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Financial Risk Mitigation Strategies to Improve the Effectiveness and Efficiency of Budget Management (A Case Study of Talise Community Health Center, Palu City)

Tiara Priska Andani[1], Ni Made Suwitri Parwati[2], Sugianto Sugianto[3], Muhammad Bashri Bas[4]
[1]Universitas Tadulako, Palu, Indonesia, tiarafriskaandani@gmail.com
[2]Universitas Tadulako, Palu, Indonesia, nimade.sparwati@gmail.com
[3]Universitas Tadulako, Palu, Indonesia, sugianto@untad.ac.id
[4]Universitas Tadulako, Palu, Indonesia, basri.bazz@untad.ac.id

Corresponding Author: tiarafriskaandani@gmail.com[1]

Abstract: Financial risk management is important for maintaining accountable budget management in public health facilities, particularly during changes in financial management and service infrastructure. However, limited research has linked financial risk mitigation strategies to measured budget effectiveness and efficiency during the transition to regional public service agency financial management and facility relocation. This study aims to analyze financial risk mitigation strategies and their relationship with budget effectiveness and efficiency at Talise Community Health Center, Palu City. A case study approach was employed using interviews with four key informants and financial documents. Qualitative descriptive analysis was combined with quantitative analysis of revenue effectiveness and expenditure efficiency ratios. The findings indicate risks related to revenue uncertainty, budget planning, expenditure control, and accountability documentation. Mitigation measures include realistic budget planning, periodic monitoring, transaction verification, reconciliation, and internal and external supervision. Revenue effectiveness reached 102.87% in 2025 and 111.32% against the prorated target for January–September 2026. The expenditure-to-revenue ratio was 90.57% in 2025, classified as efficient, and 111.99% in January–September 2026, classified as less efficient under the study criteria. The novelty lies in integrating risk mitigation analysis with financial ratios in the context of regional public service agency transition and facility relocation.

Keywords: Financial Risk Mitigation, Budget Management, Effectiveness, Efficiency, Community Health Center

INTRODUCTION

Budget management in the healthcare sector plays an important role in supporting effective, efficient, and accountable public services. Community health centers are expected to use financial resources according to service needs, achieve established targets, and account for

their budget use. These requirements become particularly important when a community health center adopts the Regional Public Service Agency (BLUD) financial management model, which provides flexibility while still requiring adequate controls. Herawati et al. (2022) examined community health centers' readiness to adopt BLUD status, while Sulistyowati and Sunaningsih (2023) discussed their financial management after obtaining BLUD status. These studies provide a basis for understanding the importance of readiness and financial management in implementing the BLUD model.

One way to keep budget management on track is through financial risk mitigation. Risks may arise during planning, revenue collection, expenditure execution, and financial accountability. Risks therefore need to be identified and addressed in accordance with the organization's circumstances. SNI ISO 31000:2018 can serve as a reference for systematic risk management. Liwang et al. (2024) discussed the application of this standard in the Kaimana Regency Government, while Bracci et al. (2021) reviewed risk management in the public sector. This study focuses on four risk categories: revenue risk, planning and budgeting risk, fraud risk, and expenditure and procurement risk. These categories serve as an analytical framework for identifying risks relevant to the field findings; they do not imply that all such risks have occurred.

Risk mitigation should be examined alongside budget management outcomes through measures of efficiency and effectiveness. Revenue effectiveness can be measured by comparing realized BLUD revenue with the revenue target, while efficiency can be assessed by comparing expenditure incurred to generate revenue with the revenue realized. Prasetyo et al. (2022) used a value-for-money approach to assess the financial performance of the Penumping Community Health Center BLUD, while Retnosari et al. (2022) examined budget efficiency and effectiveness at Dr. Kariadi Central General Hospital. Building on these studies, the present research combines interviews with financial data analysis so that the assessment is based not only on informants' accounts but also on relevant financial indicators.

This context is particularly relevant to Talise Community Health Center (UPTD Puskesmas Talise) in Palu City, which began adopting the BLUD financial management model in 2025 while also relocating its service facility. The BLUD transition and facility relocation are important budget-management considerations because they involve adjustments to financial governance, infrastructure needs, and service funding priorities. Previous studies have examined BLUD financial management at Konda Community Health Center (Husin et al., 2024) and the implementation of BLUD financial management at community health centers in Karanganyar Regency (Sutaryo et al., 2024). However, studies integrating financial risk mitigation strategies with measures of budget effectiveness and efficiency during a BLUD transition that coincides with facility relocation remain limited. Accordingly, this study's novelty lies in combining the analysis of financial risks and mitigation strategies with financial ratios based on realized revenue and expenditure, taking into account the BLUD transition beginning in 2025 and the relocation of Talise Community Health Center. The novelty concerns the focus and analytical context, rather than a claim that the mitigation strategies themselves are entirely new.

