

**DISTRICT OF COLUMBIA BOARD OF EDUCATION**

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**NOTICE OF FINAL RULEMAKING**

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The District of Columbia Board of Education ("Board"), pursuant to the authority generally set forth in D.C. Code, 2001 Edition, Section 38-101, and specifically provided in D.C. Official Code, Section 38-102(c) (relating to the establishment of guidelines for admission eligibility), hereby gives notice of final rulemaking action taken by the Board at its meeting held on September 20, 2006, to amend Chapter 20 of the Board Rules, Title 5 of the D.C. Municipal Regulations regarding Eligibility for Admission.

This amendment will effect the following actions: 1.) Change the date used to determine admissions for pre-kindergarten students over the 2006-2007 and 2007-2008 school years; 2.) Change the date used to determine admissions for kindergarten students over the next two school years; and 3.) Change the date used to determine admissions for first grade students for the 2008-2009 school year.

The final rulemaking will take upon its publication in the D.C. Register. The emergency and proposed rulemaking on this subject was published in the D.C. Register on August 11, 2006.

**2004 ELIGIBILITY FOR ADMISSION**

Amend Section 2004.2 as follows:

A student who is or will become four (4) years of age on or before December 31st of the 2006-2007 or 2007-2008 school year and September 30<sup>th</sup> in all subsequent school years shall be eligible for the pre-kindergarten program. A student who is or will become four (4) years of age between September 30 and December 31 during the 2006-2007 or 2007-2008 school year will have a choice between the old cut-off date of December 31 or the new cut-off date of September 30.

Amend Section 2004.3 as follows:

2004.3 A student who is or will become five (5) years of age on or before December 31st of the 2006-2007 school year and September 30<sup>th</sup> in all subsequent school years shall be eligible for admission to the kindergarten program.

Amend Section 2004.5 as follows:

2004.5 A student who is or will become six (6) years of age on or before December 31st of the 2006-2007 and 2007-2008 school years and September 30<sup>th</sup> in all subsequent school years shall be eligible for admission to the first (1st) grade.

This rulemaking is available on the District of Columbia Public Schools website at [http://www.k12.dc.us/dcps/boe/boe\\_frame.html](http://www.k12.dc.us/dcps/boe/boe_frame.html). Copies of this rulemaking are available from the Office of the Board of Education by calling (202) 442-4289.

**DISTRICT OF COLUMBIA BOARD OF EDUCATION**

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**NOTICE OF FINAL RULEMAKING**

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The Board of Education ("Board"), pursuant to the authority set forth in D.C. Official Code, §§38-101 & 38-102 et seq., hereby gives notice of final rulemaking action taken by the Board at its meeting held on September 20, 2006, to amend Chapter 21 of the Board Rules (Title 5 of the D.C. Municipal Regulations).

This amendment will effect the following actions: 1) Clarify early dismissals and Half-Day Schedules; 2) Clarify the grades secondary students will receive for certain unexcused absences; 3) Establish the number of unexcused absences that will cause elementary and secondary students not to be promoted; and 4) Establish that certain unexcused absences shall be referred to the Student Support Teams, the Child and Family Services Agency, Office of the Attorney General or D.C. Superior Court for suspected educational neglect.

The final rulemaking will take effect upon its publication in the D.C. Register. The proposed rulemaking on this subject was published in the D.C. Register on July 28, 2006.

**Amend Section 2103 as follows:**

2103.4 Elementary and Secondary students attending D.C. Public Schools shall remain in school until the official close of the school day. The end of the school day is 3:15 p.m. D.C. Public Schools will not recognize early dismissal of students prior to 3:15 p.m. unless such dismissal is related to a lawful reason for absence.

2103.5 Half-day schedules for students attending D.C. Public Schools are restricted to the following:

a) employed students aged 17 or older whose hours of employment fall within the regular school day; or

b) secondary students attending one of the local colleges or universities.

The student's employment and work hours or college schedule must be verified by the local school. Students who are not employed or attending one of the local colleges or universities will have a full schedule as will those whose employment begins after regular school hours.

- 2103.6 Elementary and Secondary students attending D.C. Public Schools with five or more unexcused absences will be referred to the Student Support Teams (SST). The Student Support Teams located in each local school shall be available to address and review attendance issues. The Student Support Team's duties shall include but not be limited to reviewing academic and attendance concerns, developing attendance intervention strategies and identifying local school and community resources to abate truancy and improve school attendance.
- 2103.7 D.C. Public School secondary students with five (5) or more unexcused absences in any class during a single advisory shall receive a grade reduction in that subject.
- 2103.8 D.C. Public School secondary students with ten (10) or more unexcused absences in any class during a single advisory shall receive a grade of "FA" (failure due to absences) in that subject.
- 2103.9 D.C. Public School elementary students accumulating thirty (30) or more unexcused absences within a full school year shall not be promoted.
- 2103.10 D.C. Public School secondary students accumulating thirty (30) or more unexcused absences in a course within a full school year shall receive a failing final grade in that course with a resulting loss of course credit.
- 2103.11 Elementary and Secondary students attending D.C. Public Schools with ten (10) or more unexcused absences will be referred to the Child and Family Services Agency (CFSA) for suspected educational neglect.
- 2103.12 Elementary and Secondary students attending D.C. Public Schools who have demonstrated a pattern of unexcused absences, in excess of fifteen (15) days, unabated by local school intervention, shall be referred to the Office of the Attorney General and or the Family Branch, Social Services Division, D.C. Superior Court.
- 2103.13 A written appeal may be filed by a parent or student on behalf of any student receiving a reduced or a failing grade(s) due to unexcused absences.
- 2103.14 An appeal filed pursuant to § 2103.10 shall be submitted to the principal of the school involved within ten (10) business days after receipt of the failing grade(s).
- 2103.15 Upon receipt of an appeal, filed pursuant to § 2103.13, the principal shall appoint an Appeals Panel and shall forward all written appeal requests to the panel chairperson within three (3) business days.

