SEC FORM-ACGR (FOR PC/RI)

ANNUAL CORPORATE GOVERNANCE REPORT FOR PUBLIC COMPANIES AND REGISTERED ISSUERS

1. For the fiscal year ended: December 31, 2021
2. SEC Registration Number: AS094-00011249
3. BIR Tax Identification Number: 004-502-062-000
4. Exact Name of the Issuer as specified in its charter: Asian Hospital, Inc.
5. Province, Country or other jurisdiction of incorporation or organization: Philippines
6. Address of Principal Office:

   2205 Civic Drive, Filinvest Corporate City, Alabang, Muntinlupa City
7. Postal Code: 1780
8. Issuer's telephone number, including area code: (632) 8771-9000 to 9002
9. Former name, former address, and former fiscal year, if changed since last report

   N/A
10. Industry Classification Code (For SEC's use only) .....

SECURITIES AND EXCHANGE COMMISSION
SEC FORM MCG – 2009

CERTIFICATE

I, ARVIN MARK T. PASCUAL, of legal age and with office address at 2205 Civic Drive, Filinvest Corporate City, Alabang, Muntinlupa City after being sworn to in accordance with law, depose and state that:

1. I am the incumbent Compliance Officer of Asian Hospital, Inc. (the "Company"), a corporation duly organized and existing in accordance with the laws of the Republic of the Philippines, with office address at 2205 Civic Drive, Filinvest Corporate City, Alabang, Muntinlupa City.

2. In 2021, the Company substantially adopted all the provisions of the Manual on Corporate Governance (Model Corporation), as prescribed by SEC Memorandum Circular No. 6, Series of 2009.

3. During the same year, the Company deviated from the following provisions of the said Manual for the reasons stated below:

Provision(s) of the Manual	Explanation
Please see the Company's 2021 ACGR	

4. I am issuing this Certificate in compliance with the requirement of the Securities and Exchange Commission on the annual reporting on the Company's compliance with the Manual of Corporate Governance.

IN WITNESS WHEREOF, I have signed this Certificate this 30 JUN 2022 at Makati City, Philippines.

ARVIN MARK T. PASCUAL
Compliance Officer

Countersigned by:

ANDRES M. LICAROS, JR.
President

SUBSCRIBED AND SWORN TO before me this 30 JUN 2022 in Makati City, Philippines, affiant exhibiting his Driver's License No. N03-07-021650 valid until 30 January 2024 as competent proof of his identity.

WITNESS my hand and notarial seal on the date and place above written.

Doc. No. 372
Page No. 74
Book No. I;
Series of 2022

MAUREEN DYAN D. ERNI
NOTARY PUBLIC
ROLL NO. 75572
MAKATI CITY, PHILIPPINES

MAUREEN DYAN D. ERNI
Notary Public for Makati City
Until December 31, 2022
PTR No. 8855402 Jan. 05, 2022/Makati City
IBP No. 173[illegible] Jan. 03, 2022/Quezon City
Roll of Attorneys No. 75572
MCLE Compliance [illegible] Admitted to the Bar in 2020
Appointment No. M-309
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Legaspi Sts., Legaspi Village, Makati City

ANNUAL CORPORATE GOVERNANCE REPORT FOR PUBLIC COMPANIES AND REGISTERED ISSUERS

	RECOMMENDATION	COMPLIANT/ NON-COMPLIANT	ADDITIONAL INFORMATION	EXPLANATION
THE BOARD'S GOVERNANCE RESPONSIBILITIES				
Principle 1. ESTABLISHING A COMPETENT BOARD				
The company should be headed by a competent, working Board to foster the long-term success of the corporation, and to sustain its competitiveness and growth in a manner consistent with its corporate objectives and the long-term best interests of its shareholders/members and other stakeholders.				
Recommendation 1.1				
1	The Board is composed of directors with collective working knowledge, experience or expertise that is relevant to the company's industry/sector.	Compliant	Section 2, Article 3.1.1 of the Revised Manual of Corporate Governance of Asian Hospital, Inc. ("AHI")[1] provides: "x x x The Board shall be composed of fifteen (15) members, with collective working knowledge, experience or expertise relevant to the Corporation's business, and shall adhere to a policy of diversity in gender, age, ethnicity, culture, skills, competence and knowledge. A majority of the Board shall be non-executive directors with the necessary qualifications to effectively participate and help secure objective, and independent judgment on corporate affairs and to carry out proper checks and balance. At least three (3) members of the Board shall be independent directors. x x x"	The business background and qualifications of the Company's directors can be found in the Company's Annual Report and Definitive Information Statement, which were submitted to the SEC and posted in the Company's website. https://www.asianhospital.com/annual-report/
2	The Board has an appropriate mix of competence and expertise.	Compliant		
3	Directors remain qualified for their positions individually and collectively to enable them to fulfill their roles and responsibilities and respond to the needs of the organization.	Compliant		

[1] Attached as **Annex "A"** is a copy of the Revised Manual of Corporate Governance of AHI.

			Section 2, Article 3.1.1.2.1 of the Revised Manual of Corporate Governance of AHI likewise provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.1 Install a process of selection to ensure an appropriate mix of competent, expert and qualified directors and officers, and ensure that said members and officers remain qualified for their positions individually and collectively, through an annual evaluation, to enable it to fulfill its roles and responsibilities and respond to the needs of the Corporation based on evolving medical, business environment and strategic direction."	
Recommendation 1.2				
1	The Board is headed by a competent and qualified Chairperson.	Compliant	Section 2, Article 3.1.1 of the Revised Manual of Corporate Governance of AHI provides: "x x x The Board shall be headed by a competent and qualified Chairman."	In 2021 and at present, the Board is headed by Mr. Augusto P. Palisoc, Jr. His profile and background, which shows his qualifications as Chairperson of the Board is provided in the Company's Annual Report and Definitive Information Statement, which were submitted to the SEC and posted in the Company's website. https://www.asianhospital.com/annual-report/
Recommendation 1.3				

1	The company provides a policy on training of directors.	Compliant		The Company's policy on training is provided in Section 2, Article 6 of the Revised Manual of Corporate Governance.
2	The company has an orientation program for first-time directors.	Compliant	Section 2, Article 6 of the Revised Manual of Corporate Governance of AHI provides: "6.1 If necessary, funds shall be allocated by the CEO or its equivalent officer for the purpose of conducting an orientation program or workshop and annual continuing training to operationalize this Manual. 6.2 A director shall, before assuming as such, be required to attend a seminar on corporate governance which shall be conducted by a duly recognized private or public institute."	The Company has an orientation program for first-time directors (see Section 2, Article 6). However, no first-time director was elected the previous year or in recent years. As such, it cannot provide details on any such orientation program.
3	The company has relevant annual continuing training for all directors.	Compliant		Metro Pacific Investments Corporation ("MPIC") conducts an Annual Corporate Governance Enhancement Session ("ACGES"), which is accredited by the SEC. Such training on good corporate governance is made available to all directors and officers of MPIC's subsidiaries and affiliates, which include the Company. The content of the ACGES varies each year and covers a range of matters, including traditional corporate governance topics such as audit, internal controls, anti-corruption and risk management as well as new and forward-looking areas of interest.
Recommendation 1.4				
1	The Board has a policy on board diversity.	Compliant	Section 2, Article 3.1.1 of the Revised Manual of Corporate Governance of AHI provides: "The Board shall be composed of fifteen (15) members, with collective working knowledge, experience or expertise relevant to the Corporation's business, and	The Company's diversity policy is provided in Section 2, Article 3.1.1 of the Revised Manual of Corporate Governance. In 2021 and at present, the Board is composed of directors with a wide age range and with different expertise, qualifications and academic backgrounds. The Board is composed of ten (10) male directors and one (1)

			shall adhere to a policy of diversity in gender, age, ethnicity, culture, skills, competence and knowledge. A majority of the Board shall be non-executive directors with the necessary qualifications to effectively participate and help secure objective, and independent judgment on corporate affairs and to carry out proper checks and balance. At least three (3) members of the Board shall be independent directors.	female director.

Below is the updated composition of the Board of Directors of the Corporation for the year 2021:

Name of Director	Age	Citizenship	Date of First Election to the Board
Fernandino Jose A. Fontanilla (Independent Director)	57	Filipino	July 25, 2006
Manuel V. Pangilinan	75	Filipino	December 6, 2011
Augusto P. Palisoc Jr. (Chairperson)	64	Filipino	December 6, 2011
Andres M. Licaros Jr. (President and Chief Executive Officer)	63	Filipino	December 6, 2011
Carmelita I. Quebengco (Independent Director)	74	Filipino	March 21, 2012
Ricardo V. Buencamino	77	Filipino	February 27, 2013
Jose Noel C. de la Paz	65	Filipino	April 30, 2015
Sol Z. Alvarez	89	Filipino	August 7, 2015
Retired Chief Justice Artemio Panganiban (Independent Director)	85	Filipino	March 3, 2017
Reymundo S. Cochangco	55	Filipino	September 15, 2020
Celso Bernard G. Lopez	48	Filipino	September 15, 2020

Recommendation 1.5				
1	The Board is assisted by a Corporate Secretary.	Compliant	Section 2, Article 3.2.4 of the Revised Manual of Corporate Governance of AHI provides: "3.2.4.1 The Corporate Secretary is an officer of the company and	The Company's Corporate Secretary is Atty. Gilbert Raymund T. Reyes, who was appointed on 21 October 2021.
2	The Corporate Secretary is a separate individual from the Compliance Officer.	Compliant		Atty. Reyes is not the Compliance Officer of the Company.

3	The Corporate Secretary is not a member of the Board of Directors.	Compliant	he must perform his duties and functions in accordance with the highest professional standards. Likewise, he must exhibit loyalty to the mission, vision and specific business objectives of the corporate entity. 3.2.4.2 The Corporate Secretary shall be a Filipino citizen. 3.2.4.3 The Corporate Secretary shall not be a member of the Board. 3.2.4.4 Considering his varied functions and duties, he must possess administrative and interpersonal skills, and if he is not the general counsel, then he must have some legal knowledge. He must also have some financial and accounting skills."	Atty. Reyes is not a member of the Board of the Company.
4	The Corporate Secretary attends annual training/s on corporate governance.	Non-Compliant	Section 2, Article 3.2.5.9 of the Revised Manual of Corporate Governance of AHI provides: "3.2.4.5 Duties and Responsibilities: x x x 3.2.4.5.9 Attend annual training on corporate governance."	The current Corporate Secretary was only appointed on 21 October 2021. The previous Corporate Secretary has regularly attended the ACGES organized by MPIC and the ACGES invitation will be extended to the Company's current Corporate Secretary yearly.
Recommendation 1.6				
1	The Board is assisted by a Compliance Officer.	Compliant	Section 2, Article 3.2.8.1 of the Revised Manual of Corporate	The Company's Compliance Officer is Arvin Mark T. Pascual, who assumed his position on 16 June 2021 and whose designation as

			Governance of AHI provides:	such was ratified by the Board of Directors on 6 June 2022.
2	The Compliance Officer has a rank of Senior Vice-President or an equivalent position with adequate stature and authority in the corporation.	Compliant	"3.2.8 Compliance Officer 3.2.8.1 To ensure adherence to corporate principles and best practices, the Chairman of the Board shall designate a Compliance Officer who shall hold the position of a Senior Officer or its equivalent. He shall not be a member of the Board but have direct reporting responsibilities to the Board at large, and his recommendation/s should be acted upon by the Board at large."	Mr. Pascual, as the Compliance Officer, is a senior officer of the Company based on the Revised Manual of Corporate Governance and the Company's Leadership Structure, which is available at : https://www.asianhospital.com/leadership/
3	The Compliance Officer is not a member of the board.	Compliant		Mr. Pascual is not a member of the Board of Directors of the Company.
4	The Compliance Officer attends annual training/s on corporate governance.	Compliant	Section 2, Article 3.2.8.2 of the Revised Manual of Corporate Governance of AHI provides: "3.2.8 Compliance Officer 3.2.8.2 He shall perform the following duties: 3.2.8.2.1 Monitor compliance with the provisions and requirements of this Manual and all relevant laws and regulations of the Republic of the Philippines. 3.2.8.2.2 Appear before the	Mr. Pascual, attended the 2021 Annual Corporate Governance Enhancement Session conducted by MPIC on 17 September 2021.[2]

[2] Attached as Annex "B" is the Certificate of Attendance issued to Mr. Pascual for his attendance at the Annual Corporate Governance Enhancement Session conducted by the Metro Pacific Investments Corporation on 17 September 2021.

			Securities and Exchange Commission ("the Commission") upon summon on similar matters that need to be clarified by the same; 3.2.8.2.3 Determine violation/s of the Manual and recommend penalty to the Board for violation thereof; 3.2.8.2.4 Issue certification every January 30th of the year on the extent of the Corporation's compliance with this Manual for the completed year, explaining the reason/s of the latter's deviation from the same, if any; and 3.2.8.2.5 Identify, monitor and control compliance risks."	
Principle 2. ESTABLISHING CLEAR ROLES AND RESPONSIBILITIES OF THE BOARD				
The fiduciary roles, responsibilities, and accountabilities of the Board, as provided under the law, the company's articles of incorporation and bylaws, and other legal pronouncements and guidelines should be clearly made known to all directors as well as to shareholders/members and other stakeholders.				
Recommendation 2.1				
1	The Directors act on a fully informed basis, in good faith, with due diligence and care, and in the best interest of the company, shareholders and stakeholders.	Compliant	Section 2, Article 3.1.1 of the Revised Manual of Corporate Governance of AHI provides: "It shall be the Board's responsibility to foster the long-term success of the Corporation and secure its sustained competitiveness in a manner consistent with its fiduciary responsibility, which it shall	The undersigned Chairman of the Board of Directors, Compliance Officer and Corporate Secretary attest that: a. Directors actively attend regular board and committee meetings; b. In 2021, the Board held nine (9) meetings, all of which were attended by all, if not most of the directors. In all meetings, at least nine (9) directors attended and actively participated; c. To ensure that directors are able to act on a fully informed basis, they receive copies of the Notice, Agenda and

			exercise in the best interest of the Corporation, its stockholders and other stakeholders. The Board shall conduct itself with utmost honesty and integrity in the discharge of its duties, functions and responsibilities.	relevant materials ahead of the meeting.
Recommendation 2.2				
1	The Board oversees the development and approval of the company's business objectives and strategy.	Compliant	Section 2, Article 3.1.1.2.19 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.19 Oversee the development of and approve the Corporation's business and strategy, and monitor its implementation, in order to sustain the Corporation's long-term viability and strength.	The undersigned Chairman of the Board of Directors, Compliance Officer and Corporate Secretary attest that: a. The Board of Directors approves the annual budget of the Company, which includes the approval of the Company's objectives and strategy for the upcoming year, which approval is made on an annual basis; b. The President and Chief Finance Officer report to the Board of Directors during regular Board meetings on the implementation of the Company's business objectives and strategy; and c. The Board of Directors approves the financial report and financial position of the Company, as embodied in the Company's Audited Financial Statements filed with the SEC.
2	The Board oversees and monitors the implementation of the company's business objectives and strategy.	Compliant		
Recommendation 2.3				
1	The Board ensures and adopts an effective succession planning program for directors, key officers and management.	Non-compliant	Section 2, Article 3.1.1.2.7 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.7 Ensure and adopt an effective succession-planning	The Board has yet to formulate a formal succession planning program.
2	The Board adopts a policy for the retirement of directors and key officers.	Non-compliant		The Board has yet to formulate a formal retirement policy for its directors and key officers.

			program for members of the Board, key officers and Management, including the adoption of a retirement policy."	
Recommendation 2.4				
1	The Board aligns the remuneration of key officers and board members with the long-term interests of the company.	Compliant	Section 2, Article 3.1.1.2.20 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.20 Align the renumeration of key officers and Directors with the long-term interest of the Corporation. In doing so, it should formulate and adopt a policy specifying the relationship between renumeration and performance. No Director should participate in the determination of his own per diem or compensation.	
2	The Board adopts a policy specifying the relationship between remuneration and performance.	Compliant		
3	The Directors do not participate in discussions or deliberations involving his/her own remuneration.	Compliant		
Recommendation 2.5				
1	The Board has a formal and transparent board nomination and election policy.	Non-compliant	Article III, Sections 2 of the Amended By-laws of the AHI provides: "Section 2. Election and Term – The Board of Directors shall be elected during each regular meeting of stockholders and shall hold office for one (1) year and until their successors are elected and qualified.	While the Company has no separate formal nomination and election policy, election of directors are conducted in accordance with applicable laws and the By-Laws of the Company. Moving forward, the Company will endeavor to adopt a formal and transparent board nomination and election policy.
2	The Board nomination and election policy is disclosed in the company's Manual on Corporate Governance.	Non-compliant		The manner of election of directors is set out in the Company's By-Laws, but not in its Corporate Governance Manual.

3	The Board nomination and election policy includes how the company accepted nominations from shareholders/members.	Non-compliant	Section 2-A. Independent Directors. From among the number of directors provided in the Articles of Incorporation, two (2) shall be independent directors. The qualifications of independent directors of the Corporation and the procedure for their nomination and election shall be in accordance with Section 38 of the Securities and Regulation Code (Rep. Act No. 8799 [2000], SRC Rule 38, SEC Memorandum Circular No. 02-02 dated April 5, 2002 and SEC Memorandum Circular No. 16-02 dated November 28, 2002, as any of the foregoing may be promulgated in connection with the qualification, nomination, and election of independent directors of the corporations. Section 3. Vacancies – Any vacancy occurring in the Board of Directors other than by removal by the stockholders or by expiration of term, may be filled by the vote of at least a majority of the remaining directors, if still constituting a quorum; otherwise, the vacancy must be filled by the stockholders at a regular or at any special meeting of stockholders duly called for the purpose. A director so elected to fill a vacancy shall be elected only for the unexpired term of	Same explanation as in Item 1.
4	The Board nomination and election policy includes how the board reviews the qualifications of nominated candidates.	Non-compliant		Same explanation as in Item 1.
5	The Board nomination and election policy includes an assessment of the effectiveness of the Board's processes in the nomination, election or replacement/removal of a director.	Non-compliant		Same explanation as in Item 1.
6	The Board has a process for identifying the quality of directors/trustees that is aligned with the strategic direction of the company.	Non-compliant		

			his predecessor in office. Any directorship to be filled by reason of an increase in the number of directors shall be filled only by an election at a regular or at a special meeting of stockholders duly called for the purpose, or the same meeting authorizing the increase of directors if so stated in the notice of the meeting. The vacancy resulting from the removal of a director by the stockholders in the manner provided by law may be filed by election at the same meeting of stockholders without further notice, or at any regular or at any special meeting of stockholders called for the purpose, after giving notice as prescribed in these by laws."	
Recommendation 2.6				
1	The Board has overall responsibility in ensuring that there is a policy and system governing related party transactions (RPTs) and other unusual or infrequently occurring transactions.	Non-Compliant	Section 2, Article 3.1.1.2.21 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.21 Ensure that the	The Company currently has no RPT policy. However, the Company has a Conflict of Interest Policy[3], which deals with the management of conflicts of interest among clinical and non-clinical staff members, directors and officers of the Company, in order to maintain the integrity of their professional judgment and to sustain public confidence in that judgment. This ensures that the principles of integrity, transparency, accountability and fairness are upheld in all transactions and official actions of the Company. The Policy provides for the rules on reporting and investigation of activities that constitute conflict of interest or irregular
2	The RPT policy includes appropriate review and approval of material RPTs, which guarantee fairness and transparency of the transactions.	Non-Compliant		

[3] A copy of the Conflict of Interest Policy is attached hereto as **Annex "C"**.

			Corporation adopt a policy and system governing related party transactions and other unusual or infrequently occurring transaction, including appropriate review and approval of material related party transactions guaranteeing fairness and transparency."	activities/transactions. It is submitted that in some instances, the Policy may also cover RPTs. Moving forward, the Company will endeavor to adopt a formal policy on RPTs.
Recommendation 2.7				
1	The Board is primarily responsible for approving the selection of Management, led by the Chief Executive Officer (CEO) or his/her equivalent, and the heads of the other control functions (Chief Risk Officer, Chief Compliance Officer and Chief Audit Executive, as may be applicable).	Compliant	Section 2, Article 3.1.1.2.25 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.5 Appoint the hospital's chief executive(s) who is responsible for operating the hospital and complying with applicable laws and regulations, and evaluate his/her performance."	For 2021, the Company's management officers, such as its CEO/President, Chief Financial Officer, Chief Medical Officer, and Chief Strategy Officer/Head of Strategic Support Group, were appointed by the Board during its organizational meeting held on 30 April 2021.
2	The Board is primarily responsible for assessing the performance of Management, led by the CEO or his/her equivalent and the heads of the other control functions (Chief Risk Officer, Chief Compliance Officer and Chief Audit Executive, as may be applicable).	Compliant	Section 2, Article 3.1.1.2.25 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.5 Appoint the hospital's chief executive(s) who is responsible for operating the	

			hospital and complying with applicable laws and regulations, and evaluate his/her performance."	
Recommendation 2.8				
1	The Board establishes an effective performance evaluation framework that includes a standard or criteria for assessment and ensures that Management's performance is on par with the standards set by the Board and Senior Management.	Compliant	Section 2, Article 3.2.1.3 of the Revised Manual of Corporate Governance of AHI provides: "3.2.1.3 The Board shall be evaluated annually, and the results of which are documented based on their duties and responsibilities." Section 3, Article 9.1 of the Revised Manual of Corporate Governance of AHI likewise provides: 9.0 MONITORING AND ASSESSMENT 9.1 The Board shall establish an effective performance evaluation framework, which includes the standard criteria for assessment, that will ensure that the Management Committee, including the Chief Executive Officer, and personnel's performance is at par with the standards set by the Board and Senior Management."	
2	The Board establishes an effective performance evaluation framework that includes a standard or criteria for assessment and ensures that personnel's performance is on par with the standards set by the Board and Senior Management.	Compliant		
Recommendation 2.9				
1	The Board ensures that an appropriate internal control system is in place.	Compliant	Section 2, Article 3.1.1.2.22 of the Revised Manual of Corporate Governance of AHI e provides:	The Company has an Internal Audit Manager who reports to the President and CEO, with functional reporting to the Audit Committee.

2	The internal control system includes a mechanism for monitoring and managing potential/actual conflicts of interest of the board members/trustees, management and shareholders/members.	Compliant	"To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.22 Oversee that an appropriate internal control system is in place, including setting a up a mechanism for monitoring and managing potential/actual conflicts of interest of board members, management, and shareholders. The Board should also adopt an Internal Audit Charter."	Same explanation as Item No. 1.
3	The Board adopts an Internal Audit Charter.	Non-Compliant	Section 2, Article 3.1.1.2.22 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.22 Oversee that an appropriate internal control system is in place, including setting a up a mechanism for monitoring and managing potential/actual conflicts of interest of board members, management, and shareholders. The Board should also adopt an Internal Audit Charter."	The Board has yet to adopt an Internal Audit Charter, as prescribed by Section 2, Article 3.1.1.2.22 of the Revised Manual of Corporate Governance.
Recommendation 2.10				

1	The Board ensures that the company has in place a sound enterprise risk management (ERM) framework to effectively identify, monitor, assess and manage key business risks.	Compliant	Section 2, Article 3.1.1.2.14 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.14 Identify key risk areas and key performance indicators and monitor these factors with due diligence and oversee that a sound Enterprise Risk Management framework is in place to effectively identify, monitor, assess and manage key business risk. The risk management framework should guide the Board in identifying units/business lines and enterprise-level risk exposures, as well as the effectiveness of risk management strategies."	The Company has adopted a Risk Management Program, which establishes an organization-wide process of assessing, reducing, eliminating and managing all forms of risks.[4]
2	The risk management framework guides the Board in identifying units/business lines and enterprise-level risk exposures, as well as the effectiveness of risk management strategies.	Compliant		
Recommendation 2.11				
1	The Board has a Board Charter that formalizes and clearly states its roles, responsibilities and accountabilities in carrying out its fiduciary duties.	Compliant	Section 2, Article 3.1.1.2.23 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.23 The Board shall create	The duties and powers of the members of the Board are provided in Article III of the Company's By-laws, which is a publicly-available corporate document.
2	The Board Charter serves as a guide to the directors/trustees in the performance of their functions.	Compliant		
3	The Board Charter is publicly available.	Compliant		

[4] A copy of the Company's Risk Management Program is attached hereto as **Annex "D"**.

			a Board Charter that formalizes and clearly states its roles, responsibilities and accountabilities in carrying out its fiduciary duties. The Board Charter should serve as a guide to the directors in the performance of their functions and should be made publicly available."	
Principle 3. ESTABLISHING BOARD COMMITTEES				
The board committees should be set up to the extent possible to support the effective performance of the Board's functions, particularly with respect to audit, risk management, compliance and other key corporate governance concerns, such as nomination and remuneration. The composition, functions and responsibilities of all the board committees should be contained in their respective board committee charters.				
Recommendation 3.1				
1	The Board establishes board committees that focus on specific board functions to aid in the optimal performance of its roles and responsibilities.	Compliant	Section 2, Article 3.2.9 of the Revised Manual of Corporate Governance of AHI provides: "To aid in complying with the principles of good corporate governance, the Board shall establish Board committees that focus on specific Board functions to aid in the optimal performance of its roles and responsibilities. x x x"	During the organizational meeting of the Board held on 30 April 2021, the Board organized themselves into the following committees: (i) Executive Committee, (ii) Nomination Committee, (iii) Audit Committee, and (iv) Compensation and Renumeration Committee.
Recommendation 3.2				
1	The Board establishes an Audit Committee to enhance its oversight capability over the company's financial reporting, internal control system, internal and external audit processes, and compliance with applicable laws	Compliant	The members of the Audit Committee are Dr. Fernandino Jose A. Fontanilla (Independent Director and Chairman), Mr. Ricardo V. Buencamino and Mr. Reymundo S. Cochangco.	

	and regulations.		Said information was disclosed to the SEC under SEC Form 17-C filed by the Company on 6 May 2021.[5]	
2	The Audit Committee is composed of at least three (3) qualified non-executive directors, the majority of whom, including the Chairperson, are independent directors.	Non-compliant	SEC Form 17-C filed by the Company on 7 May 2021.	The 2021 Audit Committee was composed of three (3) members. However, only the Chairperson is an Independent Director.
3	All the members of the committee have relevant background, knowledge, skills, and/or experience in the areas of accounting, auditing and finance.	Non-compliant	The professional background, knowledge, skills, and/or experience of the members of the Audit Committee are provided in the in the Company's Annual Report and Definitive Information Statement, which were submitted to the SEC and posted in the Company's website. https://www.asianhospital.com/annual-report/	Mr. Cochangco has over 20 years of experience in finance, treasury, controllership, audit and business operations. While Dr. Fontanilla is a medical doctor by profession, he holds a Master's Degree in Business Administration and Health from the Ateneo Graduate Business School. Similarly, Mr. Buencamino holds a Master's Degree in Management from the Asian Institute of Management.
4	The Chairperson of the Audit Committee is not the Chairperson of the Board or of any other committee.	Compliant	SEC Form 17-C filed by the Company on 7 May 2021.	During his term as Chairperson of the Audit Committee in 2021, Dr. Fontanilla was not the Chairperson of the Executive Committee, Nomination Committee, and Compensation and Renumeration.
Recommendation 3.3				
1	The Board establishes a Corporate Governance Committee tasked to assist the Board in the performance of its corporate governance responsibilities, including the functions that were formerly assigned to a Nomination	Compliant	Section 2, Article 3.2.9.3 of the Revised Manual of Corporate Governance of AHI provides: "3.2.9.3 Organizational Ethics and Compliance Committee	The Company has already organized an Organizational Ethics and Compliance Committee which handles the corporate governance matters of the Company. The Organizational Ethics and Compliance Committee was established on 23 November 2021, and is composed of the following: Dr. Roseny Mae Singson (a physician at Asian Hospital) as Chairperson, and the Compliance Officer, HR Manager, Nursing Associate Director, Supply Chain

[5] Attached as **Annex "E"** is a copy of SEC Form 17-C filed on 6 May 2021.

	and Remuneration Committee.		x x x 3.2.9.3.1 Considers and recommends corporate governance principles to be adopted by the Management Committee. 3.2.9.3.2 Monitors best practices in corporate governance worldwide. 3.2.9.3.7 Assist the Management Committee in the performance of its continuous governance responsibilities." The Organizational Ethics and Compliance Committee has adopted its Charter on 23 November 2021.[6]	Senior Manager and Finance Manager, as members.
2	The Corporate Governance Committee is composed of at least three (3) members, majority of whom, including the Chairperson, should be independent directors.	Non-Compliant	Section 2, Article 3.2.9.3 of the Revised Manual of Corporate Governance of AHI provides: "The Board shall establish an Organizational Ethics Committee, which will be composed of six (6) members, with at least one (1) Physician, who shall act as the head of the committee." The Organizational Ethics and Compliance Committee Charter further provides: "5.1 The Committee shall be	The Committee is composed of Dr. Roseny Mae Singson (a physician at Asian Hospital) as Chairperson, and the Compliance Officer, HR Manager, Nursing Associate Director, Supply Chain Senior Manager and Finance Manager, as members.

[6] A copy of the Organizational Ethics and Compliance Committee Charter is attached hereto as **Annex "L".**

			composed of at least seven (7) members, all of whom shall be at least holds a senior managerial position. To greatest extent possible, the membership of the Committee shall comply with the following general guidelines: a. The Chairman of the Committee shall be an active professional staff or an employee of Asian Hospital b. The Committee membership shall not include executive directors; and c. The members shall possess the experience, capacity, and resources to meaningfully carry out their functions."	
Recommendation 3.4				
1	The Board establishes a separate Board Risk Oversight Committee (BROC) that should be responsible for the oversight of a company's Enterprise Risk Management system to ensure its functionality and effectiveness.	Non-compliant	Section 2, Article 3.2.9.2 of the Revised Manual of Corporate Governance of AHI provides: 3.2.9.2 Quality Management Committees The Hospital shall establish a Quality Council, Risk Management Committee and Patient Safety Committee, which shall be responsible for the oversight of the hospital's Quality, Risk Management and Patient Safety program to ensure that a high quality and safe care is delivered at all times. The chairperson of the committee	In view of the recent adoption of the Revised Manual of Corporate Governance, the Board has yet to create a Board Risk Oversight Committee. However, the Company has a Quality Management Office, composed of the Quality Council, Risk Management Committee and Patient Safety Committee[7], which functions similar to the Board Risk Oversight Committee.

[7] The Charters of the Quality Council, Risk Management Committee and Patient Safety Committee are attached hereto as **Annexes "M", "N" and "O".**

			shall be appointed by the President and Chief Executive Officer every three years. At least two (2) members of the committee including the chairperson of the committee must have relevant, thorough knowledge and experience on risk and risk management.	
2	The BROC is composed of at least three (3) members, the majority of whom should be independent directors, including the Chairperson.	Non-compliant	Section 2, Article 3.2.9.2 of the Revised Manual of Corporate Governance of AHI provides: 3.2.9.2 Quality Management Committees The Hospital shall establish a Quality Council, Risk Management Committee and Patient Safety Committee, which shall be responsible for the oversight of the hospital's Quality, Risk Management and Patient Safety program to ensure that a high quality and safe care is delivered at all times. The chairperson of the committee shall be appointed by the President and Chief Executive Officer every three years. At least two (2) members of the committee including the chairperson of the committee must have relevant, thorough knowledge and experience on risk and risk management.	Please see explanation above.
3	At least one member of the BROC has relevant thorough knowledge and experience on risk and risk management.	Non-compliant	Section 2, Article 3.2.9.2 of the Revised Manual of Corporate Governance of AHI provides:	Please see explanation above.

			3.2.9.2 Quality Management Committees The Hospital shall establish a Quality Council, Risk Management Committee and Patient Safety Committee, which shall be responsible for the oversight of the hospital's Quality, Risk Management and Patient Safety program to ensure that a high quality and safe care is delivered at all times. The chairperson of the committee shall be appointed by the President and Chief Executive Officer every three years. At least two (2) members of the committee including the chairperson of the committee must have relevant, thorough knowledge and experience on risk and risk management.	
Recommendation 3.5				
1	All established committees have a Committee Charter stating in plain terms their respective purposes, memberships, structures, operations, reporting process, resources and other relevant information.	Non-compliant		Please see explanation above.
2	The Committee Charters provide standards for evaluating the performance of a committee and its members.	Non-compliant		Please see explanation above.
Principle 4. FOSTERING COMMITMENT				
To show full commitment to the company, the directors should devote the time and attention necessary to properly and effectively perform their duties and responsibilities, including sufficient time to be familiar with the corporation's business.				

1	The Directors attend and actively participate in all meetings of the Board, Committees and shareholders/members in person or through tele-/videoconferencing conducted in accordance with the rules and regulations of the Commission.	Compliant	Section 2, Article 3.1.1.2..15 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.15 Properly discharge Board functions by meeting regularly, such as for example at least once every two (2) months, or when circumstances requires a special meeting, shall be convened to address urgent important matters. Board members will be compensated for attendance at each board meeting with a reasonable per diem as determined by the compensation committee and approved by a simple majority of the board. Independent views during Board meetings shall be given due consideration and all such meetings shall be duly minutes."	The undersigned Chairman of the Board of Directors, Compliance Officer and Corporate Secretary attest that the directors actively attend and participate in board and shareholders' meetings, through tele-/videoconferencing conducted in accordance with the rules and regulations of the SEC.
2	The Directors review meeting materials for all Board and Committee meetings.	Compliant		The undersigned Chairman of the Board of Directors, Compliance Officer and Corporate Secretary attest that meeting materials are distributed ahead of all Board meetings as to enable the directors to act of a fully informed basis.
3	The Directors ask the necessary questions or seek clarifications and explanations during the Board and Committee meetings.	Compliant		The undersigned Chairman of the Board of Directors, Compliance Officer and Corporate Secretary attest that in all Board meetings, directors engage in fruitful discussions by propounding questions and requesting explanations.

1	Non-executive directors concurrently serve in not more than ten (10) public companies and/or registered issuers. If concurrently sitting in at least three (3) publicly listed companies, the maximum concurrent directorships shall be five (5) public companies and/or registered issuers.	Non-Compliant		The Company has not yet formally adopted a policy setting the limit of board seats that a non-executive director can hold simultaneously. Nonetheless, Section 2, Article 3.2.14.8 Revised Manual of Corporate Governance of AHI provides that the directors are required to notify the Board before accepting a directorship in another corporation.
Recommendation 4.3c				
1	The Directors notify the company's board before accepting a directorship in another company.	Compliant	Section 2, Article 3.2.1.4.8 of the Revised Manual of Corporate Governance of AHI provides: "3.2.1.4 Duties and Responsibilities of a Director A director shall have the following duties and responsibilities: 3.2.1.4.8 To notify the Board before accepting a directorship in another corporation."	
Principle 5. REINFORCING BOARD INDEPENDENCE				
The Board should endeavor to exercise an objective and independent judgment on all corporate affairs.				
Recommendation 5.1				
1	The Board is composed of a majority of non-executive directors who possess the necessary qualifications.	Compliant	Section 2, Article 3.1.1.2.6 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall:	Of the eleven (11) directors of AHI elected in 2021, only two (2) held executive positions (Mr. Licaros who was also the President/CEO and Mr. Cochangco who was the Treasurer of the Company).