Based on this discussion, the research question is: How are financial risk mitigation strategies implemented to improve the efficiency and effectiveness of budget management at Talise Community Health Center, Palu City? This study aims to analyze the implementation of financial risk mitigation strategies and their relationship with budget efficiency and effectiveness through interviews and financial data analysis. The findings are expected to provide insight into financial risk control during the BLUD transition and facility relocation, and to inform evaluations aimed at supporting more efficient, effective, and accountable budget management.

METHOD

This study employed a mixed-method case study approach at Talise Community Health Center, Palu City. The approach combined qualitative analysis of interview data with quantitative descriptive analysis of financial data. The study was conducted from September to October 2026. Informants were selected through purposive sampling based on their knowledge of and direct involvement in budget management: the Head of Talise Community Health Center, the Head of the Administrative Subdivision, the Treasurer/Financial Manager, and the Person in Charge of Programs/Activities.

The study used primary data obtained through in-depth interviews and secondary data consisting of planning and budgeting documents, budget realization reports, financial accountability documents, and other relevant records. Qualitative descriptive analysis was used to identify financial risks and mitigation strategies, while quantitative descriptive analysis was used to assess budget effectiveness and the expenditure-to-revenue ratio. Revenue effectiveness was calculated as realized BLUD revenue divided by the corresponding revenue target in the RBA, multiplied by 100%. The effectiveness categories followed the criteria commonly attributed to Minister of Home Affairs Decree No. 690.900-327 of 1996: above 100% = highly effective; 90% to 100% = effective; 80% to below 90% = moderately effective; 60% to below 80% = less effective; and below 60% = ineffective. For 2026, the same realized revenue for January–September was compared separately with (1) the full-year annual target and (2) the prorated target for nine months, calculated as nine-twelfths of the annual target. The prorated comparison assumes an even distribution of the annual target across the twelve months, consistent with the monthly monitoring approach described by the Head of the Community Health Center. The annual-target comparison indicates progress against the full-year target, whereas the prorated comparison assesses performance against the elapsed nine-month period. SiLPA was excluded from the revenue target because it is a financing receipt from a prior period, not current-period revenue. The expenditure-to-revenue ratio was calculated as total BLUD expenditure divided by realized BLUD revenue, multiplied by 100%. In this study, a ratio of 100% or less was operationally classified as efficient because expenditure did not exceed current-period revenue; a ratio above 100% was classified as less efficient because expenditure exceeded current-period revenue. This binary threshold is an operational criterion adopted for the study, not a claim that it is a universally applicable or official graded efficiency standard. The ratio is interpreted as a measure of expenditure relative to revenue and is considered alongside the use of SiLPA, budget absorption, service needs, and the timing of relocation-related expenditure. Data trustworthiness was assessed through source and method triangulation by comparing information from informants with interview findings and documentary evidence.

RESULTS AND DISCUSSION

Results

Interviews with the Head of Talise Community Health Center (RM), the Head of the Administrative Subdivision (A), the Treasurer (N), and the Program Officer (T) indicated that budget management faces risks including revenue falling short of targets, delayed non-capitation claim payments, changing needs and budget priorities, and expenditure and accountability risks such as recording errors and incomplete transaction evidence. These risks are addressed through needs-based budgeting and prioritization, monitoring realized revenue and expenditure, transaction checks and reconciliation, and internal and external oversight. The Head of the Community Health Center (RM) identified the risk of revenue falling below projections, limited expenditure ceilings when revenue exceeds projections, spending needs for contracted doctors, and higher electricity costs associated with air conditioning. The Administrative Subdivision Head (A) identified budget constraints, unforeseen needs such as damaged medical equipment, and incomplete transaction documentation. The Treasurer (N)

identified BPJS payment delays that disrupt cash flow, operating costs exceeding the budget, and recording errors. The Treasurer also identified four potential forms of fraud requiring preventive controls: failure to deposit all receipts, fictitious expenditures, price mark-ups, and procurement unrelated to actual needs. These are treated as potential risks, not as evidence that fraud has occurred at Talise Community Health Center. The Program Officer (T), meanwhile, stated that the program budget under their responsibility follows the activity implementation plan (RPK).

