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BOARD OF MANAGERS ORDER **OCTOBER 27, 2026**

ORDER REVISING THE RULES AND PROCEDURES OF THE HEALTH CARE PROVIDER PARTICIPATION PROGRAM TO BE EFFECTIVE OCTOBER 1, 2026

WHEREAS, the 86th Texas Legislature enacted Senate Bill 2315 in 2019, establishing Chapter 298C of the Texas Health and Safety Code ("Chapter") and authorizing the Nueces County Hospital District ("District"), acting through its Board of Managers ("Board"), to establish a local Health Care Provider Participation Program ("Program"); and the 87th Texas Legislature subsequently amended Chapter 298C through House Bill 1456 in 2021;

WHEREAS, the purpose of the Program is to assess and collect mandatory payments from institutional health care providers located within the boundaries of the District to finance the nonfederal share of Medicaid supplemental payments and managed care payment enhancements through intergovernmental transfers to the Texas Health and Human Services Commission, thereby supporting the availability of federal Medicaid matching funds for hospital services;

WHEREAS, for purposes of the Program, an institutional health care provider ("Provider") is a hospital that provides inpatient hospital services and is not owned or operated by the federal or state government;

WHEREAS, pursuant to §298C.003 of the Chapter, the Board has authorized the District's participation in the Program for fiscal years 2021 through 2027 through actions taken at its meetings held on September 29, 2020; August 3, 2021; September 20, 2022; July 24, 2023; July 23, 2024; August 26, 2025; and October 27, 2026, respectively;

WHEREAS, pursuant to §298C.052 of the Chapter, the Board is required to adopt rules governing the administration of the Program, including the collection of mandatory payments, expenditures, audits, and other administrative matters; and the Board initially adopted such rules on September 29, 2020, and subsequently amended them on July 24, 2023 ("First Amended Rules");

WHEREAS, the Texas Health and Human Services Commission ("HHSC"), by notice dated September 17, 2026 and through subsequent implementing guidance, announced revised requirements, effective October 1, 2026, governing the acceptance and administration of intergovernmental transfers used to finance Medicaid payments, pursuant to which HHSC will accept intergovernmental transfers supported by mandatory payments applicable to periods beginning on or after October 1, 2026, only if such mandatory payments are imposed exclusively and separately on net patient revenue attributable to inpatient hospital services and on net patient revenue attributable to outpatient hospital services, and the Board desires to modify the Program's rules and procedures to facilitate compliance with those requirements;

WHEREAS, the Board recognizes the need to revise the Program's rules and procedures to address changes in applicable federal and state Medicaid financing requirements, including the separate identification and treatment of inpatient and outpatient net patient revenues in determining mandatory payment amounts, and to establish corresponding administrative procedures governing the assessment, collection, accounting, and expenditure of mandatory payments effective October 1, 2026; and

WHEREAS, the Board desires to amend and supersede the First Amended Rules by adopting the revised rules and procedures attached to this Order as Exhibit A, entitled "Nueces County Hospital District Health Care Provider Participation Program Revised Rules and Procedures, Effective October 1, 2026" ("Revised Rules"), which are incorporated into this Order by reference and intended to become effective October 1, 2026.

NOW, THEREFORE, BE IT ORDERED BY THE BOARD OF MANAGERS OF THE NUECES COUNTY HOSPITAL DISTRICT THAT:

Section 1. Adoption of Revised Rules. The Board hereby adopts the Nueces County Hospital District Health Care Provider Participation Program Revised Rules and Procedures, attached hereto as Exhibit A and incorporated herein by reference.

Section 2. Supersession of Prior Rules. The Revised Rules shall supersede and replace in their entirety the First Amended Rules adopted by the Board on July 24, 2023.

Section 3. Effective Date. The Revised Rules shall be effective as of October 1, 2026.

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**NUECES COUNTY HOSPITAL DISTRICT
BOARD OF MANAGERS**

Vishnu V. Reddy Chairman

Sylvia Tryon Oliver
Vice Chairman

Mariana Garza
Member

Georgia Neblett
Member

Karen O'Connor Urban
Member

Pamela Brower
Member

Sunil Reddy
Member

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**NUECES COUNTY HOSPITAL DISTRICT
HEALTH CARE PROVIDER PARTICIPATION PROGRAM
RULES AND PROCEDURES
Effective: October 1, 2026**

General Provisions

Rule 1. Definitions. In these rules and procedures:

(a) "Mandatory payment" means a mandatory payment authorized under Texas Health and Safety Code, Chapter 298C.