			3.1.1.2.6 Ensure that its directors possess the necessary qualifications and none of the disqualifications for a director to hold the position." Section 2, Article 3.1.1 of the Revised Manual of Corporate Governance of AHI likewise provides: "3.1.1 Board of Directors x x x The Board shall be composed of fifteen (15) members, with collective working knowledge, experience or expertise relevant to the Corporation's business, and shall adhere to a policy of diversity in gender, age, ethnicity, culture, skills, competence and knowledge. A majority of the Board shall be non-executive directors with the necessary qualifications to effectively participate and help secure objective, and independent judgment on corporate affairs and to carry out proper checks and balance. At least three (3) members of the Board shall be independent directors."	
Recommendation 5.2				

1	The Board has at least two (2) independent directors or such number as to constitute one-third (1/3) of the board, whichever is higher.	Non-compliant	Section 2, Article 3.1.1 of the Revised Manual of Corporate Governance of AHI provides: "3.1.1 Board of Directors x x x The Board shall be composed of fifteen (15) members, with collective working knowledge, experience or expertise relevant to the Corporation's business, and shall adhere to a policy of diversity in gender, age, ethnicity, culture, skills, competence and knowledge. A majority of the Board shall be non-executive directors with the necessary qualifications to effectively participate and help secure objective, and independent judgment on corporate affairs and to carry out proper checks and balance. At least three (3) members of the Board shall be independent directors."	For 2021, the Company had three (3) independent directors out of the eleven (11) members of the Board.
Recommendation 5.3				
1	The independent directors possess all the qualifications and none of the disqualifications to hold the position.	Compliant	Section 2, Article 3.1.1.2.6 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall:	The Board's independent directors possess all the qualifications and none of the disqualifications to hold the position, as shown by the Certifications of Independent Director appended to the Definitive Information Statement, accessible at: https://www.asianhospital.com/annual-report/

			3.1.1.2.6 Ensure that its directors possess the necessary qualifications and none of the disqualifications for a director to hold the position."	
Recommendation 5.4				
1	The company perpetually bars an independent director from serving in such capacity after the term limit of nine (9) years.	Compliant	Section 2, Article 3.2.1.5.1 of the Revised Manual of Corporate Governance of AHI provides: "The Board's independent directors shall serve for a maximum cumulative term of nine (9) years. After which, the independent director shall be perpetually barred from re-election as such but may continue to qualify for nomination and election as a non-independent director, except for meritorious justification/s and upon approval of shareholders during the annual shareholders meeting."	
2	In the instance that the company retains an independent director in the same capacity after nine (9) years, the Board provides meritorious justification and seeks shareholders'/members' approval during the annual regular meeting.	Compliant	Section 2, Article 3.2.1.5.1 of the Revised Manual of Corporate Governance of AHI provides: "The Board's independent directors shall serve for a maximum cumulative term of nine (9) years. After which, the independent director shall be perpetually barred from re-election as such but may continue to qualify for nomination and election as a non-independent director, except for meritorious	In a letter dated 24 February 2021 (Schedule 1 of the 2021 Definitive Information Statement), the Company notified to the SEC its intention to re-elect its incumbent independent directors, (i) Dr. Fernando Jose Fontanilla, and (ii) Dra. Carmelita I. Quebengco. The Company requested for their re-election since the Company was unable to find other replacements that will provide the same comparable skills, qualifications and experience that the said independent directors were then currently providing. This matter was disclosed to the stockholders as the letter was attached as Schedule 1 of the 2021 Definitive Information Statement. The re-election of Dr. Fontanilla and Dra. Quebengco as independent directors were approved by the stockholders at the 2021 Annual Stockholders' Meeting.

			justification/s and upon approval of shareholders during the annual shareholders meeting."	
Recommendation 5.5				
1	The positions of Chairperson of the Board and Chief Executive Officer (or its equivalent) are held by separate individuals.	Compliant	Section 2, Article 3.2.2.4 of the Revised Manual of Corporate Governance of AHI provides: "3.2.2.4 The Chairman shall be a separate individual from the Chief Executive Officer." Section 2, Article 3.2.10 of the Revised Manual of Corporate Governance of AHI also provides: "x x x The roles of the Chairman and the Chief Executive Officer are separated to ensure an appropriate balance of power, increased accountability a greater capacity of the Board for independent decision-making."	For 2021, the Chairman of the Board was Mr. Augusto P. Palisoc while the Chief Executive Officer and President was Mr. Andres M. Licaros, Jr.
2	The Chairperson of the Board and Chief Executive Officer (or its equivalent) have clearly defined responsibilities.	Compliant	Section 2, Article 3.2.2 of the Revised Manual of Corporate Governance of AHI provides the responsibilities of the Chairman: "3.2.2 Chairman of the Board The duties of the Chairman of the Board of Directors shall include:	

			3.2.2.1 Schedule meetings to enable the Board to perform its duties responsibly while not interfering with the flow of the company's operations. 3.2.2.2 Approve meeting agenda prepared by the President and CEO. 3.2.2.3 Vote on matters when there are deadlocks among the Board Members. 3.2.2.4 The Chairman shall be a separate individual from the Chief Executive Officer." Section 2, Article 3.2.10 of the Revised Manual of Corporate Governance of AHI provides the responsibilities of the Chief Executive Officer/President.. Section 2, Article 3.2.9.1 of the Revised Manual of Corporate Governance of AHI also provides: "The Management Committee is composed of the President and Chief Executive Officer, and Directors as may be designated by the President and Chief Executive Officer who heads the Management Committee. This Committee shall implement all Board-approved policies and strategic directions governing the organization, management	

			and operation of the Hospital. The Committee shall regularly report to the Board through the President and Chief Executive Officer on all matters concerning the Hospital's operation as well as significant events or Occurrences affecting the Hospital. x x x"	
Recommendation 5.6				
1	The Board designates a lead director among the independent directors if the Chairperson of the Board is not an independent director.	Non-compliant	Section 2, Article 3.2.10 of the Revised Manual of Corporate Governance of AHI provides: "3.2.10 Chief Executive Officer / President x x x The Board shall designate a lead director among the independent directors if the Chairman of the Board is not independent. x x x"	The Board has not yet designated the "lead director" among the independent directors.
Recommendation 5.7				
1	The Directors/Trustees with material interest in a transaction affecting the corporation fully disclose his/her adverse interest, abstain from taking part in the deliberations for the same, and recuse from voting on the approval of transaction.	Compliant	Section 2, Article 3.2.1.4.9 of the Revised Manual of Corporate Governance of AHI provides: "3.2.1.4 Duties and Responsibilities of a Director A director shall have the	

			following duties and responsibilities: 3.2.1.4.9 To, in any transaction affecting the Corporation, fully disclose his adverse interest, abstain from taking part in the deliberations for the same and recuse from voting on the approval of the transaction wherein he has a material or potential interest."	
Recommendation 5.8				
1	The non-executive directors (NEDs) have separate periodic meetings with the external auditor and heads of the internal audit, compliance, and risk functions, without any executive directors present.	Compliant		The Audit Committee and the Company's External Auditor, SyCip Gorres Velayo & Co., held two (2) meetings in 2021: the first on 20 October 2021 regarding the proposed December 31, 2021 Audit Plan of the Company; and the second on 22 February 2022 regarding the December 31, 2021 Audit Results of the Company.
2	The meetings are chaired by the lead independent director, if applicable.	Non-compliant		The Board has not yet designated the "lead director" among the independent directors.
Principle 6. ASSESSING BOARD PERFORMANCE				
The best measure of the Board's effectiveness is through an assessment process. The Board should regularly carry out evaluations to appraise its performance as a body, and assess whether it possesses the right mix of backgrounds and competencies.				
Recommendation 6.1				
1	The Board conducts an annual self-assessment of its performance as a whole.	Compliant	Section 3, Article 9.2 of the Revised Manual of Corporate Governance of AHI provides: 9.0 MONITORING AND ASSESSMENT 9.2 The Board should conduct an annual self-assessment of its	The Board as a whole has conducted a self-assessment of its performance for year 2021, which was reported during the 22 February 2022 Regular Meeting of the Board.[8]
2	The Chairperson conducts an annual self-assessment of his performance.	Non-compliant		The Chairman has yet to conduct a formal self-assessment of his performance.
3	The individual members conduct a self-assessment of their	Compliant		The directors have conducted a self-assessment of their performance for year 2021, which was reported during the 22

[8] A copy of the presentation is attached hereto as **Annex "F"**.

	performance.		performance.".	February 2022 Regular Meeting of the Board.[9]
4	Each committee conducts a self-assessment of its performance.	Non-compliant		The Committees have yet to conduct formal self-assessments of their respective performances.
1	The Board has in place a system that provides, at the minimum, criteria and process to determine the performance of the Board, individual directors/trustees and committees.	Non-compliant		The Board has yet to formally set up a system that provides criteria and process to determine the performance of the Board, individual directors and committees. It will do so at the soonest practicable time.
2	The system allows for a feedback mechanism from the shareholders/members.	Non-compliant		Please see explanation above.
Principle 7. STRENGTHENING BOARD ETHICS				
The Board directors are duty-bound to apply high ethical standards, taking into account the interests of all stakeholders.				
Recommendation 7.1				
1	The Board adopts a Code of Business Conduct and Ethics, which provide standards for professional and ethical behavior, as well as articulate acceptable and unacceptable conduct and practices in internal and external dealings of board members.	Compliant	Section 2, Article 3.1.1.2.17 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.17 Ensure that the Hospital operates ethically and responsibly and in compliance with internal codes of conduct, including the establishment of a framework for ethical management that ensures that	The Company has adopted a Code of Organizational Ethics, which took effect on 20 March 2019.[10]

[9] *Ibid.*

[10] A copy of the Code of Organizational Ethics is attached hereto as **Annex "G"**.

			patient care is provided within business, financial, ethical and legal norms that protect patients and their rights. A Code of Business Conduct and Ethics shall be adopted for this purpose.	
2	The Code is properly disseminated to the members of Board.	Non-compliant		A copy of the Code of Organizational Ethics is available upon request by any director.
3	The Code is disclosed and made available to the public through the company website.	Non-compliant	Section 2, Article 7.8 of the Revised Manual of Corporate Governance of AHI provide: "7.8 The Corporation shall have a website to ensure a comprehensive, cost-effective transparent and timely manner of disseminating relevant information to the public."	The Code is not yet uploaded in the Company's website.
Recommendation 7.2				
1	The Board ensures the proper and efficient implementation and monitoring of compliance with the Code of Business Conduct and Ethics.	Compliant	Section 2, Article 3.1.1.2.18 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.18 The Board should ensure the proper and efficient implementation and monitoring of compliance with the Code of Business Conduct and Ethics."	
Principle 8. ENHANCING COMPANY DISCLOSURE POLICIES AND PROCEDURES				

The Board should establish corporate disclosure policies and procedures that are practical and in accordance with generally accepted best practices and regulatory expectations.				
Recommendation 8.1				
	The Board establishes corporate disclosure policies and procedures to ensure a comprehensive, accurate, reliable and timely report to shareholders/members and other stakeholders that gives a fair and complete picture of a company's financial condition, results and business operations.	Compliant	Section 2, Article 3.1.1.2.18 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.24 The Board shall establish corporate disclosure policies and procedures to ensure a comprehensive, accurate, reliable and timely report to shareholders and other stakeholders that gives a fair and complete picture of a Corporation's financial condition, results and business operations."	The Board of Directors recognizes that it is primarily accountable to the shareholders. A comprehensive report on the Company's performance, position and prospects are disseminated to the shareholders on an annual basis, particularly through the publication of its Annual Report and Information Statement. The Company dedicates a section of its website to said corporate disclosures at: https://www.asianhospital.com/annual-report/
Recommendation 8.2				
1	The company has a policy requiring all directors to disclose/report to the company any dealings in the company's shares within five (5) business days.	Compliant	Section 2, Article 7.6 of the Revised Manual of Corporate Governance of AHI provides: 7.6 All directors and officers shall disclose/report to the Corporation within fifteen (15) business days, any dealings in the Corporation's shares by the said directors and officers.	To the undersigned's knowledge, there were no dealings of directors involving the Company's shares occurring in 2021.
2	The company has a policy requiring all officers to disclose/report to the company any dealings in the company's shares within five (5) business days.	Compliant		To the undersigned's knowledge, there were no dealings of officers involving the Company's shares occurring in 2021.
Recommendation 8.3				

1	The company's corporate governance policies, programs and procedures are contained in its Manual on Corporate Governance (MCG).	Compliant	Section 2, Article 5 of the Revised Manual of Corporate Governance of AHI provides: "5.0 COMMUNICATION PROCESS 5.1 This manual shall be available for inspection by any stockholder of the Corporation at reasonable hours on business days. 5.2 All directors, executives, department/group heads are tasked to ensure the thorough dissemination of this Manual to all employees and related third parties, and to enjoin compliance in the process. 5.3 An adequate number of printed copies of this Manual must be reproduced under the supervision of QMG and at least one (1) hard copy of the Manual shall be issued per department/group. 5.4 This Manual shall be posted on the Corporation's website."	
2	The company's MCG is submitted to the SEC.	Compliant		The Revised Manual of Corporate Governance of AHI was filed with the SEC on 13 June 2022.
3	The company's MCG is posted on the company website.	Compliant		The Company dedicates a section of its website to said MCG at: About Us > Corporate Governance (https://drive.google.com/file/d/1wSBpgY_mPMhNZlEPGbtFlfz0TXAtPK1j/view)
Recommendation 8.4				
1	The company's corporate governance policies and practices and all relevant information are disclosed in its Annual Corporate Governance Report (ACGR).	Compliant		
2	The company's ACGR is submitted to the SEC.	Compliant		
3	The company's ACGR is posted on	Non-compliant		The Company was not able to post its ACGR for 2021. However,

	the company website.			starting from 2022, its ACGRs will be posted at a dedicated section in the Company's website.
Principle 9. STRENGTHENING EXTERNAL AUDITOR'S INDEPENDENCE AND IMPROVING AUDIT QUALITY				
The company should establish standards for the appropriate selection of an external auditor, and exercise effective oversight of the same to strengthen the external auditor's independence and enhance audit quality.				
Recommendation 9.1				
1	The Audit Committee has a robust process for approving and recommending the appointment, reappointment, removal, and fees of external auditors.	Compliant	Section 2, Article 3.2.6.1 of the Revised Manual of Corporate Governance of AHI provides: "3.2.6 External Auditor 3.2.6.1 An external auditor shall be selected, appointed and reappointed, and its fees approved, by the Board and stockholders upon recommendation of the Audit and Finance Committee. He/she shall enable an environment of good corporate governance as reflected in the financial records and reports of the Corporation."	
2	The appointment, reappointment, removal, and fees of the external auditor is recommended by the Audit Committee, approved by the Board and the shareholders/members.	Compliant	Section 2, Article 3.2.6.1 of the Revised Manual of Corporate Governance of AHI provides: "3.2.6 External Auditor 3.2.6.1 An external auditor shall be selected, appointed and reappointed, and its fees approved, by the Board and stockholders upon recommendation of the Audit	

			and Finance Committee. He/she shall enable an environment of good corporate governance as reflected in the financial records and reports of the Corporation"	
3	For the removal of external auditor, the reasons for such removal or change are disclosed to the SEC, the shareholders/members, and the public through the company website and required disclosures.	Compliant	Section 2, Article 3.2.6.2 of the Revised Manual of Corporate Governance of AHI provides: "3.2.6 External Auditor 3.2.6.2 The reason/s for the resignation, dismissal or cessation from service and the date thereof of an external auditor shall be reported in the company's annual and current reports. Said report shall include a discussion of any disagreement with said former external auditor on any matter of accounting principles or practices, financial statement disclosure or auditing scope or procedure."	This is not applicable because the Company did not remove or change its external auditor in the preceding year.
Recommendation 9.2				
1	The Audit Committee Charter includes the Audit Committee's responsibility on: i. assessing the integrity and independence of external auditors; ii. exercising effective oversight to review and monitor the external auditor's independence and objectivity; and iii. exercising effective oversight to review and monitor the effectiveness of the audit process, taking into consideration relevant Philippine professional and	Non-compliant		The Audit Committee has not yet to adopted an Audit Committee Charter.

	regulatory requirements.			
2	The Audit Committee Charter contains the Committee's responsibility on reviewing and monitoring the external auditor's suitability and effectiveness on an annual basis.	Non-compliant		Please see explanation above.
Recommendation 9.3				
1	The company discloses the nature of non-audit services performed by its external auditor in the Annual Report to manage potential conflict of interest cases.	Compliant	Section 2, Article 3.2.6.3 of the Revised Manual of Corporate Governance of AHI provides: "3.2.6 External Auditor 3.2.6.3 The external auditor shall not at the same time provide to the Corporation the services of an internal auditor. The Corporation shall ensure that other non-audit work shall not be in conflict with the functions of the external auditor."	This is not applicable because the Company's external auditor did not perform any non-audit services in the preceding year.
2	The Audit Committee stays alert for any potential conflict of interest situations, given the guidelines or policies on non-audit services, which could be viewed as impairing the external auditor's objectivity.	Non-Compliant		Although not expressly documented, the Audit Committee stays alert for non-audit work which may conflict with the functions of the external auditor, thus effectuating Section 2, Article 3.2.6.3 of the Revised Manual of Corporate Governance.

Principle 10. INCREASING FOCUS ON NON-FINANCIAL AND SUSTAINABILITY REPORTING				
The Board should ensure that the company discloses material and reportable non-financial and sustainability issues.				
Recommendation 10.1				
1	The Board has a clear and focused strategy on the disclosure of non-financial information.	Compliant	The Company is included in MPIC Group's 2021 Integrated Report providing for information relating to its EESG impacts for year 2021. The 2021 Integrated Report is available at: https://www.mpic.com.ph/wp-content/uploads/MPIC_IR21.pdf	
2	The company discloses to all shareholders/members and other stakeholders the company's strategic and operational objectives with emphasis on the management of environmental, economic, social and governance (EESG) issues of its business which underpin sustainability.	Compliant		
Principle 11. PROMOTING A COMPREHENSIVE AND COST-EFFICIENT ACCESS TO RELEVANT INFORMATION				
The company should maintain a comprehensive and cost-efficient communication channel for disseminating relevant information. This channel is crucial for an informed decision-making by investors, stakeholders and other interested users.				
Recommendation 11.1				
1	The company has a website to ensure a comprehensive, cost-efficient, transparent and timely manner of disseminating relevant information to the public.	Compliant	Section 2, Article 7.8 of the Revised Manual of Corporate Governance of AHI provide: "7.8 The Corporation shall have a website to ensure a comprehensive, cost-effective transparent and timely manner of disseminating relevant information to the public."	The Company's website may be accessed at: https://www.asianhospital.com/
Principle 12. STRENGTHENING INTERNAL CONTROL AND RISK MANAGEMENT SYSTEMS				
To ensure the integrity, transparency and proper governance in the conduct of its affairs, the company should have a strong and effective internal control system and enterprise risk management system.				
Recommendation 12.1				

1	The company has an adequate and effective internal control system in the conduct of its business.	Compliant	Section 2, Article 3.1.1.2.22 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.22 Oversee that an appropriate internal control system is in place, including setting up a mechanism for monitoring and managing potential/actual conflicts of interest of board members, management, and shareholders. The Board should also adopt an Internal Audit Charter." Section 2, Article 3.2.7 of the Revised Manual of Corporate Governance further states: 3.2.7 Internal Auditor 3.2.7.1. The Corporation shall have in place an independent internal audit function which shall be performed by an Internal Auditor who shall provide Board, senior management, and stockholders with reasonable assurance that the company's key organizational and procedural controls are effective, appropriate and complied with.	At the Board level, the Audit Committee ensures that internal audit functions and internal control systems are in place and working effectively. The Internal Auditor supports the Board and provides assurance that its key organizational and procedural controls are effective, appropriate, and complied with.

			3.2.7.2. The Internal Auditor shall report to the Audit committee. 3.2.7.3. The minimum internal control mechanisms for management's operational responsibility shall center on the CEO, being ultimately accountable for the Corporation's organizational and procedural controls.	
2	The company has an adequate and effective enterprise risk management framework in the conduct of its business.	Compliant	Section 2, Article 3.1.1.2.14 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.14 Identify key risk areas and key performance indicators and monitor these factors with due diligence and oversee that a sound Enterprise Risk Management framework is in place to effectively identify, monitor, assess and manage key business risk. The risk management framework should guide the Board in identifying units/business lines and enterprise-level risk exposures, as well as the effectiveness of risk management strategies.	The Company has adopted a Risk Management Program, which establishes an organization-wide process of assessing, reducing, eliminating and managing all forms of risks.[11]

[11] A copy of the Company's Risk Management Program is attached hereto as **Annex "D".**

Recommendation 12.2				
1	The company has in place an independent internal audit function that provides an independent and objective assurance, and consulting services designed to add value and improve the company's operations.	Compliant	Section 2, Article 3.2.7.1 of the Revised Manual of Corporate Governance of AHI provides: "3.2.7.1 The Corporation shall have in place an independent internal audit function which shall be performed by an Internal Auditor who shall provide Board, senior management, and stockholders with reasonable assurance that the company's key organizational and procedural controls are effective, appropriate and complied with."	The Company's internal audit is an in-house function. The Internal Auditor's added value to the company in terms of independent and objective assurance and consulting services proceeds from his duties, as outlined in Section 2, Article 3.2.7 of the Revised Manual on Corporate Governance.
Principle 13. PROMOTING SHAREHOLDER/MEMBER RIGHTS				
The company should treat all shareholders/members fairly and equitably, and also recognize, protect and facilitate the exercise of their rights.				
Recommendation 13.1				
1	The Board ensures that basic shareholder/member rights are disclosed in the Manual on Corporate Governance.	Compliant	Section 2, Article 8 of the Revised Manual of Corporate Governance of AHI enumerates the Shareholders" Benefits (i.e., rights of shareholders).	
Recommendation 13.2				

1	The Board encourages active shareholder participation by sending the Notice of Annual and Special Shareholders'/Members' Meeting with sufficient and relevant information at least twenty-one (21) days before the meeting.	Compliant		The notice and agenda for the 2021 Annual Stockholders' Meeting conducted on 30 April 2021 were posted in the Company's website and published in the Philippine Star on February 15, 2021, which is 74 days before the meeting.[12]
Recommendation 13.3				
1	The Board encourages active shareholder/member participation by making the result of the votes taken during the most recent Annual or Special Shareholders'/Members' Meeting publicly available the next working day.	Compliant		Votes taken during the Annual Stockholders' Meeting are announced on the same day.
2	The minutes of the Annual and Special Shareholders'/Members' Meetings were made available on the company website within five (5) business days from the date of the meeting.	Compliant		The minutes of the Annual Stockholders' Meeting were made available on the Company's website within five (5) business days from the date of the meeting as such minutes were uploaded to the Company's website as part of the materials for the 2022 Annual Stockholders' Meeting.
Recommendation 13.4				
1	The Board makes available, at the option of a shareholder/member, an alternative dispute mechanism to resolve intra-corporate disputes in an amicable and effective manner.	Compliant	Section 2, Article 8.9 of the Revised Manual of Corporate Governance of AHI provides: "8.1.9 The Board shall make available, at the option of a shareholder, an alternative dispute mechanism to resolve intra-corporate disputes in an amicable and effective manner."	
Recommendation 13.5				

[12] See Item II of the Minutes of the 30 April 2021 meeting available at : https://www.asianhospital.com/annual-report/.

1	The Board establishes an Investor Relations Office (IRO) or Customer Relations Office (CRO) or its equivalent to ensure constant engagement with its shareholders/members.	Non-compliant	Section 2, Article 8.10 of the Revised Manual of Corporate Governance of AHI provides: "8.1.10 The Board should establish an Investor Relations Office (IRO) to ensure constant engagement and communication with its shareholders. The IRO shall be present at every shareholders' meeting.	The Board has not yet appointed an IRO for the Company. Shareholders' issues are directly handled by the Corporate Secretary and the Stock Transfer Agent of the Company.
2	The IRO or CRO or its equivalent is present at every shareholders'/members' meeting.	Compliant	Section 2, Article 8.10 of the Revised Manual of Corporate Governance of AHI provides: "8.1.10 The Board should establish an Investor Relations Office (IRO) to ensure constant engagement and communication with its shareholders. The IRO shall be present at every shareholders' meeting."	Please see explanation above.
Principle 14. RESPECTING RIGHTS OF STAKEHOLDERS AND EFFECTIVE REDRESS FOR VIOLATION OF STAKEHOLDER'S RIGHTS				
The rights of stakeholders established by law, by contractual relations and through voluntary commitments must be respected. Where stakeholders' rights and/or interests are at stake, stakeholders should have the opportunity to obtain prompt effective redress for the violation of their rights.				
Recommendation 14.1				
1	The Board identifies the company's various stakeholders and promotes cooperation between them and the company in creating wealth, growth and sustainability.	Compliant	Section 2, Article 3.1.1.2.22 of the Revised Manual of Corporate Governance of AHI provides: "To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall: 3.1.1.2.2 Identify the	The Company identifies the following to be its stakeholders: patients, guests, employees, suppliers, stockholders as well as the government and the community in which it operates. The Company's objective is to promote a mutually beneficial relationship with its stockholders and stakeholders.

			corporation's stakeholders in the community in which it operates or are directly affected by its operations and formulate a clear policy of accurate, timely and effective communication with them and promote cooperation between them and the corporation in creating wealth, growth and sustainability."	
Recommendation 14.2				
1	The Board establishes clear policies and programs to provide a mechanism on the fair treatment, protection and enforcement of the rights of stakeholders.	Compliant	Section 2, Article 8 of the Revised Manual of Corporate Governance of AHI provides: "The company recognizes that the most cogent proof of good corporate governance is that which is visible to the eyes of its investors. The Board shall establish clear policies and programs to provide a mechanism on the fair treatment, protection and enforcement of the rights of stakeholders. Therefore, the following provisions are issued for the guidance of all internal and external parties concerned, as a governance covenant between the company and all its investors: x x x"	The Company has adopted a Culture of Safety Program issued on 20 July 2015, and revised on 10 October 2021.[13]
Principle 15. ENCOURAGING EMPLOYEES' PARTICIPATION				

[13] A copy of the Company's Culture of Safety Program is attached hereto as **Annex "H".**

A mechanism for employee participation should be developed to create a symbiotic working environment consistent with the realization of the company's objectives and good corporate governance goals.				
Recommendation 15.1				
1	The Board establishes policies, programs and procedures that encourage employees to actively participate in the realization of the company's goals and in its governance.	Non-compliant		While the Board welcomes and encourages the active participation of the Company's employees in the realization of the Company's goals and its governance, no formal policy has yet been established by the Board.
Recommendation 15.2				
1	The Board sets the tone and makes a stand against corrupt practices by adopting an anti-corruption policy and program in its Code of Business Conduct and Ethics.	Compliant	The Code of Organizational Ethics (Annex "G") provides for the Company's policy on non-acceptance of gifts and entertainment. In addition, the Company has adopted an Anti-Bribery and Anti-Corruption Policy on 1 November 2021.[14]	
2	The Board disseminates the policy and program to employees across the organization through trainings to embed them in the company's culture.	Compliant		The Company provides online training modules to disseminate policies and procedures for all hospital and medical staff.
Recommendation 15.3				
1	The Board establishes a suitable framework for whistleblowing that allows employees to freely communicate their concerns about illegal or unethical practices, without fear of retaliation.	Compliant	Section 2, Article 9.8 of the Revised Manual of Corporate Governance of AHI provides: 9.8 The Board shall establish a suitable framework that allows employees to freely communicate their concerns about illegal or unethical practices through the Code of Business Conduct and Ethics.	
2	The Board establishes a suitable framework for whistleblowing that allows employees to have direct access to an independent member of the Board or a unit created to	Compliant		

[14] A copy of the Company's Anti-Bribery and Anti-Corruption Policy is attached hereto as **Annex "I".**

	handle whistleblowing concerns.		The Company has a Whistleblowing Policy issued on 1 October 2021, and revised on 15 November 2021.[15] The Code of Organizational Ethics (Annex G) further provides for the Company's policy on safe reporting	
3	The Board supervises and ensures the enforcement of the whistleblowing framework.	Compliant	Under Sec. 5.4.2.3 of the Whistleblowing Policy, the Compliance Officers is responsible for ensuring appropriate monthly reporting to the Board of the receipt, disposition and resolution of all whistleblowing reports.	
Principle 16. ENCOURAGING SUSTAINABILITY AND SOCIAL RESPONSIBILITY				
The company should be socially responsible in all its dealings with the communities in which it operates. It should ensure that its interactions serve its environment and stakeholders in a positive and progressive manner that is fully supportive of its comprehensive and balanced development.				
Recommendation 16.1				
1	The company recognizes and places importance on the interdependence between business and society, and promotes a mutually beneficial relationship that allows the company to grow its business, while contributing to the advancement of the society where it operates.	Compliant	The Company has adopted a Volunteers' Circle Policy[16], as part of its Corporate Social Responsibility program, on 10 March 2016.	

[15] A copy of the Company's Whistleblowing Policy is attached hereto as **Annex "J".**
[16] A copy of the Company's Volunteer Policy is attached hereto as **Annex "K".**

Pursuant to the requirement of the Securiti .s & Exchange Commission this integrated Annual Corporate Governance Report is signed on behalf of the Company by the undersigned, thereunto duly authorized in the City of Makati on 29 JUN 2022.

AUGUSTO P. PALISOC JR.
Chairperson

ANDRES M. LICAROS, JR.
Chief Executive Officer and President

ARVIN MARK T. PASCUAL
Compliance Officer

FERNANDO JOSE A. FONTANILLA
Independent Director

CARMELITA I. QUEBENGCO
Independent Director

ARTEMIO P. PANGANIBAN
Independent Director

GILBERT RAYMUND T. REYES
Corporate Secretary

SUBSCRIBED AND SWORN to before me this 29 JUN 2022 in Makati City, affiants exhibiting to me their competent evidence of identity as follows:

Name	Competent Evidence of Identity	Date of Issuance
August P. Palisoc Jr.	Passport No. P6294589A	07 Mar. 2018
Andres M. Licaros, Jr.	DL#D16-77-003729	valid until 15 Oct. 2023
Arvin Mark T. Pascual	DL#N03-07-021650	valid until 30 Jan. 2024
Fernando Jose A. Fontanilla	PRC ID No. 0073779	26 December 1991
Carmelita I. Quebengco	Senior Citizen ID No. 15632	26 November 2007
Artemio P. Panganiban	Passport No. P0388884b	24 January 2019
Gilbert Raymund T. Reyes	Voter's ID No. 7404-4353A-D1658GTR10001-8	

Doc. No. 364;
Page No. 74;
Book No. I;
Series of 2022

MAUREEN DYAN D. ERNI
NOTARY PUBLIC
ROLL NO. 75572
MAKATI CITY, PHILIPPINES

MAUREEN DYAN D. ERNI
Notary Public for Makati City
Until December 31, 2023
PTR No. 8856423/Jan 05, 202[illegible] City
IBP No. 172182/Jan 05, 202[illegible] City
Roll of Attorneys No. [illegible]
MCLE Compliance: Admitted to [illegible] 2020
Appointment No. M-[illegible]
5th Floor, SEDCCO I Bldg. 120 Rada corner
Legaspi Sts., Legaspi Village, Makati City

ANNEX "A"

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I. Section 1 Introduction

1.0 INTRODUCTION

The Board of Directors ("the Board") and Management of Asian Hospital, Inc. (the "Corporation") hereby commit themselves to the principles and best practices contained in this Manual, and acknowledge that the same may guide the attainment of our corporate goals.

II. Section 2 Governance Leadership and Direction

2.0 OBJECTIVE

This Manual shall institutionalize the principles of good corporate governance in the entire organization. The Board and Management believe that corporate governance is a necessary component of what constitutes sound strategic business management and will therefore undertake every effort necessary to promote the development of a strong corporate governance culture, to create awareness of corporate governance within the organization, and ensure its implementation, as soon as possible. They shall also keep abreast of developments in corporate governance best practices.

The Corporation also recognizes and places an importance on the interdependence between business and society and aims to promote a mutually beneficial relationship that allows the Corporation to grow its business, while contributing to the advancement of the society where it operates.

3.0 COMPLIANCE SYSTEM

3.1 Plan of Compliance

3.1.1 Board of Directors

Compliance with the principles of good corporate governance shall start with the Board.

It shall be the Board's responsibility to foster the long-term success of the Corporation and secure its sustained competitiveness in a manner consistent with its fiduciary responsibility, which it shall exercise in the best interest of the Corporation, its stockholders and other stakeholders. The Board shall conduct itself with utmost honesty and integrity in the discharge of its duties, functions and responsibilities.

The Board shall be composed of fifteen (15) members, with collective working knowledge, experience or expertise relevant to the Corporation's business, and shall adhere to a policy of diversity in gender, age, ethnicity, culture, skills, competence and knowledge. A majority of the Board shall be non-executive directors with the necessary qualifications to effectively participate and help secure objective and independent judgment on corporate affairs and to carry out proper checks and balance. At least three (3) members of the Board shall be independent directors.

The Board shall be headed by a competent and qualified Chairman.

3.1.1.1 General Responsibility

A director's office is one of trust and confidence. He shall act in a manner characterized by transparency, accountability and fairness.

3.1.1.2 Specific Duties and Functions

To insure a high standard of best practice for the Corporation, its stockholders and other stakeholders, the Board shall:

3.1.1.2.1 Install a process of selection to ensure an appropriate mix of competent, expert and qualified directors and officers, and ensure that said members and officers remain qualified for their positions individually and collectively, through an annual evaluation, to enable it to fulfill its roles and responsibilities and respond to the needs of the Corporation based on evolving medical, business environment and strategic direction.

3.1.1.2.2 Identify the corporation's stakeholders in the community in which it operates or are directly affected by its operations and formulate a clear policy of accurate, timely and effective communication with them and promote cooperation between them and the corporation in creating wealth, growth and sustainability.

3.1.1.2.3 Approve the hospital's strategic, operational and management plans, as well as its policies and procedures, periodically reviews, including strategies and programs related to health care professional education and research and in the oversight of the quality of such programs.

3.1.1.2.4 Approve the capital and operating budget and allocate the resources required to operate the Corporation and meet its mission.

3.1.1.2.5 Appoint the hospital's chief executive(s) who is responsible for operating the hospital and complying with applicable laws and regulations, and evaluate his/her performance.

3.1.1.2.6 Ensure that its directors possess the necessary qualifications and none of the disqualifications for a director to hold the position.

3.1.1.2.7 Ensure and adopt an effective succession-planning program for members of the Board, key officers and Management, including the adoption of a retirement policy.

3.1.1.2.8 Use available processes that provide and support communication and cooperation with management.

3.1.1.2.9 Approve the hospital's program and plan for quality and patient safety, and regularly act on reports of the quality and patient safety program, including reports of adverse and sentinel events. The minutes of the meeting shall reflect needed actions and any follow-up as necessary.

3.1.1.2.10 Ensure that the Corporation complies with all relevant laws, regulations and codes of best business practices.

3.1.1.2.11 Identify the Corporation's major stockholders and stakeholders and formulate a clear policy on communicating or relating with them through an effective investor relations program.

3.1.1.2.12 Adopt a system of internal checks and balances.

3.1.1.2.13 Adopt an independent internal audit function that provides an independent and objective assurance, and consulting services designed to add value and improve the corporation's operations.

3.1.1.2.14 Identify key risk areas and key performance indicators and monitor these factors with due diligence and oversee that a sound Enterprise Risk Management framework is in place to effectively identify, monitor, assess and manage key business risk. The risk management framework should guide the Board in identifying units/business lines and enterprise-level risk exposures, as well as the effectiveness of risk management strategies.

3.1.1.2.15 Properly discharge Board functions by meeting regularly, such as for example at least once every two (2) months, or when circumstances requires a special meeting, shall be convened to address urgent important matters. Board members will be compensated for attendance at each board meeting with a reasonable per diem as determined by the compensation committee and approved by a simple majority of the board. Independent views during Board meetings shall be given due consideration and all such meetings shall be duly minutes.

3.1.1.2.16 Keep Board authority within the powers of the institution as prescribed in the Articles of Incorporation, By-Laws and in existing laws, rules and regulations.

3.1.1.2.17 Ensure that the Hospital operates ethically and responsibly and in compliance with internal codes of conduct, including the establishment of a framework for ethical management that ensures that patient care is provided within business, financial, ethical and legal norms that protect patients and their rights. A Code of Business Conduct and Ethics shall be adopted for this purpose.

3.1.1.2.18 The Board should ensure the proper and efficient implementation and monitoring of compliance with the Code of Business Conduct and Ethics.

3.1.1.2.19 Oversee the development of and approve the Corporation's business and strategy, and monitor its implementation, in order to sustain the Corporation's long-term viability and strength.

3.1.1.2.20 Align the renumeration of key officers and Directors with the long-term interest of the Corporation. In doing so, it should formulate and adopt a policy specifying the relationship between renumeration and performance. No Director should participate in the determination of his own per diem or compensation.

3.1.1.2.21 Ensure that the Corporation adopt a policy and system governing related party transactions and other unusual or infrequently occurring transaction, including appropriate review and approval of material related party transactions guaranteeing fairness and transparency.

3.1.1.2.22 Oversee that an appropriate internal control system is in place, including setting up a mechanism for monitoring and managing potential/actual conflicts of interest of board members, management, and shareholders. The Board should also adopt an Internal Audit Charter.

3.1.1.2.23 The Board shall create a Board Charter that formalizes and clearly states its roles, responsibilities and accountabilities in carrying out its fiduciary duties. The Board Charter should serve as a guide to the directors in the performance of their functions and should be made publicly available.

3.1.1.2.24 The Board shall establish corporate disclosure policies and procedures to ensure a comprehensive, accurate, reliable and timely report to shareholders and other stakeholders that gives a fair and complete picture of a Corporation's financial condition, results and business operations.

3.2.1.3 The Board shall be evaluated annually, and the results of which are documented based on their duties and responsibilities

3.2.1.4 Duties and Responsibilities of a Director
A director shall have the following duties and responsibilities:

3.2.1.4.1 To conduct fair business transactions with the Corporation and to ensure that personal interest does not in any way influence or affect or be bias with his or her Board decisions;

3.2.1.4.2 To devote time and attention necessary to properly discharge his duties and responsibilities;

3.2.1.4.3 To act judiciously;

3.2.1.4.4 To exercise independent judgment;

3.2.1.4.5 To have a working knowledge of the statutory requirements affecting the Corporation, including the contents of its Articles of Incorporation and By-Laws, the requirements of the Commission, and where applicable, the requirements of other regulatory agencies.

3.2.1.4.6 To observe confidentiality. A director should observe the confidentiality of non-public information acquired by reason of his or her position as director. He or she should not disclose any information to any other without the authority of the Board.

3.2.1.4.7 To ensure the continuing soundness, effectiveness and adequacy of the Corporation's control environment.

3.2.1.4.8 To notify the Board before accepting a directorship in another corporation.

3.2.1.4.9 To, in any transaction affecting the Corporation, fully disclose his adverse interest, abstain from taking part in the deliberations for the same and recuse from voting on the approval of the transaction wherein he has a material or potential interest.

3.2.1.4.10 To act on fully informed basis, in good faith, with due diligence and care and in the best interest of the Corporation and all stockholders and stakeholders.

3.2.1.5 Term of an Independent Director

3.2.1.5.1 The Board's independent directors shall serve for a maximum cumulative term of nine (9) years. After which, the independent director shall be perpetually barred from re-election as such but may continue to qualify for nomination and election as a non-independent director, except for meritorious justification/s and upon approval of shareholders during the annual shareholders meeting.

3.2.2 Chairman of the Board
The duties of the Chairman of the Board of Directors shall include:

3.2.2.1 Schedule meetings to enable the Board to perform its duties responsibly while not interfering with the flow of the company's operations.

3.2.2.2 Approve meeting agenda prepared by the President and CEO.

3.2.2.3 Vote on matters when there are deadlocks among the Board Members.

3.2.2.4 The Chairman shall be a separate individual from the Chief Executive Officer.

3.2.3 Vice Chairman of the Board

The Vice Chairman of the Board assists the Chairman in executing his/her functions. In the absence of the Chairman of the Board, the Vice Chairman assumes his/her responsibilities.

3.2.4 Corporate Secretary

3.2.4.1 The Corporate Secretary is an officer of the company and he must perform his duties and functions in accordance with the highest professional standards. Likewise, he must exhibit loyalty to the mission, vision and specific business objectives of the corporate entity.

3.2.4.2 The Corporate Secretary shall be a Filipino citizen.

3.2.4.3 The Corporate Secretary shall not be a member of the Board.

3.2.4.4 Considering his varied functions and duties, he must possess administrative and interpersonal skills, and if he is not the general counsel, then he must have some legal knowledge. He must also have some financial and accounting skills.

3.2.4.5 Duties and Responsibilities:

3.2.4.5.1 Gather and analyze all documents, records and other information essential to the performance of his duties and responsibilities to the Corporation.

3.2.4.5.2 Secure a complete schedule of agenda at least for the current year and put the Board on notice before every meeting.

3.2.4.5.3 Work fairly and objectively with the Board, Management, stockholders and other stakeholders.

3.2.4.5.4 Assist the Board in making business judgment in good faith and in the performance of their responsibilities and obligations.

3.2.4.5.5 Attend all Board meetings and maintain record of the same.

3.2.4.5.6 Submit to the Commission, at the end of every fiscal year, an annual certification as to the attendance of the Directors during Board meetings.

3.2.4.5.7 Be fully informed and be part of scheduling the activities of the Board.

3.2.4.5.8 Advise the Board on matters pertaining to their legal responsibilities and obligations and ensure that appropriate Board procedures are followed, and the applicable rules and regulations are complied with.

3.2.4.5.9 Attend annual training on corporate governance.

3.2.5 Treasurer

The Treasurer is the officer of the Corporation with the following duties and responsibilities:

3.2.5.1 Faithfully account for company funds.

3.2.5.2 Make reports as necessary to keep the Chairman of the Board, the President and Board of Directors fully informed at all times as to the financial condition of the Hospital.

3.2.5.3 Establish relationships with banks and financing institutions for purposes of securing loans and other financial services.

3.2.5.4 Perform such other duties as may be prescribed by the Chairman of the Board, the Vice Chairman of the Board or the Board of Directors.

3.2.6 External Auditor

3.2.6.1 An external auditor shall be selected, appointed and reappointed, and its fees approved, by the Board and stockholders upon recommendation of the Audit and Finance Committee. He/she shall enable an environment of good corporate governance as reflected in the financial records and reports of the Corporation.

3.2.6.2 The reason/s for the resignation, dismissal or cessation from service and the date thereof of an external auditor shall be reported in the company's annual and current reports. Said report shall include a discussion of any disagreement with said former external auditor on any matter of accounting principles or practices, financial statement disclosure or auditing scope or procedure.

3.2.6.3 The external auditor shall not at the same time provide to the Corporation the services of an internal auditor. The Corporation shall ensure that other non-audit work shall not be in conflict with the functions of the external auditor.

3.2.6.4 The company's external auditor shall be rotated, or the handling partner shall be changed every five (5) years or earlier.

3.2.6.5 If an external auditor believes that the statements made in the company's annual report, information statement or proxy statement filed during his engagement is incorrect or incomplete, he shall present his views in said reports.

3.2.7 Internal Auditor

3.2.7.1 The Corporation shall have in place an independent internal audit function which shall be performed by an Internal Auditor who shall provide Board, senior management, and stockholders with reasonable assurance that the company's key organizational and procedural controls are effective, appropriate and complied with.

3.2.7.2 The Internal Auditor shall report to the Audit Committee.

3.2.7.3 The minimum internal control mechanisms for management's operational responsibility shall center on the CEO, being ultimately accountable for the Corporation's organizational and procedural controls.

3.2.7.4 The scope and particulars of a system of effective organizational and procedural controls shall be based on the following factors: the nature and complexity of business and the business culture; the volume, size and complexity of transactions; the degree of risk; the degree of centralization and delegation of authority; the extent and effectiveness of information technology; and the extent of regulatory compliance.

3.2.8 Compliance Officer

3.2.8.1 To ensure adherence to corporate principles and best practices, the Chairman of the Board shall designate a Compliance Officer who shall hold the position of a Senior Officer or its equivalent. He shall not be a member of the Board but have direct reporting responsibilities to the Board at large, and his recommendation/s should be acted upon by the Board at large.

3.2.8.2 He shall perform the following duties:

3.2.8.2.1 Monitor compliance with the provisions and requirements of this Manual and all relevant laws and regulations of the Republic of the Philippines.

3.2.8.2.2 Appear before the Securities and Exchange Commission ("the Commission") upon summon on similar matters that need to be clarified by the same;

3.2.8.2.3 Determine violation/s of the Manual and recommend penalty to the Board for violation thereof;

3.2.8.2.4 Issue a certification every January 30th of the year on the extent of the Corporation's compliance with this Manual for the completed year, explaining the reason/s of the latter's deviation from the same, if any; and

3.2.8.2.5 Identify, monitor and control compliance risks.

3.2.8.3 The appointment of the compliance officer shall be immediately disclosed to the Commission on SEC Form 17-C. All correspondence relative to his functions as Compliance Officer shall be addressed to him.