The mitigation strategies include preparing the BLUD Business Plan and Budget (RBA) based on needs and historical data, setting priorities, monitoring monthly realizations, recalculating needs, and postponing or reallocating activities that are not urgent. The Treasurer rechecks transaction amounts and conducts periodic reconciliations, while the Administrative Subdivision Head emphasizes complete transaction evidence and submission of accountability reports no later than the fifth day of each month. At the program level, accountability reports (SPJ) are reviewed by the Treasurer and signed by both the Treasurer and the Head of the Community Health Center; one challenge is obtaining signatures from village officials. Oversight is also provided by internal units, the Health Office, the BLUD assistance team, the Audit Board of the Republic of Indonesia (BPK), and the Inspectorate. The Head of the Community Health Center stated that by September, revenue had exceeded the prorated target of 75% by approximately IDR 243 million.

In addition to budget-management risks, relocation to a new building, which began operating on 1 June 2026, also affected expenditure priorities, particularly those related to service facilities and infrastructure. The Head of the Community Health Center stated that the new building was not yet furnished and that its more distant location could affect revenue and participant enrollment. The Administrative Subdivision Head explained that funds for non-urgent activities were redirected to relocation needs, while the Treasurer stated that revenue surpluses accumulated over the previous two years were used to purchase waiting-room chairs, desks, sound equipment, cabinets, and computers. In contrast, the Program Officer stated that relocation did not change the surveillance budget because the service area remained the same. BLUD status, coordination between management and the finance unit, monthly monitoring, and prioritization supported budget management, whereas budget constraints and unplanned needs hindered it.

Identification of Financial Risks and Risk Mitigation Strategies

Based on the informants' accounts, financial risks were grouped into four categories that formed the analytical framework, with facility relocation treated as an additional contextual factor (Table 1).

Table 1. Risks, Causes, Impacts and Mitigation Strategies Identified through Interviews

Risk category	Identified risk	Causes and impacts	Mitigation strategy
Revenue	Actual revenue below the RBA target; delayed BPJS claim payments; possible revenue decline due to the greater distance of the new building	Unrealistic targets; disrupted cash flow; delays to operations and service programs	Set targets using historical data and realistic potential; review actual results monthly; bill all revenue sources in accordance with local regulations
Planning and budgeting	Budget does not match needs; limited expenditure ceiling despite revenue exceeding target; unexpected needs (equipment breakdowns or a doctor's unavailability requiring a new contract doctor)	Budget prepared in advance with limited funds; some activities postponed; contracted-doctor funding and medical-service payments share one ceiling	Prepare a rational RBA based on usage data and previous-year evaluation; conduct rapid reviews; set priorities; recalculate needs; reallocate the budget

Fraud (potential risk)	Failure to deposit all receipts, fictitious expenditures, price mark-ups, and procurement that does not match actual needs	Potential revenue loss, unauthorized payments, waste, and inaccurate accountability records; no evidence that these practices occurred	Match receipts with cash/bank records; verify accountability reports and transaction evidence; assess price reasonableness and procurement relevance; conduct reconciliation and internal and external oversight
Expenditure and procurement	Capital expenditure ceiling rapidly depleted; rising operating costs (electricity, air conditioning, maintenance, medical supplies); incomplete receipts; erroneous or duplicate entries	Relocation and service needs increase; expenditure cannot proceed once the ceiling is exhausted unless funds are reallocated; cash balances and reports may be inaccurate	Apply controls from planning through realization review; ensure expenditure aligns with needs and the RBA; recheck amounts against supporting evidence; conduct internal reviews and external oversight

Source: Interviews with the Head of the Community Health Center, the Administrative Subdivision Head, the Treasurer, and the Surveillance Program Officer (processed by the authors)

Budget Management Effectiveness

Effectiveness was calculated by comparing realized BLUD revenue with the revenue target in the RBA. The ratio was calculated as realized revenue divided by the relevant revenue target, multiplied by 100%. The effectiveness categories were adopted from the criteria commonly attributed to Minister of Home Affairs Decree No. 690.900-327 of 1996: above 100% = highly effective; 90–100% = effective; 80–90% = moderately effective; 60–80% = less effective; and below 60% = ineffective. The budget surplus from previous periods (SiLPA) was excluded from the target because it is a financing receipt rather than revenue realized in the current year. For 2026, the same January–September realized revenue was assessed against both the full-year annual target and the prorated nine-month target. The prorated target equals 9/12 of the annual target and assumes an even monthly distribution. These are two distinct reference points: the annual comparison shows progress toward the full-year target, while the prorated comparison evaluates achievement relative to the nine months elapsed. The two percentages are therefore not interchangeable.

