one party provides the services of its employees to another party, CRA considers that to be a taxable supply of administrative services and not a cost-sharing arrangement[3].

GST/HST Considerations

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[2] https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/14-9-1/partnerships-determining-existence-of-a-partnership.html

[3] 5 July 1999 GST/HST Interpretation HQR0001676 - Cost-Sharing Arrangement Among Medical Practitioners

Most health and medical services performed by physicians are exempt supplies pursuant to section 2 of Part II of Schedule V to the ETA. As a result, physicians and MPCs are generally not registered for GST/HST and they do not collect or remit GST/HST on their services. Certain uninsured services such as cosmetic services (i.e. those not for medical or reconstructive purposes), third-party reports such as those for CPP disability, legal proceedings or insurance companies, or administrative fees (e.g. for non-essential letters or witness fees) will be subject to GST/HST. The supply of qualifying medical devices, prescription drugs and drug-dispensing services qualifies as a zero-rated supply (i.e. they are taxable supplies but taxed at 0%).

Since most medical services are exempt supplies, physicians cannot generally claim input tax credits ("**ITCs**") for GST/HST paid on business expenses, meaning that any GST/HST paid is an unrecoverable cost. If there are taxable (including zero-rated) supplies being provided, the physician may be required to register for GST/HST and can claim ITCs on expenses related to those specific activities. Input tax credits must be pro-rated based on percentage of taxable income for practices involving exempt and taxable supplies.

For CRA commentary concerning agency and cost sharing arrangements in the context of GST/HST, see GST/HST Policy Statement P-182R[4], which explains CRA's understanding of the application of the law in the determination of the existence of an agency relationship (not only in the context of a medical clinic). In addition, GST/HST Policy Statement P-238, Application of the GST/HST to Payments Made Between Parties Within a Medical Practice Organization[5] discusses the following clinic structures:

1. sole proprietor using the services of a locum;
2. principal practitioner using the services of one or more contracted associates;
3. partnership;
4. cost-sharing among practitioners under an agency arrangement; and
5. practitioners using the services of a management company.

Where a physician-owned clinic (for example, a clinic owned by a partnership consisting of physicians/MPCs) engages with independent contractor physicians, and the agreement between the clinic and the physician is that fees belong to the clinic and the clinic pays the physicians a portion of their fees for their services, then GST/HST is not payable. If, however, the agreement is that the fees belong to the physicians and the physicians pay a portion to the clinic, the portion payable to the clinic will bear GST/HST but if the clinic is collecting GST/HST, ITCs can be claimed on a portion of the clinic's costs allocable to providing facilities to the independent contractor physicians. The first determination is who "owns" the fees (per the agreement between the parties) and the second determination is what amount is moving between the physician and clinic (or vice versa) and what that amount is for.

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[4] https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/p-182r/agency.html#P201_34002

[5] https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/p-238/application-gst-hst-payments-made-between-parties-within-a-medical-practice-organization.html

It should be noted that if there is a contractual relationship between the independent contractor physicians and a facility not owned by other physicians, inevitably there will be GST on the facility's charges.

GST/HST Policy Statement P-238 provides that the following principles will be applicable with respect to GST/HST:

1. Where there is a "bona fide" arrangement to share fees for insured exempt health care services between a principal/locum or principal/associate, then GST/HST will not be applicable regardless of who actually bills and initially receives the fee from the province.
2. Where there is an agreement between a principal and a locum/associate where the locum/associate agrees to pay for the use of the clinic facilities/administration, the principal has made a taxable supply to the locum/associate. The supply may be administrative services and/or real property, depending on the facts.
3. For purpose of GST/HST, partners cannot be distinguished from the partnership. In this context, there is no supply from a partnership to its partners, or vice versa.
4. In a cost-sharing agency arrangement, if one physician incurs an expense in the capacity as agent for the other physicians in the clinic, there is no supply and therefore no GST/HST.
5. In a cost-sharing agency agreement, if an entity separate from the physicians (the "Agent Corporation") acts as agent for the physicians, no GST/HST will be applicable for expenses reimbursed to the agent by the physicians. However, it will be a question of fact as to whether the Agent Corporation is acting as agent for the physicians in every transaction. For example, if the cost-sharing agreement provides for joint hiring of employees, those employees will need to be paid. If the Agent Corporation contracts with a payroll service on behalf of the physicians, then the reimbursement of that expense will not be subject to GST/HST. If, however, the Agent Corporation attends to payroll matters itself, it is providing that service to the physicians and is not acting as agent, and that is a taxable supply that will be subject to GST/HST. Further, if the Agent Corporation is reimbursed for its own expenses incurred in the course of its activities (i.e. expenses not incurred as agent for the physicians), that reimbursement is also a taxable supply.
6. The clinic may be managed by an entity that is separate from the physicians (although the ownership entity may be owned by one or more of the physicians) (the "Manager"). The Manager may own or lease the clinic facilities and equipment, and may employ receptionists and nurses. The Manager enters into contracts with physicians pursuant to which the physicians will provide services to individuals at the clinic and the Manager will receive a percentage of fees collected. In such a case:
    a. The Manager is not supplying health care services, but rather has been engaged by the physicians to supply administrative services.
    b. The portion of fees retained by the Manager, or any amount paid to the Manager by the physicians, will be a taxable supply of administrative services, being use of the facility and medical equipment and administrative services.