(b) "Institutional health care provider" means a hospital that is not owned and operated by a federal or state government and provides inpatient hospital services.

(c) "Paying provider" or "Paying hospital" means an institutional health care provider required to make a mandatory payment under Texas Health and Safety Code, Chapter 298C.

(d) "Program" means the health care provider participation program authorized under Texas Health & Safety Code, Chapter 298C.

(e) "Hospital District" means the Nueces County Hospital District.

(f) "Board of Managers" means the Board of Managers of the Nueces County Hospital District.

Rule 2. Health Care Provider Participation Program; Participation in Program.

(a) The Program authorizes the Hospital District to collect a mandatory payment from each institutional health care provider located in the Hospital District as shown in Exhibit A, "Institutional Health Care Providers" to be deposited in a local provider participation fund established by the Hospital District. Money in the fund may be used by the Hospital District to fund certain intergovernmental transfers as provided by these rules and procedures.

(b) The Board of Managers may adopt an order authorizing the Hospital District to participate in the Program, subject to the limitations provided by these rules and procedures.

(c) To the extent any provision or procedure under Texas Health & Safety Code, Chapter 298C causes a mandatory payment to be ineligible for federal matching funds, the Hospital District may provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare & Medicaid Services (CMS).

Powers and Duties of Board of Managers

Rule 3. Limitation on Authority to Require Mandatory Payment. The Hospital District may require a mandatory payment from an institutional health care provider only in the manner provided in these rules and procedures.

Rule 4. Majority Vote Required Prior to Mandatory Payment. The Hospital District may not collect a mandatory payment without an affirmative vote of a majority of the

members of the Board of Managers authorizing the Hospital District to participate in the Program.

Rule 5. Institutional Health Care Provider Reporting; Inspection of Records.

(a) The Hospital District shall require each institutional health care provider to submit to the Hospital District a copy of any financial and utilization data required by and reported to the Department of State Health Services under Texas Health & Safety Code, §311.032 and §311.033 and any rules adopted by the Executive Commissioner of the Texas Health and Human Services Commission (HHSC) to implement those sections.

(b) The Hospital District may inspect the records of an institutional health care provider to the extent necessary to ensure that the institutional health care provider has submitted all required data under this Rule.

(c) Effective October 1, 2026, each institutional health care provider shall furnish the Hospital District with copies of its most recent available Medicare Hospital Cost Reports (CMS Form 2552-10), as maintained in the CMS Healthcare Cost Report Information System (HCRIS), for the Hospital District use in determining the provider's mandatory payment amounts pursuant to Rule 9B.

General Financing Provisions

Rule 6. Hearing.

(a) Each year, the Board of Managers shall hold a public hearing to receive comments on the amounts of mandatory payments proposed to be assessed during the year, the allocation of such payments between net patient revenue attributable to inpatient hospital services and net patient revenue attributable to outpatient hospital services, and the intended use of such payments.

(b) Not later than the fifth (5th) day before the date of the hearing required under Subdivision 6(a), the Board of Managers shall publish notice of the hearing in a newspaper of general circulation in the Hospital District.

(c) A representative of a paying hospital is entitled to appear at the time and place designated in the public notice and to be heard regarding any matter related to the mandatory payments.

Rule 7. Depository and Investment of Funds.

(a) The Hospital District shall designate one or more banks as the depository for the Hospital District local provider participation fund.

(b) All income received by the Hospital District under these rules and procedures, including the revenue from mandatory payments remaining after fees for assessing and collecting the payments are deducted, shall be deposited with the Hospital District depository in the District's local provider participation fund and may be withdrawn only as provided by these rules and procedures.

(c) All funds under these rules and procedures shall be secured in the manner provided for securing other Hospital District funds.

(d) All funds received under these rules and procedures may be invested consistent with the Investment Policy of the Hospital District, except that such investment shall be limited to overnight funds.