- 2103.16 The Appeals Panel referenced in § 2103.15 shall consist of not less than three (3) members to be selected from the following:
- (a) The principal's designee, who shall be the panel chairperson;
  - (b) A guidance counselor;
  - (c) A department chairperson;
  - (d) A teacher, other than the one involved;
  - (e) An attendance staff person;
  - (f) A student body representative; or
  - (g) A parent organization representative.
- 2103.17 Appropriate substitutions in the Appeals Panel described in § 2103.16 may be made when necessary; provided, that a student body representative shall be on each Appeal Panel.
- 2103.18 The Appeals Panel shall hold a hearing within ten (10) calendar days after its appointment by the principal.
- 2103.19 The student or his or her parent, guardian or duly authorized representative shall appear at the hearing. One of these individuals shall be given the opportunity to present the student's case and, upon request, to question the involved teacher and to be duly informed of the panel's recommendations.
- 2103.20 Each appeals panelist, including the chair, shall have an equal vote.
- 2103.21 In the case of a tie vote, the Appeals Panel shall recommend that the initial grade be upheld.
- 2103.22 The Appeals Panel's recommendation shall be forwarded immediately to the principal who shall issue the Panel's decision within ten (10) calendar days after the hearing.

- 2103.23 The student or his or her parent or guardian may appeal the decision of the Appeals Panel by writing to the D.C. Public Schools Student Hearing Office within ten (10) calendar days after receipt of the decision.
- 2103.24 When an appeal is filed pursuant to § 2103.23, the Student Hearing Office shall convene a hearing before an independent hearing officer who shall issue the final administrative decision in the matter.
- 2103.25 The following procedural guidelines shall apply to hearings convened pursuant to § 2103.24:
- (a) The burden to show why the grade(s) in question should be changed shall be on the student or his or her parent or guardian;
  - (b) Strict rules of evidence shall not apply;
  - (c) Testimony or evidence shall be heard from both parties; and
  - (d) A written determination shall be issued within five (5) business days of the hearing.

This rulemaking is available on the District of Columbia Public Schools website at [http://www.k12.dc.us/dcps/boe/boe\\_frame.html](http://www.k12.dc.us/dcps/boe/boe_frame.html). Copies of this rulemaking are available from the Office of the Board of Education by calling (202) 442-4289.

## DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to section 549(g) of the Public Assistance Act of 1982, effective April 6, 1982 (D.C. Law 4-101; D.C. Official Code § 4-205.49(g)) (the "Act"), and Mayor's Order 2006-50, dated April 13, 2006, hereby gives notice of the adoption of the following amendments to section 1450 of Chapter 14 of Title 29 of the District of Columbia Municipal Regulations (DCMR). Notice of Proposed Rulemaking was published on September 1, 2006 (53 DCR 7237). Two comments submitted by two organizations have been received and reviewed. No changes have been incorporated into the final rules.

**Chapter 14 (Health-Care Assistance Reimbursement) of Title 29 (Public Welfare) (May 1987) is amended as follows:**

**Section 1450 is amended to read as follows:**

**1450 PERSONAL NEEDS ALLOWANCES**

- 1450.1 The Director of the Department of Health (Director) shall allow each District of Columbia resident who is a recipient of Supplemental Security Income (SSI) and who lives in a community residence facility or Assisted Living Residence to retain a personal needs allowance for clothing and personal needs.
- 1450.2 Each individual entitled to a personal needs allowance pursuant to § 1450.1 shall retain the personal needs allowance from his or her monthly SSI benefit amount.
- 1450.3 The personal needs allowance in § 1450.1 shall be one hundred dollars (\$100) per month.

**DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

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**NOTICE OF FINAL RULEMAKING**

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The Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner"), pursuant to the authority set forth in sections 4, 5, 6, 9, and 11 of the Medicare Supplement Insurance Minimum Standards Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-170, D.C. Official Code §§ 31-3703, 31-3704, 31-3705, 31-3708, and 31-3710 (2001)), and Mayor's Order 93-60, dated May 12, 1993, hereby gives notice of the adoption of amendments to Chapter 22 (Medicare Supplement Insurance Minimum Standards) of Title 26 (Insurance) of the District of Columbia Municipal Regulations. Notice of Emergency and Proposed Rulemaking was published on August 11, 2006 at 53 DCR 6596. No comments were received concerning these rules and no changes have been made since publication as a Notice of Emergency and Proposed Rulemaking. These final rules will be effective upon publication of this notice in the D.C. Register.

Chapter 22 (Medicare Supplement Insurance Minimum Standards) of Title 26 (Insurance) of the District of Columbia Municipal Regulation is amended as follows:

1. Subsection 2205.4 is amended to read as follows:

2205.4            Subject to subsections 2206.7, 2206.8, 2206.9, 2206.10, 2206.11, 2206.13, 2207.7, and 2207.8, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

2. Subsection 2208.2 is amended to read as follows:

2208.2            No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in the District, except as may be permitted in subsection 2208.9 and 2208A.