Where the physicians/MPCs who operate the clinic and are responsible for bearing the overhead costs engage other physicians to act as independent contractors, CRA has expressed the view

that in exchange for the monthly payment from the associate physicians, the owner physicians/MPCs are making a taxable supply of management services to the associate physician[6]. This aligns with the CRA's statements in GST/HST Policy Statement P-238.

However, GST/HST Policy Statement P-238 and other CRA documents should be reviewed in if there are circumstances that parallel those in the decision of the Tax Court of Canada in *MedSleep Inc. v The King*[7].

MedSleep v The King

MedSleep operates sleep clinics throughout Canada and provides diagnostic sleep studies to patients in coordination with physicians specializing in sleep disorders (called "Sleep Physicians" in the decision). It hires administrative staff, nurses, technicians, a director of education and medical directors. It also contracts with the Sleep Physicians. When a patient is referred by a third party physician (usually their family physician) to MedSleep, they complete a medical questionnaire which is reviewed by MedSleep employees. The patient is then referred to a Sleep Physician who reviews the file, meets with the patient, and determines an initial course of treatment. The patient may undergo an overnight sleep test conducted at a MedSleep clinic, called a "Sleep Study" in the decision. A registered polysomnographic technician prepares the patient and collects the data, a Sleep Physician (not necessarily the one assigned to the patient) is on call during the test, and a scoring technician reviews the pre- and post-sleep questionnaires and scores the data, resulting in identification of data indicative of a sleep disorder. The overall report is sent to the assigned Sleep Physician who reviews and revises the report as necessary and signs off on the content and recommendations. MedSleep then communicates the patient's complete medical records back to the referring physician.

The Sleep Studies involved a professional fee relating to the parts of the process performed by Sleep Physicians. The professional fee is paid by provincial health insurance and billing was coordinated between MedSleep and the Sleep Physician under the Sleep Physician's individual billing code and MedSleep's health facility code. While MedSleep prefers to perform all billing activities, some Sleep Physicians did bill the professional fees themselves. The professional fee is allocated between MedSleep and the Sleep Physician according to an agreement between them pursuant to a provision called "Fee Sharing", typically 80% to MedSleep and 20% to the Sleep Physician (with some variation).

MedSleep was assessed for GST/HST under s. 221(1) of the ETA on the basis that MedSleep made a separate taxable supply of services to the Sleep Physicians and did not collect GST/HST as required on that supply. MedSleep took the position that it provided exempt medical services to patients and that the component parts of those services cannot be separated.

The Minister took the position that MedSleep provided the Sleep Physicians with administrative services including referral intake, scheduling and rescheduling appointments, billings, and

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[6] 17 March 2000 GST/HST Interpretation 7355/HQR0000961 - Cost-Sharing Agreement Among Physicians Operating a Medical Clinic

[7] *MedSleep Inc. v The King*, 2025 TCC 70

communication service, together with extensive marketing services, for which the Sleep Physicians pay MedSleep a percentage of professional fees earned by them.

The TCC determined that notwithstanding that provincial health insurance will only pay physicians, fee sharing arrangements can be effective for tax law purposes, and that the professional fee could properly be allocated between the Sleep Physician and MedSleep in accordance with services provided to patients by the Sleep Physicians and MedSleep working jointly together. Further, the TCC confirmed that "when individual components of an overall supply are interdependent and intertwined to such an extent that they cannot be sensibly separated, for GST purposes, such components should be considered a single compound supply"[8] and that the predominant element of the supply is the supply of a medical service. There was no separate taxable supply provided to physicians and s. 221(1) of the ETA did not apply.

[8] *MedSleep Inc. v The King*, 2025 TCC 70, at para. 64