(e) The Hospital District shall establish and designate a new, separate bank account for the local provider participation fund, into which all mandatory payments assessed for periods on or after October 1, 2026, shall be deposited. Such mandatory payments shall not be commingled with funds attributable to mandatory payments assessed for periods before October 1, 2026.

Rule 8. Local Provider Participation Fund; Authorized Uses of Money.

(a) If the Hospital District requires a mandatory payment, it shall create a local provider participation fund.

(b) The local provider participation fund of the Hospital District consists of:

(1) all revenue received by the Hospital District attributable to mandatory payments;

(2) money received from the HHSC as a refund of an intergovernmental transfer under the Program, provided that the intergovernmental transfer does not receive a federal matching payment; and

(3) the earnings of the fund.

(c) Money deposited to the local provider participation fund may be used only to:

(1) fund intergovernmental transfers from the Hospital District to the State of Texas to provide the nonfederal share of Medicaid payments for:

(A) uncompensated care payments to hospitals in the Medicaid managed care service area in which the Hospital District is located, if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315);

(B) delivery system reform incentive payments, if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315);

(C) uniform rate enhancements for hospitals in the Medicaid managed care service area in which the Hospital District is located;

(D) payments available under another waiver program authorizing payments that are substantially similar to Medicaid payments to hospitals described by Paragraph (A), (B), or (C); or

(E) any reimbursement to hospitals for which federal matching funds are available;

(2) pay the administrative expenses of the Hospital District in administering the Program, including the collateralization of deposits;

(3) refund of a mandatory payment collected in error from a paying hospital;

(4) refund to paying providers the proportionate share of money that the Hospital District:

(A) receives from the HHSC that is not used to fund the nonfederal share of Medicaid supplemental payment program payments or uniform rate enhancements described by Subdivision (1)(C); or

(B) determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments of uniform rate enhancements described by Subdivision (1)(C).

(5) transfer funds to the HHSC if the Hospital District is legally required to transfer the funds to address a disallowance of federal matching funds with respect to programs for which the Hospital District made intergovernmental transfers described by Subdivision (c)(1); and

(6) reimburse the Hospital District if the Hospital District is required by the rules governing the uniform rate enhancement program described by Subdivision (1)(C) to incur an expense or forego Medicaid reimbursements from the State because the balance of the local provider participation fund is not sufficient to fund that rate enhancement program.

(d) Money in the local provider participation fund may not be commingled with other Hospital District funds.

(e) An intergovernmental transfer of funds described by Subdivision (c)(1) and any funds received by the Hospital District as a result of an intergovernmental transfer described by that rule may not be used by the State, Hospital District, or other entity to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152).

Mandatory Payments

Rule 9A. Mandatory Payments Based on Paying Hospital Net Patient Revenue for Periods Prior to October 1, 2026.

(a) Except as provided by Rule 11, if the Board of Managers collects a mandatory payment, it may require that a mandatory payment be assessed annually or periodically throughout the fiscal year at the discretion of the Board of Managers on the net patient revenue of each institutional health care provider located in the boundaries of the Hospital District.

(b) The Board of Managers shall provide an institutional health care provider written notice of each assessment and the mandatory payments shall be made 30 days following the date of receipt of the notice of payment.

(c) In the first year in which the mandatory payment is required, the mandatory payment is assessed based on the most recent fiscal year data collected pursuant to Subdivision 5(a). If no such data is available for an institutional health care provider, the mandatory payment may be calculated based on the institutional health care provider's Medicare cost report submitted for the previous fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report.

(d) The net patient revenue basis of the mandatory payment may be updated during the fiscal year using the most recent fiscal year data collected pursuant to Subdivision 5(a). Use of data that is updated during the fiscal year does not require Board of Managers approval.

(e) This Rule 9A applies only to mandatory payments assessed for periods prior to October 1, 2026. Such mandatory payments may continue to be invoiced and collected

after October 1, 2026, and funds held in the local provider participation fund account as of September 30, 2026, may be used as authorized by Rule 8(c) until expended.

Rule 9B. Mandatory Payments Effective October 1, 2026; Assessments Based Exclusively and Separately on Net Patient Revenue Attributable to Inpatient Hospital Services and Outpatient Hospital Services.