3.2.9 Board Committees

To aid in complying with the principles of good corporate governance, the Board shall establish Board committees that focus on specific Board functions to aid in the optimal performance of its roles and responsibilities.

All Board committees shall have Committee Charters stating in plain terms their respective purposes, memberships, structures, operations, reporting processes, resources and other relevant information. The Charters shall provide the standards for evaluating the performance of the Committees and its members.

Majority of the members of the Board committees shall be Board members, as follows:

3.2.9.1 Management Committee (ManCom)

The Management Committee is composed of the President and Chief Executive Officer, and Directors as may be designated by the President and Chief Executive Officer who heads the Management Committee. This Committee shall implement all Board-approved policies and strategic directions governing the organization, management and operation of the Hospital. The Committee shall regularly report to the Board through the President and Chief Executive Officer on all matters concerning the Hospital's operation as well as significant events or occurrences affecting the Hospital.
The Board should be primarily responsible for approving the selection and assessing the performance of the Management Committee.

The Management Committee shall provide the Board with appropriate and timely information. If the information provided by Management is insufficient, the Board may make further inquiries to which the persons responsible will respond as fully and promptly as possible.

The hospital leadership is identified and is collectively responsible for defining the hospital's mission and creating the programs and policies to fulfill the mission. The hospital leadership:

3.2.9.1.1 Defines the hospital's values and mission
3.2.9.1.2 Create policies and procedures necessary to carry out the hospital's mission
3.2.9.1.3 Ensures that policies and procedures are followed.
3.2.9.1.4 Determines and plans with departments/ service leaders for the type of care and services to be provided by the hospital that are consistent with the hospital's mission and needs of the patients served by the hospital.
3.2.9.1.5 Communicates with key stakeholders in the community to facilitate access to care and access to information about the hospital's patient care services
3.2.9.1.6 Provides data and communicates information related to safety and quality of its services to stakeholders, which include nursing staff, nonclinical and management staff, patients, families and external interested parties.
3.2.9.1.7 Describes and documents the care and services to be provided.
3.2.9.1.8 Ensures that processes are in place for communicating relevant information throughout the hospital in a timely manner.
3.2.9.1.9 Ensures effective communication among clinical and nonclinical departments, services, and individual staff members.
3.2.9.1.10 Communicates the hospital's vision, mission, goals, policies, and plans to staff.
3.2.9.1.11 Develops and implements a process for staff recruitment, retention, personal development and continuing education.
3.2.9.1.12 Ensures that the planning is collaborative and includes all departments and services in the hospital.
3.2.9.1.13 Develops, plans, and implements a quality improvement and patient safety program.
3.2.9.1.14 Participates in developing and implementing a hospital wide quality improvement and patient safety program.
3.2.9.1.15 Selects and implements a hospital wide process to measure, assess data, plan change, and sustain improvements in quality and patient safety, and provides for staff education on the quality improvement process.
3.2.9.1.16 Determines how the program will be directed and managed on a daily basis and ensures that the program has adequate technology and other resources to be effective.
3.2.9.1.17 Implements a structure and process for the overall monitoring and coordination of the quality improvement and patient safety program.
3.2.9.1.18 Communicates quality improvement and patient safety information to the governing entity and hospital staff on a regular basis.
3.2.9.1.19 Reports on the quality and patient safety program at least quarterly, to the governing entity.
3.2.9.1.20 Reports to the governing entity include, at least quarterly, the number and type of sentinel events and root causes, whether the patients and families were informed of the sentinel event, actions taken to improve safety in response to sentinel events, and if the improvements were sustained

3.2.9.1.21 Regularly communicates information on the quality improvement and patient safety program to staff, including progress on meeting the International Patient Safety Goals

3.2.9.1.22 Prioritize which hospital wide processes will be measured, which hospital wide improvement and patient safety activities will be implemented, and how success of these hospital wide efforts will be measured.

3.2.9.1.23 Use available data to set collective priorities for the hospital wide measurement and improvement activities and consider potential system improvements.

3.2.9.1.24 Ensure that, when present, clinical research and health professional education programs are represented in the priorities.

3.2.9.1.25 Set priorities for compliance with the International Patient Safety Goals.

3.2.9.1.26 Assess the impact of hospital wide and departmental/ service improvements on efficiency and resource use.

3.2.9.1.27 Reviews, selects and monitors clinical and non-clinical and inspects compliance with contracted services as needed.

3.2.9.1.28 Accountable for contracts to meet patient and management needs

3.2.9.1.29 Ensure that the hospital has a written description of the nature and scope of those services to be provided through contractual agreements.

3.2.9.1.30 Ensure that the department and service leaders share accountability for the review, selection, and monitoring of clinical and non-clinical contracts.

3.2.9.1.31 Inspects compliance with contracted services as needed.

3.2.9.1.32 Ensures the continuity of service when contracts are renegotiated or terminated.

3.2.9.1.33 Ensures that contracts and other arrangements are included as part of the hospital's quality improvement and patient safety program.

3.2.9.1.34 Ensures that all contracts stipulate the quality data that are to be reported to the hospital, the reporting frequency and mechanism, and how the hospital will respond when quality requirements or expectations are not met.

3.2.9.1.35 Ensures that quality data reported under contracts are integrated into the hospital's quality monitoring program.

3.2.9.1.36 Ensures that the relevant clinical and managerial leaders participate with the quality improvement program in the analysis of quality and safety information from outside contracts.

3.2.9.1.37 Ensures that licensed health care professionals and independent health care practitioners are not employed by the hospital have the right credentials and are competent and/or privileged for the services provided to the hospital's patients.

3.2.9.1.38 Determines those services that will be provided by independent practitioners outside the hospital.

3.2.9.1.39 Makes decisions related to the purchase or use of resources—human and technical—with an understanding of the quality and safety implications of those decisions.

3.2.9.1.40 Uses data and information on the quality and safety implications of medical equipment choices and of staffing choices.

3.2.9.1.41 Uses the recommendations of professional organizations and other authoritative sources in making resource decisions.

3.2.9.1.42 Provides direction, support, and oversight of information technology resources and the emergency disaster management program (s).

3.2.9.1.43 Monitors the results of its decisions and uses the data to evaluate and improve the quality of its resource purchasing and allocation decisions.

3.2.9.1.44 Seeks and uses data and information on the safety of the supply chain to protect patients and staff from unstable, contaminated, defective and counterfeit supplies.
3.2.9.1.45 Outlines the steps in the supply chains for supplies defined as at most risk.
3.2.9.1.46 Identifies any significant risk points in the steps of the supply chains.
3.2.9.1.47 Makes resource decisions based on their understanding of the risk points in the supply chains.
3.2.9.1.48 Establishes a framework for ethical management that promotes a culture of ethical practices and decision making to ensure that patient care is provided within the business, financial, ethical and legal norms and protects patients and their rights.
3.2.9.1.49 Establishes a framework for ethical management that promotes a culture of ethical practices and decision making to ensure that patient care is provided within the business, financial, ethical and legal norms and protects patients and their rights.
3.2.9.1.50 Examines national and international ethical norms for incorporation when developing the hospital's framework for ethical conduct.
3.2.9.1.51 Creates and supports a culture of safety program throughout the hospital.
3.2.9.1.52 Implements, monitors, and takes action to improve the program for a culture of safety throughout the hospital.
3.2.9.1.53 Establishes and supports an organizational culture that promotes accountability and transparency.
3.2.9.1.54 Develops and documents a code of conduct and identifies and corrects behaviors that are unacceptable.
3.2.9.1.55 Provides education and information relevant to the hospital's culture of safety to all individuals who work in the hospital.
3.2.9.1.56 Defines how issues related to culture of safety within the hospital are identified and managed.
3.2.9.1.57 Provides resources to promote and support the culture of safety within the hospital.
3.2.9.1.58 Provides a simple, accessible, and confidential system for reporting issues relevant to a culture of safety in the hospital.
3.2.9.1.59 Ensures that all reports related to the hospital's culture of safety are investigated in a timely manner.
3.2.9.1.60 Identify system issues that lead health care practitioners to engage in unsafe behaviors.
3.2.9.1.61 Uses measures to evaluate and monitor the safety culture within the hospital and implements improvements identified from measurement and evaluation.
3.2.9.1.62 Implements a process to prevent retribution against individuals who report issues related to the culture of safety.

3.2.9.2 Quality Management Committees

The Hospital shall establish a Quality Council, Risk Management Committee and Patient Safety Committee, which shall be responsible for the oversight of the hospital's Quality, Risk Management and Patient Safety program to ensure that a high quality and safe care is delivered at all times. The chairperson of the committee shall be appointed by the President and Chief Executive Officer every three years. At least two (2) members of the committee including the chairperson of the committee must have relevant, thorough knowledge and experience on risk and risk management.

3.2.9.3 Organizational Ethics and Compliance Committee

The Board shall establish an Organizational Ethics Committee, which will be composed of six (6) members, with at least one (1) Physician, who shall act as the head of the committee.

3.2.9.3.1 Considers and recommends corporate governance principles to be adopted by the Management Committee.

3.2.9.3.2 Monitors best practices in corporate governance worldwide.

3.2.9.3.3 Settle and maintain, as appropriate, other key corporate document materials to governance, e.g. Code of Conduct.

3.2.9.3.4 Oversee the general procedures and policies within the hospital concerned with organizational ethics and compliance

The Quality Management Group supports the Organizational Ethics and Compliance Committee in assessing and reporting risks.

3.2.9.3.5 Regularly assess whether the interests of all relevant stakeholders are recognized in key policies and directions of the Hospital.

3.2.9.3.6 Monitor the application and effectiveness of the continuous disclosure procedures and generally promote the understanding of good corporate governance within the Hospital.

3.2.9.3.7 Assist the Management Committee in the performance of its continuous governance responsibilities.

3.2.10 Chief Executive Officer / President

The roles of the Chairman and the Chief Executive Officer are separated to ensure an appropriate balance of power, increased accountability and greater capacity of the Board for independent decision-making.

The Board shall designate a lead director among the independent directors if the Chairman of the Board is not independent.

The Chief Executive Officer / President of the Corporation is appointed by the Board of Directors and shall have responsibility for the general day-to-day management and supervision of the business of the hospital. It is his/her duty to maintain strict supervision over all the affairs and interests of the Hospital.

Specific responsibilities and authorities of the Chief Executive Officer/ President of the Corporation are, but not limited to:

3.2.10.1 Strategic Planning and Policy Formulation:

3.2.10.1.1 Ensures the development of long-term strategy.

3.2.10.1.2 Establishes objectives and plans that meet the needs of shareholders, customers, employees and other corporate stakeholders.

3.2.10.1.3 Ensures consistent and timely progress toward strategic objectives.

3.2.10.1.4 Obtains and allocates resources consistent with strategic objectives.

3.2.10.1.5 Reports regularly to the Board on progress made toward strategic plan milestones.

3.2.10.1.6 Recommends policies, strategic plans and budgets to the Board.

3.2.10.1.7 Ensures compliance with approved policies and applicable laws and regulations.

3.2.10.1.8 Responds to any reports from inspecting and regulatory agencies

3.2.10.2 Leadership:

3.2.10.2.1 Develops and communicates clear and consistent vision of the Hospital's objectives and values and ensures that it is well understood, widely supported, and effectively implemented within the organization.

3.2.10.2.2 Fosters a culture that encourages, recognizes and rewards leadership, excellence and innovation.

3.2.10.2.3 Ensures a culture that promotes ethical practices, individual integrity and cooperation.

3.2.10.3 Budget Planning and Implementation:

Together with the Chief Finance Officer, prepares annual budget (operating and capital budget) for approval of the Board of Directors.

Once the budget (operating and capital budget) is approved by the Board of Directors, the President and CEO is authorized to spend within the limits of the budget without interference from any member of the Board.

3.2.10.4 Financial Results:

3.2.10.4.1 Ensures the development and maintenance of appropriate systems to protect the Hospital's assets and ensure effective control of operations.

3.2.10.4.2 Establishes and achieves appropriate annual and long-term financial performance goals.

3.2.10.5 Management of Operations:

3.2.10.5.1 Ensures high quality, cost-effective management of the day-to-day operations of the hospital.

3.2.10.5.2 Promotes continuous improvement of the quality, value and competitiveness of the Hospital services and business systems.

3.2.10.5.3 Encourages and rewards creative solutions to business and management challenges.

3.2.10.5.4 Ensures compliance with approved policies, applicable laws and regulations; and responds to any reports from inspecting and regulatory agencies.

3.2.10.6 Management Development And Succession Planning:

3.2.10.6.1 Develops, attracts, retains and motivates an effective and unified senior management team.

3.2.10.6.2 Ensures that programs for management development and succession planning have the required resources and direction to develop the future leaders of the Hospital.

3.2.10.7 Human Resources:

3.2.10.7.1 Ensures the development of effective programs for the training, compensation, retention and motivation of personnel.

3.2.10.7.2 Ensures the availability of personnel needed to achieve the hospital's objectives.

3.2.10.7.3 Establishes and monitors programs to promote workplace diversity.

3.2.10.7.4 Provides appropriate recognition of the achievements of individuals and groups.

The President and CEO is authorized to hire/fire, promote/demote all executives without interference from any members of the Board. However, he shall confer and coordinate with the Chief Medical Officer on matters and activities that directly pertain to the practice of the medical profession. Any impasse between the President and CEO and the Chief Medical Officer shall be elevated to the Board at large.

3.2.10.8 Communications:

3.2.10.8.1 Serves as chief spokesperson for the Hospital, communicating effectively with the shareholders, prospective investors, employees, customers and suppliers.

3.2.10.8.2 Represents the Hospital in relationship with other hospitals, the government and the financial community.

3.2.10.9 Board Relations:

3.2.10.9.1 Reports directly and works closely with the Board of Directors.

3.2.10.9.2 Keeps directors informed on the state of the hospital, on crucial issues relating to the Hospital, and on the Hospital's progress toward the achievement of operating plan and strategic plan milestones.

4.0 ACCOUNTABILITY AND AUDIT

The Board is accountable to the stockholders and Management Committee is accountable to the Board. The Board shall provide the shareholders with a balanced and understandable assessment of the corporation's performance, position and prospects on a quarterly basis; An effective system of internal control that will ensure the integrity of the financial reports and protection of the assets of the corporation for the benefit of all stockholders and other stakeholders. The Management Committee should provide all members of the Board with a balanced and understandable account of the corporation's performance, position and prospects on a monthly basis.

5.0 COMMUNICATION PROCESS

5.1 This manual shall be available for inspection by any stockholder of the Corporation at reasonable hours on business days.

5.2 All directors, executives, department/group heads are tasked to ensure the thorough dissemination of this Manual to all employees and related third parties, and to enjoin compliance in the process.

5.3 An adequate number of printed copies of this Manual must be reproduced under the supervision of QMG and at least one (1) hard copy of the Manual shall be issued per department/group.

5.4 This Manual shall be posted on the Corporation's website.

6.0 TRAINING PROCESS

6.1 If necessary, funds shall be allocated by the CEO or its equivalent officer for the purpose of conducting an orientation program or workshop and annual continuing training to operationalize this Manual.

6.2 A director shall, before assuming as such, be required to attend a seminar on corporate governance which shall be conducted by a duly recognized private or public institute.

7.0 REPORTORIAL OR DISCLOSURE SYSTEM OF COMPANY'S CORPORATE GOVERNANCE POLICIES

7.1 The reports or disclosures required under this Manual shall be prepared and submitted to the Commission by the responsible Committee or officer through the Corporation's Compliance Officer.

7.2 All material information shall be publicly disclosed. Such information shall include earning results, acquisition or disposal of assets, board changes, related party transactions, shareholdings of directors and changes to ownership.

7.3 Other information that shall always be disclosed includes remuneration (including stock options, if any) of all directors and senior management, corporate strategy, and off balance sheet transactions.

7.4 All disclosed information shall be included in company announcements as well as through the annual report.

7.5 The Board shall therefore commit at all times to full disclosure of material information dealings. It shall cause the filing of all required information and submissions to the Commission for the interest of its stockholders and other stakeholders.

7.6 All directors and officers shall disclose/report to the Corporation within fifteen (15) business days, any dealings in the Corporation's shares by the said directors and officers.

7.7 The Corporation shall disclose, to all shareholders and other stakeholders the corporation's strategic (long-term goals) and operational objectives (short-term goals) as well as impacts of a wide range of sustainability issues, with emphasis on the management of environmental, economic, social and governance issues of its business which underpin sustainability.

7.8 The Corporation shall have a website to ensure a comprehensive, cost-effective transparent and timely manner of disseminating relevant information to the public.

8.0 SHAREHOLDERS' BENEFIT

The company recognizes that the most cogent proof of good corporate governance is that which is visible to the eyes of its investors. The Board shall establish clear policies and programs to provide a mechanism on the fair treatment, protection and enforcement of the rights of stakeholders. Therefore, the following provisions are issued for the guidance of all internal and external parties concerned, as a governance covenant between the company and all its investors:

8.1 Investors' Rights and Protection

8.1.1 Rights of investors/Minority Interests

The Board shall be committed to respect the following rights of the stockholders

8.1.2 Voting Right

8.1.2.1 Shareholders shall have the right to elect, remove and replace directors and vote on certain corporate acts in accordance with the Revised Corporation Code.

8.1.2.2 Cumulative voting shall be used in the election of directors.

8.1.2.3 A director shall not be removed without cause if it will deny minority shareholders representation in the Board.

8.1.3 Pre-emptive Right

All stockholders shall have pre-emptive rights, unless the same is denied in the articles of incorporation or an amendment thereto. They shall have the right to subscribe to the capital stock of the Corporation. The Articles of Incorporation shall lay down the specific rights and powers of shareholders with respect to the particular shares they hold, all of which shall be protected by law so long as they shall not be in conflict with the Revised Corporation Code.

8.1.4 Power of Inspection

All shareholders shall be allowed to inspect corporate books and records including minutes of Board meetings and stock registries in accordance with the Revised Corporation Code and shall be furnished with annual reports, including financial statements, without cost or restrictions.

8.1.5 Right to Information

8.1.5.1 The shareholders shall be provided, upon request, with periodic reports which disclose personal and professional information about the directors and officers and certain other matters such as their holdings of the company's shares, dealings with the company,

relationships among directors and key officers, and the aggregate compensation of directors and officers.

8.1.5.2 The minority shareholders shall be granted the right to propose holding of a meeting and the right to propose items in the agenda of the meeting, provided the items are for legitimate business purposes.

8.1.5.3 The minority shareholders shall have access to any and all information relating to matters for which the management is accountable and shall include such information and, if not included, then the minority shareholders shall be allowed to propose to include such matters in the agenda of stockholders' meeting, being within the definition of "legitimate purposes".

8.1.5.4 The shareholders shall be sent a Notice of Annual and Special Shareholders' Meeting with sufficient and relevant information at least twenty-one (21) days before the meeting.

8.1.5.5 The result of the votes on matters taken during the most recent Annual or Special Shareholders' Meeting shall be made publicly available the next working day. In addition, the Minutes of the Annual and Special Shareholders' Meeting should be available on the Corporation's website within fifteen (15) business days from the date of the meeting.

8.1.6 Right to Dividends

8.1.6.1 Shareholders shall have the right to receive dividends subject to the discretion of the Board.

8.1.6.2 The company shall be compelled to declare dividends when its retained earnings shall be in excess of 100% of its paid-in capital stock, except: a) when justified by definite corporate expansion projects or programs approved by the Board or b) when the corporation is prohibited under any loan agreement with any financial institution or creditor, whether local or foreign, from declaring dividends without its consent, and such consent has not been secured; or c) when it can be clearly shown that such retention is necessary under special circumstances obtaining in the Corporation, such as when there is a need for special reserve for probable contingencies.

8.1.7 Appraisal Right

The shareholders shall have appraisal right or the right to dissent and demand payment of the fair value of their shares in the manner provided for under Section 81 of the Revised Corporation Code of the Philippines, under any of the following circumstances:

8.1.7.1 In case any amendment to the Articles of Incorporation has the effect of changing or restricting the rights of any stockholders or class or shares, or of authorizing preferences in any respect superior to those of outstanding shares of any class, or of extending or shortening the term of corporate existence;

8.1.7.2 In case of sale, lease, exchange, transfer, mortgage, pledge or other disposition of all or substantially all of the corporate property and assets as provided in the Revised Corporation Code; and

8.1.7.3 In case of merger or consolidation.

8.1.8 It shall be the duty of the directors to promote shareholders' rights, remove impediments to the exercise of shareholders' rights and allow possibilities to seek redress for violation of their rights. They shall encourage the exercise of shareholders' voting rights and the solution of collective action problems through appropriate mechanisms. They shall be instrumental in removing excessive costs and other administrative or practical impediments to shareholders participating in meetings and/or voting in person. The directors shall pave the way for the electronic filing and distribution of shareholder information necessary to make informed decisions subject to legal constraints.

8.1.9 The Board shall make available, at the option of a shareholder, an alternative dispute mechanism to resolve intra-corporate disputes in an amicable and effective manner.

8.1.10 The Board should establish an Investor Relations Office (IRO) to ensure constant engagement and communication with its shareholders. The IRO shall be present at every shareholders' meeting.

8.1.11 The stockholders or member may vote through remote communication or in absentia. A stockholder or member who participates through remote communication or in absentia, shall be deemed present for purposes of quorum.

9.0 MONITORING AND ASSESSMENT

9.1 The Board shall establish an effective performance evaluation framework, which includes the standard criteria for assessment, that will ensure that the Management Committee, including the Chief Executive Officer, and personnel's performance is at par with the standards set by the Board and Senior Management.

9.2 The Board should conduct an annual self-assessment of its performance.

9.3 Each Committee shall report regularly to the Board.

9.4 The Compliance Officer shall establish an evaluation system to determine and measure compliance with this Manual. Any violation thereof shall subject the responsible officer or employee to the penalty provided under Part 8 of this Manual.

9.5 The establishment of such evaluation system, including the features thereof, shall be disclosed in the company's annual report (SEC Form 17-A) or in such form of report that is applicable to the Corporation. The adoption of such performance evaluation system must be covered by a Board approval.

9.6 This Manual shall be subject to quarterly review unless the same frequency is amended by the Board.

9.7 All business processes and practices being performed within any department or business unit of the Corporation that are not consistent with any portion of this manual shall be revoked unless upgraded to the compliant extent.

9.8 The Board shall establish a suitable framework that allows employees to freely communicate their concerns about illegal or unethical practices through the Code of Business Conduct and Ethics.

10.0 PENALTIES FOR NON-COMPLIANCE WITH THE MANUAL

10.1 To strictly observe and implement the provisions of this manual, the following penalties shall be imposed, after notice and hearing, on the company's directors, officers, staff, subsidiaries and affiliates and their respective directors, officers and staff in case of violation of any of the provision of this Manual:

10.1.1 In case of **first violation**, the subject person shall be reprimanded.

10.1.2 For **second violation**, suspension from office. The duration of the suspension shall depend on the gravity of the violation.

10.1.3 For **third violation**, the maximum penalty of removal from office shall be imposed.

10.2 The commission of a third violation of this manual by any member of the board of the company or its subsidiaries and affiliates shall be sufficient cause for removal from directorship. The Compliance Officer shall be responsible for determining violation/s through notice and hearing and shall recommend to the Chairman of the Board the imposable penalty for such violation, for further review and approval of the Board.

11.0 REPEALING CLAUSE

This Manual supersedes the Code of Corporate Governance issued on 08 March 2007.

12.0 REVIEW AND REISSUE DATE

The Compliance Officer shall have the primary responsibility to initiate the review of this Manual on a quarterly basis.

13.0 RESPONSIBILITY

It is the responsibility of the Board of Directors and Corporate Officials to fully implement this Manual.

III. Section 3 Documentation Requirements

14.0 REFERENCES:

14.1 Joint Commission International Standards, 7th edition, January 2021
14.2 Security and Exchange Commission (SEC)

15.0 REVISION HISTORY:

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16.0 DOCUMENT REVIEW AND APPROVAL:

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Approved by: **Calso Bernard G. Lopez** Director	Reviewed by: **Raymundo S. Cochangco** Treasurer/Director
Approved by: **Fernandino Jose A. Fontanilla** Independent Director	Approved by: **Retired Chief Justice Artemio V. Panganiban** Independent Director
Approved by: **Carmelita A. Quebengco** Independent Director	Approved by: **Sol Z. Alvarez** Director
Approved by: **Augusto P. Palisoc, Jr.** Chairman/Director	Approved by: **Ricardo V. Buencamino** Director
Approved by: **Manuel V. Pangilinan** Director	

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PROCESS / TITLE:

APPENDIX A: Definition of Terms
(Adapted from SEC Memorandum Circular no. 2 Code of Corporate Governance)

Support Document to: PM-AHI-002 Manual of Corporate Governance

Board of Directors: refers to the collegial body that exercises the corporate powers of all Corporations formed under the Revised Corporation Code. It conducts all business and controls or holds all property of such corporations.

Corporate Governance: refers to a system whereby shareholders, creditors and other stockholders of a corporation ensure that management enhances the value of the corporation as it competes in an increasingly global market place.

Executive Director: refers to a director who is at the same time appointed to head a division/department/unit within the corporate organization.

Independence: refers to that environment which allows the person to carry out his/her work freely and objectively.

Independent Director: refers to a person other than an officer or employee of the corporation, its parent or subsidiaries, or any other individual having any relationship with the corporation, which would interfere with the exercise of independent judgment in carrying out the responsibilities of a director. This means that apart from the directors' fees and shareholdings, he should be independent of management and free from any business or other relationship, which could materially interfere with the exercise of his independent judgment.

Internal Audit Department (Financial Systems Audit): refers to a department, division team of consultants or other practitioner(s) that provide independent, objective assurance and consulting services designed to add value and improve an organization's operations.

Internal Audit Director: refers to the top position within the organization responsible for internal audit activities.

Internal Auditing: refers to an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

nternal Control: refers to the process effected by a company's Board of Directors, management and other personnel, designed to provide reasonable assurance regarding the achievement of objectives in the effectiveness and efficiency of operations, the reliability of financial reporting, and compliance with applicable laws, regulations and internal policies.

Internal Control Environment: refers to the framework under which internal controls are developed, implemented, alone or in concert with other policies or procedures, to manage and control a particular risk or business activity, or combination of risks or business activities, to which the company is exposed.

Management: refers to the body given the authority to implement the policies determined by the Board in directing the course / business activity/ies of the corporation.

Non-audit work: refers to other services offered by the external auditor to a corporation that are not directly related and relevant to its statutory audit function. Examples include accounting, payroll, bookkeeping, reconciliation, computer project management, data processing or information technology outsourcing services, internal auditing and services that may compromise the independence and objectivity of the external audit.

PROCESS / TITLE:

APPENDIX A: Definition of Terms
(Adapted from SEC Memorandum Circular no. 2 Code of Corporate Governance)

Support Document to: PM-AHI-002 Manual of Corporate Governance

Non-executive Director: refers to a Board member with non-executive functions.

Objectivity: refers to unbiased mental attitude that requires the person to carry out his/her work in such a manner that he/she has an honest belief in his/her work product and that no significant quality compromises are made. Objectivity requires the person not to subordinate his/her judgment to that of others.

Public Company: refers to any corporation with a class of equity securities listed in an Exchange or with assets in excess of Fifty Million Pesos (PhP50,000,000.00) and having two hundred (200) or more stockholders each holding a least one hundred (100) shares of a class of its securities.

PROCESS / TITLE:

APPENDIX B: Independent Directors
(Formerly SRC Rule 38.1 – Definition of "Independent Director")

Support Document to: PM-AHI-002 Manual of Corporate Governance

1. An independent director means a person, who, apart from his fees and shareholdings, is independent of management and free form any business or other relationship which could, or could be reasonably be perceived to, materially interfere with his exercise of independent judgment in carrying out his responsibilities as a director in any covered company and includes, among others, any person who:

   1.1 Is not a director or officer of the covered company or of its related companies or any of its substantial shareholders except when the same shall be an independent director of any of the foregoing;

   1.2 Does not own more than 2% of the shares of the covered company and/or its related companies or any of its substantial shareholders;

   1.3 Is not related to any director, office or substantial shareholder of the covered company, any of its related companies or any of its substantial shareholders. For this purpose, relatives, include spouse, parent, child, brother, sister, and the spouse of such child, brother or sister;

   1.4 Is not acting as a nominee or representative of any director or substantial shareholder of the covered company, and/or any of its related companies and/or any of its substantial shareholders, pursuant to a Deed of Trust or under any contract or arrangement;

   1.5 Has not been employed in any executive capacity by the covered company, any of its related companies and/or by any of its substantial shareholders within the last two (2) years;

   1.6 Is not retained, either personally or through his firm or any similar entity, as professional adviser by that covered company, any of its related companies and/or any of its substantial shareholders, within the last two (2) years;

   1.7 Has not engaged and does not engage in any transaction with the covered company and/or with any of its related companies and/or with any of its substantial shareholders, whether by himself and/or with other persons and/or through a firm which he is a partner and/or a company of which he is a director or substantial shareholder, other than transactions which are conducted at arms length and are immaterial.

2. No person convicted by final judgment of an offense punishable by imprisonment for a period exceeding six (6) years, or a violation of this Code, committed within five (5) years prior to the date of his election, shall qualify as an independent director. This is without prejudice to other disqualifications which the covered company's Manual of Corporate Governance provides. When used in relation to a company subject to the requirements of this Rule and Section 38 of the code:

   2.1 Related company means another company which is; (a) its holding company; (b) a subsidiary of its holding company; and

   2.2 Substantial shareholders mean any person who is directly or indirectly the beneficial owner of more than ten percent (10%) of any class of its equity security.

PROCESS / TITLE:

APPENDIX B: Independent Directors
(Formerly SRC Rule 38.1 – Definition of "Independent Director")

Support Document to: PM-AHI-002 Manual of Corporate Governance

3. QUALIFICATIONS:
An independent director shall have the following qualifications:

3.1 He shall have at least one (1) share of stock of the corporation;

3.2 He shall be at least a college graduate, or he shall have been engaged or exposed to the business of the corporation for at least five (5) years.

3.3 He shall possess integrity/probity; and

3.4 He shall be assiduous.

4. DISQUALIFICATIONS:
No person under Disqualifications of Board of Directors as listed above shall qualify as an independent director. He shall likewise be disqualified during his tenure under the following instances or causes:

4.1 He becomes an officer or employee of the corporation where he is such member of the board of director / trustees, or becomes any of the persons listed above (Disqualifications of Board of Directors);

4.2 His beneficial security ownership exceeds two percent (2%) of the outstanding capital stock of the company where he is such director;

4.3 Fails, without any justifiable cause, to attend at least 50% of the total number of Board meetings during his incumbency;

4.4 Such other qualifications which the company's Manual on Corporate Governance provide.

2021 ANNUAL CORPORATE GOVERNANCE ENHANCEMENT SESSION

For Directors, Advisory Board Members and Officers

Annex "B"

THIS CERTIFICATE IS AWARDED TO

ARVIN MARK PASCUAL

FOR HAVING ATTENDED THE ONLINE SEMINAR

"Becoming Obsessed with the Customer"

HELD ON SEPTEMBER 17, 2021

RICARDO M. PILARES III
VP FOR LEGAL/COMPLIANCE OFFICER
CORPORATE GOVERNANCE OFFICER
METRO PACIFIC INVESTMENTS CORPORATION

MA. LOURDES C. RAUSA-CHAN
CHIEF GOVERNANCE OFFICER
PLDT INC.

JOCELYN C. VILLAR-ALTAMIRA
CORPORATE GOVERNANCE & COMPLIANCE HEAD
MANILA ELECTRIC COMPANY

PARALUMAN M. NAVARRO
CHIEF COMPLIANCE OFFICER
PXP ENERGY CORPORATION

ROMEO B. BACHOCO
CHIEF GOVERNANCE OFFICER
PHILEX MINING CORPORATION

FREDERICK E. REYES
CHIEF GOVERNANCE OFFICER
ROXAS HOLDINGS, INC.

	POLICY & PROCEDURE	DOC CODE: PL-HRD-046
		Issue Date: 01/01/00
Conflict of Interest		Revision Date: 07/05/2021 –Revision No.4
		Page No. 1 of 8
		Human Resources

1.0 PURPOSE:

This policy is established to manage conflicts of interest among clinical and nonclinical staff members including directors and officers of Asian Hospital and Medical Center (AHMC) in order to maintain the integrity of their professional judgment and to sustain public confidence in that judgment. This also ensures that the principles of integrity, transparency, accountability and fairness are upheld in all transactions and official actions of AHMC.

2.0 SCOPE:

This policy covers all AHMC Personnel.

3.0 POLICY STATEMENT:

All AHMC Personnel must avoid exposing themselves to conflicts of interest, actual or potential, disclose during appointment and at any time during their engagement any conflict of interest and cooperate with the hospital management in managing or eliminating such conflicts of interest. All business decisions of the AHMC Personnel must be based on the best interest of the Company and its stakeholders and must not be motivated by personal considerations and other relationships that can interfere with their independent and impartial judgement. All AHMC Personnel are expected to adhere to this Policy and make the necessary disclosures as prescribed and scheduled.

4.0 DEFINITIONS:

4.1 Employee- Any individual hired by AHMC for salaries and/or benefits provided in regular amounts at stated intervals in exchange for services rendered personally for the hospital's business on a regular basis and who does not provide such services as part of an independent business. This includes AHMC's officers, executives, supervisors, rank and file, and, only for purposes of this Policy, other corporate officers under AHMC's By-laws, temporary staff, casual employees, project employees or employees of affiliated companies who also work for/serve AHMC (e.g. on seconded basis)

4.2 Consultants- includes professional consultants, firms, partnerships, counsels, outsourced companies or such other professional entities or individuals rendering professional or specialized expert services to AHMC, as well as advisors of AHMC who may be appointed by the Board of Directors or the President/ CEO, or who act as representatives of AHMC's investors, shareholders, affiliates or partners.

4.3 Conflict of Interest (COI)- Occurs when the private interest of an employee, medical staff and/or his affiliate interferes or appears to interfere in any way with the interest of AHMC. It can arise when an employee and/or medical staff has interests that may make it difficult to perform his or her work objectively and effectively regardless of whether or not he or his affiliate receives or will receive Personal Benefit (as hereinafter defined). Conflict of interest can also arise when an employee or medical staff and/or his affiliate receives or will receive improper Personal Benefit from a transaction with AHMC as a result of the employee or medical staff's position in AHMC.

4.4 Affiliate- any person, entity, organization, business, or venture with any person, entity, organization, business, or venture with whom/which an AHMC Personnel has an affiliation, personal relationship or financial involvement. These includeamong others:

4.4.1 Relatives (as hereinafter defined);

4.4.2 Associates (as hereinafter defined);

4.4.3 Corporations or firms where an AHMC Personnel and/or his Relative holds aposition as director, officer or executive of such corporations or firms.

4.4.4 Corporations or firms where an AHMC Personnel and/or his Relative, either singly or collectively, holds/owns more than ten percent (10%) of the subscribed capital or equity of such corporations or firms.

4.4.5 Corporations or firms wholly or majority owned or controlled by the corporation or firm where an AHMC Personnel and/or his Relative, either singly or collectively, holds/owns more than ten percent (10%) of the subscribed capital or equity of such corporations or firms.

4.4.6 Partnerships of which an AHMC Personnel or his Affiliate is a general partner.

4.4.7 A co-ownership in which an AHMC Personnel or his Affiliate is one of the co- owners of a property sold, assigned or leased to AHMC, except where the sale, assignment and/or lease covers only the other co- owner's (who is not the AHMC Personnel or his Affiliate) undivided interest in theproperty.

4.5 ASSOCIATES - third parties with existing or previous close personal or business affiliation or relationship with an AHMC Personnel in view of which AHMC Personnel's decisions or actions in the best interest of AHMC is unduly affected or compromised.

4.6 RELATIVES - relatives of up to the third civil degree, by consanguinity, affinity or legal adoption, including, spouse, parents, children (and their spouses), siblings (and their spouses),nieces and nephews (limited to children of brothers and sisters) [and their spouses], grandparents, and aunts and uncles (limited to brothers or sisters of parents); and a domestic partner and his relatives of up to third civil degree, by consanguinity, affinity or legal adoption.

4.7 AHMC interest – includes AHMC institutional goals, benefit of AHMC patients and professional development of AHMC staff.

4.8 Personal Benefit- refers to gain or advantage, whether material or non-material, directly or indirectly provided to or received by staff member and/or his affiliate, such as financial gain, professional advancement, travel, facilities and/or accommodation benefits, entertainment, preferential treatment in personal transactions and other similar advantages.

5.0 PROCEDURES:

5.1 Avoidance of COIs

5.1.1 All AHMC Personnel are expected to uphold the integrity of the hospital's services and operations to patients, customers, service providers and to concerned regulatory bodies. All personnel must disclose in writing any actual or potential instances and/ or situations where they may have a Conflict of Interest or the appearance of a Conflict of Interest to the relevant authorities specified herein, as soon as they become aware of such actual or potential instances and/or situations.

5.1.2 All AHMC Personnel must avoid situations that can be regarded as perceived, potential or actual conflict of interests. Such situations include but are not limited to the following:

5.1.2.1 Utilizing confidential information for personal gain;
5.1.2.2 Using current position to promote external business activity or generate funds;
5.1.2.3 Accepting or offering rewards to influence business transactions with the hospital;
5.1.2.4 Using hospital resources such as manpower, supplies and equipment to offset personal costs;
5.1.2.5 Using hospital contact details such as address and phone numbers which augments personal business opportunities;
5.1.2.6 Referring sources to obtain preferential status and then personal gain;
5.1.2.7 Using authority to influence purchasing, where the staff or member of his/ her family is favored financially;
5.1.2.8 Representing the hospital to obtain any benefit or gain for oneself or member of his/ her family.

5.1.3 Suppliers, Contractors, Business Partners, Consultants and Third-Parties

5.1.3.1 AMHC Personnel are enjoined from giving undue preferential treatment to any individual or entity with whom AHMC does business.

5.1.3.2 AHMC Personnel shall avoid circumstances that could, or could be reasonably expected to, impair their objectivity in the performance of their duties and obligations to AHMC. In this regard, AHMC Personnel are prescribed from participating in any part of the transactions, dealings or decision-making process with respect to any existing or potential supplier, contractor, business partner or consultant of AHMC in which they or their Affiliate have an interest including any acts that may be deemed as seeking to influence any action or inaction with respect to such parties.

5.1.3.3 Authorized employees shall select and deal with suppliers, contractors, business partners, consultants and third parties doing or seeking to do business with AHMC in an impartial and fair manner. In this connection, authorized Employees shall award and maintain contracts or transactions on arm's length commercial terms, based only on the best interest of AHMC and under strict rules of fairness and confidentiality.

5.1.4 AHMC Personnel and Prospective Employees or Consultants

5.1.4.1 AHMC Personnel shall ensure that they treat each other, as well as prospective employees/consultants, with respect, fairness, impartiality, and equal opportunity, including respect for varying views and individual ideas, regardless of rank, seniority, or relationship.

5.1.4.2 AHMC Personnel shall avoid any action or inaction that gives undue preferential treatment or discriminated against any AHMC Personnel or prospective employee/consultant. In this regard, AHMC Personnel are prescribed from taking part in any decision-making process on human resources matters with respect to their Affiliates, including any action that may be deemed as seeking to influence any official action with respect to such Affiliates.

5.1.5 Gifts, Donation, and Entertainment

5.1.5.1 No AHMC Personnel may solicit or accept, directly or indirectly, any gift, dole-outs, donations or entertainment for any purpose that benefits himself/ herself. Any gift shall be rejected politely according to the Gifts and Hospitality Policy.

5.1.5.1.1 When the giver insists or delivers the gift with or without prior notice, the staff member should declare the gift using the Gift Registry Report form (QF-HRD-117)

a. The accomplished form must be submitted to HR **within 3 days.**
b. Gift items specifically cash and gift checks should be forwarded to Asian Charities for donation
c. All gift items shall be donated under the name of either the receiver or giver.
d. Gift items that may be considered personal such as fans, mugs, tumblers, towels, handkerchiefs, office supplies and the like amounting to a maximum of estimated Php 250 may be accepted once approved and should be endorsed to the concerned department manager for the proper use of the department.
e. Gifts in the form of food items may be accepted by the unit and should be declared
f. Donations such as events venue and the like must not be accepted unless approved in accordance with the Gifts and Hospitality Policy.