3. Subsection 2208.7 is amended as follows:

A. Paragraph (f) is amended to read as follows:

- (f)    (1)    Standardized Medicare supplement benefit plan "F" shall include only the following:
- (A)    The Core Benefit as defined in subsection 2207.14; and
  - (B)    The Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and

Medically Necessary Emergency Care in a foreign Country as defined in subsections 2207.15(a), (b), (c), (e), and (h);

- (2) Standardized Medicare supplement benefit high deductible "F" shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in section 2207.14, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in section 2207.15(a), (b), (c), (e), and (h). The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be \$1500 for 1998 and 1999 and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

B. Paragraph (j) is amended to read as follows:

- (j) Standardized Medicare supplement benefit plan "J" shall consist of only the following:
  - (1) The Core Benefit as defined in subsection 2207.14; and
  - (2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in subsections 2207.15(a), (b), (c), (e), (g), (h), (i), and (j); and
  - (3) The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005; and

C. Paragraph (k) is deleted.

4. Paragraph (a) of subsection 2209.6 is amended to read as follows:

- (a) In the case of an individual described in subsection 2209.3(b), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation) or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

5. Subsection 2220.9 is amended to read as follows:

2220.9 The following items shall be included in the outline of coverage in the order prescribed below. (The bracketed numbers contained in the charts displaying the features of each benefit plan shall be updated by the issuer so that the numbers remain consistent with any updated amounts promulgated by the Secretary.)

6. Section 2228 is amended to read as follows:

**2228 MEDICARE SELECT POLICIES AND CERTIFICATES**

- 2228.1 (a) This section shall apply to Medicare Select policies and certificates, as defined in this section.
- (b) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.
- 2228.2 For the purposes of this section, the following words and phrases shall have the meanings ascribed:
- (a) Complaint - any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
- (b) Grievance - dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.
- (3) Medicare Select issuer - an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
- (4) Medicare Select policy or Medicare Select certificate - respectively a Medicare supplement policy or certificate that contains restricted network provisions.
- (5) Network provider - a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.
- (6) Restricted network provision - any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.
- (7) Service area - the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

- 2228.3 The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act of 1990, approved November 5, 1990 (104 Stat. 1388-135; 42 U.S.C. § 1395), if the Commissioner finds that the issuer has satisfied all of the requirements of this section.
- 2228.4 A Medicare Select issuer shall not issue a Medicare Select policy or certificate in the District until its plan of operation has been approved by the Commissioner.
- 2228.5 A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:
- (a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:
    - (1) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;
    - (2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to:
      - (A) Deliver adequately all services that are subject to a restricted network provision; or
      - (B) Make appropriate referrals;
    - (3) There are written agreements with network providers describing specific responsibilities;
    - (4) Emergency care is available twenty-four (24) hours per day and seven (7) days per week; and
    - (5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual

insured under a Medicare Select policy or certificate. This sub-paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate;

- (b) A statement or map providing a clear description of the service area;
- (c) A description of the grievance procedure to be utilized;
- (d) A description of the quality assurance program, including:
  - (1) The formal organizational structure;
  - (2) The written criteria for selection, retention and removal of network providers; and
  - (3) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;
- (e) A list and description, by specialty, of the network providers;
- (f) Copies of the written information proposed to be used by the issuer to comply with subsection 2208.9; and
- (g) Any other information requested by the Commissioner.

2228.6

- (a) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved.
- (b) An updated list of network providers shall be filed with the Commissioner at least quarterly.

2228.7

A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

- (a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
- (b) It is not reasonable to obtain services through a network provider.

- 2228.8 A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.
- 2228.9 A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
- (a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
    - (1) Other Medicare supplement policies or certificates offered by the issuer; and
    - (2) Other Medicare Select policies or certificates;
  - (b) A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;
  - (c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L;
  - (d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage;
  - (e) A description of limitations on referrals to restricted network providers and to other providers;
  - (f) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and
  - (g) A description of the Medicare Select issuer's quality assurance program and grievance procedure.
- 2228.10 Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to

Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

- 2228.11
- (a) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.
  - (b) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.
  - (c) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
  - (d) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.
  - (e) If a grievance is found to be valid, corrective action shall be taken promptly.
  - (f) All concerned parties shall be notified about the results of a grievance.
  - (g) The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.
- 2228.12
- At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.
- 2228.13
- (a) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

- (b) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.
- 2228.14 (a) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.
- (b) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.
- (c) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.
- 2228.15 A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

7. A new section 2229 is added to read as follows:

**2229 SEVERABILITY**

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

**DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

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**CORRECTED  
NOTICE OF FINAL RULEMAKING**

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The Commissioner of the Department of Insurance, Securities, and Banking, pursuant to the authority set forth in section 147 of the Continuing Care Retirement Communities Act of 2004, effective April 6, 2005 (D.C. Law 15-270; D.C. Official Code § 44-151.01 *et seq.*) (2005 Supp.) (“Act”), hereby gives notice of the adoption of a new Chapter 82, entitled Continuing Care Retirement Communities, to Title 26 (Insurance) of the D.C. Municipal Regulations. The purpose of this new chapter is to implement the Act by establishing the licensing process for continuing care retirement communities; establishing the information to be included in a financial forecast; establishing standards for revocation of a start-up certificate, preliminary certificate, permanent license, and restricted or conditional license; and establishing standards for the Commissioner to determine whether a continuing care retirement community is insolvent or in a hazardous financial condition. Notice of Proposed Rulemaking was published on December 2, 2005, at 52 DCR 10572. No comments were received concerning the proposed rules. An erroneous Notice of Final Rulemaking was published on February 24, 2006, at 53 DCR 1399. **This Notice of Final Rulemaking corrects and replaces the Notice of Final Rulemaking published on February 24, 2006.**

Title 26 (Insurance) of the D.C. Municipal Regulations is amended by adding a new Chapter 82, Continuing Care Retirement Communities, to read as follows:

**Chapter 82 CONTINUING CARE RETIREMENT COMMUNITIES**

**8200 LICENSURE PROCEDURES**

- 8200.1 An individual or business entity seeking to develop, construct, operate, purchase, or expand a continuing care facility (“applicant”) shall apply for a license in accordance with the procedures contained in this section. All forms referred to in this section and following sections may be found on the Department of Insurance, Securities, and Banking website at [disb.dc.gov](http://disb.dc.gov).
- 8200.2 For new or development stage facilities, the applicant shall submit the following items to the Commissioner for review:
- (a) The applicant’s name, address, and telephone number;
  - (b) A copy of a non-binding reservation agreement form (a nonbinding agreement between a continuing care facility and future resident (or his or her representative) to reserve a unit in the continuing care facility);

- (c) An escrow agreement to establish an escrow account in compliance with the requirements of section 109 of the Act;
- (d) A narrative describing the facility, its mode of operation, and its location; and
- (e) Any advertising materials to be used.