(a) Except as otherwise provided in Rule 11, the Board of Managers may assess and collect mandatory payments for periods on or after October 1, 2026, from each institutional health care provider located within the boundaries of the Hospital District. Such payments shall be assessed exclusively and separately on each provider's net patient revenue attributable to inpatient hospital services and on each provider's net patient revenue attributable to outpatient hospital services. At its discretion, the Board of Managers may impose such assessments annually or periodically throughout the Hospital District's fiscal year.

(b) The Board of Managers shall provide each institutional health care provider with written notice of each mandatory payment assessment. Each assessed payment shall be due and payable within thirty (30) days following the provider's receipt of the written notice.

(c) Mandatory payments assessed under this Rule 9B shall be imposed exclusively and separately on each institutional health care provider at rates not exceeding six percent (6%) of the provider's net patient revenue attributable to inpatient hospital services and six percent (6%) of the provider's net patient revenue attributable to outpatient hospital services. Each assessment shall be calculated independently using the applicable inpatient or outpatient net patient revenue amount.

(d) The Hospital District shall determine each institutional health care provider's net patient revenue attributable to inpatient hospital services and net patient revenue attributable to outpatient hospital services using financial information reported in the provider's Medicare Hospital Cost Report (CMS Form 2552-10), as maintained in the HCRIS. For determining such revenues:

- (1) the Hospital District shall use the provider-specific Medicare Hospital Cost Report designated as "As Submitted" in HCRIS from the CMS data release identified as updated September 30 of the fiscal year in which the assessment is imposed, available at <https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports>, or such other Medicare Hospital Cost Report as HHSC and the Board of Managers designates as the most recent Medicare Cost Report for this purpose.
- (2) the Hospital District shall calculate each institutional health care provider's net patient revenue attributable to inpatient hospital services and net patient revenue attributable to outpatient hospital services in accordance with the methodology prescribed in Exhibit B, "Calculation of Inpatient and Outpatient Net Patient Revenue," which is attached hereto, incorporated herein by reference, and made a part of these Rules. The methodology, which is based on the CMS Medicare Upper Payment Limit guidance, determines inpatient and outpatient net patient revenues by applying the provider's overall ratio of net patient revenue to total patient revenue, as reported in Worksheet G-3 of its Medicare

Hospital Cost Report, separately to the applicable inpatient and outpatient gross patient charges reported in Worksheet C, Part I, of that report.

(e) The net patient revenue amounts established pursuant to subsection (d) shall constitute the basis for calculating mandatory payments assessed under this Rule 9B for the applicable fiscal year. Once established, such amounts shall remain fixed and shall not be updated, recalculated, or otherwise modified during that fiscal year.

Rule 10. Mandatory Payment Requirements

(a) The amount of each mandatory payment assessed under these Rules shall be uniformly proportionate to the net patient revenue attributable to inpatient hospital services and the net patient revenue attributable to outpatient hospital services of each paying hospital located within the boundaries of the Hospital District. Mandatory payments shall be assessed separately on each category of net patient revenue in accordance with the applicable provisions of these Rules.

(b) If the Board of Managers requires mandatory payments, it shall establish the applicable assessment rates and determine the amounts payable by each institutional health care provider. The aggregate mandatory payments assessed against any individual paying hospital during a fiscal year shall not exceed six percent (6%) of the hospital's net patient revenue attributable to inpatient hospital services and six percent (6%) of the hospital's net patient revenue attributable to outpatient hospital services, calculated separately in accordance with Rule 9B.

(c) Subject to the maximum amount prescribed by Rule 11(a), if the Board of Managers requires a mandatory payment, it shall set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the Hospital District for activities under these rules and procedures and to fund purposes described in Rule 8(c).

(1) The annual amount of revenue from mandatory payments used for administrative expenses of the Hospital District for activities under these rules and procedures is \$150,000, plus the cost of collateralization of deposits, regardless of actual expenses.

(d) The mandatory payment may not be collected for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary to fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for hospitals to cover the administrative expenses of the Hospital District associated with the Program.

(e) To the extent any Program provision or procedure causes a mandatory payment to be ineligible for federal matching funds, the Board may provide by rule for an alternative provision or procedure that conforms to the requirements of CMS.

Rule 11. Mandatory Payment Prohibitions.