5.1.5.2 External donations and sponsorships for clinical or nonclinical training programs, such as attendance in professional development programs including CMEs, academic degrees or residency and fellowship training may not be accepted unless approved. *Refer to PL-HRD-059 Attendance to External Training Program.*

5.1.6 Procurement and Selection of Health Technologies

5.1.6.1 AHMC Personnel who directly participate in procedures to select and procure products or services for the hospital should first disclose their conflicts of interest before being allowed to proceed.

5.1.6.2 Depending on the severity of their COIs, they may be requested to inhibit themselves in varying degrees from the decision making process or continue their participation without any change.

5.1.6.3 Authorized AHMC Personnel shall award and maintain contracts or transactions based only on the best interest of the Hospital and MPHHI.

5.1.7 Directorship, Executive Positions and Employment in Other Companies or Organizations

5.1.7.1 AHMC Personnel shall avoid accepting positions or employment carrying out work outside of AHMC or MPHHI or its affiliated companies where Conflict of Interest or loyalty may arise and which may significantly affect the staff's efficiency in the performance of his/her duties and obligations to AHMC. For Employees and Consultants, the Human Resources Department (HRD) shall prescribe the requirements and/or guidelines for permissible outside positions, employment or work. For Directors and Officers, the requirements and conditions in this policy shall apply along with AHMC's by-laws and Manual on Corporate Governance, other applicable laws, rules and regulations set forth by the Company.

5.1.8 Use of Property, Services and Other Resources

5.1.8.1 All AHMC Personnel must only use the property, services or the other resources of AHMC responsibly, efficiently and only for purposes authorized or allowed under the hospital's policy and not for his/her personal benefit unless an applicable policy or guideline expressly allows such personal use (*e.g.*, company issued cars, cellular phones, laptops etc.)

5.1.8.2 The HR Department shall be responsible for releasing implementing guidelines with respect to the responsible use of Company-issued properties and/or rights.

5.1.8.3 AHMC Personnel shall refrain from taking advantage of the property, information of, or their positions in AHMC, or opportunities arising from these, for their Personal Benefit or to act against the best interest of AHMC

5.1.9 **Dealers and Distributors of AHMC's Products**

5.1.9.1 Conflicts of Interest may also arise in situations where AHMC Personnel and/or their Affiliates are or become dealers and/or distributors of the products and/or services of AHMC.

5.1.9.2 AHMC Personnel shall ensure that they treat all dealers and/or distributors with respect, fairness, impartiality, and equal opportunity.

5.1.9.3 AHMC Personnel shall avoid any action or inaction that gives undue preferential treatment or discriminates against any dealer, distributor, or potential dealer/distributor. In this regard, AHMC Personnel are prescribed from participating in any part of the transactions, dealings, or decision-making process with respect to any dealers or distributors in which they and/or their Affiliate have an interest, including any acts that may be deemed as seeking to influence any such action or inaction with respect to such dealers or distributors.

5.1.10 **Customers or Clients**

AHMC Personnel shall ensure that they treat all customers and clients of MPHHI and the Group with respect, fairness, impartiality, and equal opportunity. AHMC Personnel shall avoid granting to their Affiliates preferential terms including discounts not ordinarily available to other customers/clients, from which Personal Benefit will be derived by such Affiliate.

5.1.11 **Prohibited Conflict of Interest Situation**

5.1.11.1 No Director or officer shall, in breach of his fiduciary duty to AHMC, acquire or attempt to acquire directly or indirectly through an Affiliate any business opportunity in the line of AHMC's business, in which AHMC has an interest or a reasonable expectancy and which the AHMC is financially able to undertake, where the personal interest of the Director or officer will be in conflict with the interest of AHMC.

5.1.11.2 AHMC shall not, directly or indirectly, including through any Subsidiary or Affiliate, grant or arrange for any credit (or extensions thereof) in the form of personal loans to any Director or officer, unless allowed by applicable laws and regulations, or when sanctioned by a duly passed and approved AHMC policy.

5.1.12 **Other Examples of Situations which may Lead to Conflict of Interest**

Being a Relative of government official who may have dealings with AHMC. Having a reporting relationship with a family member. Employment of Relatives within AHMC. Being the hiring decision maker of any Relative.

5.2 **Management of COIs**

5.2.1 In the event the AHMC Personnel enters or will enter into a situation creating a conflict of interest as defined in this policy, disclosure or advanced consultation with the approval of their respective Department Managers, Group Heads and HR Director is required. The disclosure should be made using the Disclosure of Potential Conflict of Interest form (QF-HRD-116)

5.2.2 The following are the steps in managing COIs:

5.2.2.1 Disclosure of COI

5.2.2.2 Assessment of severity of COI

5.2.2.3 Formulation of management action to address COI

5.2.2.4 Implementation of management action

5.2.2.5 Monitoring

5.2.2.6 Actions on noncompliance

5.2.3 Disclosures should be made and addressed to:

5.2.3.1 For ManCom

To: The President and CEO

Cc: Head of HRD

5.2.3.3 All Employees except ManCom

To: The Department Head

Cc: Head of HRD and Compliance Officer

5.2.3.4 For Consultants and MDs; all chairs of committees that makes decisions about procurement of drugs, supplies, equipment and other forms of medical technology

To: The Chief Medical Officer

Cc: Medical Affairs

5.3 Disclosure of COI

5.3.3 Disclosure of COI must be done upon hiring or appointment and regularly henceforth.

5.3.3.4 Annually **all employees** and MDs; all chairs of committees that makes decisions about procurement of drugs, supplies, equipment and other forms of medical technology; (QF- HRD-047 and QF-MAF-298)

5.3.3.5 AHMC Personnel who have any engagement or outside employment/directorships on part-time or week-end basis other than the hospital should disclose such annually.

5.3.3.6 All staff disclosures of COIs must be documented using the Employment Disclosure Form (QF-HRD-047) and approved by the Manager, Group Head, HR Director and CEO as discussed above. The accomplished and duly approved form should be submitted to HR for 201 file. The Employment Disclosure Form must be updated should there be any changes.

5.3.3.7 All Medical Doctor COI disclosures must be documented using the Conflict of Interest disclosure form for Physicians (QF-MAF-298). The accomplished form must be submitted to the medical Affairs Department.

5.4 Assessment of COI Severity

5.4.1 Upon disclosure of a COI, the HR Director, in coordination with the Department Managers, and Group Heads will assess the severity of the COI based on:

5.4.1.1 The likelihood that professional decisions made under the relevant circumstances would be unduly influenced by a conflict of interest and likelihood of undue influence.

5.4.1.1.1 What is the value of the conflicting interest? Greater estimated monetary benefits to the staff member pose higher COI risks although even benefits of low monetary value may, if repeatedly received, also influence judgment.

5.4.1.1.2 What is the scope of the relationship between the AHMC Personnel and the secondary interest? Relationships that are closer and/or longer pose more COI risks.

5.4.1.1.3 What is the extent of discretion by the AHMC Personnel on the Conflict of Interest? The larger the latitude of judgment, the higher the COI risks.

5.4.1.2 The seriousness of possible harm to AHMC or wrong that could result from such influence

5.4.1.2.1 What is the value of the Conflict of Interest? The higher the value of outcomes or benefits related to patient care, professional development, education, research and institutional goals the greater the COI risks.

5.4.1.2.2 What is the scope of the consequences of the harm from such influence? The larger the scope, the greater the COI risks.

5.4.1.2.3 What is the extent of accountability? The less the accountability of the AHMC Personnel to oversight bodies, the greater the COI risks.

5.4.1.3 The likelihood and scope of Conflict of Interest on the staff member's decisions combined with the seriousness of possible harm to AHMC both determine the severity of the COI. Management action is prompted by COIs of sufficient severity.

5.4.2 Disclosures and approvals shall follow the reporting level as discussed in item 5.2.3.

5.5 Formulation of Management Action to Address COI

5.5.1 The HR Director, in coordination with the Department Managers, and Group Heads determines whether the relationship is one prohibited under institutional or other policies. Whether the risks of the relationship can be tolerated or reduced and approve the relationship causing the COI with appropriate oversight or procedural safeguards. The evaluation and approval of such shall be in accordance to item 5.2.3.

5.5.2 Whether the risks are so serious that the individual should either eliminate the conflict of interest or forgo participation in the activity put at risk by the relationship such as when:

5.5.1.1 It interferes or affects the efficient performance of their duties and responsibilities in the hospital;

5.5.1.2 It competes with the hospital's business or be interpreted by others as conflicting with hospital's interest;

5.5.1.3 It involves the use of confidential information obtained as a result of employment that may be detrimental to the hospital and its client, and

5.5.1.4 It brings the hospital into discredit or cause adverse criticism.

5.6 Implementation of management action to address COI

5.6.1 If COI management is appropriate, the HR Director, in coordination with the Department Managers, and Group Heads devise and implement a plan to manage the conflict.

5.6.1 The action plan must define specific activities or steps to resolve or reduce the COI with timelines and measurable outputs.

5.6.2 Available measures may include, but are not limited to:

5.6.2.1 Decline of gifts, benefits and hospitality

5.6.2.2 Divestment of conflicting private interests and transfer of duty, up to resignation

5.6.2.3 Increase transparency and scrutiny of decisions, such as requiring closer review and monitoring by the department manager or group head of the conflicted AHMC Personnel's performance

5.6.2.4 Requiring the conflicted AHMC Personnel to inhibit himself the specific processes or decision and placing such decisions in other AHMC Personnel's scope of responsibilities.

5.7 Monitoring Conflict Elimination or Management Plan and Assessing Adherence

5.7.1 The HR Director, in coordination with the Department Managers, and Group Heads includes adherence to management action plan to address COI in annual PAR of managers and conflicted staff members.

5.8 Actions to Address Noncompliance

5.8.1 The HR Director, in coordination with the Compliance Officer, Department Managers, and Group Heads determine the nature of the noncompliance and the appropriate response.

5.8.2 Such responses may include education, documented warnings and other penalties subject to results of deliberation of the Dialogue Committee or in the case of doctors- the Ethics Committee of the Hospital, or revision of the plan and implement the response.

5.9 Reporting

5.9.1 Staff members are encouraged to report any activity they reasonably believe constitute violations of conflict of interest or corporate wrongdoing particularly concerning the conduct of irregular activities/ transactions and as indicated in the Code of Ethics (PM-HRD-004) *(Refer to PL-QMD-056 Whistleblowing policy)*.

5.9.2 A staff member may report an irregular activity or transaction, verbally or in writing, anonymously or by identifying himself/herself to Human Resources, coursed through the HR Director.

5.9.3 The staff member is assured that all reports will be treated in strict confidence and be investigated to the fullest extent. They are also assured protection from any possible retribution as covered in the Staff member Complaints and Grievance Procedure (PL-HRD-034).

5.9.4 In reporting any irregularity, a staff member must consider/include the following:

5.9.4.1 Identify the concern/particular incident

5.9.4.2 Indicate who or what does it involve

5.9.5 The manager should document (using the Whistleblower Disclosure Form), evaluate the report and investigate if needed. He/ she then reviews the subject's COI disclosure form (in collaboration with HR) to determine if any noncompliance has occurred.

5.10 Investigation

5.10.1 The findings of the manager's report must be validated by the HR Director to ensure due diligence.

5.10.2 Once validated, an investigation through the Dialogue Committee shall be initiated along with the Compliance Officer. The alleged staff member may be subject to Disciplinary Action as stipulated in,

5.10.2.1 PL-HRD -026 Handling of Disciplinary Cases for employees

5.10.2.2 Medical Bylaws for medical staff (consultants, residents, and house physicians).

5.10.3 Appropriate sanctions apply based on,

5.10.3.1 PM-HRD-004 Code of Ethics for employees

5.10.3.2 Ethics Committee of the Hospital for medical staff (consultants, residents, and house physicians).

5.10.4 The hospital's leadership and governance including all Directors, Chiefs and the Board are enjoined to promote professionalism, transparency and self-regulation in all their conduct.

5.10.4.1 When a hospital leader and governance's conduct is in question, an ad hoc committee (such as the Organizational Ethics Committee) deliberates to resolve those concerns.

6.0 DOCUMENTATION:

Document Code	Document Title	To be Accomplished by:	When to Accomplish
QF-HRD-116	Disclosure of Potential Conflict of Interest	Staff member or medical staff	Upon acknowledgement of violation
QF-HRD-051	Declaration of Received Gifts	Staff member or medical staff	Upon receipt of token/item
QF-HRD-047	Employment Disclosure Form	Staff member or medical staff	Upon engagement with other companies
QF-QMD-063	Whistleblower Disclosure Form	Staff member or medical staff	
QF-MAF-298	Conflict of Interest Disclosure Form for Physicians	Medical Doctors	Upon engagement with other companies

7.0 REFERENCES:

7.1 PM-HRD-004 AHMC Code of Ethics
7.2 PL-HRD-015 Policy on Personal and Professional Conduct
7.3 PL-HRD-026 Handling of Disciplinary Cases
7.4 PL-HRD-034 Staff member Complaints and Grievance Procedure
7.5 PL-HRD-059 Attendance to External Training Programs
7.6 PL-QMD-056 Whistle Blowing Policy
7.7 Conflict of Interest in Medical Research, Education, and Practice / Bernard Lo and Marilyn J. Field, editors; Committee on Conflict of Interest in Medical Research, Education, and Practice, Board on Health Sciences Policy, 2009.
7.8 Joint Commission International Accreditation Standards, 7th edition, January 2021
7.9 Annex A - Disclosure of Potential Conflict of Interest
7.10 Annex B – Employment Disclosure Form
7.11 Annex C – Conflict of Interest Disclosure Form for Physicians

8.0 REVISION HISTORY:

Rev. No.	Rev. Date	Reason(s) for Change	Page(s) Affected	Initiated by:	Noted by: (Document Controller)
0	01/01/2000	Origination	0	Elvira Zablan	
1	05/27/2010	• Due for revision • Update of process, template and signatories	All	Elvira Zablan	Niel G. Jaymalin, RN
2	10/19/2015	• Revision of Policy Template • Update of Signatories • Inclusion of provision on declaration of received gifts • Inclusion of reporting of violations on Conflict of Interest	All	Michael P. Runas	Jayson M. Chavez, CDPP
3	01/10/2017	• Revision in procedure items 5.1.3.1.2 to 5.1.3.1.7 • Gifts from any customer or vendor shall be forwarded to Asian Charities	2	Jemah Cristobal	Jayson M. Chavez, CDPP
4	07/05/2021	• Policy update and alignment to MPHHI policy. • Update on 2.0 Policy Statement, Inclusion of Personal Benefits Definition	All	Arvin Mark T. Pascual, MAS, RN	Jayson M. Chavez, CDPP

		of Terms used in item 4.0 • Inclusion of item 5.8.6 address and disclosures using the COI declaration form • Update of template and signatories • Inclusions of Appendix A and B			

9.0 DOCUMENT REVIEW AND APPROVAL:

Prepared by: Sarah Jemmah Cristobal- Aguilloso Manager, Employee Engagement and Labor Relations	Prepared by: Arvin Mark T. Pascual, MAS, RN Senior Manager, Risk and Compliance
Reviewed by: Hennesy Lou E. Miranda Director, Corporate Affairs	Reviewed by: Melanie J. Balane Director, Financial Operations
Reviewed by: Engr. Novy S. Sun Director, Facilities Planning & Management	Reviewed by: Carolina P. Buhain, RN, MAN Director, Nursing Services
Reviewed by: Corazon Ngelangel (Dec 14, 2021 11:01 GMT+8) Corazon A. Ngelangel, MD Director, Ancillary Services and Asian Cancer Institute	Reviewed by: Ana Maria Y. Jimenez, PhD, RN, CPHQ Director, Quality Management
Reviewed by: Sharon C. Hernandez Chief Strategy Officer	Reviewed by: RD Martinez RD Martinez (Dec 15, 2021 12:09 GMT+8) Robert D. Martinez Chief Finance Officer
Reviewed by: Jose M. Acuin, MD Chief Medical Officer	Approved by: Andres M. Licaros, Jr. President and CEO

PROCESS / TITLE:

Annex A : Disclosure of Potential Conflict of Interest

Support Document to: PL-HRD-046 Conflict of Interest

Date

Name [Chairman or President or Division Head]
Position

Dear Sir/Madame,

I confirm that I have received, read and understood the Conflict of Interest policy of the [Company name] and I shall fully abide by the said policy in letter and spirit. I further confirm that: *(strike off whichever is not applicable and narrate if required)*:

a) There is no conflict of interest with my roles and responsibilities entrusted to me by [Company name] or

b) I would like to declare the following associations which is or may create a potential conflict of interest situation in the discharge of my duties concerning [Company name]. The name and nature of my personal associations/interest is as under:

i) Government Officials which are covered as my relatives are:

_____

_____

ii) Current and/or past position/role in government bodies, such as government hospitals:

_____

_____

iii) Persons/Companies with whom I have official dealings/private interest with:

_____

_____

Signature
Name
Position

Cc:
Name [President or Head of HRD]
Position

PROCESS / TITLE:

Annex A : Disclosure of Potential Conflict of Interest

Support Document to: PL-HRD-046 Conflict of Interest

Date of Disclosure:			
Name of Disclosing Party:			
Department:		Position:	
Disclosure Submitted To:		Position:	

Background of the Disclosure

Other Information

Reviewer's Resolution

Signature of Disclosing Party:		Date:	
Signature of Reviewer:		Date:	

PROCESS / TITLE:

Annex B : Employment Disclosure Form

Support Document to: PL-HRD-046 Conflict of Interest

EMPLOYMENT DISCLOSURE FORM

Date

Name [Chairman or President or Division Head]
Position

Dear Sir,

I confirm that I have received, read and understood the Conflict of Interest policy of Asian Hospital and Medical Center and I shall fully abide by the said policy in letter and spirit.

I further confirm that: (*strike off whichever is not applicable and narrate if required*):

a) There is no conflict of interest with my roles and responsibilities entrusted to me by AHMC or

b) I would like to declare the following associations, which is or may create a potential conflict of interest situation in the discharge of my duties concerning AHMC. The name and nature of my personal associations/interest is as under:

i) Government Officials which are covered as my relatives are:

_____

ii) Current and/or past position/role in government bodies, such as government hospitals:

_____

iii) Persons/Companies with whom I have official dealings/private interest with:

_____

_____

Signature

Name

Position

Cc:

Name [President or Head of HRD]
Position

PROCESS / TITLE:

Annex C – Conflict of Interest Disclosure Form for Physicians

Support Document to: PL-HRD-046 Conflict of Interest

ASIAN HOSPITAL AND MEDICAL CENTER
Global Expertise. Filipino Heart.

CONFLICT OF INTEREST DISCLOSURE FORM for PHYSICIANS

Date

Name [Chief Medical Officer]
Position

Dear Sir,

I confirm that I have received, read and understood the Conflict of Interest policy of Asian Hospital and Medical Center and I shall fully abide by the said policy in letter and spirit.

I further confirm that: (*Check whichever is applicable and narrate if required*):

☐ a) There is no conflict of interest with my roles and responsibilities entrusted to me by AHMC or

☐ b) I would like to declare the following associations, which is or may create a potential conflict of interest situation in the discharge of my duties concerning AHMC. The name and nature of my personal associations/interest is as under:

i) Government Officials which are covered as my relatives are:

_____

_____

ii) Current and/or past position/role in government bodies, such as government hospitals:

_____

_____

iii) Persons/Companies who are suppliers of or do business with AHMC:

_____

_____

Signature

Name

Department

Cc: Medical Affairs

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise. Filipino Heart.	POLICY & PROCEDURE	DOC CODE: PL-AHI-005
		Issue Date: 11/15/2021
		Revision Date: 00/00/0000 – Revision No.0
	Third-Party Risk Management Policy	Page No. 1 of 7
		Asian Hospital Inc.

1.0 PURPOSE:

The purpose of this Policy is to define roles, responsibilities, and processes for assuring Third-Party entities (e.g., vendors, consultants, contractors, service providers, etc.) comply with the Asian Hospital and Medical Center's internal governance requirements and the hospital's policies and procedures. This policy also aims to assist AHMC in managing risks associated with its Third Party partners by defining the principles in managing Third-Party risks, outline the expectations for employees and hospital staff in dealing with Third-Party partners and establish the roles and responsibilities of key stakeholders involved in the management of Third-Party risks

2.0 SCOPE:

This Policy applies to and shall be implemented by all AHMC employees and medical staff.

3.0 POLICY STATEMENT:

Asian Hospital and Medical Center recognizes that, from time to time, interaction with Third Parties is essential in efficiently conducting the hospital's business. In so doing, interactions and dealings should always be characterized by honesty, integrity, transparency, and the highest standards of ethics and good behavior. This policy outlines and reinforces AHMC's commitment to the highest ethical standards and best practices of professional conduct in the course of its business operations.

Adherence to this Policy ensures that Third-Party risks are managed in a holistic and consistent manner that enhances the hospital's capability to build and protect value for its stakeholders and advances the broader interests of society as a whole.

4.0 DEFINITIONS:

4.1 End-user – refers to the person or department that has responsibility over the project or transaction that requires the engagement of a Third Party and who has the authority to direct the engagement, agree to and sign the contract, and is the main point of contact for AHMC.

4.2 Employees and Medical staff- refers to any individual hired by AHMC for salaries and/or benefits provided in regular amounts at stated intervals in exchange for services rendered personally for the hospital's business on a regular basis and who does not provide such services as part of an independent business. This includes AHMC's officers, executives, supervisors, rank and file, and, only for purposes of this Policy, other corporate officers under the AHMC's By-laws, temporary staff, casual employees, project employees.

4.3 Government Official - all officers or employees of a government department, agency, or instrumentality at all levels and subdivisions (*i.e.*, local, regional, national); permitting agencies; customs officials; candidates for political office; officer or employee of political parties; and officials of public international organizations (*e.g.*, the Red Cross). This term also includes officers or employees of government-owned or controlled commercial enterprises such as state-owned or controlled universities, airlines, oil companies, health care facilities, or other vendors. The term also includes family members and close associates (*i.e.*, person representing or acting on behalf of the official in meetings and/or business partners) of such individuals (*e.g.*, it is not permissible to give a lavish gift to the sibling, spouse, or child of a government official if a gift to the latter would be prohibited under this Policy). This term also includes healthcare professionals (HCPs) who are practicing in government hospitals or any department, agency, or instrument of a government, when any of the following instances apply: (i) the HCP has an official decision-making role, (ii) the HCP has responsibility for performing regulatory inspections, government authorizations or licenses, or (iii) the HCP has the capacity to make decisions with the potential to affect the business of AHMC.

4.4 High risk Third-Party – refers to consultants, contractors, service providers, vendors, etc. whose engagement with AHMC is of such frequency, nature, and scale that renders the hospital's operation vulnerable should there be breach, violation, and or abuse of trust on the part of such Third-Party. High Risk Third Parties include but are not limited to:

a. those that deal with the most business-critical operations or the most sensitive data of AHMC,
b. Third Parties to whom AHMC depends on to run its operations,
c. Third Parties that deal with Government on behalf of AHMC and has access to the hospital's sensitive corporate information or handles its financial transactions and there is high risk of information loss,
d. Third Parties that are owned by a Government Official or someone related to a Government Official,
e. Third Parties that have been associated with allegations of improper payments or corruption in the past,
f. Third Parties that do not cooperate with the AHMC's screening process, and
g. When a customer/Government Official pressures AHMC to retain a particular Third Party.

4.5 Third-Party - an individual, entity, organization and/or its representatives that has existing and/or intended business dealings with AHMC. This includes prospective or existing suppliers, contractors, consultants (including, Healthcare Providers), buyers, dealers and customers. This also covers associates (former classmates, co-workers, co-fraternity members, co-members in closed knit associations such as masonry/lodge, etc.) who are also prospective or existing suppliers, contractors, buyers, dealers or customers. This also covers partners in CSR activities, grants, sponsorships, foundations and other similar organizations.

4.6 Third-Party Due Diligence Review – refers to the act of ensuring and documenting that there is: (i) business reason to engage the Third Party, (ii) selection process, (iii) background check using the Third-Party Due Diligence Questionnaire and Certification (See Annex "A"), including checking whether the Third-Party is on the prohibited list (if any), check and resolution of any conflicts of interest, and due diligence is refreshed as appropriate to maintain adequate oversight of Third Parties.

4.7 Third-Party Risk Assessment – the process by which the end-user or the Contract Management Committee conducts an assessment relative to the engagement of a Third-Party and ensures that the following steps are complied with: (i) conduct of Third-Party Due Diligence Review, (ii) ensure that appropriate Anti-Bribery and Anti-Corruption (ABAC) contractual clauses are added to contracts and purchase orders, (iii) conduct compliance training to Third Parties, and (iv) monitoring of Third Parties and reporting breaches. (PL-QMD-012)

4.8 Third-Party Risk Management - The process by which AHMC manages interactions with Third Parties for the purpose of assessing and monitoring the ongoing risk that each Third-Party relationship represents.

5.0 PROCEDURES:

These are the details of implementation, such as

5.1 Third-Party Relationship

5.1.1 Anti-corruption laws prohibit indirect payments made through a Third-Party, including giving anything of value to a Third-Party while knowing that value will be given to a Government Official for an improper purpose. Therefore, all AHMC employees and medical staff should avoid situations involving Third Parties that might lead to a violation of this Policy.

5.1.2 All AHMC employees and/or medical staff who deal with Third Parties are responsible for taking reasonable precautions to ensure that the Third Parties conduct business ethically and in compliance with this Policy. Such precautions may include:

5.1.2.1 conducting a due diligence review of a Third-Party,

5.1.2.2 inserting appropriate anti-corruption compliance provisions in the Third-Party's written contract (depending on the circumstances, such provisions could include representations, warranties, covenants, and may require the agent to undergo training),

5.1.2.3 requiring the Third-Party to certify that it has not violated and will not violate this Policy and any applicable anti-corruption laws during the course of its/his/her business with AHMC, and

5.1.2.4 monitoring the reasonableness and legitimacy of the goods and services provided by and the compensation paid to the Third-Party during the engagement.

5.1.3 End-users retaining High Risk Third Parties, including Third Parties that will be representing AHMC before governmental entities must conduct a more detailed due diligence and must discuss the

engagement with and seek prior written approval from AHMC's Contract Management Committee and the Compliance Officer prior to hiring the High Risk Third-Party. Any doubts regarding the scope of appropriate due diligence efforts in this regard should be resolved by contacting and consulting with the Compliance Officer.

5.1.4 End-users who deal with Third Parties must always be aware of potential red flags. Red flags are certain actions or facts which should alert a company that there is a possibility of improper conduct by a Third-Party. A red flag does not mean that something illegal has happened, but rather that further investigation is necessary. Red flags are highly fact-dependent, but some examples of red flags are:

5.1.4.1 Unusual or excessive payment requests, such as requests for over-invoicing, up-front payments, ill-defined or last-minute payments, success fees, unusual commissions, or mid-stream compensation payments.

5.1.4.2 Requests for payments to an account in a country other than where the Third-Party is located or is working.

5.1.4.3 Requests for payment to another Third-Party, to a numbered account, or in cash or other untraceable funds.

5.1.4.4 Requests for political of charitable contributions

5.1.4.5 The Third-Party is related to a Government Official or has a personal or close business relationship with a Government Official

5.1.4.6 When there is any refusal or hesitancy by a third party to disclose its owners, partners, or principals

5.1.4.7 The Third-Party uses holding companies or other methods to obscure its ownership, without adequate business justification.

5.1.4.8 The Third-Party expresses a desire to keep his representation of AHMC or the terms of his retention secret.

5.1.4.9 The Third-Party has little experience in the industry but claims to "know the right people."

5.1.5 If the end-user has a reason to suspect that a Third-Party is engaging in potentially improper conduct, they shall report the case to Compliance Officer and the Contract Management Committee either by writing or via electronic mail as soon as possible. AHMC shall conduct an investigation and stop further payments to the Third-Party if the reported suspicions are verified through the investigation.

5.2 **Stakeholders in the Management of Third-Party Risks and Their Roles and Responsibilities**

5.2.1 End-user

5.2.1.1 Holds relationship with Third Parties and is responsible for the business impact of the transaction with Third Parties, other than those falling within the jurisdiction and authority of the Supply Chain/ Purchasing Department.

5.2.1.2 Assumes and owns any risk(s) identified with the Third Party.

5.2.1.3 Carry out tasks such as initiating the Third-Party Risk Assessment process, providing data for information or queries, lead remediation activities to address identified risks, and liaising with relevant parties to ensure that specific contract clauses required are included in the contract with the Third-Party.

5.2.2 Supply Chain/ Purchasing Department and Pharmacy services

5.2.2.1 Holds relationship with Third Parties and is responsible for the business impact of the transaction with Third Parties falling within the scope of its authority.

5.2.2.2 Assumes and owns any risk(s) identified with the Third Party.

5.2.2.3 Carry out tasks such as initiating the Third-Party Risk Assessment process.

5.2.2.4 Ensures that relevant provisions of this Policy are incorporated and taken into account in bidding procedures or tender for procurement.

5.2.3 Risk Management and Compliance Office

5.2.3.1 Defines specific risk policies in their area of responsibility.

5.2.3.2 Liaises with end-users and the Supply Chain/ Purchasing Department to support and ensure the proper functioning of TPRM, support in managing Third-Party risk, oversee the Third-Party Risk

Assessment procedure for their risk area and ensure that relevant compliance standards and requirements are contained in the Policy.

5.2.3.3 Provides ABAC training to and obtain Third-Party Compliance Affirmation on an annual basis (See Annex "B") to Third Parties.

5.3 Third-Party Management Principles

5.3.1 Work with Third Parties who conduct business in a manner that is consistent with the AHMC's core values and standards.

5.3.2 A robust and risk-based assessment process should be in place to ensure that Third Parties operate to the same standards as AHMC to maintain risks at an acceptable level.

5.3.3 All respective end-users owns and manages the risks identified with the Third Party.

5.3.4 Compliance with the Third Party Risk Assessment procedure supports the end-user in this process by identifying, assessing, remediating and monitoring risks. End-users must also abide to the Hospital's Contract Management policy (PL-QMD-012)

5.3.5 The Third Party Risk Assessment procedure enables Third Party risk assessments to be managed through a risk-based approach in a single, mandatory process and system. The framework is scalable and flexible to enable the inclusion of additional risks over time.

5.3.6 Respective end-users must always initiate the Third Party Risk Assessment procedure and the outcome of the risk assessment determines whether a commitment can be made or if additional steps (e.g. remediation) are first required with the Third Party.

5.3.7 No transaction with the Third Party can be made before the risk assessment is completed. If a "No-Go" (or Red flag/unacceptable/un-mitigatable) criterion is identified during the risk assessment, no contract with the Third Party will be possible.

5.3.8 Third Parties are monitored on an ongoing basis throughout the entire relationship through Third Party audits and subsequent remediation actions, if applicable.

5.3.9 Effective monitoring also requires the end-users to share with the stakeholders any relevant information that they become aware of which may have an impact on the risk classification of the Third Party.

5.3.10 A re-assessment of the Third Party is triggered every three years at the latest - or earlier in certain circumstances (e.g., where the contract is extended or renewed or the nature of our relationship with the Third Party changes significantly). For High Risk Third Parties, re-assessment should be made on an annual basis.

5.4 Third Party Risk Assessment process

5.4.1 Vendor Selection- evaluation and approval process to determine prospective vendors and suppliers that meets our defined standards and requirements. The selection goal is to secure a low-risk, best-in-class vendor and supplier portfolio.

5.4.2 Vendor Screening- Evaluation of Third-Party will be undertaken through: (i) requiring the filling up and submission of AHMC's Third-Party Due Diligence Questionnaire and Certification (QF-AHI-009), and (ii) risk assessment, by assigning the appropriate risk rating (low, normal, high). Based on the results of the due diligence / risk assessment, AHMC will determine whether to engage in a business relationship with the Third Party. The risk assessment should consider the following:

5.4.2.1 The information and/or assets being accessed.

5.4.2.2 Determine the type and the extent of access to the following as needed:

5.4.2.2.1 Physical access to offices

5.4.2.2.2 Database and information systems

5.4.2.2.3 Value, Sensitivity, Criticality of the information including the legitimate purpose of the request

5.4.2.2.4 Accessibility needs

5.4.2.2.5 Legal and regulatory requirements and other contractual obligations

5.4.2.2.6 Fair market value for the services rendered

5.4.3 Contracting- Third party entities will not be engaged until:
- 5.4.3.1 Due diligence has been completed and risk assessment has been done to determine if the risks are acceptable
- 5.4.3.2 Remediation of identified unacceptable risks
- 5.4.3.3 Completion of background checks
- 5.4.3.4 Third Party personnel have read and understood AHMC's relevant policies and procedures and signed the Third-Party Compliance Affirmation (QF-AHI-010)

5.4.4 Anti-Bribery and Anti-Corruption training and certification upon onboarding
- 5.4.4.1 End-users must familiarize themselves with this Policy. They shall also be trained in line with AHMC's company-wide Compliance training curriculum, if applicable.
- 5.4.4.2 Additional training may be provided for High Risk Third parties as identified by AHMC.
- 5.4.4.3 Trainings must be provided to Third Parties for them to familiarize AHMC's applicable policies and procedures.

5.4.5 Monitoring
- 5.4.5.1 End-users, in coordination with AHMC's Supply Chain, Pharmacy and Compliance office will establish and carry out surveys, questionnaires and inspections to review the compliance of Third Parties on an on-going basis. Year-to-year comparisons can flag potential lapses in security control environments.
- 5.4.5.2 Non-observance and violation of AHMC's policies and guidelines or local laws will result in remedial corrective or disciplinary actions up to and including termination of engagement or business relationship to the concerned Third Party.
- 5.4.5.3 Actual or suspected incidents of violation and/or misconduct should be reported.
- 5.4.5.4 AHMC guarantees non-retaliation and confidentiality, to the extent legally possible, for good-faith reports such as breaches.
- 5.4.5.5 All AHMC Personnel are encouraged to report suspected violations of law, rules and regulations related to their work. This includes reporting misconduct by other AHMC Personnel and with whom they do business.
- 5.4.5.6 AHMC shall ensure non-retaliation and confidentiality and will maintain anonymity of such reports and disclosures.
- 5.4.5.7 Reporting shall be done in accordance with the Whistleblowing policy of AHMC. (PL-QMD-056)
- 5.4.5.8 Due diligence must be upon the renewal of contract or due diligence expiry date, whichever comes first.

5.4.6 Retention of records and documents
- 5.4.6.1 All engagement of Third Parties must be documented using the Third-Party Engagement Documentation Form (QF-AHI-011). Documentations must include the following:
  - 5.4.6.1.1 How and from whom the need for acquisition originated
  - 5.4.6.1.2 Approval by which the purchase and/or engagement was authorized
  - 5.4.6.1.3 How the cost or compensation was determined and approved
  - 5.4.6.1.4 Business justification for selecting the Third Party
  - 5.4.6.1.5 Expertise and resources that the prospective Third-Party brings to the role that they propose to undertake
  - 5.4.6.1.6 Third-Party Risk Assessment and due diligence report and background checks shall be documented thoroughly by the End-user and the Compliance office.
  - 5.4.6.1.7 All records of proof of supply or performance of the goods/services by the Third-Party
- 5.4.6.2 End-users shall maintain all records pertinent to the engagement of the Third-Party as enumerated above and such pertinent supporting documentation for the duration of the engagement and for a period of no less than five (5) years from the termination of engagement.

5.4.7 Violations to this Policy

5.4.7.1 Any AHMC Personnel who fails to comply with this Policy shall be subjected to penalties and sanctions as may be determined by AHMC's Compliance department and in accordance with the rules and regulations of AHMC in coordination with the Human Resources Department.

5.4.7.2 Third Parties found to have defied this Policy shall also be penalized accordingly.

5.4.8 Effectivity

5.4.8.1 This Policy shall take effect immediately. All existing policies, rules, system practices, and related implementing guidelines concerning the same matters covered by this Policy are deemed superseded. In the event of any inconsistency between this Policy and guidelines contained herein and the terms of other existing policies, rules, system practices and related implementing guidelines, the Policy and guidelines contained herein shall prevail.

5.4.9 Approval, Amendment or Alteration of this Policy

5.4.9.1 This Policy has been approved and adopted by the Management Committee of AHMC. The Compliance Officer and AHMC's Management Committee has the overall responsibility for implementation, monitoring and periodic review of this Policy.

5.4.9.2 This Policy shall not be amended, altered or varied unless such amendment, alteration or variation shall have been approved by resolutions of AHMC's Management Committee.

6.0 DOCUMENTATION:

Document Code	Document Title	To be Accomplished by:	When to Accomplish
QF-AHI-009	Third-Party Due Diligence Questionnaire and Certification	Supply chain/ Pharmacy	During vendor accreditation
QF-AHI-010	Third-Party Compliance Affirmation	Vendor	During vendor accreditation
QF-AHI-011	Third-Party Engagement Documentation Form	End-user	During vendor selection

7.0 REFERENCES:

7.1 Joint Commission International Standards, 7th edition January 2021
7.2 Annex A - Third-Party Due Diligence Questionnaire and Certification
7.3 Annex B - Third-Party Compliance Affirmation
7.4 Annex C - Third-Party Engagement Documentation Form
7.5 Vendor accreditation policy (PL-PUR-006)
7.6 Pharmacy Procurement policy (PL-PHS-014)
7.7 Contract management policy (PL-QMD-012)

8.0 REVISION HISTORY:

Rev. No.	Rev. Date	Reason(s) for Change	Page(s) Affected	Initiated by:	Noted by: (Document Controller)
0	11/15/2021	Policy Origination	0	Arvin Mark T. Pascual, MAS, RN / Maria Loutjie Marty / Maria Christina Liza Sta. Maria, RPh	Jayson M. Chavez, CDPP

9.0 DOCUMENT REVIEW AND APPROVAL:

Prepared by: MARIA LOUTJIE G. MARTY Maria Loutjie G. Marty Senior Manager, Supply Chain	Prepared by: Christina Liza R. Sta. Maria, RPh Associate Director, Pharmacy Services
Prepared by: Arvin Mark T. Pascual, MAS, RN Senior Manager, Risk and Compliance	Reviewed by: Hennesy E. Miranda Director, Corporate Affairs
Reviewed by: Melanie J. Balane Director, Financial Operations	Reviewed by: Carolina P. Buhain, RN, MAN Director, Nursing Services
Reviewed by: Engr. Novy S. Sun Director, Facilities Planning & Management	Reviewed by: Corazon A. Nuelandet, MD Director, Ancillary Services and Asian Cancer Institute
Reviewed by: Ana Maria Y. Jimenez, PhD, RN, CPHQ Director, Quality management	Reviewed by: Sheron C. Hernandez Chief Strategy Officer
Reviewed by: Robert D. Martinez Chief Finance Officer	Reviewed by: Jose M. Acuin, MD Chief Medical Officer
Approved by: Andres M. Licaros, Jr. President and CEO	

ANNEX "E"

Coro, Yvette

From: ICTD Submission <ictdsubmission+canned.response@sec.gov.ph>
Sent: Friday, 7 May 2021 12:38 PM
To: prvs=0761ce9bce=ycoro@asianhospital.com
Subject: Re: CGFD_Asian Hospital, Inc._Form 17C_07 May 2021

Dear Customer,

SUCCESSFULLY ACCEPTED
(subject to verification and review of the quality of the attached document)

Thank you.

SEC ICTD.

COVER SHEET

A	S	O	9	4	-	0	0	0	1	1	2	4	9

S.E.C. Registration Number

A	S	I	A	N		H	O	S	P	I	T	A	L	,		I	N	C	.

(Company's Full Name)

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M	U	N	T	I	N	L	U	P	A		C	I	T	Y													

(Business Address: No. Street City / Town / Province)

Ricardo M. Pilares III	8888-0888
Contact Person	Company Telephone Number

1	2	3	1	17C	0	4	3	0
Month	Day			FORM TYPE	Month		Day	
Fiscal Year					Annual Meeting			

Secondary License Type, If Applicable

Dept. Requiring this Doc.