8200.3 After submitting all of the items described in subsection 8200.2, the applicant for a new or development stage facility may:

- (a) Disseminate materials describing the intent to develop a continuing care facility; and
- (b) Enter into fully refundable non-binding reservation agreements for up to one thousand dollars (\$1,000). All funds received shall be escrowed with a bank, trust company, or other independent person or entity agreed upon by the provider and the resident.

8200.4 To obtain a Start-Up Certificate, an applicant for a new or development stage facility or provider shall have submitted the items described in section 8200.2 and shall submit the following to the Commissioner for review:

- (a) An application for licensure, accompanied by a five hundred dollar (\$500) filing fee;
- (b) A disclosure statement as required by section 105 of the Act;
- (c) A copy of a binding reservation agreement form or resident agreement form; and
- (d) A market feasibility study.

8200.5 Upon issuance of a Start-Up Certificate, the applicant or provider may:

- (a) Enter into binding reservation agreements or resident agreements;
- (b) Accept entrance fees and entrance fee deposits over one thousand dollars (\$1,000). Any funds received shall be escrowed and shall be released only with the approval of the Commissioner;
- (c) Begin site preparation work; and
- (d) Construct model units for marketing.

- 8200.6 To obtain a Preliminary Certificate, an applicant or provider must hold a valid Start-Up Certificate and shall submit the following to the Commissioner for review:
- (a) An explanation of any material differences between actual costs and projected costs contained in the Start-Up Certificate submission, except that an explanation is not required for existing continuing care facilities that are seeking to expand;
  - (b) An updated disclosure statement;
  - (c) Current interim financial statements; and
  - (d) Confirmation of signed reservation agreements for at least 50 percent (50%) of any new units and confirmation that those units were reserved through a deposit equal to at least 10 percent (10%) of the entrance fee or by a non-refundable deposit equal to the periodic fee for at least two (2) months for continuing care facilities that have no entrance fee.
- 8200.7 Upon issuance of a Preliminary Certificate, an applicant or provider may:
- (a) Purchase or construct a continuing care facility;
  - (b) Renovate or develop structure(s) not already licensed as a continuing care facility; or
  - (c) Expand an existing continuing care facility in excess of ten percent (10%) of the current number of available independent living units or available health related units/beds.
- 8200.8 To obtain a Permanent License, an applicant or provider must hold a valid Preliminary Certificate and shall submit the following to the Commissioner for review at least sixty (60) days before the opening of the continuing care facility:
- (a) An updated application for licensure;
  - (b) An updated disclosure statement;
  - (c) Confirmation of signed reservation agreements for new units required by the continuing care facility to break even and confirmation that those units were reserved by a deposit equal to at least ten percent (10%) of the entrance fee or by a non-refundable deposit equal to the periodic fee for at least two (2) months for continuing care facilities that have no entrance fee;

- (d) All reports as required by an approved accrediting organization for the continuing care facility to maintain its accreditation; and
- (e) A summary of the report of an actuary estimating the capacity of the applicant or provider to meet its contractual obligation to the residents.

8200.9 Upon issuance of a Permanent License and satisfaction of all other legal requirements, the applicant or provider may:

- (a) Open the continuing care facility; and
- (b) Provide continuing care services.

8200.10 If all other licensing requirements are met, the Commissioner may, in lieu of denying the issuance of a Permanent License, issue a Restricted or Conditional License to an applicant if one (1) or more of the following conditions exist:

- (a) A hazardous financial condition; or
- (b) Occupancy at the facility, or the number of executed agreements for new units at the facility, is below the level at which the facility would break even.

8200.11 Upon issuance of a Restricted or Conditional License, a provider may operate the facility under the conditions or restrictions established by the Commissioner until such time as the Commissioner alters the conditions or restrictions or issues a Permanent License.

8200.12 Upon issuance of a Restricted or Conditional License, a provider shall file with the Commissioner each quarter a financial statement and an occupancy report, both due no later than forty-five (45) days following the end of each fiscal quarter.

8200.13 All continuing care facilities operating in the District of Columbia on the effective date of these regulations shall submit an application for a Permanent License with a filing fee of five hundred dollars (\$500) attached within one hundred twenty (120) days after the effective date of these regulations. An existing continuing care facility may apply for a Permanent License without first obtaining a Start-Up Certificate or Preliminary Certificate. An application for a Permanent License under this subsection shall be accompanied by the following:

- (1) Disclosure statement;
- (2) Financial statements;
- (3) Escrow agreement;

- (4) Narrative describing the facility, its mode of operation, and its location;
- (5) Advertising materials that are used or to be used; and
- (6) Confirmation of signed agreements for units in the continuing care facility to break even and confirmation that those units were reserved by a deposit equal to at least ten percent (10%) of the entrance fee or by a non-refundable deposit equal to the periodic fee for at least two (2) months for continuing care facilities that have no entrance fee.

8200.14 A continuing care facility that has applied for a Permanent License pursuant to subsection 8200.13 may continue to operate until the Commissioner acts upon the application for a Permanent License. If the application is denied, the applicant shall thereafter be treated as a continuing care facility whose license or certificate of authority has been revoked.