(a) The amount of mandatory payments assessed against each paying hospital, when combined with the mandatory payments assessed against all other paying hospitals located within the boundaries of the Hospital District, shall not exceed, in the aggregate, six percent (6%) of the total net patient revenue attributable to inpatient hospital services and six percent (6%) of the total net patient revenue attributable to outpatient hospital

services of all paying hospitals within the Hospital District, with each limitation calculated and applied separately to its respective category of net patient revenue.

(b) A mandatory payment may not hold harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).

(c) A paying provider may not add a mandatory payment required under this section as a surcharge to a patient.

(d) A mandatory payment assessed hereunder is not a tax for hospital purposes for purposes of Texas Constitution, Section 4, Article IX or Texas Health and Safety Code, §281.045.

(e) The amount of the mandatory payment required of each paying hospital may not be discounted.

Rule 12. Assessment and Collection of Mandatory Payments.

(a) The Hospital District may designate an official of the Hospital District or contract with another person to assess and collect the mandatory payments.

(b) The person charged by the Hospital District with the assessment and collection of mandatory payments shall charge and deduct from the mandatory payments collected for the Hospital District a collection fee in the amount not to exceed the person's usual and customary charges for like services.

(c) If the person charged with the assessment and collection of mandatory payments is an official of the Hospital District, any revenue from a collection fee charged under Subdivision (b) shall be deposited in the Hospital District's general fund and, if appropriate, shall be reported as fees of the Hospital District.

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EXHIBIT A**Institutional Health Care Providers**

Hospital Name	Medicare Provider Number
CHRISTUS SPOHN HOSP CORPUS CHRISTI	450046
CORPUS CHRISTI MEDICAL CENTER	450788
PAM SPECIALTY HOSPITAL OF CORPUS CHRISTI NORTH	452086
DRISCOLL CHILDREN'S HOSPITAL	453301
OCEANS BEHAVIORAL HOSPITAL CORPUS CHRISTI	454155
CORPUS CHRISTI REHABILITATION HOSPITAL	673053
PAM REHAB HOSPITAL OF CORPUS CHRISTI	673067

EXHIBIT A Exhibit B

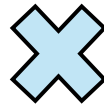
Calculation of Inpatient and Outpatient Net Patient Revenue

Multiply the Total Charges (i.e., Total Revenue) lines identified in the Medicare Upper Payment Limit (UPL) Guidance documents by the hospitals' overall net patient revenue divided by total patient revenue to calculate the inpatient and outpatient portion of net patient revenue.

Inpatient Net Patient Revenue

Formula

**Total Inpatient Routine
and Ancillary Charges**



***[Net Patient Revenue
Total Patient Revenue]***

Medicare
Cost Report
Lines

**Worksheet C Part 1
Column 6 Lines 30 to 76***

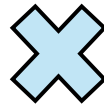


***[Worksheet G – 3
Column 1 Line 3
Worksheet G – 3
Column 1 Line 1]***

Outpatient Net Patient Revenue

Formula

**Total Outpatient Routine
and Ancillary Charges**



***[Net Patient Revenue
Total Patient Revenue]***

Medicare
Cost Report
Lines

**Worksheet C Part 1
Column 7 Lines 50 to 98***



***[Worksheet G – 3
Column 1 Line 3
Worksheet G – 3
Column 1 Line 1]***

*Include all subscripted lines (e.g., Line 31.01, 31.02, etc.).

Medicare UPL Guidance Links:

- [Inpatient Hospital Services UPL Guidance](#)
- [Outpatient Hospital Services UPL Guidance](#)