Amended Articles Number/Section

Total Amount of Borrowings

Total No. of Stockholders

Domestic

Foreign

To be accomplished by SEC Personnel concerned

File Number

LCU

Document I.D.

Cashier

STAMPS

Remarks = pls. Use black ink for scanning purposes

SECURITIES AND EXCHANGE COMMISSION

SEC FORM 17-C

CURRENT REPORT UNDER SECTION 17
OF THE SECURITIES REGULATION CODE
AND SRC RULE 17.2(c) THEREUNDER

1. May 07, 2021
Date of Report (Date of earliest event reported)

2. SEC Identification No.: AS094-00011249

3. BIR Tax Identification No.: 004-502-062-000

4. Asian Hospital, Inc. (the "Corporation")
Exact name of issuer as specified in its charter

5. Philippines
Province, country or other jurisdiction of incorporation

6. [redacted]
(SEC Use Only)
Industry Classification Code:

7. 2205 Civic Drive, Filinvest Corporate City, Alabang, Muntinlupa City
Address of principal office

1781
Postal Code

8. (0632) 771-9000 to 9002
Issuer's telephone number, including area code

9. N/A
Former name or former address, if changed since last report

10. Securities registered pursuant to Sections 8 and 12 of the SRC or Sections 4 and 8 of the RSA: None

11. Indicate the item numbers reported herein:

Item 4 Election of Directors or Officers

I. During the annual meeting of the stockholders of the Corporation held on April 30, 2021, the following were elected as directors of the Corporation:

1. Mr. Manuel V. Pangilinan
2. Mr. Augusto P. Palisoc Jr.
3. Mr. Andres M. Licaros Jr.

4. Mr. Jose Noel C. de la Paz;
5. Mr. Ricardo V. Buencamino;
6. Dr. Sol Z. Alvarez;
7. Mr. Reymundo S. Cochangco;
8. Mr. Celso Bernard G. Lopez;
9. Dr. Fernandino Jose A. Fontanilla, Jr. (independent director);
10. Dra. Carmelita I. Quebengco (independent director); and
11. Retired Chief Justice Artemio V. Panganiban (independent director).

II. During the organizational meeting of the Board of Directors held immediately after the annual stockholders' meeting held on April 30, 2021, the Board elected the following as officers of the Corporation:

Chairman:	Augusto P. Palisoc Jr.
President and Chief Executive Officer:	Andres M. Licaros Jr.
Chief Financial Officer:	Robert D. Martinez
Chief Medical Officer:	Dr. Jose M. Acuin
Treasurer:	Reymundo S. Cochangco
Corporate Secretary/ Compliance Officer:	Ricardo M. Pilares III
Assistant Corporate Secretary:	Jane Catherine C. Rojo-Tiu
Chief Strategy Officer/Head of the Strategic Support Group:	Sharon C. Hernandez

III. During the same meeting, the Board organized themselves into the following Committees:

1. Executive Committee

   Mr. Augusto P. Palisoc Jr. (Chairman)
   Dr. Fernandino Jose A. Fontanilla (independent director)
   Mr. Jose Noel C. de la Paz
   Mr. Andres M. Licaros Jr.

2. Nomination Committee:

   Dra. Carmelita I. Quebengco (independent director - Chairperson)
   Mr. Jose Noel C. de la Paz
   Mr. Manuel V. Pangilinan

3. Audit Committee:

   Dr. Fernandino Jose A. Fontanilla (independent director - Chairperson)
   Mr. Reymundo S. Cochangco
   Mr. Ricardo V. Buencamino

4. Compensation and Remuneration Committee:

Dra. Carmelita I. Quebengco (Chairperson - independent director)
Mr. Jose Noel C. de la Paz
Mr. Augusto P. Palisoc Jr.

Item 9 Other Events

I. During the meeting of the stockholders of the Corporation, the stockholders resolved to appoint SyCip Gorres Velayo & Co. (SGV & Co.) as the Corporation's external auditor for the year 2021.

SIGNATURE

Pursuant to the requirements of the Securities Regulation Code, the issuer has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

ASIAN HOSPITAL, INC.	May 07, 2021
Issuer	Date

JANE CATHERINE C. ROJO-TIU
Assistant Corporate Secretary

ANNEX "F"

2021 BOD Assessment Results & Approval

2021 AHI Board of Directors Self-Assessment Questionnaire

	Board Responsibilities	Board Processes	Individual Board Members	Management Relationship	Average
BOD 1	1.2	1.6	2.0	1.4	1.6
BOD 2	1.4	2.2	1.2	1.8	1.7
BOD 3	2.0	2.0	1.0	1.8	1.7
BOD 4	1.2	1.2	1.2	1.2	1.2
BOD 5	1.2	1.0	1.0	1.0	1.1
BOD 6	1.6	1.8	1.2	1.8	1.6
BOD 7	1.0	1.0	1.0	1.0	1.0
BOD 8	1.2	1.4	1.0	1.0	1.2
BOD 9	1.4	2.0	2.0	2.6	2.0
BOD 10					
BOD 11					
	1.4	1.6	1.3	1.5	1.4

2021 Board Evaluation of AHI's President Performance

	Leadership and Administration Skills	Board Relations	Social Responsibility and Public Relations	Average
BOD 1	1.4	1.1	1.0	1.2
BOD 2	2.3	2.3	2.2	2.3
BOD 3	2.0	2.0	2.0	2.0
BOD 4	1.4	1.1	1.4	1.3
BOD 5	1.2	1.0	1.0	1.1
BOD 6	1.3	1.4	1.6	1.4
BOD 7	1.0	1.0	1.2	1.1
BOD 8	3.3	3.3	3.0	3.2
BOD 9				
BOD 10				
	1.7	1.7	1.7	1.7

ANNEX "G"

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise. Filipino Heart.	HOSPITAL MANUAL	DOC CODE: PM-EXO-003 Issue Date: 11/14/13
CODE OF ORGANIZATIONAL ETHICS		Revision Date: 03/05/19–Revision No.2 Page No. 1 of 11 Executive Office
Prepared By: Jose M. Acuin, MD Chief Medical Officer	Reviewed By: Andres M. Licaros, Jr. President & CEO	Approved by: Augusto P. Palileo Jr. Chairman of the Board

TABLE OF CONTENTS

A Code of Organizational Behavior helps unite all of us by providing a set of behavioral expectations that we can all follow. Commonly practiced ethical behavior helps to create a safe, secure and healthy work environment.

The Code of Organizational Behavior applies to all Asian Hospital Board members, executives and employees, including medical / professional staff, contracted staff, residents, fellows and other trainees, volunteers, students, researchers, training staff and all other employees. Without exception, this Code applies equally to everyone at all levels in the organization. We also expect our patients, families, visitors and community partners to know and honour this Code.

All members of Asian Hospital hold one another accountable for upholding this Code.

The Senior Management group of Asian Hospital has overall responsibility for ensuring the implementation of the Code of Organizational Behavior. The Human Resources Department is the policy owner of the Code. The Code is also overseen by the Organizational Ethics Committee, which has representation from Human Resources, Legal Affairs, Medical Affairs, Nursing, Corporate Affairs, Finance and Senior Management. This Committee reviews the Code annually and is convened by the CEO. Annually, all individuals subject to this policy will acknowledge their understanding of the Code and acknowledge that they are not in breach of its principles and terms.

It is the duty of all Asian Hospital employees and relevant third parties

- to know and understand the ethical standards, legal standards, and company policies applicable in performing their daily tasks.
- to comply with applicable laws, rules, regulations, and the Code. Failure to do so may subject employees to disciplinary action.
- to report actual or suspected violations of applicable law, rules, regulations, or the Code to their Supervisor or the Compliance Officer, committed by other employees, subcontractors or suppliers of Asian Hospital.

Asian Vision, Mission and Values

We aspire to be the Center of Global Expertise in caring for the unique needs of our patients and the communities that we serve. Our reason for being is delivering accessible world class compassionate and integrative healthcare service to every individual, bringing global healthcare expertise with a Filipino heart.
To remain true to our vision and achieve our mission, we live and work by five core values: fairness, integrity, teamwork, excellence and respect.

Fairness
We treat each other, our patients and their families, our stakeholders and the general public as we would like ourselves treated, equally and justly.
We have the right to:

- Work in a supportive environment.
- Be free from discrimination and harassment.
- Be assigned duties, privileges and promotions based on job description, experience and performance and not based on membership in a specific group.
- Lodge complaints and voice out concerns without fear of reprisal.
- Due process when complaints are lodged against us

We have the responsibility to:

- Provide the same good quality of care and treatment to all patients.
- Report to any middle or senior manager any discriminatory or harassing conduct in the Hospital community that we become aware of or witness.
- Make decisions about hiring, work assignments, educational opportunities, promotions or terminations fairly and equitably.
- Fully and truthfully cooperate with investigations according to hospital policies.
- Protect and uphold our patients' and families' rights to:
  - Be treated with dignity and respect by everyone in the Hospital.
  - Be free from discrimination and harassment.
  - Receive, appropriate, accessible and equitable care.
  - Lodge complaints without fear of reprisal.

Integrity
We behave and support each other to behave according to the highest moral and professional standards.
We have the right to

- Be treated professionally by our co-workers and superiors
- Be informed of all policies and codes for which we will be held accountable

We have the responsibility to

- Tell the truth at all times
- Act professionally
- Get paid only by honest means, and not earning from referrals, favors or conflicts of interest
- Communicate honestly and sincerely with each other
- Fulfill completely and promptly our commitments, duties and obligations to each other
- Comply with work instructions and procedures.
- Keep work related issues confidential.
- Demonstrate a good work ethic.
- Admit mistakes and learn from them.
- Safeguard and wisely use hospital resources
- Work efficiently and on time

Teamwork
We work in concert with our colleagues and managers in order to become our very best and to help others do the same.
We have the right to

- Receive orientation and continuing training
- Constructive feedback on the quality of our work
- Effective and respectful supervision
- Be acknowledged for the work that we do
- A culture of safety

We have the responsibility to

- Go out of our way to help each other promptly and considerately
- Share accountability with our co-workers for team outputs
- Be open to the ideas and contributions of others.
- Share information, knowledge and expertise with colleagues.
- Recognize those who have performed well.
- Take the initiative to assist and encourage each other with a task
- Be involved in group efforts
- Contribute to creating an environment where we trust, grow and change together.

Excellence
We ceaselessly improve and expand ourselves and others.
We have the right to

- Practice to the full extent of our professions
- Be valued for our competence and expertise
- Take pride in our work, our workplace and our appearance
- A safe and low-risk workplace
- Speak up whenever there are safety concerns without fear of retribution from others

We have the responsibility to

- Work to the best of our ability at all times, refraining from mediocre work.
- Innovate and try out new ideas in the pursuit of better results
- Admit our mistakes and use them to improve ourselves
- Take initiative to develop ourselves and expand our expertise to the fullest
- Address root causes of unsafe conditions or adverse events
- Proactively act on and lead in meeting the challenges of quality improvement.

Respect
We celebrate and uphold each others' uniqueness and relate to each other with sensitivity and compassion.
We have the right to

- Be treated with courtesy and sensitivity
- A considered response to inadvertent mistakes
- Make informed choices
- Open and trustful communication
- Report disrespectful or disruptive behavior of our co-workers

We have the responsibility to

- Preserve each other's privacy
- Treat personal and professional information of our co-workers confidentially
- Consider our co-workers' individual beliefs and ideas when relating to them

- Report and eliminate aggressive or bullying behavior
- Refrain from gossip, rumor mongering and relating to each other in inappropriate or disrespectful ways by words, actions or gestures
- Withhold judgment and criticism of others

PATIENT RELATIONS

Patient Care

Asian Hospital's provides for the well-being, comfort, and dignity of all patients through appropriate and compassionate care, without regard to race, color, creed, sex, religion, national origin, sexual orientation, marital status, age, source of payment, or ability to pay. All clinical decisions are based upon identified health care needs and their acuity. Upon admission to Asian Hospital, we provide patients a written statement of their rights and responsibilities. We give patients and, as appropriate, their families or representatives, the information necessary to enable them to give informed consent prior to the start of any non-emergency procedure or treatment. We inform patients about their proposed plan of care, including the risks, benefits, and alternatives available to them. Asian Hospital honors patients' advance directives, within the limits of the law and the hospital's philosophy and capabilities. Global expertise with Filipino heart is our commitment to the communities we serve. We treat patients without regard for their ability to pay and will not withhold treatment or undertreat patients for any economic reasons. We strive to provide health education, health promotion, and illness prevention programs as part of our efforts to improve the quality of life for our patients and our communities. Any questions or concerns about this policy should be directed to the Customer Relations Department Manager or the Compliance Officer.

Patient Information Confidentiality

We zealously protect all sensitive information collected from patients about their medical condition, history, medication, and family illnesses. We do not release or discuss patient-specific information with others unless it is appropriate and necessary to serve the patient, or is required by law.

PHYSICIAN AND PROVIDER RELATIONSHIPS

We Do Not Pay for Referrals

We accept patient referrals/admissions solely based on the patient's clinical needs and our ability to render the needed services. We do not, however, pay or offer to pay anyone -employees, physicians, or other persons - for referrals of patients. No employee, or other person acting on behalf of Asian Hospital, is permitted to enter into any agreements (especially with physicians) that are linked directly, or indirectly, to the referral of patients.

We Do Not Accept Payments for Referrals that We Make

Our physicians and other health care providers make patient referrals solely based on the patient's clinical needs and the abilities of the referred provider to render such services. No employee or any other person acting on behalf of Asian Hospital is permitted to solicit or receive anything of value, directly, or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another health care provider we do not take into account the volume or value of referrals that the provider has made (or may make) to Asian Hospital.

We Do Not Allow Personal Interests To Influence Referrals

We inform patients of their options as to medical tests, treatments, rehabilitation services, hospice care and other ancillary services and facilitate their informed selection of such services. However, physicians and other healthcare providers are prohibited from referring patients to other health care providers in which they (or family members or owned entities) have financial or compensatory interests.

PHYSICIAN AND PHARMACEUTICAL INDUSTRY RELATIONSHIPS

Practicing physicians' primary obligations are toward their patients. The primary objective of relating to the pharmaceutical industry is to advance the heath of all Filipinos and not for the good of individual patients, physicians or the industry. Physicians should always maintain their professional independence in making decisions and remain committed to evidence-based medicine.

Physicians may participate in industry – sponsored research or educational activities if these are ethically defensible, socially responsible and scientifically valid. Research studies should pass all IRB requirements. CME activities should be educationally valuable to its audience and should fulfill all requirements set by the Medical Affairs.

Funding decisions for CME activities should be entirely controlled by physician organizers. Travel and accommodation arrangements, social events and venues for industry – sponsored CMEs should be similar to those which would have been made without industry sponsorship.

Physicians may distribute drug samples solely for the purpose of evaluating their clinical performance outside of post marketing surveillance studies and never for personal gain. Sample medical devices, infant formulas and other health care products should be treated in the same way.

Organizers of industry – sponsored CME events must fully control its content and conduct and ensure compliance with PMA and PHAP guidelines.

Practicing physicians should not accept personal gifts or fees beyond the nominal amount which preserves professional autonomy.

WE DO NOT PAY PATIENTS

We do not pay or provide financial benefits to patients or their agents, including middlemen, in exchange for admission or services such as surgical procedures. We do waive certain charges for financially needy patients as part of our corporate social responsibility and residency training programs.

BILLING

We Code and Bill Accurately

We will bill the patient when appropriate, or their insurance company (which may be the government). We are committed to preparing and submitting honest, accurate, and complete claims to third party payers and bills to patients that fully comply with the law.

Asian Hospital is committed to full compliance with all rules and regulations of government health care programs, including PhilHealth, as well as HMOs and corporate medical insurance programs. We bill only for services rendered and all claims shall have adequate supporting documentation in the patient's medical record. We will apply the correct Current Procedural Terminology (CPT-4) and International Classification of Disease (ICD-10-CM) coding principles and guidelines and any other applicable medical record documentation regulations. We do not misrepresent medical diagnoses or procedures in order to obtain payment or maximize reimbursement.

We Promptly Address Billing Issues

When employees receive a question from a patient or third party payer about an invoice or charge, they will promptly review and address the question, if authorized to do so, or will refer the matter to an individual who is so authorized. If employees are unable to resolve a dispute regarding a patient's bill, they will refer the issue to their Supervisor for resolution.

SUPPLY CHAIN ETHICS

Asian Hospital promotes an ethical, professional and accountable supply chain.

Personal Integrity and Professionalism

All individuals involved with purchasing or other supply chain-related activities must act, and be seen to act, with integrity and professionalism. We relate to each other and to external organizations, suppliers and other stakeholders with honesty, respect and due diligence. We safeguard the environment. We protect all confidential information. We

refrain from engaging in any activity that may create, or appear to create, a conflict of interest, such as accepting gifts or favours, providing preferential treatment, or publicly endorsing suppliers or products.

Accountability and Transparency

Our contracting and purchasing activities are fair, transparent and conducted with a view to obtaining the best value for money. We see to it that our resources are used in a responsible, efficient and effective manner.

Compliance and Continuous Improvement

We continuously work to improve supply chain policies and procedures, to improve our supply chain knowledge and skill levels, to enhance regulatory compliance and to share best and innovative practices.

We Avoid Conflicts Of Interest

While performing one's job at Asian Hospital, an employee or staff must think of Asian Hospital interests first. A conflict of interest may occur when one's outside activities or personal interests influence or appear to influence one's ability to make objective decisions in the course of one's job responsibilities in Asian Hospital. A conflict of interest may also exist if the demands of any outside activities hinder or distract an Asian Hospital employee from the performance of her job or cause her to use Asian Hospital resources (i.e., time, computers, facilities, supplies) for non-Asian Hospital purposes.

This policy applies to the Board of Trustees, Executive Office, all employees (including physicians with private practices) and volunteers. Some examples of potential conflict situations:

- Acting as a director, partner, consultant, or employee of a firm which provides services, supplies, or equipment to Asian Hospital. This generally means you should not have a business relationship with suppliers.
- Ownership by you or members of your family of a financial interest in a firm that is a vendor of Asian Hospital.
- Purchase or lease of real estate which may increase in value because it is known that Asian Hospital may have an interest in the property.
- Receiving or giving gifts and entertainment may create a potential conflict of interest or be interpreted by others as an attempt to influence a situation. You should not give or receive gifts if the circumstances may appear to raise questions about conflicts.

We Do Not Accept Gifts and Entertainment

Asian Hospital employees and independent contractors may not accept any gifts whatsoever from any patient, patient's family, vendor, supplier, patient referral source, or referred facility except for nominal gifts (e.g., basket of fruit, candy, flowers, etc.) received through the normal course of acceptable business practice.

STAFF RELATIONS

We Ensure Safe Reporting

Asian Hospital guarantees that it will not take any form of action to censure, harass, punish or diminish any hospital staff member, employed, contractual or otherwise, clinical and administrative, who reports any quality or safety concern about the hospital or another hospital staff member. The hospital will not tolerate any of its staff members who might take similar actions against another staff member/s for whistleblowing. Any hospital staff member can report a quality or safety concern to the Joint Commission International without fear of retribution, demotion or job transfer. Any patient of the hospital can also report to the Joint Commission International without fear of diminution of care.

We Limit Access to Controlled Substances

Asian Hospital employees who have routine access to prescription drugs, controlled substances, and other medical supplies such as drug samples and hypodermic needles, should strictly observe all regulations in handling such substances. These substances are governed and monitored according to the Dangerous Drugs Act and should be

administered by physician order only. If you become aware of the diversion of drugs from the organization, you should report the incident to the Patient Safety Officer or the Compliance Officer immediately.

We Keep Corporate Information Confidential

Asian Hospital employees must not share with others confidential information acquired in the routine job performance. This type of information include personnel data, patient lists, financial data, quality reports, incident reports, clinical information, strategic plans, marketing strategies, processes, techniques, computer software, and any information with a copyright. You may not discuss with anyone outside of Asian Hospital any information you may become aware of in the course of employment, such as corporate information and plans, marketing strategy, financial results, or other business dealings. Generally, Within Asian Hospital, you should discuss this information on a strictly "need to know" basis only with other employees who require this information to perform their jobs. If you learn confidential information about Asian Hospital while performing your job, (i.e., information that is not generally known by the public), you may not use that information to buy, sell, or retain securities of any company or benefit financially (from that information) in any way. This restriction also applies to your family members and others living in your household. Even if you do not buy or sell securities based on what you know, discussing the information with others, such as vendors, suppliers, and acquaintances is prohibited. If you use any insider information for personal benefit or disclose it to others prior to its release to the general public, you will be violating Asian Hospital policy, as well as securities laws and you could be subject to civil and criminal penalties.

We Use Corporate Communication Systems for Business Purposes Only

You should use all Asian Hospital communications, electronic mail, intranet, internet access, voice mail, all communication facilities and supplies for business purposes only. You should assume that these communications are not private. Generally, confidential information should not be sent through Intranet or the Internet since its confidentiality cannot be guaranteed.

If you abuse our communications systems or use them for non-business purposes, you may lose these privileges and/or be subject to disciplinary action. You may not use Asian Hospital communications to:

- send harassing, threatening, or obscene messages;
- send chain letters;
- access non-business information on the Internet;
- send copyrighted documents that are not authorized for reproduction;
- conduct non-Asian Hospital business;
- conduct a job search; or
- open misaddressed mail.

Employees must not use Asian Hospital resources for non-official business purposes. Asian Hospital resources include information, technology, intellectual property (e.g., copyrights, patents, and trademarks), buildings, land equipment, machines, telephones, voice mail, E-mail, copiers, computers, software, supplies, cash, and the time and skills of employees.

Examples of misuse are:

- unauthorized possession or personal use of company resources;
- permitting or directing others to misuse company resources; and
- soliciting for personal use on voice mail or E-mail such
- advertisements for the sale of a personal item (e.g., a house or a car).

We Do Not Discriminate

Asian Hospital is committed to providing a fair and equal opportunity work environment where everyone is treated with respect and courtesy. This means:

- we will not tolerate discrimination, verbal or physical harassment, or abuse (whether or not sexually related) by employees, supervisors, vendors, subcontractors, or visitors of Asian Hospital

- we will not tolerate any unlawful harassment or discrimination for any reason and expect the same from all of our contractors, vendors, and visitors to Asian Hospital;
- we provide equal opportunity for employment;
- we provide equal treatment in hiring, promotion, training, compensation, termination, and disciplinary action
- we provide equitable benefits to all eligible employees.

No employee shall discriminate against any individual with a disability with respect to any offer, term, or condition of employment. We will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities.

We Do Not Tolerate Disruptive Behavior
Disruptive behavior is a negative style of interaction with physicians, hospital personnel, contracted service employees, patients, or family members and visitors. It interferes with patient care, tends to cause distress among staff, affects morale and harms the work environment. In severe cases, disruptive behavior can reduce effectiveness and productivity, result in ineffective or substandard care and undermine Asian's culture of care.
Asian Hospital has a zero tolerance policy with respect to individuals engaging in disruptive behavior, any form of harassment or threatening to engage in workplace violence. Disruptive behavior includes all forms of sexual harassment and workplace violence. Specific examples of unacceptable conduct are raised voices, angry outbursts, throwing objects, verbal abuse, abusive treatment of patients, families, or staff; discriminatory actions against individuals based on race, color, religion or disability; disruption of meetings, willful disobedience and refusal to carry out tasks. Asian employees have a responsibility to avoid these behaviors. As important, we have a responsibility to model positive behaviors that reflect Asian's core values, and our culture of caring.

We Do Not Allow Anyone to Work while Impaired by Drugs or Alcohol
Asian Hospital's facilities are alcohol and drug-free work environments. Only properly authorized individuals during the course of their job responsibilities may handle pharmaceuticals. Under no circumstances will pharmaceuticals be diverted for personal use. Employees are expected to perform their responsibilities in a professional manner, free from the effects of alcohol, drugs, or other substances which may hinder job performance or judgment. Employees suspected of being under the influence of drugs or alcohol must submit to appropriate drug or alcohol tests. An employee or independent contractor who performs an activity for Asian Hospital while impaired or otherwise under the influence of alcohol or illicit drugs shall be immediately suspended, and may be subject to further disciplinary action, including but not limited to termination of employment. Additionally, any employee or independent contractor discovered to be so impaired (or under the influence) shall be subject to the applicable legal action.
Employees are expected to report through the established channels, any employee that they may suspect is impaired or has performed an activity while impaired.

We Promote Workplace Safety
We are committed to providing a healthy and safe workplace. Asian Hospital complies with laws and regulations that protect the staff from potential workplace hazards. All employees are expected to understand how these regulations apply to their specific job responsibilities and to abide by them. Any question or concern should be directed to the Supervisor or the Safety Officer. You must also contact these managers if you or your co-workers have experienced any serious workplace injury or have observed any situation presenting a danger of injury. This information will help us prevent these incidents either from happening or from happening again.

We Protect the Environment
Asian Hospital complies with all environmental laws and regulations as they relate to our business. You are responsible for understanding how your job responsibilities may impact the environment and for observing all environmental laws and regulations, as well as Asian Hospital policies and procedures. If you have questions about environmental regulations or the proper handling of hazardous materials, ask your Supervisor for assistance or notify the Safety Officer.

We Observe Truth in Advertising and Marketing
Asian Hospital markets its services in a fair, truthful, and ethical manner. Asian Hospital uses marketing and advertising to educate the public, report to its communities, increase awareness of its services, and recruit personnel. Marketing materials are designed to reflect only the services available and the availability of properly qualified and accredited providers.

We Keep Accurate and Complete Financial Records and Reports
Asian Hospital maintains high standards of accuracy and completeness in our financial records consistent with applicable laws, established financial standards, and generally accepted accounting principles. This policy is essential to sound business management, to meeting our obligations to our patients and partners and to complying with tax and financial reporting requirements. Records, such as paper copies, electronic files, microfiche, and microfilm, are retained, secured and accessed according to industry regulations and legal statutes. Employees are instructed not to tamper with or remove records.

We Refer All Media Inquiries to Corporate Affairs
The Director of Corporate Affairs is responsible for all contact with the media. Please do not respond to inquires or requests for information from newspapers, magazines, trade publications, radio, television, as well as any other external source who is looking for information about Asian Hospital. If you have any questions or concerns or if the media contacts you about any topic, contact the Director of Corporate Affairs or the Executive Office.

TRAINING
Asian Hospital doctors, nurses and staff recognize clinical training and supervision as intrinsic professional responsibilities and provide a supportive educational environment for all trainees and students. All of our trainees are expected to

1. Demonstrate fairness and treat everyone with dignity and respect,
2. Promote equality and acceptance of people from diverse backgrounds and communities, cultures and religion and those with physical and mental challenges,
3. Provide a secure, clean and safe environment for those in our care
4. Search out challenging opportunities to change, grow innovate and improve,
5. Work collaboratively with others within the department, across programs and across the Hospital and the community,
6. Follow safe work practices that ensure patient and staff safety, and best practice in infection control.
7. Maintain confidentiality of patient information at all times and in all places
8. Provide an environment that supports privacy when examining the patient.
9. Provide patients and families the opportunity to express concerns or opinions without prejudice or discrimination,
10. Conduct themselves appropriately.

RESEARCH
All research activities by Asian doctors, nurses and employees, whether done on inpatients or outpatients, must first be approved by the Institutional Review Board to ensure scientific rigor, ethical compliance and overall adherence to good clinical practice policies. All research participants undergo education prior to soliciting their voluntary informed consents and all such consents are evaluated for compliance with the Helsinki Declaration. Patients and families are informed of ongoing clinical trials and how they can access experimental drugs if they so wish. The Review Board monitors the conduct of all approved research studies and principal investigators are accountable for all compliance issues with hospital requirements and third party sponsors' expectations.

RESOURCES

This Code provides general guidance regarding appropriate conduct, behavior, and appearance. For more specific information and guidance, please refer to the following documents:

- AHMC Vision Mission Values Statement
- AHMC Employee Handbook
- Corporate Bylaws
- Medical Staff Bylaws, Rules and Regulations
- AHMC Patient Handbook
- Patient Rights and Responsibilities Statement
- Administrative Policies and Procedures Manual
- Data Privacy Manual
- Conflict of Interest Policy
- Confidential Document Storage/Destruction/Retention Policy
- Human Resources Policies and Procedures Manual
- Sexual Harassment Policy
- Disruptive Behaviour Policy
- Infection Control Policies and Procedures Manual
- HIV Confidentiality Policy
- Safety Manual
- Disaster Preparedness Plan
- Occupational Health and Safety Program
- Department Policies and Procedures Manuals
- Research Manual

REVISION HISTORY:

Rev. No.	Rev. Date	Reason(s) for Change	Page(s) Affected	Initiated by:	Noted by: (Document Controller)
0	05/23/12	Origination	--/--	Jose M. Acuin, MD	Niel Jaymalin, RN,MAN
1	03/10/16	• Update of new and revised policy and procedures. • Update of template and signatories	All	Jose M. Acuin, MD	Jayson M. Chavez, CDPP
2	03/05/19	• Update of new and revised policy and procedures. • Update of template and signatories	All	Jose M. Acuin, MD	Jayson M. Chavez, CDPP

DEPARTMENTAL REVIEW:

NAME	POSITION	SIGNATURE
Aimee Jane T. Martinez	Director, Human Resources	
Ana Maria Y. Jimenez, PhD, RN	Director, Quality Management	
Sharon C. Hernandez	Chief Strategy Officer	

ANNEX "H"

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise. Filipino Heart.	HOSPITAL PROGRAM	DOC CODE: PG-QMD-001 Issue Date: 07/20/2015 Revision Date: 10/10/2021–Revision No.2 Page No. 1 of 7
Culture of Safety		Quality Management Department

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I. Section 1 - Program Content

1.0 Definition

A culture of safety is the product of individual and groups values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to the organization's health and safety management. It is a collaborative environment where the staff treat each other with respect, the leadership drives effective teamwork and promote psychological safety, teams learn from errors and near misses, caregivers are aware of the inherent limitations of human performance in complex systems, and there is a visible process of learning and driving improvement. A culture of safety also includes identifying and addressing issues related to systems that lead to unsafe behaviors.

2.0 Scope

This program covers the management and staff of Asian Hospital and Medical Center (AHMC), all of its appointed, contracted and employed physicians, nurses and allied medical professionals, all management and staff of its contracted services, its patients, family members, caregivers, visitors, the community and business partners.

3.0 Policy Statement

AHMC is committed to establishing and sustaining values, attitudes, and patterns of behavior that protect and preserve the health and safety of its patients, visitors and staff. This safety culture is characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. The hospital has a fair and just culture, and maintains accountability, establishing zero tolerance for reckless and unsafe behaviors. This is consistent with the AHMC values of fairness, integrity, teamwork, excellence and respect.

4.0 Organizational Structure

The Patient Safety Office under the office of the Quality Management Group oversees all patient safety programs of the hospital. Its members are the following:

4.1 Director of Quality
4.2 Manager for Patient Safety
4.3 Patient Safety Officer
4.4 Data Specialist
4.3 Regular members:
- 4.3.1 Chair, Patient Safety Committee
- 4.3.2 Chair, Medication Safety Committee (Patient Safety Sub-committee)
- 4.3.3 Chair, Fall and Prevention Committee (Patient Safety Sub-committee)
- 4.3.4 Senior Nurse representing Nursing Services
- 4.3.5 Head, Environment of Care Committee
- 4.3.6 Senior Manager representing Medical Affairs
- 4.3.7 Head, Patient and Family Education Committee
- 4.3.8 Head, Operating Room Committee

4.4 As needed members:
- 4.4.1 Senior Infection Control Practitioner
- 4.4.2 Head, Critical Care Committee
- 4.4.3 Head, Code Blue / Purple Committee
- 4.4.4 Head, Emergency Department
- 4.4.5 Head, Human Resources Department
- 4.4.6 Senior Medical Consultants representing Care of High-Risk Patients
- 4.4.7 Occupational Health and Safety Senior Representative
- 4.4.8 Head, Radiation Safety Committee
- 4.4.9 Head, Organizational Ethics and Compliance Committee
- 4.4.10 Head, Facilities Safety

4.5 The main functions of Patient Safety Office include the following:
- 4.5.1 Develops and oversees the dissemination and implementation of policies, programs and activities that promote a culture of safety.

4.5.2 Leads, trains and coaches managers and staff in establishing a safety culture and all its associated programs
4.5.3 Oversees the development, coordination and evaluation of policies and procedures for responding to adverse events, near misses and conditions that threaten patient safety.
4.5.4 The Patient Safety office leads and oversees the conduct of the following key activities:
4.5.4.1 Leadership Safety Walk rounds and tracers (WI-QMD-017)
4.5.4.2 Patient safety walk rounds (coaching and mentoring)
4.5.4.4 Patient safety training for staff and for patients
4.5.4.4 Immediate and follow-up responses to adverse events, including disclosure, analyses and investigation of adverse events; Peer Reviews (PL-MAF-027) and root cause analyses, and morbidity and mortality audits. (PL-QMD-006)
4.5.4.5 Failure mode and effects analyses (FMEA) and other risk management activities

4.5 The Patient Safety Office adopts the Institute for Healthcare Improvement's Framework for Safe, Reliable, and Effective Care in developing and assessing safety levels across the hospital. It is comprised of two foundational domains and nine interrelated components: (See Appendix A:Framework for Safe, Reliable, and Effective Care)
4.6.1 Culture
4.6.1.1 Leadership (shared with Learning System Domain)
4.6.1.2 Psychological Safety
4.6.1.3 Accountability
4.6.1.4 Teamwork and Communication
4.6.1.5 Negotiation
4.6.2 Learning System
4.6.2.1 Leadership
4.6.2.2 Transparency
4.6.2.3 Reliability
4.6.2.4 Improvement and Measurement
4.6.2.5 Continuous Learning

4.7 The regular members meet monthly. As needed members are invited whenever appropriate. The regular and as needed members meet twice a year to plan and evaluate the culture of safety program. The program includes:
4.7.1 Safety leadership rounds and tracer activities
4.7.1.1 Standardize methods (e.g. develop checklists)
4.7.1.2 Prioritize focus areas for quality improvement
4.7.1.3 Develop database based on findings
4.7.1.4 Assess its impact on hospital staff
4.7.1.5 Inform unit leaders of results and plan interventions
4.7.1.6 Monitor status of implemented interventions
4.7.1.7 Evaluate processes and outcomes
4.7.1.8 Determine effects on safety culture (Administer annually the Hospital Survey on Patent Safety Culture)
4.7.1.8 Encourage participation from all hospital leaders and staff.
4.7.2 Safety training through baker's Dozen e-learning Series platform of Asian Quality Academy
4.7.2.1 Identify and involve specific individuals / groups
4.7.2.1.1 Physicians (Consultants, House Officers, Fellows and Residents)
4.7.2.1.2 Nurses
4.7.2.1.3 Ancillary staff
4.7.2.1.4 Housekeepers
4.7.2.1.5 Contracted services
4.7.2.1.6 Security
4.7.2.2 Evaluation of current status of training with HR, and review training needs analysis with HR
4.7.2.3 Develop training curriculum and schedule together with the involved units or groups
4.7.3 Patient Safety Event Management Plans

Standardize and improve the following activities to align with JCI expectations
- 4.7.3.1 Management of Patient Safety Events (PL-QMD-006)
- 4.7.3.2 Patient Safety Briefing (town hall meeting)
- 4.7.3.3 Root Cause Analysis (RCA)
- 4.7.3.4 Preventive Analysis / Event investigations
- 4.7.3.5 Interdisciplinary Team Conference (PL-QMD-033) and Family Conference (PL-QMD-031)
- 4.7.3.6 Patient and family education (PL-QMD-043)
- 4.7.3.7 Medico-legal risk management
- 4.7.3.8 Lean management
- 4.7.3.9 Sustainable and evidence based actions
- 4.7.3.10 Utilization of Survey Analysis for Evaluation risk (SAFER) Matrix

4.7.4 Risk Assessment and Management Plans (PN-QMD-001)
Standardize and integrate the following risk assessment activities:
- 4.7.4.1 Failure Mode and Effect Analysis (QF-FPM-200)
- 4.7.4.2 Infection Control Risk Assessment (QF-ICC-069)
- 4.7.4.3 Hazards surveillance (QF-FPM-125)
- 4.7.4.4 System audits
- 4.7.4.5 Environment of care rounds (QF-FPM-125)

5.0 Policies and Procedures

5.1 AHMC acknowledges the high-risk nature of healthcare and the complexity and severity of healthcare needs of its patients.

5.2 AHMC affirms that it will be the last place where a patient, staff or visitor can be harmed and will relentlessly reduce, mitigate or eliminate all risks to their health and safety through voluntary error reporting, routine risk and error hunting and continuing quality improvement.

5.3 AHMC holds all board, management, staff and physicians accountable to the AHMC Code of Conduct, Code of Business Ethics and to their respective professional codes. Violations to these codes may be addressed by hospital-wide committees on organizational ethics and compliance (PL-EXO-011 and CC-QMD-011), bioethics (PL-PCS-024), peer review and staff grievance committees (PL-MAF-027 and PL-HRD-034)

5.4 Through Human Resource and Medical Affairs policies and procedures, only healthcare professionals with verified evidence of education, expertise and experience are allowed to provide care to all admitted and ambulatory patients and the maintenance of their clinical privileges depend on their continuing demonstration of exemplary professional behavior, professional growth and outstanding patient outcomes. The performance of managerial and support staff is similarly managed.

5.5 Improvements in safety and quality are pursued by interdisciplinary teams and committees that value expertise over rank and honest relationships over deference to authority. Such improvement projects are managed and scaled up by hospital-wide quality committees.

5.6 The Board and management of AHMC commit all of the organization's resources towards building and maintaining a culture of safety. In line with this, hospital managers and staff regularly conduct safety culture building activities such as but not limited to:
- 5.6.1 leadership walk rounds,
- 5.6.2 patient safety briefings,
- 5.6.3 tracer activities,
- 5.6.4 clinical audits, noted event reviews,
- 5.6.5 health technology assessment including proposed clinical pathways and guidelines,
- 5.6.6 contract reviews,
- 5.6.7 environment of care rounds and
- 5.6.8 compliance audits.

Findings from these activities are then addressed by relevant units and committees, escalated to MANCOM if required and appropriately communicated to the Board.

5.7 AHMC expects managers, staff and physicians to voluntarily and promptly report all safety concerns, errors, near-misses and adverse events through its online reporting system. Such reports are screened, farmed out, investigated and addressed through a hospital-wide process managed by the Patient Safety Office.

5.8 AHMC does not tolerate any form of harassment. Disciplinary action or retaliation on any staff, patient or visitor who speaks out, exposes or publicly communicates any concern about the safety of its employees, services and facilities will not be carried out. Employees who report any safety concern to AHMC management, to the general public and to regulatory agencies, both domestic (e.g., DOH, SEC etc.) and international (e.g., the JCI) can expect full protection of their rights, zero sanctions for their actions and timely investigations and feedback on their concerns as stipulated by current policies and procedures (Refer to PL-QMD-056 Whistleblowing Policy).

5.8.1 AHMC likewise will not tolerate any behavior from its board, management, staff or from its physicians that undermines the culture of safety, intimidates others, degrades morale or exposes its staff, patients or visitors to unsafe conditions or actual harm. (PL-HRD-056 Managing Disruptive Behavior in the Workplace Violence)

5.8.2 AHMC recognizes that healthcare providers can become "second victims". These are hospital staff involved in unanticipated adverse or sentinel events, medical errors and/or patient related injuries who become victims in the sense that the provider is traumatized, by the event. The hospital acknowledges that the emotional health and performance of healthcare providers involved in patient safety events have an impact on the quality and safety of patient care and programs are developed to address these issues (WI-HRD-015 Guidelines for Extreme Life Incident Team)

5.9 AHMC will educate, train, evaluate and improve the performance of its managers, staff, physicians, and partners on critical safety culture competencies, such as:

5.9.1 Aligning professional and personal behavior with hospital codes of conduct

5.9.2 How to promptly recognize, appropriately report, evaluate and prevent errors, adverse events and near-misses

5.9.3 How to communicate safety concerns effectively, despite differences in rank or authority

5.9.4 How to work as effective healthcare team members and leaders and manage team resources

5.9.5 How to manage one's self and promote situational awareness and resilience

5.9.6 How to assess, contain and manage healthcare risks.

5.9.7 How to engage patients in a common safety agenda

5.9.8 How to eliminate waste, inefficiencies and unjustified variations in healthcare that exposes patients and staff to unwarranted risks

5.10 AHMC acknowledges that, while most individual errors are caused by system-wide failures and that failures are golden opportunities for improvement, it will not hesitate to exact full accountability on all physicians and staff who willfully violate its policies and procedures that are meant to protect them and their patients from harm.