Table 2. Revenue Effectiveness of Talise Community Health Center BLUD

Period	RBA target excluding SiLPA (IDR)	Realized revenue (IDR)	Effectiveness	Category
2025	2,618,884,277	2,694,008,611	102.87%	Highly effective
2026 (through September), against annual target	2,862,676,204	2,390,152,295	83.49%	Moderately effective
2026 (through September), against prorated 9/12 target	2,147,007,153	2,390,152,295	111.32%	Highly effective

Source: Talise Community Health Center BLUD Evaluation Report 2026 (processed by the authors). Effectiveness categories are based on the criteria commonly attributed to Minister of Home Affairs Decree No. 690.900-327 of 1996. The 2026 annual-target ratio uses the full-year target; the prorated ratio uses 9/12 of that same annual target

In 2025, realized revenue of IDR 2,694,008,611 exceeded the annual target of IDR 2,618,884,277, resulting in an effectiveness ratio of 102.87%, classified as highly effective. If SiLPA were included in the target, effectiveness in 2025 would be 98.11%, classified as effective; however, SiLPA was excluded because it is a financing receipt carried forward from a previous period. For 2026, realized revenue from January to September amounted to IDR 2,390,152,295. Compared with the full-year annual target of IDR 2,862,676,204, the achievement was 83.49%. This comparison indicates progress toward the twelve-month target

and does not by itself mean that the nine-month performance was below the expected level. For a period-matched assessment, the annual target was prorated to nine months (9/12), producing a target of IDR 2,147,007,153; against this target, achievement was 111.32%. Thus, 83.49% and 111.32% use the same realized revenue but different, explicitly stated denominators. The prorated calculation assumes an even monthly distribution of the annual target, consistent with the monthly monitoring approach described by informant RM. The difference between realized revenue and the prorated target was IDR 243,145,142, equivalent to 8.49% of the annual target.

By revenue source (Table 3), JKN capitation was the largest source, accounting for 89.8% of service revenue in 2025 and 84.6% in 2026. Capitation increased as the number of registered JKN participants grew from 31,350 in December 2025 to 34,390 in September 2026, an increase of 9.7%. Average monthly capitation in 2026 was IDR 222,390,232, compared with IDR 199,020,174 in 2025. Over the longer term, capitation amounted to IDR 2,034,825,766 in 2023, IDR 2,177,632,127 in 2024, and IDR 2,388,242,087 in 2025. The 2023 and 2024 reports contain only JKN capitation funds from before BLUD implementation; therefore, they are not compared with total BLUD revenue.

Table 3. Realized BLUD Revenue by Source (IDR million)

Revenue source	2025 RBA	2025 actual	2025 %	2026 RBA	Actual through Sept. 2026	% of annual target	% of prorated target
JKN capitation	2,352.9	2,388.2	101.5%	2,545.7	2,001.5	78.6%	104.8%
JKN non-capitation	175.0	162.2	92.7%	200.0	289.5	144.7%	193.0%
Healthcare service charges	90.0	108.7	120.8%	100.0	74.0	74.0%	98.7%
Cooperation revenue	0.0	17.7	–	15.0	23.9	159.6%	212.8%

Source: Talise Community Health Center BLUD Evaluation Report 2026 (processed by the authors). The prorated target percentage is calculated against 9/12 of the annual target. Cooperation revenue was not budgeted in the 2025 RBA

Non-capitation revenue fluctuated considerably throughout 2026, from IDR 0 in May to IDR 75,561,585 in July. Cooperation revenue (from student placements, comparative studies, and data collection) reached IDR 17,703,500 in 2025 despite not being budgeted, and amounted to 159.6% of the 2026 target. This is consistent with informant RM's statement that, after BLUD implementation, these revenue sources were billed in accordance with local regulations. Non-capitation revenue in 2026 had reached 144.7% of its annual target.

Budget Management Efficiency

Efficiency was assessed using the expenditure-to-revenue ratio, calculated as total BLUD expenditure divided by realized BLUD revenue, multiplied by 100%. A lower ratio indicates that expenditure represents a smaller share of realized revenue. For this study, a ratio of 100% or less was classified as efficient because expenditure did not exceed revenue realized in the same period, while a ratio above 100% was classified as less efficient because expenditure exceeded current-period revenue. This threshold is an operational classification used to assess the relationship between expenditure and revenue; it is not presented as an official graded standard for all public-sector entities. The ratio should not be interpreted in isolation, particularly when expenditure is financed from SiLPA or reflects one-time relocation requirements.