EXHIBIT A Exhibit B continued

Inpatient Net Patient Revenue Calculation Example

Medicare UPL Lines from Worksheet C Part I		
COMPUTATION OF RATIO OF COSTS TO CHARGES		
COST CENTER DESCRIPTIONS		Column 6
INPATIENT ROUTINE SERVICE COST CENTERS		
30	Adults and Pediatrics (General Routine Care)	100
31	Intensive Care Unit	200
32	Coronary Care Unit	100
33	Burn Intensive Care Unit	100
34	Surgical Intensive Care Unit	500
35	Other Special Care (specify)	100
40	Subprovider IPF	0
41	Subprovider IRF	100
42	Subprovider (Specify)	100
43	Nursery	0
44	Skilled Nursing Facility	100
45	Nursing Facility	100
46	Other Long Term Care	100
ANCILLARY SERVICE COST CENTERS		
50	Operating Room	100
51	Recovery Room	100
52	Labor Room and Delivery Room	0
53	Anesthesiology	0
54	Radiology-Diagnostic	0
55	Radiology-Therapeutic	0
56	Radioisotope	0
57	Computed Tomography (CT) Scan	0
58	Magnetic Resonance Imaging (MRI)	0
59	Cardiac Catheterization	0
60	Laboratory	0
61	PBP Clinical Laboratory Services-Prgm. Only	0
62	Whole Blood & Packed Red Blood Cells	0
63	Blood Storing, Processing, & Trans.	0
64	Intravenous Therapy	0
65	Respiratory Therapy	0
66	Physical Therapy	0
67	Occupational Therapy	0
68	Speech Pathology	0
69	Electrocardiology	0
70	Electroencephalography	0
71	Medical Supplies Charged to Patients	0
72	Implantable Devices Charged to Patients	0
73	Drugs Charged to Patients	0
74	Renal Dialysis	0
75	ASC (Non-Distinct Part)	0
76	Other Ancillary (specify)	0
Total Inpatient Routine and Ancillary Charges = \$1,800		

Exhibit B continued

Inpatient Net Patient Revenue Calculation Example

STATEMENT OF REVENUES AND EXPENSES		PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET G-3	
Description					
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)		5,000	1	
2	Less contractual allowances and discounts on patients' accounts		1,000	2	
3	Net patient revenues (line 1 minus line 2)		4,000	3	
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)		1,000	4	
5	Net income from service to patients (line 3 minus line 4)		3,000	5	

**Total Inpatient Routine
and Ancillary Charges**



***[Net Patient Revenue
Total Patient Revenue]***

**Worksheet C Part 1
Column 6 Lines 30 to 76***



***[Worksheet G – 3
Column 1 Line 3
Worksheet G – 3
Column 1 Line 1]***

\$1,800



**[4,000
5,000]**

\$1,800



0.8

Total Net Patient Revenue = \$1,440

THE STATE OF TEXAS §
COUNTY OF NUECES §

1. The members of the Board of Managers (the “Board”) of the Nueces County Hospital District (the “Hospital District”) have been duly appointed pursuant to Texas Health and Safety Code (the “Health Code”), §281.021.
2. Pursuant to Health Code, §281.021(a), the Board has been duly appointed; pursuant to Health Code, §281.048, the Board is the governing body of the Hospital District; and pursuant to the collective authorities of Health Code, §281.047 and §281.048, the Board has, and at the time of adoption of this Order had, full power and authority to manage, control, administer, and to adopt rules governing operation of the Hospital District.
3. On the 27th day of October, 2026, the Board convened in a regular meeting at the Hospital District’s regular meeting place (the “Meeting”), the duly constituted members and officers of the Board being as follows:

and all of said persons were present, except the following absentees:
_____, thus, constituting a quorum.

**ORDER REVISING THE RULES AND PROCEDURES
OF THE HEALTH CARE PROVIDER PARTICIPATION PROGRAM
TO BE EFFECTIVE OCTOBER 1, 2026**

YEAS: ()
NAYS: ()
PRESENT NOT VOTING: ()
ABSENT: ()

all as shown in the official Minutes of the Board for the Meeting.

5. The attached Order is a true and correct copy of the original on file in the official records of the Hospital District; the duly qualified and acting members of the Board on the date of the Meeting are those persons shown above, and, according to the records of my office, each member of the Board was given actual notice of the time, place, and purpose of the Meeting and had actual notice that the Order would be considered; and the Meeting and deliberation of the aforesaid public business, was open to the public and written notice of said meeting, including the subject of the Order, was posted and given in advance thereof in compliance with the provisions of Chapter 551, Texas Government Code, as amended.
6. I am the Secretary of the Board having been duly appointed pursuant to Health Code, §281.023(b).
7. The foregoing Order is in full force and effect; that the same has not been rescinded, nor has it been amended or modified in any way.

IN WITNESS WHEREOF, I have hereunto signed my name officially and affixed the seal of the Hospital District on this the 27th day of October, 2026.

Jonny F. Hipp
Secretary, Board of Managers
Nueces County Hospital District

{HOSPITAL DISTRICT SEAL}