5.11 AHMC board and managers evaluate the culture on a regular basis using a variety of methods, such as the quality and safety dashboard, hospital surveys, patient survey on patient safety culture, patient surveys, staff interviews, voice of the employees, trigger tools and data analysis.

6.0 Safety Culture Program

The patient safety office together with the risk management and quality improvement groups have identified several intiatives to promote a culture of safety in AHMC approved by the board. These are cascaded to the whole organization through briefings, unit meetings and huddles. (please see Quality Improvement and Patient Safety Program PG-QMD-003).

7.0 Code of Organizational Ethics

AHMC recognizes that harms caused by indignities and inequities in healthcare are just as preventable and unacceptable as physical harm. These are addressed in the hospital's code of organizational ethics. (See Code of Organizational Ethics PM-EXO-003)

II. Section 2. Documentation Requirements

8.0 References

8.1 Joint Commission International Accreditation Standards for Hospital; 7th Edition, January 2021
8.2 Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.
8.3 Sorra J, Gray L, Streagle S, et al. AHRQ Hospital Survey on Patient Safety Culture: User's Guide. (Prepared by Westat, under Contract No. HHSA290201300003C). AHRQ Publication No. 15-0049-EF (Replaces 04-0041). Rockville, MD: Agency for Healthcare Research and Quality, January 2016.
8.4 Appendix A: Framework for Safe, Reliable, and Effective Care
8.5 PL-MAF-027 Peer Review policy
8.6 PL-PCS-024 Bio-Ethics Consultation
8.7 PL-EXO-011 Organizational Ethics Framework
8.8 PM-EXO-003 Code of Organizational Ethics
8.9 PL-HRD-056 Managing Disruptive Behavior in the Workplace
8.10 PL-HRD-034 Employee Complaints and Grievance Procedure
8.11 WI-HRD-015 Guidelines for Extreme Life incident Team
8.12 PL-QMD-006 Management of Patient Safety Events
8.13 PL-QMD-043 Patient and family management
8.14 PL-QMD-033 Interdisciplinary Team Conference
8.15 PL-QMD-031 Family Conference
8.16 PL-QMD-056 Whistleblowing Policy
8.17 WI-QMD-000 Safety Leadership Rounds Guidelines
8.18 PG-QMD-003 Quality Improvement and Patient Safety Program
8.19 PN-QMD-001 Quality Improvement, Patient Safety and Risk and Compliance Program
8.20 CC-QMD-011 Organizational Ethics and Compliance Committee

9.0 REVISION HISTORY:

Rev. No.	Rev. Date	Reason(s) for Change	Page(s) Affected	Initiated by:	Noted by: (Document Controller)
0	07/20/2015	Document Origination	0	Noel P. Ligaya, DNM, RN	Jayson M. Chavez, CDPP
1	05/10/2019	Update of process, template and signatories	All	Mary Grace A. Lim, MD	Jayson M. Chavez, CDPP
2	10/10/2021	Update of template and signatories. Update of Document Management system process via Adobe sign electronic platform Update of items 4.7.3.1 to 4.7.3.10 (Patient safety event management plan)	All	Fides F. Adiviso, PhDN, MAN, RN	Jayson M. Chavez, CDPP

9.0 DOCUMENT REVIEW AND APPROVAL:

Prepared by: Fides F. Adiviso, PhDN, MAN, RN Manager, Patient Safety	Reviewed by: Arvin Mark T. Pascual, MAS, RN Senior Manager, Risk and Compliance
Reviewed by: Marc Louie Del Rosario (May 20, 2022 23:53 GMT+8) Marc Louie E. Del Rosario, MD, FACC Chair, Patient Safety Committee	Reviewed by: Carolina Buhain (May 21, 2022 08:16 GMT+8) Carolina P. Buhain, MAN, RN Director, Nursing Services
Reviewed by: Corazon Ngelangel (May 22, 2022 05:57 GMT+8) Corazon A. Ngelangel, MD Director, Institutes and Ancillary Services	Reviewed by: Engr. Novy S. Sun Director, Facilities Planning and Management
Reviewed by: Ana Maria Y. Jimenez, PhD, RN, CPHQ Director, Quality Management	Reviewed by: Sharon C. Hernandez Chief Strategy Officer
Reviewed by: Robert D. Martinez Chief Finance Officer	Reviewed by: Jose M. Acuin, MD Chief Medical Officer
Approved by: Andres M. Licaros Jr. President and CEO	

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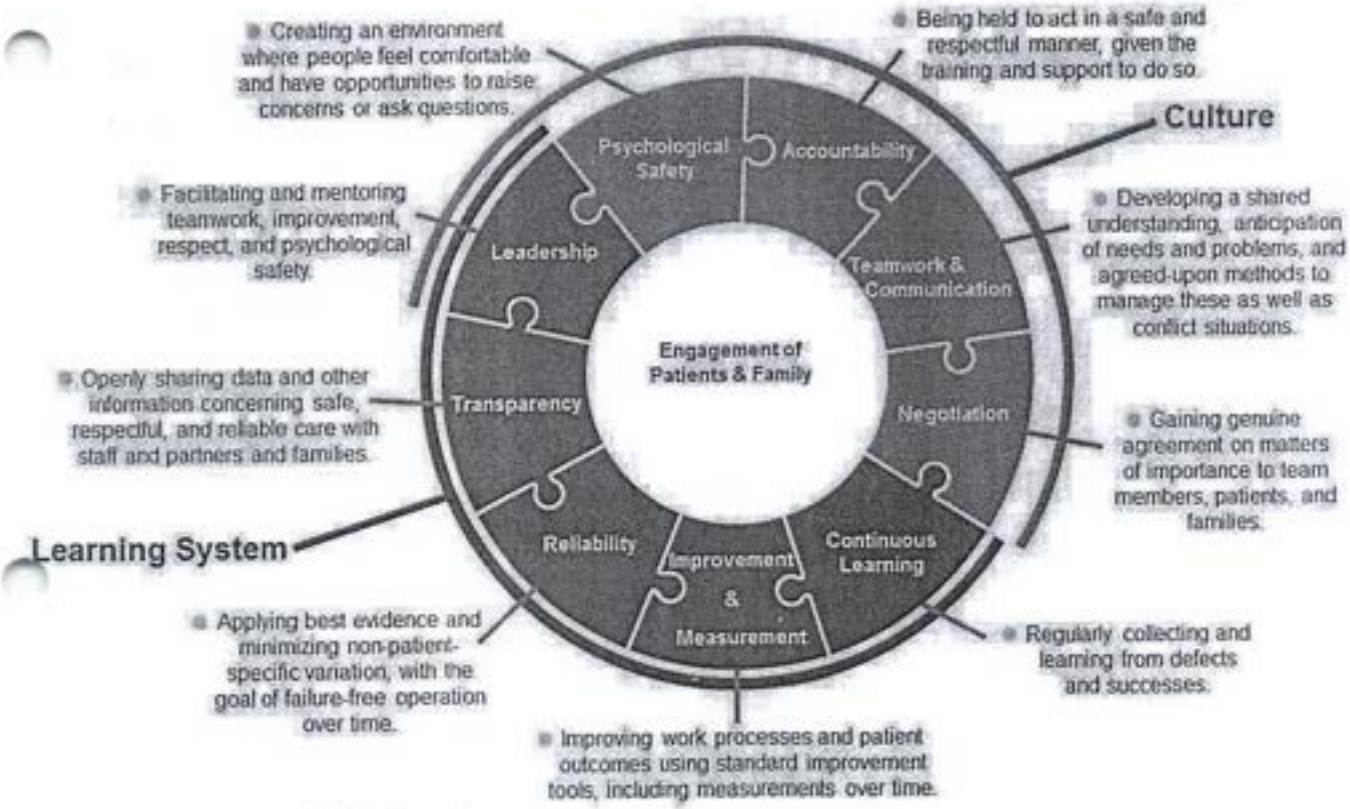
Prepared by: Fides F. Adiviso, PhDN, MAN, RN Manager, Patient Safety	Reviewed by: Arvin Mark T. Pascual, MAS, RN Senior Manager, Risk and Compliance
Reviewed by: Marc Louie Del Rosario (May 20, 2022 23:53 GMT+8) Marc Louie E. Del Rosario, MD, FACC Chair, Patient Safety Committee	Reviewed by: Carolina Buhain (May 21, 2022 08:16 GMT+8) Carolina P. Buhain, MAN, RN Director, Nursing Services
Reviewed by: Corazon Ngelangel (May 22, 2022 05:37 GMT+8) Corazon A. Ngelangel, MD Director, Institutes and Ancillary Services	Reviewed by: Engr. Novy S. Sun Director, Facilities Planning and Management
Reviewed by: Ana Maria Y. Jimenez, PhD, RN, CPHQ Director, Quality Management	Reviewed by: Sharon C. Hernandez Chief Strategy Officer
Reviewed by: Robert D. Martinez Chief Finance Officer	Reviewed by: Jose M. Acuin, MD Chief Medical Officer
Approved by: Andres M. Licaros Jr. President and CEO	

PROCESS / TITLE :

Appendix A: Framework for Safe, Reliable, and Effective Care

Support Document to: PG-QMD-001 Culture of Safety



Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care.* White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.

1.0 PURPOSE:

Asian Hospital and Medical Center is committed to continuously improve its governance practices and for this purpose, hereby adopts this Anti-Bribery and Corruption Policy, which will serve as a guide for all hospital and medical staff in line with the hospital's Code of Ethics

AHMC will not tolerate bribery, kickbacks, or corruption of any kind, directly or through third parties, whether or not explicitly prohibited by this Policy or by law. AHMC Personnel are not permitted to give or offer anything of value (including gifts, hospitality, or entertainment) to anyone for the purpose of improperly obtaining or retaining a business advantage. Similarly, AHMC Personnel may not solicit or accept such improper payments.

2.0 SCOPE:

This policy applies to all personnel of Asian Hospital and Medical Center.

3.0 POLICY STATEMENT:

This Policy and the internal controls herein have been designed to prevent bribery from occurring, avoid the appearance of wrongdoing and enable AHMC to respond promptly and effectively to any inquiries about its conduct. Any hospital staff who violates this Policy may be subjected to disciplinary action, up to and including termination as determined and indicated it the hospital's Code of Ethics (PM-HRD-004).

Under this Policy, all AHMC Personnel are not permitted to give or offer anything of value, directly or indirectly, to any Government Official or any commercial party for the purpose of improperly obtaining or retaining a business advantage. "Anything of value" should be broadly interpreted to include cash, gifts to family members, forgiveness of a debt, loans, personal favors, entertainment, meals and travel, political and charitable contributions, business opportunities and medical care, among other items. All hospital and medical staff are also prohibited from making Facilitation Payments, those relatively insubstantial payments made to facilitate or expedite routine governmental action. Simply put, bribes, kickbacks or similar payments are never permitted, whether made to a Government Official or to customers, investors, clients, or other private parties. Similarly, all hospital and medical staff may not solicit or accept such payments and are required to exercise common sense and judgment in assessing whether any arrangement could be perceived to be corrupt or otherwise inappropriate.

All AHMC Personnel must conduct their activities in full compliance with this Policy, the Philippine Anti-Graft and Corrupt Practices Act ("RA 3019"), the UK Bribery Act, and the United States Foreign Corrupt Practices Act ("FCPA"), and all other applicable laws relating to bribery or corruption in each jurisdiction in which Company Personnel do business

This Policy is intended to be read with AHMC's Whistleblowing Policy, Gift and Hospitality Policy, and other Corporate Governance Policies.

If confronted with a request or demand for an improper payment or violation of this Policy, the request of demand must be immediately rejected and reported to AHMC's Compliance Officer in writing. Similarly, if any AHMC Personnel or agent knows or believes that an improper payment has been or will be made, the concerned AHMC Personnel or agent must also report such payment to AHMC's Compliance Officer. AHMC's policy is that no adverse employment action will be taken against any AHMC Personnel in retaliation for, honestly and in good faith, reporting a violation or suspected violation of anti-corruption laws or this Policy.

4.0 DEFINITIONS:

4.1 **Corruption-** is the misuse of public or professional power for personal or material gain.

4.2 **Bribery-** refers to the offering, giving, soliciting, or receiving of any item of value as a means of influencing the actions of an individual holding a public or legal duty. This type of action results in matters that should be handled objectively in a manner best suiting the private interests of the decision maker. Bribery constitutes a crime and both the offeror and the recipient can be criminally charged.

4.3 **Facilitation Payment-** is a financial payment that is made with the intention of expediting an administrative process. It is a payment made to a public or government official or counterparty that acts as an incentive for such party to complete some action or process expeditiously, to the benefit of the party making the payment.

4.4 **Government Official-** includes all officers or employees of a government department, agency, or instrumentality at all levels and subdivisions (i.e., local, regional, national); permitting agencies; customs officials; candidates for political office; officers or employees of political parties and officials of public international organizations (*e.g.*, the Red Cross). This term also includes officers or employees of

government-owned or controlled commercial enterprises such as state-owned or controlled universities, airlines, oil companies, health care facilities, or other vendors. The term also includes family members and close associates (i.e., Person representing or acting on behalf of the official in meetings and/or business partners, etc.) of such individuals (*e.g.*, it is not permissible to give a lavish gift to the sibling, spouse, or child of a government official or employee if a gift to the individual would be prohibited under this Policy). This term also includes healthcare professionals (HCPs) who are participating in government hospitals or any department, agency, or instrument of a government when any of the following instances apply: (i) the HCP has an official decision making role, (ii) the HCP has responsibility for performing regulatory inspections, government authorizations, or licenses, or (iii) the HCP has decisions with potential to affect the business of AHMC or any of its affiliated companies.

4.5 **AHMC Personnel-** refers to any individual hired by AHMC for salaries and/or benefits provided in regular amounts at stated intervals in exchange for services rendered personally for the Hospital's business on a regular basis and who does not provide such services as part of an independent business. This includes AHMC's officers, executives, supervisors, Medical staff, rank and file, and, only for purposes of this policy, other corporate officers under the AHMC's By-laws, temporary staff, casual employees, project employees or Subsidiaries' employees who also work for/serve MPHHI (e.g. on seconded basis).

4.6 **Third Party Consultants-** includes professional consultants, firms, partnerships, counsels, outsourced companies or such other professional entities or individuals rendering professional or specialized expert services to AHMC as well as advisors of AHMC who may be appointed by the Board of Directors or the President/CEO, or who act as representatives of the AHMC's investors, shareholders, affiliates or partners.

5.0 PROCEDURES:

5.1 Gifts, Meals, Entertainment, and Employment

All such expenditures including but not limited to gifts, entertainment, travel, meals, lodging and employment must be recorded accurately in the books and records of AHMC, in accordance to the hospital's expense reimbursement policy (PL-FIN-007).

5.1.1 Gifts

As a general matter, AHMC competes for and earns business through the quality of its personnel, products and services, not with gifts or lavish entertainment. The use of AHMC's funds or assets for gifts, gratuities, or other favors to Government Officials or any other individual or entity (in the private or public sector) that has the power to decide or influence the AHMC's commercial activities is prohibited, unless ***all*** of the following circumstances are met:

a. the gift does not involve cash or cash equivalent gifts (*e.g.*, gift cards, store cards, or gambling chips);
b. the gift is permitted under both local law and the guidelines of the recipient's employer;
c. the gift is presented openly with complete transparency;
d. the gift is properly recorded in the Company's books and records;
e. the gift is provided as a token of esteem, courtesy, or in return for hospitality and should comport with local custom; and
f. the item costs less than PhP5,000.00 (the "Nominal Value").

5.1.1.1 Gifts that do not fall specifically within the above guidelines require advance consultation with and approval by the AHMC's Compliance Officer and President.

5.1.1.2 Provision of gifts, as well as the reporting requirements, in this Policy, apply even if AHMC Personnel are not seeking reimbursement for the expenses (*i.e.* paying these expenses out of your own pocket does not avoid these requirements).

5.1.1.3 AHMC Personnel must not accept, or permit any member of his or her immediate family to accept, any gifts, gratuities, or other favors from any customer, supplier, or other person doing or seeking to do business with AHMC, other than items of Nominal Value. Any gifts that are not of Nominal Value should be returned immediately and reported to your supervisor. If immediate return is not practical, they should be given to the HR/Warehouse/Pharmacy/Asian Charities for charitable disposition (Conflict of Interest PL-HRD-046 and Donation of Medical Supplies and Equipment WI-ISM-001).

5.1.1 **Meals, Entertainment, Travel, and Lodging**

5.1.2.1 Common sense and moderation should prevail in business entertainment and payment of travel and lodging expenses. AHMC Personnel should provide business entertainment to someone doing business with AHMC only if the entertainment to someone doing business with AHMC only if the entertainment is infrequent, modest, and intended to serve legitimate business goals. Meals, entertainment, travel, and lodging should never be offered as a means of influencing another person's business decision. Each should only be offered if it is appropriate, reasonable for promotional purposes, offered or accepted in the normal course of an existing business relationship, and if the primary subject of discussion or purpose of travel is business. The appropriateness of a particular type of entertainment, travel, and lodging of course, depends upon both the reasonableness of the expense and on the type of activity involved. This is determined based on whether or not the expenditure is sensible and proportionate to the nature of the business and the stature of the individual involved. Adult entertainment is strictly prohibited.

5.1.2.2 Expenses for meals, entertainment, travel, and lodging for Government Officials or any other individual or entity (in the private or public sector) that has the power to decide or influence the AHMC's commercial activities may be incurred without prior approval by the AHMC's Compliance Officer only if ***all*** of the following conditions are met:

a. The expenses are bona fide and related to a legitimate business purpose and the events involved are attended by appropriate Company representatives;
b. The cost of the meal, entertainment, travel, or lodging is less than PhP5,000.00 per person; and (Expense Reimbursement PL-FIN-007)
c. The meal, entertainment, travel, or lodging is permitted by the rules of the recipient's employer (if applicable).

5.1.2.2.1 For all such expenses, the reimbursement request must identify the total number of all attendees and their names, employer, and titles (if possible). All expense reimbursements must be supported by receipts, and expenses and approvals must be accurately and completely recorded in the hospital's records. In all instances, AHMC Personnel must ensure that the recording of the expenditure associated with meals, lodging, travel, or entertainment clearly reflects the true purpose of the expenditure. (Expense Reimbursement PL-FIN-007)

5.1.2.2.2 Note that the provision of meals, entertainment, travel, and lodging as well as the reporting requirements, in this Policy, apply even if the concerned AHMC Personnel is not seeking reimbursement for the expenses (*i.e.* paying these expenses out of your own pocket does not avoid these requirements).

5.1.2.2.3 When possible, meals, entertainment, travel, and lodging payments should be made directly by AHMC to the provider of the service, and should not be paid directly as a reimbursement. Per diem allowances may not be paid to a Government Official or any other individual (in the private or public sector) that has the power to decide or influence the hospital's commercial activities for any reason.

5.1.2.2.4 Any meal, entertainment, travel, or lodging expense greater than PhP5,000.00 per person, and any expense at all that is incurred for meals, entertainment, travel, or lodging unrelated to a legitimate business purpose, must be pre-approved by the AHMC's Compliance Officer and President.

5.1.2.2.5 Attendance to external training programs by any AHMC hospital and/or medical staff must abide by the terms and conditions of AHMC's policies on attendance to external training programs and expense reimbursement policy (PL-HRD-059 and PL-FIN-007). Please note that in addition to traditional gifts, meals, entertainment, and travel that are provided to business relationships where AHMC Personnel are not in attendance shall be considered gifts, and subject to the rules and requirements for gifts specified in this Policy and AHMC's Gift and Hospitality Policy. (PL-AHI-002)

5.1.2 **Employment/Internships**

On occasion, Government Officials or the AHMC's business partners may request that the hospital provide internships or employment to certain individuals. Offering internships or employment to Government Officials or the hospital's business partners may be viewed as providing an item of value. If a candidate is interviewed for an internship or employment within the ordinary course of filling a position, the hospital's Compliance Officer and President must be notified of the candidate's relationship to a Government Official or the hospital's business partner. If a candidate related to a Government Official or a hospital business partner is interviewed outside of the ordinary course of filling a position, any internship or employment offer must be pre-approved by the Compliance Officer and President. (Recruitment policy PL-HRD-005)

5.2 Political Contributions and Charitable Donations

5.2.1 Any AHMC Personnel may not make political or charitable donations, whether in their own name or in the name of Asian Hospital and Medical Center, to obtain or retain business or to gain an improper business advantage. Any political or charitable contributions by AHMC must be permitted under the law, permissible pursuant to the terms of this Policy, made to a *bona fide* charitable organization, and in the case of political contributions or charitable contributions connected to any Government Official or government entity made with the prior approval of AHMC's Compliance Officer and President. In certain instances, where there is heightened risk of corruption, AHMC's Compliance Officer or the President may require diligence to be conducted. The Compliance Officer and President must be notified if a Government Official solicits a political or charitable contribution in connection with any government action related to the hospital or its affiliates. Individual AHMC Personnel may not make political contributions on behalf of the hospital or its affiliates.

5.2.2 All AHMC Personnel may, of course, exercise their personal right to make charitable donations from their own resources, providing this does not give rise to any actual or apparent conflict of interest or appearance of impropriety for AHMC. (Conflict of Interest PL-HRD-046 and Donations, Sponsorships and Grants policy PL-AHI-003).

5.3 RELATIONSHIPS WITH THIRD PARTIES

Anti-corruption laws prohibit indirect payments made through a third party, including giving anything of value to a third party while knowing that value will be given to a Government Official for an improper purpose. Therefore, AHMC Personnel should avoid situations involving third parties that might lead to a violation of this Policy.

AHMC Personnel who deal with third parties are responsible for taking reasonable precautions to ensure that the third parties conduct business ethically and comply with this Policy. Such precautions may include, for third parties representing AHMC before governmental entities, conducting an integrity due diligence review of a third party, inserting appropriate anti-corruption compliance provisions in the third party's written contract (depending on the circumstances, such provisions could include representations, warranties, covenants, and may require the agent to undergo training), requiring the third party to certify that it has not violated and will not violate this Policy and any applicable anti-corruption laws during the course of its business with the hospital, and monitoring the reasonableness and legitimacy of the services provided by and the compensation paid to the third party during the engagement. Any AHMC Personnel retaining third parties that will be representing AHMC before governmental entities must discuss the engagement with the Compliance Officer prior to hiring the third party. Any doubts regarding the scope of appropriate due diligence efforts in this regard should be resolved by contacting the Compliance Officer.

In addition, once a third party is engaged, AHMC Personnel who deal with third parties must always be aware of potential red flags. Red flags are certain actions or facts which should alert a company that there is a possibility of improper conduct by a third party. A red flag does not mean that something illegal has happened, but rather that further investigation is necessary. Red flags are highly fact-dependent, but some examples of red flags are:

a. Unusual or excessive payment requests, such as requests for over-invoicing, up-front payments, ill-defined or last-minute payments, success fees, unusual commissions, or mid-stream compensation payments;

b. Requests for payments to an account in a country other than where the third party is located or is working on behalf of the Company;
c. Requests for payment to another third party, to a numbered account, or in cash or other untraceable funds;
d. Requests for political or charitable contributions;
e. The third party is related to a Government Official or has a close personal or business relationship with a Government Official;
f. Any refusal or hesitancy by the third party to disclose its owners, partners, or principals;
g. The third party uses holding companies or other methods to obscure its ownership, without adequate business justification;
h. The third party expresses a desire to keep his representation of the Company or the terms of his retention secret; or
i. The third party has little experience in the industry but claims to "know the right people."

If an AHMC Personnel has reason to suspect that a third party is engaging in potentially improper conduct, they shall report the case to AHMC's Compliance Officer immediately. AHMC shall conduct an investigation and stop further payments to the third party if the hospital's suspicions are verified through the investigation.

5.4 RECORDKEEPING AND INTERNAL CONTROLS

5.4.1 All expenditures made by the hospital are accurately reflected in the hospital's financial records and that all payments made with AHMC's funds, or on behalf of AHMC, have been properly authorized. All transactions must follow AHMC's expense reimbursement policy. (PL-FIN-007)

5.4.2 AHMC Personnel must follow all applicable standards, principles, laws, and practices for accounting and financial reporting. AHMC Personnel must be timely and complete when preparing all reports and records required by management. AHMC Personnel should ensure that no part of any payment is to be made for any purpose other than that to be fully and accurately described in the hospital's books and records.

5.4.3 Authorized AHMC Personnel should use best efforts to ensure that all transactions, dispositions, and payments involving AHMC's funds or assets are properly and accurately recorded in the hospital's financial records. No undisclosed or unrecorded accounts are to be established for any purpose. False or artificial entries are not to be made in the hospital's books and records for any reason. Finally, personal funds must not be used to accomplish what is otherwise prohibited by this Policy. The Compliance Office is primarily responsible for the oversight and enforcement of this Policy.

5.4.4 AHMC will conduct periodic audits of its books and records to monitor compliance with this Policy.

5.5 COMPLIANCE PROCEDURES AND TRAINING

5.5.1 As part of AHMC's ongoing commitment to anti-corruption compliance, all AHMC Personnel must receive and review a copy of this Policy. All AHMC Personnel must then certify in writing that they (1) have reviewed the Policy; (2) agree to abide by the Policy; and (3) agree to report any potential violations of the Policy to the Compliance Officer (see Appendix A).

5.5.2 In addition, AHMC will offer periodic anti-corruption compliance training programs to educate all hospital and medical staff about the requirements and obligations of anti-corruption laws and this Policy. All AHMC Personnel must participate in such training and the Compliance Officer must retain attendance records establishing compliance with this requirement.

5.6 REPORTING REQUIREMENTS AND WHISTLEBLOWER PROTECTION

5.6.1 AHMC takes its commitment to anti-corruption compliance very seriously and expects all personnel to share this commitment. AHMC therefore expects and requires any AHMC Personnel who have knowledge of, or reason to suspect, any violation of this Policy to contact AHMC's Compliance Officer at

compliance@asianhospital.com immediately. Reports may be made anonymously as defined in AHMC's Whistleblowing policy. (PL-QMD-056)

5.6.2 If any AHMC Personnel deliberately concealed violations or continue to conceal violations after discovery, then the relevant personnel may be subject to disciplinary action, up to and including termination.

5.6.3 It is AHMC's policy that, if the report of known or suspected violations is made honestly and in good faith, no adverse employment-related action will be taken against any personnel in retaliation for reporting a violation or suspected violation of anti-corruption laws or this Policy. (Whistle blowing policy PL-QMD-056)

5.6.4 All questions regarding this Policy should be directed to AHMC's Compliance Officer at compliance@asianhospital.com .

5.7 APPROVAL, AMENDMENT OR ALTERATION OF POLICY

5.7.1 This policy shall not be amended, altered or varied unless such amendment, alteration or variation shall have been approved by the hospital's Management Committee and Board of Directors. The hospital's Quality Management Group and the Compliance Officer shall be responsible in the implementation, monitoring and review of this Policy.

6.0 DOCUMENTATION:

Document Code	Document Title	To be Accomplished by:	When to Accomplish
QF-EXO-007	AHMC Anti-bribery and Anti-corruption Certification	AHMC Employees	Upon Employment
QF-EXO-008	Annual Third Party Compliance Affirmation	Third Party	Annually
QF-EXO-009	Third Party Certification or Documentary Protection	Third Party	Annually
QF-EXO-010	Third Party Due Diligence Questionnaire and Certification	Third Party	Annually

7.0 REFERENCES:

7.1 PL-AHI-002 AHMC's Gift and Hospitality Policy
7.2 PL-AHI-003 Donations, Sponsorships and Grants policy
7.3 PL-FIN-007 Expense reimbursement policy
7.4 PL-HRD-005 Recruitment policy
7.5 PL-HRD-046 Conflict of Interest policy
7.6 PL-HRD-059 Attendance to external training program
7.7 PL-QMD-056 Whistle blowing policy
7.8 WI-ISM-001 Donation of Medical Supplies and Equipment
7.9 PM-HRD-004 Code of Ethics Manual
7.10 Appendix A – Employee Anti-Corruption Policy Certification
7.11 Joint Commission International Accreditation Standard 7th Edition, January 2021

8.0 REVISION HISTORY:

Rev. No.	Rev. Date	Reason(s) for Change	Page(s) Affected	Initiated by:	Noted by: (Document Controller)
0	11/01/2021	Origination	0	Arvin Mark T. Pascual, MAS, RN	Jayson M. Chavez, CDPP

9.0 DOCUMENT REVIEW AND APPROVAL:

Prepared by: Arvin Mark T. Pascual, MAS, RN Senior Manager, Risk and Compliance	Reviewed by: MARIA LOUTJIE G. MARTY Maria Loutjie Marty Senior Manager, Supply Chain
Reviewed by: Christina Liza R. Sta. Maria, RPh Associate Director, Pharmacy Services	Reviewed by: Henessy Lou E. Miranda Director, Patient Experience and Engagement
Reviewed by: Melanie J. Balane Director, Financial Operations	Reviewed by: Engr. Novy S. Sun Director, Facilities Planning & Management
Reviewed by: Carolina P. Buhain, MAN, RN Director, Nursing Services	Reviewed by: Corazon A Ngelangel (Dec 6, 2021 11:53 GMT+8) Corazon A. Ngelangel, MD Director, Ancillary Services and Asian Cancer Institute
Reviewed by: Ana Maria Y. Jimenez, PhD, RN, CPHQ Director, Quality Management	Reviewed by: RD Martinez RD Martinez (Dec 6, 2021 14:21 GMT+8) Robert D. Martinez Chief Finance Officer
Reviewed by: Sharon C. Hernandez Chief Strategy Officer	Reviewed by: Jose M. Acuin, MD Chief Medical Officer
Approved by: Andres M. Licaros, Jr. President and CEO	

PROCESS / TITLE:

Appendix A: Employee Anti-Corruption Policy Certification

Support Document to: PL-EXO-017 Anti-bribery and anti-corruption policy

EMPLOYEE ANTI-CORRUPTION POLICY CERTIFICATION

This is to acknowledge that I have received, read, and fully understood Asian Hospital and Medical Center's ("AHMC") Anti- Bribery and Anti-Corruption Compliance Policy (the "Policy"). I agree to comply with all the rulescontained therein. I agree to report any potential violations to AHMC's Compliance Office. I will participate in AHMC's anti-corruption training on a periodic basis. I understand that failure to comply with the Policy, the FCPA, UK Bribery Act, and any other applicable anti-corruption laws, rules, and regulations may result in immediate termination and prosecution, with penalties including fines and/or imprisonment. Should I have any questions regarding the Policy or find any deviations or violations, I will contact the AHMC's Compliance Officer or any personnel of the Compliance Office immediately.

Signature: _____

Name (print): _____

Department: _____

Date: _____

(The signed receipt must be returned to the Compliance Office and to the HR Department and filed in the employee's personnel file.)

Delivery Instructions

Upon initial roll-out of the Policy, all current AHMC Personnel should complete this form and deliver the completed forms to AHMC's Compliance Office in an envelope labeled "Employee Anti-Bribery and Anti-Corruption Policy Certifications."

New AHMC Personnel/employees should complete this form immediately upon hiring and deliver to Human Resources, who will submit the completed questionnaires to the AHMC's Compliance Office.

ANNEX "J"

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise. Filipino Heart.	POLICY & PROCEDURE	DOC CODE: PL-QMD-056
		Issue Date: 10/01/2015
		Revision Date: 11/15/2021 – Revision No.2
	Whistleblowing	Page No. 1 of 13
		Quality Management

1.0 PURPOSE:

1.1 This policy is designed to provide a mechanism for reporting, investigating and remedying any wrongdoing and/or inappropriate behavior within or outside the workplace that threatens the hospital including its patients, visitors and staff or compromises safety and interest of the shareholders, investors, customers, other stakeholders and the wider public.

1.2 To provide implementing procedures, reporting channels, and internal controls, to increase the awareness of maintaining internal corporate justice.

1.3 To assist and encourage individual employees (permanent, project, or temporary) to disclose information relevant to suspected misconduct, malpractice, or irregularity as defined in AHMC's various Corporate Governance Policies ("CG Policies") through a confidential reporting channel as well as to provide such employees appropriate protection in the event of retaliatory acts carried out against them in relation to any disclosures they may have made.

1.4 The procedures outlined in this Policy have also been established in order to prevent overlapping action and investigations among and between the Human Resources Department, Compliance Office, and other concerned offices of AHMC.

1.5 Streamline the handling of complaints and their resolution, and prevent forum shopping - the filing of multiple complaints for the same reason - in the hope of obtaining a favorable resolution from any of the offices mentioned above.

2.0 SCOPE:

2.1 This policy applies to all temporary and permanent AHMC employees, Management Committee executives, professional staff, hospital staff, medical trainees, and third-party business partners, in so far as their conduct relates to the official function of AHMC.

2.2 Disclosures and reports initiated by third parties to the extent necessary to ensure compliance by the covered persons and personnel with AHMC's CG Policies. Reports pertaining to:

- 2.2.1 Malpractice, impropriety or fraud relating to internal controls, accounting, auditing and financial matters;
- 2.2.2 Violation of AHMC's rules and regulations;
- 2.2.3 Improper conduct or unethical behavior likely to prejudice the standing of AHMC;
- 2.2.4 Breach of legal or regulatory requirements;
- 2.2.5 Criminal offences, breach of civil law and miscarriage of justice;
- 2.2.6 Endangerment of the health and safety of an individual;
- 2.2.7 Damage caused to the environment; and
- 2.2.8 Deliberate concealment of any of the above.

3.0 POLICY STATEMENT:

3.1 AHMC supports and encourages voluntary, honest and responsible disclosure of any information (firsthand or learned information, either factual or perceived) concerning events, behaviors, circumstances, near misses and predisposing factors that place the hospital at risk or compromise the safety and interest of the public including the following systems:

- 3.1.1 Financial (safeguarding of financial assets)
- 3.1.2 Operational (safeguarding safety and confidentiality of documents, facilities, patients, visitors and staff)
- 3.1.3 Compliance (safeguarding of public interest and adhering to laws and regulations)
- 3.1.4 Reputational (safeguarding of perceived image of AHMC by the public)
- 3.1.5 Others.

3.2 AHMC treats with seriousness and urgency all reported concerns such as above. Whistleblowers are assured of confidentiality, timely investigation, appropriate response and protection from retaliatory actions against them.

4.0 DEFINITIONS:

4.1 **External entities-** are agencies outside of the hospital that may provide sanctions to institutions when laws and regulations are violated. External entities include local and international regulatory or accreditation bodies such as the Department of Health (DOH) and the Joint Commission International (JCI).

4.2 **Retaliatory actions or Retaliation-** any act of reprisal, discrimination, harassment, intimidation or abusive adverse personnel action by any of Asian Hospital's directors, officers, employees against a Whistleblower, any of his/her Witnesses or any person providing information or advise in relation to any Whistleblowing Report.

4.4.1 **Formal disciplinary actions** (i.e., admonition, reprimand, suspension, dismissal, and reassignment).

4.4.2 **Informal punitive actions** (i.e., discrimination, harassment, isolation, and abuse).

4.3 **Whistleblowing-** refers to a disclosure or filing of a Complaint by an employee or a group of employees who in good faith report serious concerns about any suspected misconduct,malpractice or irregularity which he or they may have become aware of or genuinely suspect that AHMC has been or may become involved in.

4.4 **Complaint-** refers to an official statement claiming serious concerns about any suspected misconduct, malpractice, irregularity, or violation of Corporate Governance Policies.

4.5 **Whistleblower -** refers to any person or persons, filing a report and includes individuals who work for, or are themselves, third-party business partners of AHMC.

4.6 **Dialogue Committee** – refers to a committee that may be given the authority and responsibility to conduct an investigation into a Whistleblowing Report. A Dialogue will be designated when the alleged violation pertains to matters outside of CG Policies (*i.e.* Questionable Accounting and Auditing Matters to be referred to the Audit or similar committee,Violations of Employees Code of Conduct to be referred to the Human Resources Department).

4.7 **Investigating Officer** – the officer who is given the authority and responsibility to conduct an investigation into a Whistleblowing Report. This may be a personnel from the Compliance Office, the Dialogue Committee, or an external counsel or consultant if one is appointed by the Compliance Committee or the Board of Directors.

4.8 **Witness** – refers to an employee of AHMC or any third-party other than a Whistleblower who participates or cooperates in the investigations or proceedings pertainingto a complaint.

4.9 **Respondent-** refers to the person being complained of, or the person who is implicated in a Complaint or Whistleblowing Report as the one who is responsible or is involved in any suspected misconduct, malpractice or irregularity.

.0 DETAILS:

5.1 General Guiding Principles

5.1.1 Reporting in good faith

5.1.1.1 AHMC Personnel are encouraged to employ the Whistleblowing System in good faith, with the intention of promoting adherence to the CG Policies and values and the over-all well-being of AHMC in so far as it strives to meet its responsibilities to its various stakeholders.

5.1.1.2 Whistleblowing shall at no time be employed for any personal disputes, question financial or business decisions taken by AHMC; nor should it be used to reconsider any staff matters which have been addressed under the grievance procedure already in place.

5.1.1.3 In the event that an employee is found to have deliberately made a false and/or malicious report, with an ulterior motive, or for personal gain, AHMC reserves the right to take appropriate actions against the employee to recover any loss or damage as a result of the false report. In particular, the employee may face disciplinary action, including dismissal, where appropriate.

5.1.2 When to report

5.1.2.1 Hospital staff should report a complaint if he or she believes that any staff, may have engaged in, or is about to engage in, and conduct which may be:

5.1.2.1.1 a violation of the Code or any internal policy or code practice;

5.1.2.1.2 a violation of, or otherwise involve questionable practices in connection with, accounting, internal accounting controls or auditing matters;

5.1.2.1.3 a violation of, or otherwise involve questionable practices in connection with, accounting, internal accounting controls or auditing matters;
5.1.2.1.4 a violation of any applicable law or regulation;
5.1.2.1.5 corruption, mismanagement or fraud; or
5.1.2.1.6 a danger to worker health and safety, the environment or the public.

5.1.2.2 If a hospital staff is unsure about the matter but concerned about the possibility of a violation or questionable practice, he or she should nonetheless report the matter.

5.1.3 **Confidentiality**

5.1.3.1 All Whistleblowing Reports including the identity of the Whistleblower, witnesses and employees named in the complaint will be treated in a confidential manner, unless AHMC is otherwise required or compelled by law to release such information.

5.1.3.2 The Compliance Office, the Dialogue Committee concerned, and the Investigating Officer shall take appropriate steps in order to secure and protect the integrity and confidentiality of all records and information obtained, gathered and collected pursuant to a Whistleblowing Report.

5.1.4 **Anonymous Reporting**

5.1.4.1 There are two ways to submit a complaint:
5.1.4.1.1 Filing a report online- Email whistleblowing@asianhospital.com
5.1.4.1.2 Calling the Whistleblowing hotline (local 8010)

5.1.4.2 To aid further investigation of the Whistleblowing Report, a Whistleblower who makes or files a Whistleblowing Report anonymously may opt to provide means by which he can be contacted without compromising his/her anonymity, (e.g. send and/or receive mails through a post office (P.O.) Box number, an e-mail address, or communicate through text messages using a mobile phone number, etc.).

5.1.4.3 All reports generated by the service are transmitted to the Organizational Ethics and Compliance Committee through the Secretariat with a copy to the Compliance Officer.

5.1.5 **Protection from retaliation**

5.1.5.1 Retaliation against any Whistleblower or Witness is prohibited and will be dealt with in accordance with this Policy, and other applicable laws, rules, and AHMC regulations. A Whistleblower or Witness who will identify himself shall be protected from retaliation

5.1.5.2 The Compliance Office and HR Department shall take necessary steps to ensure that all forms of appropriate and effective protection is afforded to a Whistleblower and/or his/her Witnesses.