**8201 REVOCATION, SUSPENSION, OR DENIAL OF LICENSE;  
ADMINISTRATIVE PENALTIES**

8201.1 The suspension, revocation, denial, and administrative penalty processes provided in this section shall apply to a Start-Up Certificate, Preliminary Certificate, Permanent License, and Restricted or Conditional License.

8201.2 The suspension or revocation of a license or certificate of authority, the denial of an application for a license or certificate of authority, or the imposition of an administrative penalty shall be by written order and shall be sent to the continuing care facility, provider, or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, denial, or imposition of administrative penalty is based. A continuing care facility, provider, or applicant may in writing request a hearing within thirty (30) days from the date of the mailing of the order. If no written request is made, the order shall be final upon expiration of the thirty (30) day period.

8201.3 If a continuing care facility, provider, or applicant requests a hearing, the Commissioner shall issue a written notice of hearing and send it to the continuing care facility, provider, or applicant by certified or registered mail. The notice shall include a specific date, time, and place for the hearing.

8201.4 If a hearing is requested, the Commissioner or his or her designee shall be in attendance and shall conduct the proceedings. The provisions of the District of Columbia Administrative Procedure Act, approved October 21, 1968, (82 Stat. 1204; D.C. Official Code § 1-1501 *et seq.*) shall apply to proceedings under this subsection.

8201.5 After a hearing, or upon failure of the continuing care facility, provider, or applicant to appear at a hearing, the Commissioner shall issue a decision and order that includes findings of fact and conclusions of law. The Commissioner's decision and order shall be sent to the continuing care facility, provider, or applicant by certified mail. The Commissioner's decision and order shall be subject to appeal to the District of Columbia Court of Appeals.

8201.6 If the license or certificate of authority of a continuing care facility, provider, or applicant is revoked, such entity shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs in the District and shall conduct no further business in the District except as may be essential to the orderly conclusion of its affairs in the District. The continuing care facility, provider, or applicant shall engage in no further advertising or solicitation in the District. The rehabilitation and liquidation provisions of section 111 of the Act shall be implemented unless the Commissioner, by written order, permits further operation of the continuing care facility as the Commissioner may find to be in the best interest of residents of a continuing care facility, to the end that residents will be afforded the greatest practical opportunity to obtain continuing care services.

## **8202 SALE OR TRANSFER OF OWNERSHIP**

The sale or transfer of ownership process in section 104 of the Act shall apply to the holder of a Start-Up Certificate, Preliminary Certificate, Permanent License, and Restricted or Conditional License.

## **8203 STANDARDIZED DISCLOSURE STATEMENT FORMAT**

All disclosure statements shall be prepared following a standardized format issued by the Commissioner, which the Commissioner may update as necessary.

## **8204 HEALTH AND FINANCIAL CONDITIONS FOR ACCEPTANCE**

The health and financial conditions for acceptance as a resident shall appear within the disclosure statement. The disclosure statement shall also include any conditions related to the acceptance conditions required by the provider or continuing care facility, such as age, ability to move or communicate, minimum assistance levels necessary to perform daily activities, prepared wills, and ability to pay under specified conditions.

## **8205 FINANCIAL STATEMENTS AND COMPILED FIVE -YEAR FORECASTS**

8205.1 Certified financial statements, as required by section 105(a)(10) of the Act, and compiled five (5) year forecasts, as required by section 105(a)(12) of the Act,

shall be prepared by an independent certified public accountant and shall be of the provider's corporation or other legal entity that owns the continuing care facility. The Commissioner may require the provider to supply supplementary financial data or other appropriate disclosure on individual continuing care facilities if a corporation or other legal entity owns various continuing care facilities or is engaged in various enterprises.

8205.2 The Commissioner may accept all or part of the report and supporting documentation of an approved accrediting organization acceptable to the Commissioner, to satisfy the review requirements under the Act; provided, that such acceptance shall not preclude the Commissioner from performing the examination function.

**8206 COMPILED FIVE-YEAR FORECAST**

8206.1 The compiled five (5) year forecast shall consist of the following:

- (a) A balance sheet including, at a minimum, individual categories or line items that sum into the following subtotals:
  - (1) Current assets;
  - (2) Restricted assets, including a line item for operating reserve assets;
  - (3) Fixed assets, including property, plant, and equipment;
  - (4) Total assets;
  - (5) Current liabilities;
  - (6) Long-term debt;
  - (7) Total liabilities;
  - (8) Overdue revenue – refundable;
  - (9) Deferred revenue – nonrefundable;
  - (10) Equity or fund balance – unrestricted; and
  - (11) Equity or fund balance – restricted;
- (b) A statement of operations including, at a minimum, the following categories or line items:
  - (1) Monthly fee revenues;

- (2) Amortization of entrance fees;
  - (3) Health care revenues;
  - (4) Investment/interest income;
  - (5) Contributions/gifts;
  - (6) Health care expenses;
  - (7) Operation expenses, consisting of at least maintenance, laundry, and housekeeping;
  - (8) Dietary expenses;
  - (9) Administrative expenses;
  - (10) Interest expenses; and
  - (11) Depreciation;
- (c) A statement of cash flows; and
- (d) A narrative detailing all significant assumptions.

**8207****INFORMATION REQUIRED OF PROPOSED OR DEVELOPMENT STAGE FACILITIES APPLICABLE TO FACILITIES SEEKING TO EXPAND**

The Commissioner may require all or part of the information listed in section 105(a)(14) of the Act be provided by existing continuing care facilities that apply to expand their facilities.

**8208****INSOLVENCY OR HAZARDOUS FINANCIAL CONDITION****8208.1**

The Commissioner may deem a provider or continuing care facility that has a negative fund balance to be insolvent or in imminent danger of becoming insolvent if any of the following hazardous financial condition standards or factors are applicable or present:

- (1) There are findings or conditions reported in the provider's or continuing care facility's financial statements that the Commissioner determines to be adverse to the financial stability of the provider or continuing care facility;
- (2) The current or projected ratios of total assets, including required reserve levels, to total liabilities indicate an impairment or deterioration of the

provider's or continuing care facility's operations or equity or demonstrate a trend that could lead to an impairment or a deterioration of the provider's or continuing care facility's operations, working capital, or equity;

- (3) The current or projected ratios of current assets to current liabilities indicate an impairment or deterioration of the provider's or continuing care facility's operations, working capital, or equity or demonstrate a trend that could lead to an impairment or a deterioration of the provider's or continuing care facility's operations, working capital, or equity;
- (4) The provider or continuing care facility is unable to perform normal daily activities and meet its obligations as they become due, considering the provider's or continuing care facility's current or projected cash flow and liquidity position;
- (5) The provider's or continuing care facility's operating losses for the past year or projected operating losses are of such magnitude as to jeopardize normal daily activities or continued operations of the provider or continuing care facility;
- (6) The insolvency of an affiliated provider or continuing care facility or other affiliated person results in legal liability of the provider or continuing care facility for payments and expenses of such magnitude as to jeopardize the provider's or continuing care facility's ability to meet its obligations as they become due, without the substantial disposition of assets outside the ordinary course of business, restructuring of debt, or externally forced revisions of its operations;
- (7) The provider or continuing care facility has receivables that are more than ninety (90) days old;
- (8) The insolvency is not temporary and the provider or continuing care facility cannot demonstrate that the insolvency will be materially reduced or eliminated;
- (9) There is an adverse effect on the provider or continuing care facility of reporting entrance fees as deferred revenues, with consideration given to all reporting requirements required under generally accepted accounting principles and the ultimate net income component of those revenues; and
- (10) A start-up provider or continuing care facility or any operational provider or continuing care facility undergoing plant expansion or refinancing of its debt has a financial condition as a result of such action that could seriously jeopardize its present or future operations.

8208.2 The provider or continuing care facility shall prepare a plan to address and correct any condition that has led to a determination of insolvency or imminent danger of insolvency by the Commissioner. The plan must be presented to the Commissioner within ninety (90) days after the date of the determination of insolvency or imminent danger of insolvency. If the plan is disapproved by the Commissioner, the plan does not correct the condition leading to the Commissioner's determination of insolvency, or the provider's or continuing care facility's hazardous condition is such that it cannot be significantly corrected or eliminated, the Commissioner may take action pursuant to sections 103 and 111 of the Act.

## 8209 BOOKS AND RECORDS

8209.1 Each provider shall maintain its books and records in the District of Columbia and shall not remove from the District of Columbia its books and records without the permission of the Commissioner.

8209.2 Each provider shall maintain its books and records for three (3) years.

## 8299 DEFINITIONS

For the purposes of this chapter, the following words and phrases shall have the meanings ascribed:

Act - the Continuing Care Retirement Communities Act of 2004, effective April 6, 2005 (D.C. Law 15-270; D.C. Official Code § 44-151.01 *et seq.*) (2005 Supp.)

Break even - to have sufficient executed resident agreements to assure the financial stability of a continuing care facility and to have projected revenues that are at least equal to projected expenses.

Commissioner - the Commissioner of the Department of Insurance, Securities, and Banking.

Continuing care facility - a building, or complex of buildings under common management at one (1) or more sites where continuing care services are provided.

Continuing care services - the continuum of care, ranging from independent living to assisted living to nursing home care, provided pursuant to a contract for the life of the individual purchasing the services or for a period of not less than one (1) year.

Development stage facilities - the beginning of the legal commitment to develop a continuing care facility up to the point when residents are admitted to reside in the facility.

Disclosure statement - a document containing all the information required by section 105 of the Act.

Entrance fee - a payment that assures a resident a place in a continuing care facility for a term of at least one (1) year or life.

Health related services - domiciliary (rest home) care or care provided at homes for the aged, skilled or intermediate nursing, nursing home or rest home admission, or priority admission into a facility, unit, or bed providing any of the above-named services.

Health units/beds - beds in the health center (also known as the nursing home) component of the continuing care facility that are occupied by a resident having been referred to that level of care by a hospital (as on discharge) or by a physician.

Independent living units - a room, apartment, cottage, or other area within a continuing care facility set aside for the exclusive use, or control of one (1) or more identified residents who do not need specialized health care services beyond general preventative health care.

Negative fund balance - a financial position of a provider or continuing care facility in which the assets of a provider or continuing care facility do not exceed its liabilities, under generally accepted accounting principles.

Provider - the promoter, developer, or owner, whether a natural person, partnership or other unincorporated association, however organized, trust, or corporation, whether or not operated for profit, or any other person, that solicits or undertakes to provide continuing care services.

**PUBLIC SERVICE COMMISSION OF THE DISTRICT OF COLUMBIA  
1333 H STREET, N.W., 2<sup>nd</sup> Floor, WEST TOWER  
WASHINGTON, DC 20005**

**NOTICE OF FINAL RULEMAKING**

**FORMAL CASE NO. 712, IN THE MATTER OF THE INVESTIGATION INTO  
THE PUBLIC SERVICE COMMISSION'S RULES OF PRACTICE AND  
PROCEDURE**

1. The Public Service Commission of the District of Columbia ("Commission") hereby gives notice, pursuant to Section 2-505 of the District of Columbia Code,<sup>1</sup> of its final rulemaking action taken in the above-captioned proceeding.