5.1.6 **Malicious Allegations**

5.1.6.1 In case the Compliance Office should determine, after investigation, that the Whistleblower and/or Witness has made baseless, untruthful, fabricated, malicious, or vexatious allegations, disciplinary action may be taken against the Whistleblower and Witness in accordance with applicable laws, rules, and AHMC regulations to protect the good name of persons that may have been unjustly accused or implicated:

a. the Whistleblower, if identified or can be contacted in accordance with this Policy, shall be informed by the HR Department that the case is deemed closed including the reason for such, without prejudice to this provision; the Respondent shall be informed in writing by the immediate superior of the final disposition of the Whistleblowing Report.

5.2 Specific Policies

5.2.1 AHMC upholds a policy of openness and honesty; hence, staff are encouraged to report concerns detrimental to the hospital *(see 3.1 of the policy statement)* without fear of retaliation against them. AHMC guarantees a "blame-free/non-punitive" reporting environment.

5.2.2 AHMC expects everyone to respect confidentiality of information at all times even when raising concerns; thus, appropriate procedures are followed when channeling information.

5.2.3 Staff are also encouraged to raise concerns first internally and convey information through the following:

5.2.3.1 Their Department/ Unit Managers or managers in other departments they are comfortable with or their respective Group Heads

5.2.3.2 Face to face with any member of HRD (Manager for Employee Engagement and Labor Relations) or MAF

5.2.3.3 Email the report/ letter to whistleblowing@asianhospital.com
5.2.3.4 Whistleblowing hotline at local 8010
5.2.3.5 the Compliance Officer at compliance@asianhospital.com

5.2.4 Whistleblowers who raise concerns through public media are encouraged to use internal channels listed in 5.2.3 to protect themselves from potential breach of confidentiality and other legal charges. Whistleblowers who publicly disclose information without authorization will be subjected to disciplinary actions as provided for by the relevant codes of ethics *(Code of Ethics Manual [PM-HRD-004])*.

5.2.5 If an individual reasonably believes the concern is a threat and reports it, the Hospital will not hold it against them even if the report is found to be untrue. This encourages anyone to honestly report concerns without fear of reprisal and signals that anyone raising concerns is entitled of just treatment. However, a staff who willfully makes a false report may be subject to disciplinary actions (Employee Complaints and Grievance Procedure [PL-HRD-034]).

5.2.6 In the event that an employee is found to have deliberately made a false and/or malicious report with an ulterior motive or for personal gain, AHMC reserves the right to take appropriate actions against the employee to recover any loss or damage as a result of the false report. The hospital or medical staff may face disciplinary action, including dismissal, where appropriate.

5.3 Procedures For Disclosing Information

5.3.1 Submission of Whistleblowing Report

5.3.1.1 Any Whistleblowing Report shall preferably be made in writing using the standard form (Whistleblowing Disclosure Form) or filed with the Compliance Office through the appropriate reporting channels set up for this purpose.

5.3.1.2 It may also be filed through any responsible officer of AHMC who, in turn, shall refer it to the Compliance Office for appropriate handling.

5.3.1.3 While AHMC does not expect the employee to have absolute proof or evidence of the misconduct, malpractice or irregularities reported, the report should show reasons for the concerns and full disclosure of any relevant details and supporting documentation.

5.3.1.4 As AHMC takes reporting of misconduct, malpractice, and irregularities seriously and wants to conduct warranted investigations of both potential and actual violations, it is preferred that Whistleblowing Reports are not made anonymously. However, it is recognized that for any number of reasons, employees may not feel comfortable reporting potential violations unless the same is done anonymously, in which case, the same report may be directed to the Compliance Department through any of the available reporting channels.

5.3.1.5 For verbal Whistleblowing, the Compliance Office, the Dialogue Committee, or the Investigating Officer shall:

a. solicit and document as much information and details from the Whistleblower
b. ask for documents or other evidence in support of the Whistleblowing Report (e.g., e-mails sent, etc.); and
c. ask the Whistleblower, who chooses to identify himself, if he/she is willing to sign the transcript of the relevant discussions between the Whistleblower and the Compliance Office, as prepared by the latter and/or to be identified in the course of the investigation.
d. The Investigating Officer shall prepare the corresponding Whistleblowing Disclosure Form based on the transcript referred to above.

5.3.2 Submission of Complaint on Retaliation

5.3.2.1 If a Whistleblower or a Witness believes that he has been retaliated upon for filing a Whistleblowing Report or for participating or cooperating in an investigation under this Policy, he may file a written complaint with the Compliance Department.

5.3.2.2 The complaint on Retaliation may be filed within three (3) months from the occurrence of the last alleged act or incident of Retaliation. Complaints on Retaliation should be made in writing and submitted in a sealed envelope marked "Confidential" to the Compliance Office.

5.3.2.3 Written complaints on Retaliation should indicate the following:

a. Name, designation, work address and phone number of the complainant;
b. Name and title of the director, officer, executive, supervisor or employee alleged to have

retaliated or to be involved in the Retaliation against the complainant;

c. Brief description and date of the Whistleblowing Report to which the allegedRetaliation relates;
d. Brief description and details of the alleged Retaliation (date/time, place andmanner); relevant evidence to prove the Retaliation.

5.3.2.4 Report on Retaliation

5.3.2.4.1 The Compliance Office shall receive and conduct the preliminary evaluationof the report on Retaliation to determine whether the information set forth in this Policy are indicated and the following criteria are present:

a. Meets the definition of Retaliation; and
b. Indicates serious implications of the alleged Retaliation to the complainant; and there is probable cause to warrant further investigation.

5.3.2.4.2 After the preliminary evaluation and after it is determined that the Report on Retaliation necessitates further investigation, the Compliance Office may call for the Dialogue Committee or an Investigating Officer who shall conduct an investigation, which shall include but not be limited to:

a. Conducting interviews and seeking sworn statements from the complainant;
b. Conducting interviews and seeking sworn statements from witnesses as appropriate; and
c. Maintaining files and records of Report on Retaliation and the pertinent investigation reports, and the outcome of recommendations consistent with confidentiality requirements.

5.3.3 Handling and Preliminary Assessment of Whistleblowing Report

5.3.3.1 Receipt and Handling of Whistleblowing Report

5.3.3.1.1 In the event that the report is not in writing in the prescribed form and/or merely conveyed verbally or through other means, the receiving officer/personnel from the Compliance Office shall ensure that the information received shall be transcribed onto the appropriate form in order that a file on the matter may be initiated.

5.3.3.1.2 The receiving officer/personnel shall endeavor to obtain all necessary information required to make a preliminary assessment of the disclosure.

5.3.3.1.3 He/she shall likewise ensure that communication between him/her and the Whistleblower remains open in order that additional information, if necessary, can be obtained.

5.3.3.1.4 Should the report be made verbally to any officer/employee who is not from the Compliance Office, it shall be the duty of such person to communicate to the personnel from the Compliance Office so that said personnel shall transcribe the said report as provided in the preceding paragraph.

5.3.3.1.5 AHMC will hold it a serious disciplinary offence for any person who seeks to prevent a Whistleblowing Report from reaching the designated person, or to impede any investigation which he or anyone on his behalf may make.

5.3.3.1.6 If a Whistleblowing Report refers to incident involving any of the AHMC's affiliates, the Compliance Office shall refer the same to the Compliance Officer of the concerned subsidiary or affiliate, and promptly inform the Whistleblower of such.

5.3.3.2 Case Monitoring

5.3.3.2.1 All Whistleblowing Reports received by the Compliance Office and/or the HR Department shall have a Whistleblowing Disclosure Form and assigned a corresponding case number for monitoring purposes.

5.3.3.2.2 The Compliance Office and HR Department shall maintain a log of all Whistleblowing Reports received and shall submit a report to the Company's Compliance Committee on:

5.3.3.2.2.1 All Whistleblowing Reports concerning AHMC received by the

Compliance Office and/or HR Department which should include the following details:

a. Dialogue Committee members and Investigating Officer to whom the case was referred, if any;
b. Status of outstanding Whistleblowing Reports; and
c. Final disposition or resolution of Whistleblowing Reports.

5.3.3.2.2.2 A summary of Whistleblowing Reports submitted by the affiliates on a quarterly basis.

5.3.3.2.3 The Compliance Office and the HR Department shall maintain and control a complete case file for all Whistleblowing Reports. Every case file shall include:

a. Covering Whistleblowing Disclosure Form;
b. All investigation reports;
c. All related correspondence or memoranda;
d. All documentary evidence gathered;
e. List of other physical evidence gathered and their location; and
f. Other relevant documents and records relating to the case.

5.3.3.3 Evaluation of the Whistleblowing Report

5.3.3.3.1 Upon receipt of the Whistleblowing Report, the Compliance Office shall conduct a preliminary assessment to determine whether there is:

a. Sufficient evidence and leads to initiate an investigation, in which case, he/she may proceed to gather information from other sources as may be warranted. If the complaint pertains to matters outside of CG Policies, a Dialogue Committee should be designated for a more detailed handling. The Whistleblower should be advised accordingly.
b. Insufficient evidence and leads or unclear matters, in which case, he/she should resume discussions with the Whistleblower in order to obtain more information or verify and validate information on hand.
c. A malicious or false complaint, in which case the Compliance Office or the Dialogue Committee shall dismiss the report and may proceed to investigate if the Whistleblower acted in good faith and whether he/she should be subjected to sanctions.

5.3.3.3.2 Regardless of whether there is sufficient evidence or not, the Compliance Office or the Dialogue Committee shall, in appropriate cases, make recommendations regarding applicable internal controls and procedures that may be imposed and established in order to prevent further occurrences of the act or acts reported. The same shall be communicated to the Head of the concerned office through the Compliance Office for appropriate action.

5.3.3.4 Sufficiency of the Whistleblowing Report

5.3.3.4.1 The Whistleblowing Report must contain at least the following information:

a. Full name and position of the Respondent;
b. Specification of the charge or charges;
c. Brief statement of the relevant and material facts, including the approximate time and place of the commission of the act or omission complained of, the persons involved and such other matters that will assist the Compliance Office to identify the nature of the violation or offense; and
d. any evidence that the Whistleblower may have, including affidavits of Witnesses and/or third parties, including, but not limited to the AHMC's suppliers, vendors, and contractors.

5.3.3.4.2 Notwithstanding anything to the contrary this Policy, no anonymous Whistleblowing Report shall be entertained unless there are sufficient facts and evidence cited in

the Whistleblowing Disclosure Form that would lead a reasonable man to conclude that the charge is not frivolous and intended to harass the Respondent.

5.3.3.4.3 Should the Compliance Office find the Whistleblowing Report insufficient because of the Whistleblower's failure to provide the required information, the Compliance Office shall advise the Whistleblower, if he is identified or can be contacted, that such insufficiency may constrain the Compliance Office to close the case and not to take further action on the Whistleblowing Report as the lack of information prevents the proper conduct of investigation.

5.3.3.4.4 The format and length of an investigation will vary depending upon the nature and particular circumstances of each complaint made. The matters raised may:

a. Be investigated internally;
b. Be referred to the Dialogue Committee (Human Resources Department, Ethics Committee, etc.) for appropriate action;
c. Be referred to an external counsel or consultant; or
d. Form the subject of an independent inquiry.

5.3.4 Investigation Proper and Reporting

5.3.4.1 Investigation

The Compliance Office, the Dialogue Committee, or the Investigating Officer shall ensure that the investigation is conducted in accordance with existing laws, regulations, applicable Company Policies and procedures, and with due process of law.The following factors shall be considered in the handling of a Whistleblowing Report covering matters within the scope of this Policy.

5.3.4.1.1 The gravity and relevance of the allegation(s) and issue(s) raised;
5.3.4.1.2 The probability that the allegation(s) or issue(s) raised are true;
5.3.4.1.3 The significance of details and evidence submitted; and
5.3.4.1.4 The possible sources of additional evidence, including testimonies or affidavits of third parties, including, but not limited to, the Company's suppliers, vendors, and contractors.

5.3.4.2 Conclusion

The Compliance Office, with the help of the Investigating Officer, shall determine whether the Whistleblowing Report:

5.3.4.2.1 Will not be pursued – If despite efforts to obtain additional information, the Compliance Office should still find the Whistleblowing Report insufficient for further action, it shall advise the Whistleblower, if he is identified or can be contacted, in writing of such finding and the basis thereof.

5.3.4.2.2 Needs further investigation – The Whistleblower, if he is identified or can be contacted, shall be notified that an investigation will be conducted either by the Dialogue Committee or an Investigating Officer deputized by the Compliance Office, and the report of the findings will be provided to the Compliance Office.

5.3.4.3 Reporting

5.3.4.3.1 Upon completion of the investigation, the Investigating Officer shall submit to the Compliance Office a written report on the findings, including a summary of the evidence gathered and a conclusion as to whether or not the Whistleblowing Report is substantiated.

5.3.4.3.2 If the Whistleblowing Report is determined to be substantiated, the Compliance Office shall issue a report to the immediate superior of the Respondent, for the immediate superior's appropriate action. The name of the Respondent shall not be disclosed or reported to anyone who does not have the need to know it while the investigation is pending. The immediate superior of the Respondent shall follow the procedures laid down by applicable laws, rules, and Company regulations, specifically in terms of informing the Respondent in writing of the particular act constituting the offense or infraction imputed to him, requiring the Respondent to

answer the charges against him and affording the Respondent the opportunity to be heard and to defend himself.

5.3.4.3.3 Investigation and determination of the appropriate disciplinary action shall be made by the immediate superior in accordance with applicable laws, rules, and AHMC regulations.

5.3.4.3.4 The immediate superior shall provide the Compliance Office a report of the final action/disposition. It shall likewise advise the Compliance Office to close the case records.

5.3.4.3.5 In the event that an employee who is under investigation resigns from AHMC pending the completion of the investigation or final resolution of the case against him, his resignation shall be without prejudice to the outcome of the investigation or final resolution of the case. Any benefit due the resigning employee shall be withheld pending the outcome of the investigation or final resolution of the case.

5.3.5 Protection of Whistleblowers

In the event that a Whistleblower or any Witness alleges acts of retaliation from any AHMC Personnel, on account of his/her Whistleblowing report or testimony in connection with any whistleblowing report, it shall be the duty of the Investigating Officer, in coordination with the Compliance Office, to:

5.3.5.1 Within Seventy-Two Hours (72) hours upon receipt of such information, determine the veracity of the allegations by all means necessary;

5.3.5.2 In case such acts of retaliation are true, the Investigating Officer may recommend, subject to the approval of the Compliance Officer, with the concurrence of the Head of the Human Resources Department, ancillary measures to protect the Whistleblower and/or Witnesses such as, but not limited to:

5.3.5.2.1 re-assignment, whether temporary or permanent, of one or any other party involved,

5.3.5.2.2 verbal warnings and reprimands, against the party or parties concerned, either from the Compliance Office, Human Resources Department, and/or their immediate Head;

5.3.5.2.3 designation or creation of special work areas;

5.3.5.2.4 In case of third-party reports, the Compliance Office shall endeavor to develop appropriate measures together with Procurement and/or the Finance Department in order that such third-party, and/or the company s/he represents shall continue to fairly pursue and bid for business and contracts with AHMC; and

5.3.5.2.5 Such other measures as are necessary to preserve the status quo prior to the filing of the report or to protect the rights of the parties concerned.

5.3.5.3 The Investigating Officer may also recommend other measures to sanction the behavior of the person or persons guilty of Retaliation and may file appropriate administrative charges against said persons as may be warranted under applicable laws, rules, and AHMC regulations.]

5.3.6 The **whistleblower** may verbally or in writing report concerns including other detailed information through appropriate channels (*see 5.2.3)* if he or she wishes not to report the concern using the patient safety events reporting system (PSER).

5.3.7 The Whistleblower who makes or files the report may provide means by which he/she may be contacted without compromising his/her identity by providing any of the following:

5.3.7.1 PO box/mailing address

5.3.7.2 E-mail address

5.3.7.3 Mobile number

5.3.8 The **manager or any recipient** of the whistleblower's concern shall:

5.3.8.1 Document the details of the complaint if not yet done (see Whistleblower Disclosure Form [QF-QMD-063]) then he or she

5.3.8.1.1 Lets the whistleblower review and sign the form to obtain agreement of its content,

5.3.8.1.2 Validates the report

5.3.8.1.3 Reiterates that no retaliatory sanctions will be imposed,

5.3.8.1.4 Reviews this policy to the whistleblower as necessary, and
5.3.8.1.5 Informs the whistleblower of the possible timeframe of resolution.

5.3.8.2 Depending on the seriousness and urgency of the concern, consult any of the following as necessary:
5.3.8.2.1 Manager of department/unit involved
5.3.8.2.2 ManCom
5.3.8.2.3 Compliance and Risk Management Office (RMO)- for hospital risk concerns
5.3.8.2.4 Patient Safety Office (PSO)- for patient safety concerns
5.3.8.2.5 Safety Officer (SO)- facility safety concerns
5.3.8.2.6 Human Resource Department (HRD) or Medical Affairs Services Group (MASG)- for concerns related to hospital staff or medical staff behavior and conduct
5.3.8.2.7 Others.

5.3.8.3 Request for additional information from the whistleblower as needed.
5.3.8.4 Provide the whistleblower with update, progress or result of the investigation.

5.3.9 The Compliance Officer/RMO or PSO under Quality Management Group (QMG) shall:
5.3.9.1 Conduct discrete and confidential systematic investigation and analysis of concerns reported to them.
5.3.9.2 Determine if the problem needs escalation to higher management.
5.3.9.3 Inform the manager or recipient of the concern of the result of the investigation.

5.3.10 In the event that the report has been deemed as false, baseless and/or malicious, disciplinary action/s may be taken against the Whistleblower and/or Witness in accordance with the applicable laws, regulations and rules set by AHMC.

5.4 Roles and Responsibilities

5.4.1 Management Committee (ManCom) shall:
5.4.1.1 Implement this policy and ensure that directors and department heads cascade this with their staff.
5.4.1.2 Encourage open communication in the entire hospital and promote reporting of unsafe events.
5.4.1.3 Act on concerns raised to them in a timely manner.
5.4.1.4 Review this policy every three (3) years unless an earlier date is deemed appropriate.
5.4.1.5 Takes the necessary steps to ensure that all forms of appropriate and effective protection is afforded to a Whistleblower and/or his/her Witnesses.

5.4.2 Compliance Office
5.4.2.1 Receive Whistleblowing Report, conduct a review of the Whistleblowing Report, and unless pertaining to violations of CG Policies, endorse the Whistleblowing Report to and coordinate with the Dialogue Committee for further handling and investigation.
5.4.2.2 Facilitate and complete within the prescribed period the investigation of Whistleblowing Report involving violations of CG Policies.
5.4.2.3 Monitor and maintain records of the receipt, disposition and resolution of all Whistleblowing Report and ensure the appropriate monthly reporting thereof to the Compliance Committee and the Board.
5.4.2.4 Monitor and maintain records of the receipt, disposition and resolution of all Whistleblowing Report filed by subsidiaries and affiliates and ensure the appropriate quarterly reporting thereof to the Compliance ***Committee and the Board.***
5.4.2.5 Conduct policy audits and compliance checks to mitigate identified risks.
5.4.2.6 Collate and evaluate risks data for improvements.
5.4.2.7 Aggregate data pertaining to risks involving quality and safety which may contribute to whistleblowing.
5.4.2.8 Report feedback to concerned manager or recipient of concerns.
5.4.2.9 Escalate concerns to ManCom as necessary.
5.4.2.10 Incorporate and sustain all improvement actions resulting from reports into the quality and patient safety program of the hospital.

5.4.3 Dialogue Committee
- 5.4.3.1 Facilitate and complete within the prescribed period the investigation of Whistleblowing Report, as endorsed by the Compliance Officer.
- 5.4.3.2 Regularly inform the Compliance Office of the actions taken on his Whistleblowing Report and the basis thereof.
- 5.4.1.1 Report to the Compliance Office the final action, disposition, and/or recommendation made on the Whistleblowing Report.

5.4.2 Immediate Superior of Respondent
- 5.4.2.1 During their unit orientation, provide new staff with information on how to report concerns with affirmation that threats and retaliation will not be carried out against them.
- 5.4.2.2 Reiterate this policy to their staff.
- 5.4.2.3 Ensure that staff have access to this policy and are aware of it.
- 5.4.2.4 Comply with the specific policies and procedures outlined in this policy.
- 5.4.2.5 Ensure that issues raised are taken sincerely and acted upon in a timely manner.
- 5.4.2.6 Evaluate the basis of the claims and refer to higher management as appropriate.
- 5.4.2.7 Inform the Respondent in writing of the particular act or retaliatory acts constituting the offense or infraction imputed to him, require him to answer such charges, and afford him the opportunity to be heard and to defend himself, in accordance with applicable laws, rules, and AHMC regulations.
- 5.4.2.8 Inform the Respondent in writing of the results of the investigation and/or disposition of the Whistleblowing or Retaliation Report filed against him.
- 5.4.2.9 Implement the appropriate disciplinary action.
- 5.4.2.10 Report to the Compliance Office his decision and/or the imposition of the disciplinary action on Respondent in accordance with applicable laws, rules, and AHMC regulations.
- 5.4.2.11 Ensure that in case the Respondent resigns pending the completion of the investigation or final resolution of the case against him, he shall inform the Respondent that the resignation shall be without prejudice to the results of the investigation or the final resolution of the case, and that any benefits due him, if any, shall be withheld pending final resolution of the case.

5.4.3 Human Resources Department shall:
- 5.4.3.1 Ensure that new staff are made aware of this policy, thru inclusion of Whistleblowing Policy discussion in the Hospital Orientation Program.
- 5.4.3.2 Provide support, education and training to staff as to risk awareness in the workplace.
- 5.4.3.3 Ensure that the policy is enforced.
- 5.4.3.4 Collaborate with Department/ Unit Managers in protecting the welfare of the whistleblower.
- 5.4.3.5 Protect job security of the whistleblower and arrange request for work transfer if necessary.

5.4.4 Person raising the concern (Whistleblower or Witnesses) shall:
- 5.4.4.1 Report in good faith and make an effort not to damage the legitimate interest of others and the interest of AHMC.
- 5.4.4.2 Raise the concern the soonest in an objective and fact-of-the-matter way, using this policy as a guide.
- 5.4.4.3 Cooperate with inquiries and investigations and provide only truthful information.
- 5.4.4.4 Maintain confidentiality of written documents, patients, staff and other individuals.
- 5.4.4.5 If the Whistleblower and/or Witness believes that he/she has been retaliated upon for filing a Whistleblowing report or by participating in an investigation, he/ she may write and file a report addressed to the HR Department Head or the Compliance Officer. He/ she may submit the report by emailing it to: whistleblowing@asianhospital.com

5.5 Conclusion and reporting

5.5.1 The HR Department and/ or the Quality Management Department shall determine if the report and the case:
- 5.5.1.1 will not be pursued despite the efforts to obtain information.
- 5.5.1.2 needs further investigation- if the report warrants endorsement and/or assistance by the hospital's Legal Department and/or the group's Compliance Committee.

5.5.1.3 closed- if the case has been investigated, and the appropriate resolution and/or improvement has been made.

5.5.2 All completed reports must be filed and recorded in the Whistleblowing database. These reports are then aggregated and reported to the Management and to the Board on a Quarterly basis.

5.6 Consequences of Violations

5.6.1 Any director, officer, employee or consultant found to have violated this Policy shall, in addition to any penalties that may be provided under duly approved CG Policies, applicable laws and regulations, be liable to the extent of the damage/loss suffered by AHMC, and may be subject to penalties and sanctions as may be determined by the appropriate corporate authorities, whether or not damage/loss is actually suffered by AHMC.

Specifically, the following penalties shall be applied:

NO. OF OFFENSE	PENALTY
First Offense	Written Warning
Second Offense	Five (5) day suspension to twenty (20) day suspension depending on the gravity of the offense upon the discretion of theImmediate Superior of Respondent.
Third Offense	Dismissal

5.6.1.1 Process Flows

The prescribed procedures (see Annex A) shall cover the end-to-end handling of Whistleblowing Reports and handling of Reports on Retaliation.

Both processes shall require the management and execution of tasks and activities among identified responsible units within AHMC that would ensure swift resolution of such complaints. Please refer to the attached process flow-charts.

5.6.1.2 Time Scales

Due to the varied nature of issues which may be raised it is not possible to lay down precise timescales for either internal or external investigations. Investigation will be undertaken as quickly as possible in line with the nature and severity of the allegation / concern without affecting the quality and depth of the investigation. Initial stage investigations to be conducted by the Dialogue Committee concerned or the Investigating Officer will seek to conclude their enquiries and provide feedback to the Compliance Office within four (4) weeks.

5.6.1.3 Retention and Storage of Personal Data

Records shall be kept for all reported misconducts, malpractices, and irregularities by the relevant parties in AHMC. In the event a reported irregularity leads to an investigation, the party responsible for leading/conducting the investigation shall ensure that all relevant information relating to the case is retained, including details of corrective action taken for a period not exceeding six (6) years (or whatever other period may be specified by any relevant legislation).

All personal data collected as part of this procedure will be stored securely at all times, in accordance with the AHMC's Policy on Data Privacy.

5.6.1.4 Effectivity

This Policy shall take effect immediately. All existing policies, guidelines, regulations, systems, practices and related implementing guidelines concerning the same matters covered herein are deemed superseded by this Policy. In the event of any inconsistency between the policy contained herein and the terms of other existing policies, guidelines, systems practices and related implementing guidelines, this policy shall prevail. This policy and the Code of Ethics have supplemental application to each other.

For any questions about this Policy, you may approach your immediate superior, the Human Resources Department, or the Compliance Office.

6.0 DOCUMENTATION:

Document Code	Document Title	To be Accomplished by:	When to Accomplish
QF-QMD-063	Whistleblower Disclosure Form	Manager or the recipient of the complaint	When documenting concerns from whistleblower

7.0 REFERENCES:

7.1 Joint Commission International Accreditation Standards for Hospitals, 7th Edition, January 2021
7.2 Whistleblowing in the Philippines: Awareness, Attitudes and Structures (rvrcvstarr.aim.edu/files/download/474)
7.3 Royal Marsden NHS Foundation Trust Policy (http://www.royalmarsden.nhs.uk/SiteCollectionDocuments/foi/whistleblowing-policy.pdf)
7.4 PL-HRD-026 Policy on Handling Disciplinary Cases
7.5 PL-HRD-034 Employee Complaints and Grievance Procedure
7.6 PM-HRD-004 Code of Ethics Manual
7.7 ANNEX A: Process Flow in the Investigation of Whistleblowing/Retaliation Report
7.8 ANNEX B: Whistleblowing Disclosure Form

8.0 REVISION HISTORY:

Rev. No.	Rev. Date	Reason(s) for Change	Page(s) Affected	Initiated by:	Noted by: (Document Controller)
0	10/01/2015	• ORIGINATION	0	Michael P. Runas	Jayson M. Chavez, CDPP
1	06/04/2019	• Update of process and change in signatories	All	Michael P. Runas	Jayson M. Chavez, CDPP
2	11/15/2021	• Policy update and alignment to MPHHI policy. • Update of template and signatories	All	Arvin Mark T. Pascual, MAS, RN & Sarah Jemmah Cristobal-Aguilloso	Jayson M. Chavez, CDPP

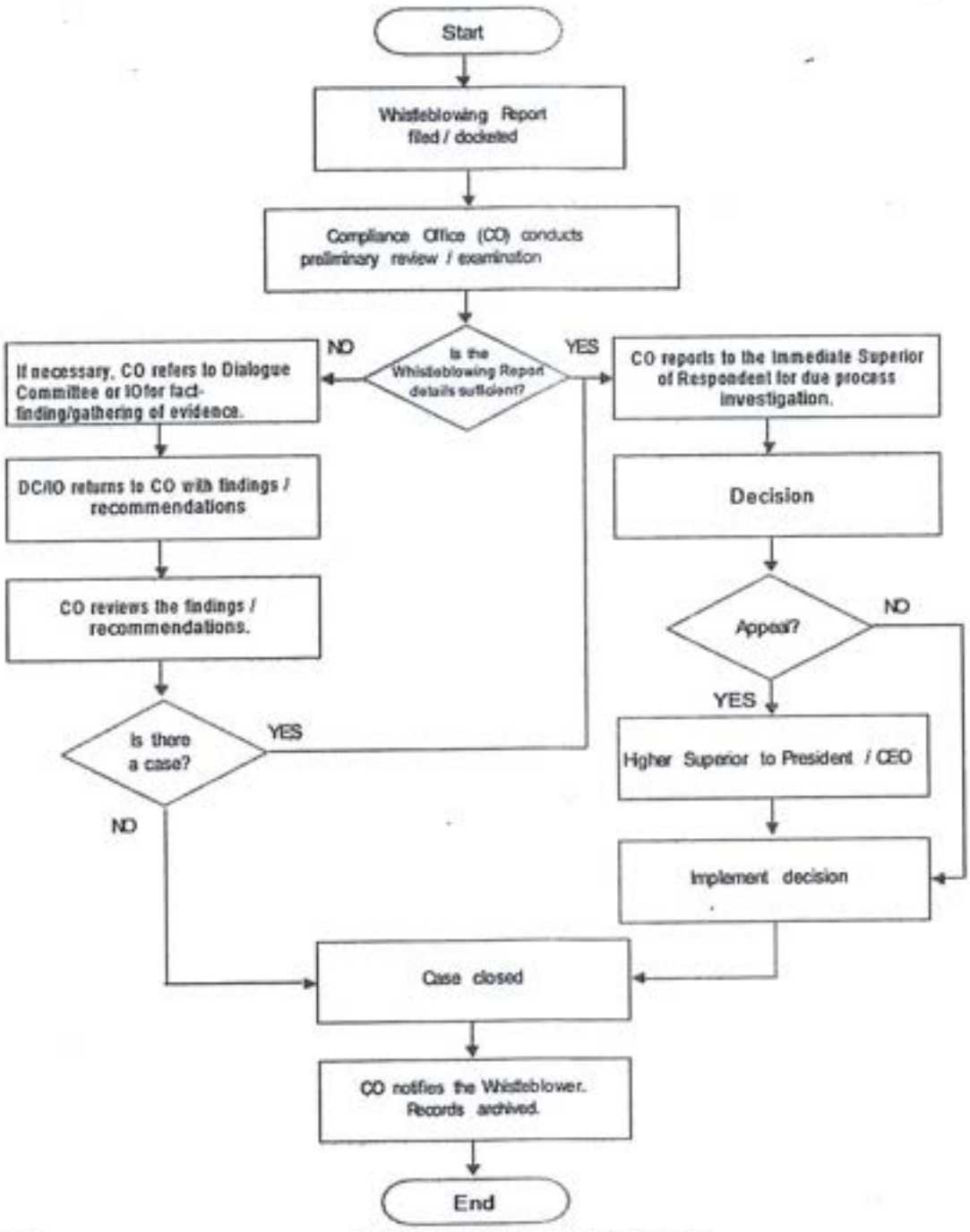
9.0 DOCUMENT REVIEW AND APPROVAL:

Prepared by: Sarah Jemmah Cristobal-Aguilloso Manager,Employee Engagement and Labor Relations	Prepared by: Arvin Mark T. Pascual, MAS, RN Senior Manager, Risk and Compliance
Reviewed by: Ana Maria Y. Jimenez, PhD, RN, CPHQ Director, Quality Management	Reviewed by: Hennesy Lou E. Miranda Director, Corporate Affairs
Reviewed by: Carolina P. Buhain, RN, MAN Director, Nursing Services	Reviewed by: Melanie J. Balane Director, Financial Operations
Reviewed by: Engr. Novy S. Sun Director, Facilities Planning & Management	Reviewed by: Corazon A Ngelangel (Dec 7, 2021 12:47 GMT+8) Corazon A. Ngelangel, MD Director, Ancillary Services and Institutes
Reviewed by: Sharon C. Hernandez Chief Strategy Officer	Reviewed by: RD Martinez RD Martinez (Dec 10, 2021 10:24 GMT+8) Robert D. Martinez Chief Finance Officer
Reviewed by: Jose M. Acuin, MD Chief Medical Officer	Approved by: Andres M. Licaros, Jr. President and CEO

PROCESS / TITLE:

ANNEX A: Process flow in the Investigation of Whistleblowing/Retaliation Report

Support Document to: PL-QMD-056 Whistle blowing policy



PROCESS / TITLE:

ANNEX B- Whistleblowing Disclosure Form

Support Document to: PL-QMD-056 Whistle blowing policy

WHISTLEBLOWER
Complaint/Disclosure Form
On violations of Corporate Governance Practices, Questionable Accounting or Auditing Matters

Note: All information provided shall be kept confidential. Please provide as much information as possible and attach additional sheet if necessary

COMPLAINANT'S INFORMATION
(Individual filing the Complaint/Disclosure)

Name:		Office Address:			
Signature:		Designation:		Employee Number	Date of Report:
Department:		Email Address:			
Phone No:					

INFORMATION CONCERNING THE COMPLAINT
(Briefly describe the misconduct/improper activity and if there is more than one allegation, number each allegation and use as many pages as needed.)

What misconduct / improper activity occurred?

When and where did the incident occur?

Supporting Evidence/s
Is there any evidence that you could provide whichwould assist us in the investigation?

___No documents attached
___With documents attached
No. of pages: _____
___Recorded / captured video or image
___Others (*Please specify*):

How did you know about the subject of the Complaint/s?

___Personal or direct knowledge
___Others have told me about it
___White paper
___Reported
___Others (*Please specify*):

Why are you making this disclosure?

If ever this goes to a formal proceeding such as a court case, will you be willing to provide evidenceand/or testify?

Note: *This document was electronically signed by Adobe Sign platform.*
Implementation of this document is fifteen (15) days after uploading.

PROCESS / TITLE:

ANNEX B- Whistleblowing Disclosure Form

Support Document to: PL-QMD-056 Whistle blowing policy

RESPONDENT'S INFORMATION Who is/are the person/s involved?			PLEASE ADVISE ON HOW WE MAY CONTACT YOU.	
Name	Designation	Department	**Complainant will:**	**HR and Compliance Office is being requested to provide feedback**
			___Email/Fax/Call again	___By phone
			___Visit the Legal and Compliance Office	___Through email
			___Others (*Please specify):*	___Others (*Please specify):*
Who is/are the possible Witness(es)?				
Name	Designation	Department		

FOR USE OF HR or COMPLIANCE OFFICE ONLY

MODE OF COMPLAINT SUBMISSION	Case No.	Receipt No.:
___Email ___Fax ___Letter ___Mail ___Mobile Phone ___Others		Investigating Officer:

What is the major issue involved? (Check as many as possible.)

Violation of Corporate Governance Rules

___Manual on Corporate Governance
___Anti-Bribery and Anti Corruption Policy
___Conflict of Interest Policy
___Whistleblowing Policy
___Others (*Please Specify):*

Fraud Classification

___Financial/Accounting
___Information Systems
___Revenue-related
___Business Operations
___Others (*Please Specify):*
___Procurement, Properties and Projects
___Subsidiaries and and Affiliates

Questionable Accounting Matter

___Misappropriation of Funds
___Circumvention / Disregard of Policies
___Acts / transaction grossly disadvantageous to the Company
___Misuse / Abuse of Company Assets
___Circumvention/violation of approving and signing authorities
___Others (*Please Specify):*

Others:

___Misconduct
___Willful Disobedience
___Sexual Harassment
___Others (*Please Specify):*
___Commission of an Offense
___Neglect of Duty
___Breach of Trust

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PROCESS / TITLE:

ANNEX B- Whistleblowing Disclosure Form

Support Document to: PL-QMD-056 Whistle blowing policy

Details of Initial Inquiry with the Complainant:		
PRELIMINARY EVALUATION		**DISCLOSURE HISTORY**
Was the complainant advised of his rights and obligations under the Whistleblowing Policy? _____Yes _____No	Meets the definition of Retaliation? ___Yes ___No	Was the disclosure previously reported to a management level? If yes, towhom was it reported? What do you think was the reason for lack of immediate action?
ACTION TAKEN ____For investigation ____For referral to AIU AUI: _____ ____No further action taken	**REMARKS:**	
DISPOSITION OF THE CASE (*Case closed?*) _____Yes _____No Date: _____ Referred to: _____ Date: _____	**REMARKS:**	
SIGNATURE OVER PRINTED NAME		
INITIAL INQUIRY	**PRELIMINARY EVALUATION / INVESTIGATION**	**DISPOSITION OF THE CASE**

Note: *This document was electronically signed by Adobe Sign platform.*
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PROCESS / TITLE:

ANNEX B- Whistleblowing Disclosure Form

Support Document to: PL-QMD-056 Whistle blowing policy

Conducted by:	Investigated by:	Reviewed by:	Approved by:
Name:_____ Designation: Date: _____	Name:_____ Designation: Date: _____	Name:_____ Designation: Date: _____	Name:_____ Designation: Date: _____

PRIVACY NOTICE: Any personal information processed by this form shall be used for the purpose of CG investigation and shall be kept confidential and shall not be disclosed outside AHI Risk and Compliance Department without the consent of the data subject. You may reach the Legal and Compliance Department directly to access, update/modify, delete your personal information if necessary. For other data privacy concerns, email: dataprivacy@asianhospital.com

SCHEDULE A: Examples of Policy Violations

- Granting a supplier undue favors.
- Collusion with a supplier to ensure award of a contract
- Unauthorized disclosure of confidential information.
- Knowingly destroying company files which are the subject of government investigation.
- Failure to disclose related party transactions.
- Solicitation of money or gifts from contractors of the Company.
- Violation of the Conflict of Interest Policy
- Violation of the ABAC Policy

SCHEDULE B: Examples of Questionable Accounting / Auditing Matters

B.1 Questionable Accounting Matters – Examples

- Intentional acts resulting in:
  - Significant overstatement or understatement of account balances.
  - Non-recording of material transactions in a complete or timely manner.
  - Gross violation of generally accepted accounting principle(s).
  - Major misclassification of accounts
  - Inaccurate or non-disclosure of significant information relevant to proper interpretationof the financial statements.
  - Accounting entries without supporting underlying transactions or proper documents

B.2 Questionable Auditing Matters – Examples

- Misappropriation of funds.
- Misuse or abuse of Company assets and facilities.
- Circumvention of or disregard of CG policies.

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- Circumvention or violation of approving and signing authorities.
- Acts of transactions grossly disadvantageous to the Company.

SCHEDULE C: Examples of Possible Instances of Retaliations

- Giving the Whistleblower or Witness a baseless low or lower rating in his performance evaluation in grave abuse of discretion and with complete disregard of the performance appraisal systems or procedures of the Company;
- Sudden involuntary reassignment to a position with demonstrably less responsibility or status asthe one held prior to the reassignment during the period of filing the Whistleblowing Report and the investigation thereof or a proximate period thereafter, except if it is pursuant to and implemented in accordance with the Company's policy on reassignments or on approved reorganization or redeployment plan;
- Unjustified or bad faith exclusion of the Whistleblower or Witness from promotion, training, or benefits that are generally available to all employees of the same level and category and performance level;
- Unjust vexation or hostile treatment by co-workers or superior, other than for causes attributable to or personal to the Whistleblower or Witness [except the filing of Whistleblowing Report or participation as Witness];
- Any discriminatory or unjustified material adverse change in the terms and conditions of employment of the Whistleblower or Witness.

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ANNEX "K"

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise. Filipino Heart.	HOSPITAL PROGRAM	DOC CODE: PG-CSR-001 Issue Date: 03/10/16 Revision Date: 00/00/00–Revision No.0 Page No. 1 of 4
VOLUNTEERS' CIRCLE		Corporate Social Responsibility (CSR)
Prepared By: Kris G. Trabes Manager, Corporate Social Responsibility	Reviewed By: Hegnesy Lou E. Miranda Director, Corporate Affairs	Approved by: Andres M. Alcaraz, Jr. President and CEO

1.0 SCOPE:

This program will recruit volunteers from the employees and doctors who are inclined to doing social and/or charity works through CSR's and Asian Hospital Charities, Inc.' (AHCI) initiatives.

The activities/programs will give the volunteers the opportunity to share their time, talent, and skills with the underprivileged/selected communities with the purpose of improving their health and wellness knowledge and practice as well as uplifting their lives.