2. On May 19, 2006, the Commission gave notice of its final rulemaking action to modify Chapter 13 of Title 15 District of Columbia Municipal Regulations, "Rules Implementing the Public Utilities Reimbursement Fee Act of 1980 ("Chapter 13"), adopting an assessment formula and regulations for the operating budget assessments of the Commission and the Office of the People's Counsel ("OPC").<sup>2</sup> On August 4, 2006, the Commission issued a notice of proposed rulemaking, noticing its intent to adopt clarifying changes to remove any ambiguity in the assessment formula.<sup>3</sup> The changes did not alter the substance of the final rules or how the Commission proposes to assess for OPC's and the Commission's operating budgets. No comments were submitted in response to the NOPR.

3. The following amendments to Chapter 13 will become effective upon the date of publication of this Notice of Final Rulemaking in the *D.C. Register*:

**1301.1 Each public utility, competitive electric supplier, competitive natural gas supplier, and competitive local exchange carrier ("CLEC") shall be assessed according to D.C. Code Section 34-912(b) for the reimbursable budgets of the Commission and the People's Counsel in the following manner:**

**(a) For CLECs, competitive electric suppliers, and competitive natural gas suppliers (collectively "alternative providers"), the**

<sup>1</sup> D. C. Official Code § 2-505.

<sup>2</sup> 53 *D.C. Register* 4141-4144 (May 19, 2006).

<sup>3</sup> 53 *D.C. Register* 6373-6375 (August 4, 2006).

assessments shall be equal to the ratio of the alternative provider's calendar year gross revenues to the sum of the calendar year gross revenues of all public utilities and all alternative providers times the budgets of the Commission and OPC. This calculation is subject to any adjustment pursuant to subsection (c).

- (b) For public utilities, the assessment shall be the utility's proportionate share of the calendar year gross revenues of all public utilities times the budgets of the Commission and OPC less the amount to be reimbursed by the alternative providers in subsection (a).
- (c) In any year in which there is a first year CLEC(s) providing local service, the CLEC(s) shall be assessed twenty-five thousand dollars (\$25,000) pursuant to D.C. Code § 34-912(b)(4). The \$25,000 assessment shall be allocated equally between the operating budgets of the Commission and OPC. For purposes of the calculations in subsection (a), the first-year CLEC(s) total revenues shall be deducted from the total gross revenues of all companies and the total amounts to be assessed for the Commission's and OPC's budgets shall be reduced by the amount of assessment to the first year CLEC(s).

PUBLIC SERVICE COMMISSION OF THE DISTRICT OF COLUMBIA  
1333 H STREET, N.W., SUITE 200, WEST TOWER  
WASHINGTON, DC 20005

NOTICE OF FINAL RULEMAKING

TT00-5, IN THE MATTER OF VERIZON WASHINGTON, DC INC.'S PUBLIC  
OCCUPANCY SURCHARGE GENERAL REGULATIONS TARIFF, P.S.C.-D.C.  
No. 201

1. The Public Service Commission of the District of Columbia ("Commission") hereby gives notice, pursuant to Section 2-505 of the District of Columbia Code,<sup>1</sup> of its final rulemaking action taken in the above-captioned proceeding. On October 11, 2006, the Commission released Order No. 14084, approving Verizon Washington, DC Inc.'s ("Verizon DC") tariff filing for an updated Public Space Occupancy Surcharge Rider ("PSOS").<sup>2</sup>

2. Pursuant to D.C. Code Section 10-1141.6,<sup>3</sup> Verizon DC filed with the Commission an updated PSOS on August 3, 2006.<sup>4</sup> In the tariff filing, Verizon DC shows the process to be used to recover from its customers the D.C. Public Rights-of-Way ("ROW") fees paid by Verizon DC to the District Columbia Government. Specifically, Verizon DC proposes to amend the following tariff page:

**GENERAL REGULATIONS TARIFF, P.S.C.-D.C. No. 201**  
**Section 1A**  
**Original Page 2**

3. Verizon DC's tariff filing states that the updated calculations are based on an increase to the ROW fee approved by the Council of the District of Columbia ("D.C. Council") in Bill 16-729, the "2007 Budget Support Act of 2006" on July 11, 2006.<sup>5</sup> Verizon DC asserts that the D.C. Council established July 1, 2006 as the effective date of the increase. Verizon DC also indicates that it proposes to implement the change

<sup>1</sup> D.C. Official Code § 2-505.

<sup>2</sup> *TT00-5, In The Matter Of Verizon Washington, DC Inc.'s Public Space Occupancy Surcharge General Regulations Tariff, P.S.C.-D.C. No. 201 ("TT00-5")*, filed August 3, 2006 (hereinafter referred to as "Verizon tariff").

<sup>3</sup> D.C. Code, § 10-1141.06 (2001 Ed.) states that "Each public utility company regulated by the Public Service Commission shall recover from its utility customers all lease payments which it pays to the District of Columbia pursuant to this title through a surcharge mechanism applied to each unit of sale and the surcharge amount shall be separately stated on each customer's monthly billing statement."

<sup>4</sup> *TT00-5, Verizon tariff.*

<sup>5</sup> *Id.* at 1.

effective October 1, 2006 by increasing the ROW surcharge by \$0.04 per Centrex line and 0.33 per Non-Centrex line. Finally, Verizon contends that these changes will incorporate both the ROW increase and the three-month implementation delay.

4. A Notice of Proposed Rulemaking was published in the *D.C. Register* on August 18, 2006.<sup>6</sup> No comments were filed in response to the filing. Subsequently, the Commission approved Verizon DC's surcharge filing by Order No. 14084. Verizon DC's Public Space Occupancy Surcharge Rider will become effective upon the date of publication of the Notice of Final Rulemaking in the *D.C. Register*.

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<sup>6</sup> 52 D.C. Reg. 6858-6859 (August 18, 2006).

## THE OFFICE OF TAX AND REVENUE

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**NOTICE OF FINAL RULEMAKING**

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The Office of Tax and Revenue ("OTR"), pursuant to the authority set forth in D.C. Official Code § 47-1335 (2001), section 155 of the District of Columbia Appropriations Act, 2001 (P.L. 106-522, D.C. Official Code §1-204.24c) (2001), and the Office of the Chief Financial Officer Financial Management and Control Order No. 00-5, effective June 7, 2000, hereby gives notice of the adoption of an amendment to Chapter 3 of Title 9 of the District of Columbia Municipal Regulations (DCMR), Real Property Taxes, by adding a new section 340, ("Conflict of Interest").

The new amendment to Chapter 3 of Title 9 DCMR prohibits specified District of Columbia government employees, contractors and certain elected officials from registering for, bidding on, or participating in the District of Columbia annual real property tax lien sale. This rulemaking is necessary to ensure a fair, impartial, and complete tax sale that complies with constitutional due process; to preserve the peace, safety, and welfare of the District; and to incorporate changes made to the Real Property Tax Sales Registration Form. The intent of this rulemaking is to prohibit specified District government employees and elected officials, contractors, and their families or business associates, with knowledge obtained from their public duties involving tax administration or economic development from participating in real property tax sales. It is necessary to prohibit such employees because they have knowledge not available to the general public which may permit them to purchase tax sale properties most likely to appreciate in value. Such purchases would create an actual or apparent conflict of interest. It would also be improper to permit employees, who work directly or indirectly with attaching a tax or other lien on property, to buy that property at a tax sale. This regulation will help to ensure a sufficient and proper revenue stream to support the health, welfare and safety of the citizens of the District of Columbia.

The emergency and proposed version of this rulemaking was published in the June 30, 2006 edition of the *D.C. Register*, at 53 DCR 5286. No comments were received concerning the published emergency and proposed rulemaking. This final rulemaking is not substantially different from the initial text of the emergency and proposed rulemaking. This final rulemaking, as set forth below, shall become effective upon publication in the *D.C. Register*.

Chapter 3 of Title 9 DCMR is amended to add a new section 340 to read as follows:

340       **Conflict of Interests.**

340.1       District of Columbia government employees and contractors, or the family members or business associates of District government employees and contractors, under the following classifications or employed in the following offices or positions, shall not be permitted to register for or bid on properties at any tax sale:

- (a) Executive Service employees as described in D.C. Official Code § 1.610.51 (2001);
- (b) Office of the City Administrator;
- (c) Office of the Deputy Mayor for Planning and Economic Development, and the following subordinate organizations thereunder: Department of Consumer and Regulatory Affairs, Department of Housing and Community Development, and the Office of Planning;
- (d) Office of the Chief Financial Officer; and
- (e) Mayor, Councilmember, Advisory Neighborhood Commissioner, or a staff member thereof.

340.2 For purposes of this section, “family member” means a person as defined in D.C. Official Code § 32-501 (4) (2001) or D.C. Official Code § 32-701 (7) (2001).

340.3 For purposes of this section, the term “business associate” means:

- (a) An organization in which the employee, elected official, or contractor serves as an officer, director, trustee, or employee; or
- (b) Any person or organization with whom the employee, elected official, or contractor is negotiating employment or has any arrangement concerning prospective employment.

**OFFICE OF TAX AND REVENUE****NOTICE OF FINAL RULEMAKING**

The Office of Tax and Revenue ("OTR"), pursuant to the authority set forth in D.C. Official Code §§ 47-1335 and 47-1342(c) (2001), as amended by D.C. Official Code § 47-317.08(c) (Feb. 2006 Supp.), section 155 of the District of Columbia Appropriations Act, 2001 (P.L. 106-522, D.C. Official Code § 1-204.24c (2001), and the Office of the Chief Financial Officer Financial Management and Control Order No. 00-5, effective June 7, 2000, hereby gives notice of the repeal of section 315 of Chapter 3 to Title 9 of the District of Columbia Municipal Regulations ("DCMR") and the adoption of a new section 315 of Chapter 3 entitled Tax Sale Costs. A real property delinquent in the payment of real property tax must be sold to collect delinquent real property taxes, and if not redeemed a deed may be issued to the purchaser. Many real properties sold at tax sale are abandoned or impose a nuisance upon the neighborhood within which they are situated. As such, these properties pose a threat to the health, safety and welfare of the citizens of the District of Columbia ("District"). In order to abate effectively nuisance properties and blight, the District needs to sell these properties as quickly and efficiently as possible. These final rules are necessary to reimburse the District for the costs of administering and complying with the tax sale laws, and to support the health, welfare and safety of the citizens of the District.

The emergency and proposed version of this rulemaking was published in the July 7, 2006 edition of the *D.C. Register*, at 53 DCR 5550. No comments were received concerning the published emergency and proposed rulemaking. This final rulemaking is not substantially different from the initial text of the emergency and proposed rulemaking. This final rulemaking, as set forth below, shall become effective upon publication in the *D.C. Register*.

Section 315 of Chapter 3 of Title 9 DCMR is repealed and a new section 315 of Chapter 3 is adopted to read as follows:

**315 TAX SALE COSTS**

- 315.1 For any real property public auction tax sale conducted after December 31, 2000 and before January 1, 2006, an advertising fee in the amount of thirteen dollars (\$13) shall be levied against each real property advertised for sale. The fee shall be included in the certificate of sale and added to the amount for which the property shall be sold at public auction.
- 315.2 For any real property public auction tax sale conducted after December 31, 2005, a tax sale fee in the amount of one hundred fifty dollars (\$150) shall be levied against each real property advertised for sale and sold or bid off. The tax sale fee shall be included in the certificate of sale and added to the amount for which the property shall be sold or bid off at public auction.