CSR initiatives aim to gratify the emotional needs of the volunteers by finding their purpose, worth, and self-fulfillment while at the workplace. It will provide opportunities on value formation/reinforcement, growth and maturity, and stress-free experience while practicing their interests/skills during the activities.

2.0 POLICY STATEMENT:

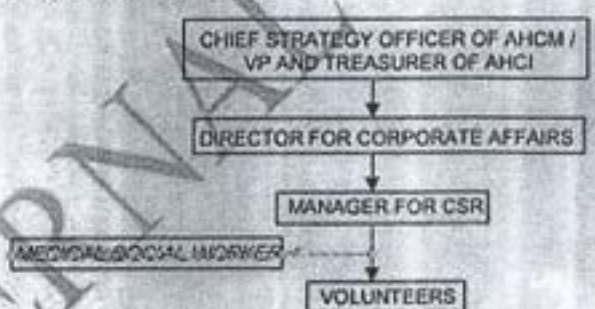
AHMC will form volunteers from the internal community to ensure that the CSR and charity initiatives will be fully implemented without any delay due to resources/manpower requirements. All doctors and employees who will apply as volunteers must understand their role, scope, tasks, expectations, as well as concept of the CSR initiatives.

3.0 DEFINITIONS:

3.1 Volunteers – anyone from the organization (either employee or doctor) who wish to share their time, talents, and selves to serve the identified communities without expecting anything in return.

3.2 CSR / Charity Initiatives – short or long term programs, events, activities that pertain to solutions that will cause impact to the beneficiaries' lives.

4.0 ORGANIZATION and RESPONSIBILITY



4.1 The CSR Manager is responsible for securing approval from the Director of Corporate Affairs/VP and Treasurer of AHCI all CSR/Charity initiatives before presenting to the Volunteers.

4.2 The CSR Manager is responsible for communicating all information and initiatives to the volunteers.

4.3 The CSR Manager will apply for club membership through HR to formalize and recognize the employees and doctors as volunteers as well as the activity/programs/events. Officers will be elected to ensure support to the CSR Manager as well as to the programs/activities:

4.3.1 Adviser

4.3.2 President

4.3.3 Vice President
4.3.4 Secretary
4.3.5 Public Relations

4.4 The CSR Manager together with the Volunteers will form working committees related to the CSR/Charity initiatives to be implemented. The CSR Manager will be the overall lead, oversee all functions, and activity/program.

4.4.1 Scientific Committee – is in charge of the health education program by outlining various topics and screenings aligned to the Department of Health's (DOH) calendar of events as well as to AHMC's flagships programs and suggesting/inviting/coordinating for speakers who will do the lecture and other medical staff who will do the screening (if available). Likewise, it is also responsible for drafting the program, selecting/inviting the guest speakers, hosts, entertainer (if needed).

4.4.2 Logistics Committee – is in charge of the venue and equipment/materials to be used during the activity. Ensures that all necessary physical arrangements/requirements including the decorations are available and in good condition. Likewise, it is also responsible for the catering/food service required during the event as well as the ingress and egress arrangements.

4.4.3 Volunteer Committee – is in charge of the volunteers by identifying their needs, disseminating relevant information for the volunteers' concurrence/suggestions/participation, profiling the volunteers based on their skills and interest, and other requirements related to the volunteers.

4.4.4 Media/PR Committee – is in charge of promoting the activity/event, inviting the Media/Press who will feature the activity/event either through TV, Radio, Print, Social Media, and other medium of promotion. It is also in charge of documenting the activity/event by taking photos to be used in reports or press releases.

4.4.5 Budget/Donations/Sponsor Committee – is in charge of managing the budget as well as looking for donors/sponsors who will support the activity/event to ensure that the monetary goal of reducing the operating costs/raising funds is attained. Likewise, it is also responsible for conceptualizing/enlisting items and coordinating with suppliers for tokens / giveaways /prizes.

4.4.6 Emergency Committee – is in charge of all disaster preparedness and management related activities such as training/workshops of volunteers, coordinating with external organization for support/donation, and debriefing activities for the victims.

4.4.7 Guest Committee – is in charge of releasing the invitations as well as securing confirmation of the guests, registering the attendees during the event, assisting the guests to the venue, as well as entertaining the guests, reserving venue and ushering the VIPs.

4.4.8 Evaluation Committee – is in charge of assessing the conceptualized/implemented programs and recommending resolutions (if needed) for further improvement. Likewise, it is responsible for ensuring that the objectives are aligned and met.

4.5 Each Committee will have a point person/head who will work closely with the CSR Manager in designing and implementing CSR/charity Initiatives.

4.6 All volunteers are expected to support the CSR/charity programs by attending to the meetings, participating during the programs/events, and contributing ideas/concepts to ensure a holistic program/activity.

4.7 The CSR Manager together with the officers and Committee Heads will develop programs for the volunteers

To ensure that their learning and development is continuously enhanced. Likewise, a reward system to constantly motivate the volunteers.

4.8 All volunteers will not receive any additional compensation. It is understood that volunteerism is a voluntary decision to engage oneself to do CSR/charity works.

PROCEDURES:

5.1 A doctor or employee who wish to become a volunteer must fill up a "Volunteer Application Form" (VAF) from the CSR Office.

5.2 The Department Manager/Head of the applicant must duly sign the VAF to ensure proper communication to the superiors.

5.3 The Department Heads/Superiors must encourage their team members to become a volunteer. Likewise, they should also allot time to participate in CSR activities.

5.4 The Medical Affairs will help reach out and encourage the doctors to become volunteers. Once a pool of volunteer doctors is available, the CSR Manager may directly communicate to this pool of volunteer doctors for the CSR activities. Medical Affairs may still be consulted especially if the requirement needs further medical assessment. However, the CSR Manager may directly invite/coordinate with the doctors to join as volunteer and implement CSR / charity initiatives aligned to the objectives of the hospital.

5.5 The applicant will be scheduled for an interview to assess his sincerity and dedication as well as his commitment and contribution to CSR programs. He / She will be requested to sign a waiver/contract about his/her engagement in volunteer works. A medical certificate will also be required to ensure that the applicant is fit to do volunteer work.

5.6 The CSR Manager will be the point person in safe keeping the records/profile of the volunteers as well as all communications related to CSR. Updates on CSR initiatives will be communicated through emails, meetings (if needed), and / or SMS.

5.7 The volunteers are responsible in informing/securing approval from his/her superior on his/her participation as volunteer in AHMC CSR initiatives. Circular letters or emails pertaining to the CSR/Charity initiatives will be provided to the volunteers if necessary.

5.7 The volunteers will be provided with FREE food, transportation, and lodging (when needed) during CSR/charity activities. Other expenses not covered as basic needs will be shouldered by the volunteer. The CSR Manager will be provided with allowance for unexpected expenses for the volunteers.

6.0 DOCUMENTATION:

Document Code	Document Title	To be Accomplished by:	When to Accomplish
QF-CSR-001	Volunteer Application Form and Waiver	Doctor/Employee	Weekdays, 8am-5pm
QF-EHS-003	Medical Certificate	Attending Physician	Before the schedule of the interview
QF-CSR-002	Volunteer Circular letter	Volunteer	At least 3 - 5 days before the CSR activity

ASIAN HOSPITAL AND MEDICAL CENTER	HOSPITAL PROGRAM	DOC CODE: PG-CSR-001
		Issue Date: 03/10/16
		Revision Date: 00/00/00–Revision No.0
		Page No. 4 of 4
VOLUNTEERS' CIRCLE		Corporate Social Responsibility (CSR)

Prepared By:	Reviewed By:	Approved by:
Kris G. Yabes Manager, Corporate Social Responsibility	Hennesy Lou E. Miranda Director, Corporate Affairs	Andres M. Licaros, Jr. President and CEO

7.0 REFERENCES:

7.1 Joint Commission International Accreditation Standards for Hospital 5th Edition April 2014

8.0 REVISION HISTORY:

Rev. No.	Rev. Date	Reason(s) for Change	Page(s) Affected	Initiated by:	Noted by: (Document Controller)
0	03/10/16	Origination	--/--	Kris G. Yabes	Jayson Chavez

9.0 DEPARTMENTAL REVIEW:

Name	Position / Designation	Signature
Carlos Vicente G. Gabriel, MD	Medical Manager - Operations	
Grace M. Aba	Chief Finance Officer	
Manuel E. Villegas, Jr., M.D.	Chief Medical Officer	
Jose M. Acuin, M.D.	Chief Quality Officer	
Sharon C. Hernandez	Chief Strategy Officer	
Corazon A. Ngelangel, M.D.	Director, Asian Cancer Institute	
Shirard Leonardo C. Adiviso, M.D.	Director, Ancillary Services	
Juan Antonio G. Javellana, M.D.	Director, Medical Informatics	
Carolina P. Buhain, RN, MAN	Director, Nursing Services	
Melanie J. Balane	Financial Services Senior Officer	
Aimee Jane T. Martinez	Director, Human Resources	
Engr. Novy S. Sun	Director, Facilities, Planning, and Management	

VOLUNTEER APPLICATION FORM AND WAIVER

Date of Application: _____ Date of Interview: _____

Name of Applicant: _____

Position: _____

Department: _____

Active Email Address: _____

Active Mobile Number: _____

Personal Information:

Age: _____ Birthday: _____ (MM/DD/YEAR) City Address: _____

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced

Religion: _____

Hobbies/Interests: _____

_____

Interview notes:

1. Have you done any volunteer work?

2. Are you a volunteer of other organization/s? State the organization/s.

3. What is your reason of volunteering?

4. Other relevant information.

I, _____, of legal age, willingly desires to engage in volunteer services for Asian Hospital and Medical Center (AHMC) and Asian Hospital Charities, Inc. (AHCI) Corporate Social Responsibility (CSR) and Charity Initiatives. I understand that as a volunteer there is no compensation expected in return for my services. I am

2205 Civic Drive, Filinvest City, Alabang, Muntinlupa City, 1780 Philippines
Tel: (632) 771-9000 • Fax: (632) 876-5710 • Website: www.asianhospital.com
Facebook/Instagram/Twitter: asianhospitalPH

VOLUNTEER APPLICATION FORM AND WAIVER

responsible of scheduling and informing my superiors of my engagement and that my priority is my job as AHMC employee/doctor. In the event that I cannot attend to my volunteer commitments due to my responsibility as employee/doctor or for other matters, it is my duty to make up for the loss opportunities and help the organizations find solution/replacement. I am fully aware that the organizations will only provide the medical coverage specified by AHMC in the contract in the event my engagement as a volunteer caused any hazardous risk. Other medical assistance needed will be for approval. I grant that any photos, videos, or audio materials with my presence may be used by the organizations for whatever purpose to help in promotion and preparation of reports.

_____

CONFORME / DATE

2205 Civic Drive, Filinvest City, Alabang, Muntinlupa City, 1780 Philippines
Tel: (632) 771-9000 • Fax: (632) 876-5710 • Website: www.asianhospital.com
Facebook/Instagram/Twitter: asianhospitalPH

VOLUNTEER CIRCULAR LETTER

TO:

CIRCULAR. NO. _____

FROM:

SUBJECT:

DATE:

CC:

2205 Civic Drive, Filinvest City, Alabang, Muntinlupa City, 1780 Philippines
Tel: (632) 771-9000 • Fax: (632) 876-5710 • Website: www.asianhospital.com
Facebook/Instagram/Twitter: asianhospitalPH

ANNEX "L"

ASIAN HOSPITAL AND MEDICAL CENTER	(COMMITTEE CHARTER)	DOC CODE: CC-QMD-011
		Issue Date: 11/23/2021
		Revision Date: 00/00/00–Revision No.0
Organizational Ethics and Compliance Committee		Page No. 1 of 4
		Quality management Group

1.0 PURPOSE OF THE COMMITTEE:

1.1 Establish a framework for the hospital's ethical management that promotes a culture of ethical practices and decision making to ensure the protection of patients and their rights.

1.2 Provide a multidisciplinary forum to guide staff in understanding the applicable compliance policies of the hospital and the group and ensure that these policies are followed. The committee also ensures that the hospital's Code of Ethics is strictly followed and that all reported compliance reports are monitored and evaluated fairly and appropriately.

1.3 Ensure that patient care is provided within business, financial, ethical, and legal norms.

1.4 Ensure nondiscrimination in employment practices and provision of patient care in the context of the cultural and regulatory norms of the country.

1.5 Review the hospital's Code of Ethics and the compliance policies annually.

1.6 Establish a mechanism by which healthcare practitioners and other staff may raise ethical concerns without fear of retribution.

1.7 Provide oversight on professional ethical issues

1.8 Provide support in identifying and addressing ethical concerns and ensure that the appropriate resources and trainings are available to the staff.

1.9 Provide an effective and timely resolution to ethical conflicts that may arise

2.0 DEFINITIONS

N/A

3.0 KEY FUNCTIONS

The Committee shall assist and advise the Management Committee of the Hospital and the Board of Directors, as appropriate, with overseeing Asian Hospital's activities in the areas of compliance with legal and regulatory requirements. The Committee shall also undertake and perform such other duties and responsibilities, as may, from time to time, be assigned to the Committee by the Management Committee and/or the Board of Directors.

4.0 SCOPE

The roles and responsibilities of the committee as defined in this charter shall apply to all AHMC employees and medical staff, including the hospital's Management Committee.

5.0 MAIN OUTPUTS / DELIVERABLES

5.1 Assist the Management Committee and the Board in ensuring and overseeing the development and implementation of the hospital's Compliance Program ("Compliance Program"), including the setting up of the appropriate structure, organization and policies, as may be necessary, to ensure Asian Hospital's strict compliance with applicable laws and regulations.

5.2 Oversee, in coordination with the Compliance Officer and the appointed Compliance Monitor, the status of the implementation of the Compliance Program, including any necessary remedial measures.

5.3 Oversee the annual review and assessment of the adequacy and effectiveness of the Compliance Program and to recommend to the Management Committee and the Board of Directors any changes, revisions or modifications including those related to new or changes in laws, rules, regulations, and government and industry standards.

5.4 Evaluate the performance of the hospital and the management with respect to the effectiveness of the Compliance Program including the implementation of actions in response to legal and regulatory developments, as well as industry and public policy issues.

5.5 Promote accountability among the Hospital's senior management with respect to compliance matters, including, by evaluating whether the hospital's senior management have: (a) clearly articulated Asian Hospital's compliance program and ethical standards, and demonstrated rigorous adherence through their words and actions; (b) empowered and positioned compliance personnel to act with adequate authority and stature; and (c) has fostered a culture of compliance within the Hospital.

5.6 Take steps, in coordination with MPHHI's Chief Compliance Officer and other relevant Board committees, including as appropriate, Audit Committee, reasonably designed to ensure that all significant allegations of misconduct, and/or recommendations for compliance improvements made, by management, employees or agents of the hospital, receive appropriate attention and remedial measures, including, as appropriate,

disciplinary measures. For this purpose, the Committee shall require the Compliance Officer to escalate any: (a) alleged or potential criminal offences (including without limitation, those alleged to have been committed relative to Anti-Corruption Laws) and violations of laws and regulations committed by a member of the hospital's senior management or directors and (b) significant alleged or potential legal or regulatory violation by the hospital or any of its employees or agents.

6.0 COMPOSITION

5.1 The Committee shall be composed of at least seven (7) members, all of whom shall be at least holds a senior managerial position. To greatest extent possible, the membership of the Committee shall comply with the following general guidelines:

a. The Chairman of the Committee shall be an active professional staff or an employee of Asian Hospital
b. The Committee membership shall not include executive directors; and
c. The members shall possess the experience, capacity, and resources to meaningfully carry out their functions.

5.2 The members of the Committee including the Chairman shall be appointed by the Board of Directors annually.

5.3 The Board of Directors may appoint one or more persons to serve as advisor(s) to the Committee, including the Company's Chief Compliance Officer. Advisors shall have the right to attend and speak at any meeting of the Committee but shall have no right to vote in respect of any action by the Committee.

5.4 The Chairman or any member or advisor of the Committee may be removed from office only by the Board of Directors.

5.5 The Compliance Officer shall provide the necessary staff support to the Committee.

7.0 MEETINGS

6.1 The Committee shall hold meetings at such times and places as it considers appropriate provided that not less than two (2) meetings shall be held each year or quarterly and when the need arises.

6.2 The Committee shall meet during the last Tuesday of the second month of the quarter, from 2pm to 4 pm or as determined by the Chairman

6.3 Meetings of the Committee shall be convened by the Chairman of the Committee as and when he/she considers appropriate or upon the request of a majority in number of the voting Members of the Committee.

6.4 A Committee meeting shall be convened by not less than one (1) week's notice in writing, specifying the place, date and time for the meeting and the general nature of the businesses to be transacted at the meeting. The Secretariat of the Committee shall ensure that pertinent materials for the meeting are properly and timely distributed to all Members.

6.5 Notwithstanding that a meeting is called by shorter notice, it shall be deemed to have been duly convened if it is so agreed by the Members of the Committee present in the meeting at which there is a quorum.

6.6 Notice of a meeting of the Committee shall be deemed to be duly given to a Member if it is given to him/her personally, in writing or orally, or sent to him/her by mail, email or facsimile transmission to his address, e-mail address or facsimile number, as appropriate, given by him/her to the Secretariat of the Committee.

6.7 A majority of all the Members of the Committee shall constitute a quorum.

6.8 Members of the Committee may participate in a meeting of the Committee through teleconference or video conference.

6.9 Resolutions at a meeting of the Committee at which there is a quorum shall be passed by a simple majority of votes of the voting Members present at such meeting. Each Member, including the Chairman of the Committee, shall have one (1) vote.

6.10 Whenever a Committee Member has a conflict of interest in a matter to be considered by the Committee which the Committee considers to be material, such interested Member shall abstain from voting on any Committee resolution in which they or any of their associates have a material interest. The Committee shall decide on the matter without taking into consideration the position of the Member who has a material conflict of interest. In case of an equality of votes, the Chairman of the Committee shall not have a second or casting vote.

8.0 REPORTING

7.1 The Committee shall appoint a Secretariat who shall issue notices and agenda for the meetings; disseminate meeting materials, if necessary; prepare minutes of meetings of the Committee and keep books and records of the Committee.

7.2 The Committee shall cause records to be kept for the following:
a. Appointments and resignations of Members of the Committee;
b. All agenda and other documents sent to the Members of the Committee; and
c. Minutes of proceedings and meetings of the Committee.

7.3 Any such books and records shall be open for inspection by any Member of the Committee upon reasonable prior notice during usual office hours of the hospital.

7.4 The minutes of the meeting of the Committee, when signed by the Chairman of the Committee, shall be conclusive evidence of the proceedings and resolutions of such meeting.

7.5 The Secretariat shall ensure that the draft and final versions of the minutes of Committee meetings shall be sent to all Committee Members for their comment and records, within one (1) month after the meeting.

7.6 The Committee shall report its activities to the Board on a regular basis and make such recommendations with respect thereto and other matters as the Committee may deem necessary or appropriate.

7.7 The Committee shall prepare and review with the Board of Directors an annual performance evaluation of the Committee, which evaluation must compare the performance of the Committee with the requirements of its Charter, set forth the goals and objectives of the Committee for the ensuing year and include any recommendation to the Board of Directors on any improvement to the Charter deemed necessary or desirable by the Committee

8.0 RESOURCES AND AUTHORITIES

8.1 The Committee shall have the resources and authorities appropriate to discharge its functions, duties and responsibilities including the authority to obtain advice from external consultants and functional specialists within the hospital.

8.2 The Committee shall report directly to the Management Committee and the Board as necessary on its decision or recommendation, unless there are legal or regulatory restrictions on its ability to do so (such as a restriction on disclosure due to regulatory requirements).

8.3 The Committee shall have the right to require Management of the hospital to furnish all information requested by the Committee as may be required for the purposes of performing its duties.

9.0 REFERENCES AND RELATED POLICIES AND PROCEDURES

9.1 Anti-Bribery and Anti-Corruption (ABAC) policy (PL-AHI-004)
9.2 Whistleblowing policy (PL-QMD-056)
9.3 Conflict of interest policy (PL-HRD-046)
9.4 Code of Ethics (PM-HRD-004)
9.5 Corporate Governance (PM-AHI-002)
9.6 Code of Organizational Ethics Manual (PM-EXO-003)
9.7 Professional Staff by-laws 2013

10.0 REVISION HISTORY

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0	11/23/2021	Document Origination	0	Arvin Mark T. Pascual, MAS, RN	Jayson M. Chavez, CDPP

11.0 DOCUMENT REVIEW AND APPROVAL

Prepared by: Arvin Mark T. Pascual, MAS, RN Senior Manager, Risk and Compliance	Reviewed by: Ana Maria Y. Jimenez, PhD, RN, CPHQ Director, Quality Management Group
Reviewed by: RD Martinez RD Martinez (Dec 6, 2021 10:36 GMT+8) Robert D. Martinez Chief Finance Officer	Reviewed by: Sharon C. Hernandez Chief Strategy Officer
Reviewed by: Jose M. Acuin, MD Chief Medical Officer	Approved by: Andres M. Licaros Jr. President and CEO

ANNEX "M"

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise, Filipino Heart	(COMMITTEE CHARTER)	DOC CODE: CC-QMD-006 Issue Date: 03/15/18
	Quality Council	Revision Date: 00/00/00–Revision No.0 Page No. 1 of 4 **Quality Management**
Prepared By: Adrian M. Lawsin, DNM, RN Manager, Quality and Innovation	**Reviewed By:** Ana Maria Y. Jimenez, PhD, RN Director, Quality Management	**Approved by:** Andres M. Licaros, Jr. President and CEO

1.0 PURPOSE OF THE COMMITTEE:

To oversee the delivery of the highest standard quality of care at Asian Hospital and Medical Center (AHMC) by ensuring that quality improvement is an integral component of the hospital's governance and management processes.

2.0 DEFINITIONS

Not Applicable

3.0 KEY FUNCTIONS

3.1 Review and recommend hospital-wide measures and department-specific quality indicators to ManCom for approval

3.2 Prioritizes performance improvement efforts utilizing the strategic goals, institutional performance data and trends, and approved benchmark data

3.3 Analyze and aggregate institutional performance data from the respective departments, and monitor performance improvement efforts for effectiveness on a quarterly basis

3.4 Review and monitor the quality processes and indicators related to the quality program

3.5 Monitor and report to ManCom on quality issues and on the overall quality of services provided at AHMC, making use of appropriate data such as hospital-wide measures and department-specific quality indicators, data related to accreditation survey findings report, Integrated Rounds Report (combined Leadership Safety WalkRounds, Patient and System Tracers report), including recommendations related to systemic or recurring quality of care issues on a quarterly basis

3.6 Recommend the long-term objectives and annual quality goals for quality at AHMC

3.7 Provide oversight for the preparation, evaluation and revision of the annual Quality Improvement Plan (QIP) for recommendation to ManCom

3.8 Consider and make recommendations regarding quality improvement initiatives and policies

3.9 Coordinate the acquisition of performance improvement information and interface with appropriate committees and departments/units to improve organizational performance

3.10 Recognizes and celebrates successful performance improvement efforts

4.0 MAIN OUTPUTS / DELIVERABLES

4.1 Policy writing/review

4.1.1 Reviews and recommends institutional policies and procedures related to quality and performance improvement initiatives

4.2 Education and training

4.2.1 Oversees the development and implementation of basic quality education and training curriculum, physician on-boarding training, employee orientation and competency testing

4.2.2 Collaborates with clinical and administrative heads to identify areas of educational need to enhance quality of care

4.2.3 To develop and oversee the dissemination and implementation of policies, programs and activities for ensuring the delivery of the highest standard quality of care to our patients

4.3 Culture building

4.3.1 Provides Institutional direction and oversight for education related to performance improvement methods and efforts

4.3.2 Oversees the quality improvement projects presented during the Annual Quality Celebration

4.4 Risk management

4.4.1 Reviews quality data, identifies trends and establishes benchmarks for comparison

4.4.2 Identifies and analyzes risks points in every measure and process presented

5.0 KEY ACTIVITIES

5.1 Annual quality strategic planning session
5.2 Leadership training
5.3 Monthly meeting
5.4 COOLER talks
5.5 Annual Quality celebration

6.0 COMPOSITION

6.1 Council membership qualifications to be eligible for nominations, candidates for council membership:
- 6.1.1 An active AHMC staff/medical staff for three years
- 6.1.2 Must be committed to AHMC's mission and goals
- 6.1.3 Able to communicate in written and verbal
- 6.1.4 With pleasant personality and people skills
- 6.1.5 Must be willing to dedicate time to participate actively on the council.
- 6.1.6 Must have interest and expertise in the areas that advance the council's mandate.
- 6.1.7 Must be committed to participate in the council orientation program and the quality improvement training and education of members
- 6.1.8 No records of disruptive/ethical behavior
- 6.1.9 Preferably with previous experience in quality improvement
- 6.1.10 Preferably with previous appointment as chair/member of a department/committee
- 6.1.11 Preferably with leadership background

6.2 Key positions in the committee
- 6.2.1 Physician - Chairman
- 6.2.2 Manager, Quality and Innovation – Co-Chairman
- 6.2.3 Senior Manager, Ancillary Services
- 6.2.4 Manager, Nursing Quality and Compliance
- 6.2.5 Manager, Magnet Nursing
- 6.2.6 Manager for Operations, Medical Affairs
- 6.2.7 Manager, Asian Cancer Institute
- 6.2.8 Manager, Asian Cardiovascular Institute
- 6.2.9 Manager, Asian Brain Institute
- 6.2.10 Intensivist, Intensive Care Unit
- 6.2.11 Physician, Emergency Department
- 6.2.12 Anesthesiologist

6.3 Executive sponsors:
- 6.3.1 Chief Strategy Officer
- 6.3.2 Chief Medical Officer
- 6.3.3 Director, Nursing Services
- 6.3.4 Director, Ancillary Services
- 6.3.5 Director, Finance Operations

Prepared By:	Reviewed By:	Approved by:
Adrian M. Lawsin, DNM, RN Manager, Quality and Innovation	Ana Maria Y. Jimenez, PhD, RN Director, Quality Management	Andres M. Licaros, Jr. President and CEO

6.4 Ad hoc members:
- 6.4.1 Senior Manager, Patient Safety
- 6.4.2 Manager, Risk and Management
- 6.4.3 Manager, Infection Prevention and Control

7.0 MEETINGS

7.1 Schedule of regular meetings

7.1.1 The Quality Council shall meet monthly or as otherwise deemed necessary, but not less than quarterly

8.0 REPORTING

8.1 The committee shall report to the Management Committee and the Medical Executive Committee, all its activities, discussions, recommendations, and decisions.
8.2 The committee shall provide an annual year-end report
8.3 The committee shall use standard note taking, minutes of the meeting, and reporting templates.
8.4 Final and approved committee notes, reports, and minutes of the meeting are submitted to the Quality Management office for filing.

9.0 DOCUMENTATION:

Document Code	Document Title	To be Accomplished by:	When to Accomplish
Not Applicable			

10.0 REFERENCES AND RELATED POLICIES AND PROCEDURES

10.1 Joint Commission International Accreditation, 6th edition, 2017

11.0 REVISION HISTORY

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0	03/15/18	Origination	--/--	Adrian M. Lawsin, DNM, RN	

12.0 DEPARTMENTAL REVIEW

Name	Position / Designation	Signature
Jose M. Acuin, MD	Chief Medical Officer	
Sharon C. Hernandez	Chief Strategy Officer	
Carolina P. Buhain, MAN, RN	Director, Nursing Services	

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise. Filipino Heart.	(COMMITTEE CHARTER)	DOC CODE: CC-QMD-006
		Issue Date: 03/15/18
		Revision Date: 00/00/00–Revision No.0
	Quality Council	Page No. 4 of 4
		Quality Management

Prepared By:	Reviewed By:	Approved by:
Adrian M. Lawsin, DNM, RN Manager, Quality and Innovation	Ana Maria Y. Jimenez, PhD, RN Director, Quality Management	Andres M. Licaros, Jr. President and CEO

Shirard Leonardo C. Adiviso, MD	Director, Ancillary Services	
Melanie J. Balane	Director, Finance Operations	

ANNEX "N"

ASIAN HOSPITAL AND MEDICAL CENTER Global Expertise. Filipino Heart.	(COMMITTEE CHARTER)	DOC CODE: CC-QMD-001 Issue Date: 05/10/18
Risk Management Committee		Revision Date: 00/00/00–Revision No.0 Page No. 1 of 3 **Quality Management**
Prepared By: Arvin Mark T. Pascual, MAS, RN Manager, Risk Management	**Reviewed By:** Ana Maria Y. Jimenez, PhDN, RN Director, Quality Management	**Approved by:** Andres M. Licaros, Jr. President and CEO

1.0 PURPOSE OF THE COMMITTEE:

The Risk Management Committee shall provide oversight and support in establishing and implementing organization-wide processes of assessing, reducing, eliminating and managing all forms of risks and hazards.

2.0 DEFINITIONS

Hazard- something with the potential to cause harm

Risk- probability or threat of damage, injury, liability, loss or any other negative occurrence to the organization that is caused by external or internal vulnerabilities and that may be avoided through pre-emptive action.

Risk Management- an approach to improving the quality and safety of healthcare by identifying what places patients at risk of harm and taking action to prevent or control the risks.

Risk assessment- the processes used to determine risk management priorities by evaluating and comparing the level of risk against organizational standards, pre-determined target risk levels or other criteria.

3.0 KEY FUNCTIONS

3.1 To develop and oversee the dissemination and implementation of Risk Management policies, programs and activities to minimize risks and ensure the safety of our patients.

3.2 To lead, train and coach managers and staff in Risk Assessment activities.

3.3 To oversee the development, coordination and evaluation of policies and procedures for responding to adverse events, near misses and conditions that may threaten the safety of AHMC's patients, clients and employees

4.0 MAIN OUTPUTS / DELIVERABLES

4.1 Policy writing /review

4.1.1 Policy infrastructure for all risk management activities ensuring a culture of safety.

4.2. Education and training

4.2.1 Oversees the development and implementation of basic risk management education and training curriculum, employee orientation and competency testing

4.2.2 Collaborates with clinical and administrative heads in identifying areas of educational need to promote risk management.

4.2.3 Develops and oversees the dissemination and implementation of policies, programs and activities to ensure the safety of our patients

4.3 Culture building

4.3.1 Performance measurement/management of selected risk management indicators and initiatives related to the results of Leadership Safety Rounds, incident reports and near misses, root cause analyses, hospital safety drills and compliance reports, strategic improvement plans for all partially met standards and evaluation of the effectiveness of hospital programs and committees.

4.3.2 Promotes a culture where errors and near-misses are openly discussed and used as learning opportunities

4.3.3 Safety leadership rounds and tracers

4.4 Risk management

4.4.1 Reviews different hospital data, identifies trends and establishes benchmarks for comparison

4.4.2 Conducts leadership rounds and safety drills to gather information and educate AHMC's employees and medical staff on routine basis

4.4.3 Immediate and follow-up responses to adverse events, including disclosure, analyses and investigation of adverse events.

4.4.4 Established risk frameworks on hospital processes and protocols

5.0 KEY ACTIVITIES

5.1 Risk Assessment Activities
5.2 Safety Leadership Rounds
5.3 Root cause analysis
5.4 Systems Tracer
5.5 Patient Tracer
5.6 Environment of Care Rounds
5.7 Patient safety briefing
5.8 Hospital wide drills
5.9 Health Technology Assessment

6.0 COMPOSITION

6.1 Committee membership qualifications

To be eligible for nominations, candidates for committee membership are as follows:

6.1.1 An active AHMC consultant /Manager for three years
6.1.2 Must be committed to AHMC's mission and goals.
6.1.3 Able to communicate in written and verbal
6.1.4 With pleasant personality and people skills
6.1.5 Must be willing to dedicate time to participate actively on the committee.
6.1.6 Must have interest and expertise in the areas that advance the committee's mandate.
6.1.7 Must be committed to participate in a committee orientation program and Risk Management training and education of members.
6.1.8 No records of disruptive/ethical behavior
6.1.9 Preferably with previous experience in Risk Management and/or Patient Safety
6.1.10 Preferably with previous appointment as chair/member of a department/committee
6.1.11 Preferably with leadership background

6.2 Key positions in the committee

- Chairman- Risk Management
- Manager – Risk Management
- Nurse Manager
- Ancillary Manager
- Finance Manager
- Supply Chain Manager
- Biomedical Manager
- Human Resources Manager
- Medical Informatics Manager
- Safety Manager/ Officer
- Data Privacy and Regulatory Compliance Assistant Manager
- Infection Prevention and Control Manager
- Medical Manager for Operations
- Asian Cancer Institute Manager/Supervisor
- Facilities Planning & Management Manager

7.0 MEETINGS

7.1 Schedule of regular meetings

7.1.1 The committee meets every last week of the quarter

7.2 Special meetings

7.2.1 Special meetings of the committee may be called for by the Director of Quality, the Chairperson of the committee, the Manager for Risk Management and/or the Patient Safety Committee, for urgent matters that may arise.

8.0 REPORTING

8.1 The committee shall report to the Director of Quality, all its activities, discussions, recommendations, and decisions.

8.2 The committee shall use standard note taking, minutes of the meeting, and reporting templates.

8.3 Final and approved committee notes, reports, and minutes of the meeting are submitted to the office of the Quality office for filing.

9.0 REFERENCES AND RELATED POLICIES AND PROCEDURES

9.1 Joint Commission International Accreditation, 6th edition, 2017

10.0 REVISION HISTORY

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0	05/10/18	Origination	--/--	Arvin Mark T. Pascual, MAS, RN	Jayson Chavez

11.0 DEPARTMENTAL REVIEW

Name	Position / Designation	Signature
Jose M. Acuin, MD	Chief Medical Officer	
Carolina P. Buhain, RN, MAN	Director, Nursing Services	
Shirard Leonardo C. Adviso, MD	Director, Ancillary Services	
Edwin L. Dimatatac, M.D.	Chair, Risk Management Committee	

ANNEX "O"

ASIAN HOSPITAL AND MEDICAL CENTER	(COMMITTEE CHARTER)	DOC CODE: CC-QMD-003
		Issue Date: 09/04/17
Patient Safety Committee		Revision Date: 00/00/00–Revision No.0
		Page No. 1 of 3
		Department
Prepared By: Noel P. Ligaya, UNM, RN Senior Manager, Patient Safety	Reviewed By: Ana Maria Y. Jimenez, PhD, RN Director, Quality Management	Approved by: Andres M. Licaros, Jr. President & CEO

1.0 PURPOSE OF THE COMMITTEE:

The Patient Safety Committee shall provide oversight and support by serving as a forum for medical staff, management and staff to discuss patient safety issues and initiatives. The committee will ensure that the hospital fulfills its obligation to achieve high standards in everything that it does for patients, staff, and stakeholders.

2.0 DEFINITIONS

N/A

3.0 KEY FUNCTIONS

3.1 To develop and oversee the dissemination and implementation of policies, programs and activities for ensuring the safety of our patients

3.2 To lead, train and coach managers and staff in establishing a safety culture and all attendant safety programs

3.3 To oversee the development, coordination and evaluation of policies and procedures for responding to adverse events, near misses and conditions that threaten patient safety

4.0 MAIN OUTPUTS / DELIVERABLES

4.1 Policy writing /review

- 4.1.1 Policy infrastructure for all patient safety activities ensuring a culture of safety and just culture

4.2 Education and training

- 4.2.1 Oversees the development and implementation of basic patient safety education and training curriculum, physician on-boarding training, employee orientation and competency testing
- 4.2.2 Collaborates with clinical and administrative heads to identify areas of educational need to enhance patient safety
- 4.2.3 To develop and oversee the dissemination and implementation of policies, programs and activities for ensuring the safety of our patients

4.3 Culture building

- 4.3.1 Performance measurement/management of selected patient safety indicators and initiatives related to the results of Leadership Safety Rounds, incident reports and near misses, root cause analyses, International Patient Safety Goals monitoring and compliance reports, strategic improvement plans for all partially met patient safety standards and evaluation of the effectiveness of patient safety programs.
- 4.3.2 Promotes a culture where errors and near-misses are openly discussed and used as learning opportunities
- 4.3.3 Safety leadership rounds and tracers

4.4 Risk management

- 4.4.1 Reviews patient safety data, identifies trends and establishes benchmarks for comparison
- 4.4.2 Conducts patient safety rounds and drills to gather information and educate on routine basis
- 4.4.3 Immediate and follow-up responses to adverse events, including disclosure, analyses and investigation of adverse events, including peer reviews and root cause analyses, M & Ms,

5.0 KEY ACTIVITIES

5.1 Safety leadership rounds and tracers
5.2 Patient safety briefing
5.3 Root cause analysis
5.4 Medication tracer
5.5 Patient tracer
5.6 Patient safety

6.0 COMPOSITION

6.1 Committee membership qualifications

To be eligible for nominations, candidates for committee membership:

- 6.1.1 An active AHMC consultant /Manager for three years
- 6.1.2 Must be committed to AHMC's mission and goals.
- 6.1.3 Able to communicate in written and verbal
- 6.1.4 With pleasant personality and people skills
- 6.1.5 Must be willing to dedicate time to participate actively on the committee(s).
- 6.1.6 Must have interest and expertise in the areas that advance the committee's mandate.
- 6.1.7 Must be committed to participate in a committee orientation program and the patient safety training and education of members.
- 6.1.8 No records of disruptive/ethical behavior
- 6.1.9 Preferably with previous experience in patient safety
- 6.1.10 Preferably with previous appointment as chair/member of a department/committee
- 6.1.11 Preferably with leadership background

6.2 Key positions in the committee

- 6.2.1 Chair - Patient Safety
- 6.2.2 Senior Manager - Patient Safety
- 6.2.3 Nurse Manager - Quality and Compliance
- 6.2.4 Ancillary Manager-Quality
- 6.2.5 Facility Safety Manager
- 6.2.6 Chair - Medication Safety Committee
- 6.2.7 Chair - Fall Committee
- 6.2.8 Chair - Sedation Committee
- 6.2.9 Chair - Infection Control Committee
- 6.2.10 Chair-OR Committee
- 6.2.11 Chair –Critical Care Committee

6.3 Ad hoc members:

- 6.3.1 Chair- Code Committee
- 6.3.2 Associate Director/Manager - Ancillary services
- 6.3.3 Chair-Radiation Safety Committee
- 6.3.4 Chair – Emergency Committee
- 6.3.5 Quality Champion - Surgery department
- 6.3.6 Quality Champion - Medicine department
- 6.3.7 Quality Champion - Pediatric department
- 6.3.8 Quality Champion - OB department
- 6.3.9 Representative from ACI
- 6.3.10 Representative from MOB

7.0 MEETINGS

7.1 Schedule of regular meetings

- 7.1.1 The committee meets monthly

7.2 Special meetings

- 7.2.1 Special meetings of the committee may be called for by the Director of Quality Management, and/or the Chief Medical Officer, the Chairperson of the committee, and/or the Medical Executive Committee, for urgent matters concerning

Prepared By:	Reviewed By:	Approved by:
Noel P. Ligaya, DNM, RN Senior Manager, Patient Safety	Ana Maria Y. Jimenez, PhD, RN Director, Quality Management	Andres M. Licaros, Jr. President & CEO

8.0 REPORTING

8.1 The committee shall report to the Director of Quality Management, all its activities, discussions, recommendations, and decisions.

8.2 The committee shall provide the Director of Quality Management and the Management Committee, an annual summary report of the patient safety data.

8.3 The committee shall use standard note taking, minutes of the meeting, and reporting templates.

8.4 Final and approved committee notes, reports, and minutes of the meeting are submitted to the office of the Quality office for filing.

9.0 REFERENCES AND RELATED POLICIES AND PROCEDURES

9.1 Joint Commission International Accreditation, 6th Edition July 2017

10.0 REVISION HISTORY

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00	N/A	Origination	--//--	Noel P. Ligaya	R. Gatdula

11.0 DEPARTMENTAL REVIEW

Name	Position / Designation	Signature
Jose M. Aculin, MD	Chief Medical Officer	
Carolina P. Buhain, RN, MAN	Director, Nursing Services	
Shirard Leonardo C. Adiviso, MD	Director, Ancillary Services	
Engr Novy S. Sun	Director, Facilities, Planning and Management	
Maria Dolma Gudez-Santos, MD, MHA	Chair, Patient Safety Committee	