Table 4. Expenditure Efficiency and Budget Absorption at Talise Community Health Center BLUD

Description	2025	2026 (through September)

Realized revenue (IDR)	2,694,008,611	2,390,152,295
Operating expenditure (IDR)	2,213,009,664	2,419,941,270
Capital expenditure (IDR)	226,941,500	256,894,250
Total expenditure (IDR)	2,439,951,164	2,676,835,520
Difference between revenue and expenditure (IDR)	254,057,447	(286,683,225)
Total expenditure-to-revenue ratio	90.57%	111.99%
Operating expenditure-to-revenue ratio	82.15%	101.25%
Operating expenditure absorption against RBA	92.47%	82.15%
Capital expenditure absorption against RBA	64.38%	86.20%
Total expenditure absorption against RBA	88.86%	82.53%

Source: Talise Community Health Center BLUD Evaluation Report 2026 (processed by the authors).
Operational criterion used in this study: expenditure-to-revenue ratio ≤100% = efficient; >100% = less efficient. This is a study-specific threshold, not an official graded standard

In 2025, total expenditure of IDR 2,439,951,164 was below realized revenue by IDR 254,057,447. The total expenditure-to-revenue ratio was 90.57%, classified as efficient under the criteria used in this study. Operating expenditure absorption reached 92.47% of the RBA, while capital expenditure absorption was 64.38%. The distinction between the expenditure-to-revenue ratio and budget absorption should be noted: a ratio below 100% indicates that expenditure was lower than revenue, but does not by itself demonstrate that all service needs were optimally planned and met.

From January to September 2026, total expenditure of IDR 2,676,835,520 exceeded realized revenue by IDR 286,683,225. The total expenditure-to-revenue ratio reached 111.99%, placing it in the less-efficient category under the study criteria. The difference was covered by the 2025 SiLPA of IDR 380,962,495, leaving a BLUD cash balance of IDR 94,279,270 as of September 2026. Capital expenditure in 2026, totaling IDR 256,894,250, was concentrated between April and June (93.1% of total capital expenditure), coinciding with relocation needs. The 2026 ratio should therefore be interpreted alongside the funding sources and timing of expenditure. It indicates pressure on current-year revenue but is insufficient to conclude that waste occurred.

Consistency with the accounts of informants RM, I, N, and A. Expenditure data support several statements made by informant RM. First, the capital expenditure ceiling was nearly exhausted: capital expenditure absorption reached 86.2% of the RBA, leaving IDR 41,130,845 by the ninth month. Second, electricity costs were not charged to the BLUD in 2026 (both budget and realization were IDR 0, compared with realized expenditure of IDR 59,410,240 in 2025), consistent with the statement that electricity would only be funded in the following year. Third, health-service expenditure, including capitation and non-capitation services, amounted to IDR 1,480,028,962, or 61.2% of operating expenditure, indicating that service personnel accounted for the largest operating expenditure component. The data do not separate contracted doctors' costs from staff medical-service payments, so the claim that a substantial portion of BLUD funds was absorbed by contracted doctors cannot be assessed separately.

Consistency of expenditure with planning. In 2026, seven expenditure items that had no allocation in the RBA nevertheless recorded actual spending totaling approximately IDR 107,750,100, primarily for non-capitation health services and event-organizing services. Two items substantially exceeded their RBA allocations: medicines and other office activity supplies/materials. Conversely, several items, such as technical guidance, had no expenditure realization (Table 5).

Table 5. 2026 Expenditure Items with Notable Deviations from the RBA

Expenditure item	2026 RBA (IDR)	Actual through Sept. 2026 (IDR)	% of RBA
Medicines	73,358,324	233,881,350	318.82%

Other office activity equipment/materials	35,289,100	129,039,984	365.67%
Non-capitation healthcare services	Not budgeted	78,970,500	–
Event-organizing services	Not budgeted	15,840,000	–
Office building maintenance	311,125,587	213,488,514	68.62%
Technical guidance/training	81,575,000	0	0.00%

Source: Talise Community Health Center BLUD Evaluation Report 2026, expenditure worksheet (processed by the authors)

Indicators Before and After Facility Relocation

Because the new building began operating on 1 June 2026, monthly data for 2026 were divided into the pre-relocation period (January–May, five months) and the post-relocation period (June–September, four months). Monthly averages were used because the two periods differ in length (Table 6).

Table 6. Average Monthly Indicators Before and After Facility Relocation

Indicator	Before (Jan–May 2026)	After (Jun–Sep 2026)	Change
Monthly BLUD revenue (IDR)	246,250,922	289,724,421	+17.7%
Monthly capitation revenue (IDR)	215,998,902	230,379,395	+6.7%
Monthly operating expenditure (IDR)	248,383,820	294,505,542	+18.6%
Monthly capital expenditure (IDR)	39,996,300	14,228,188	−64.4%
Total monthly expenditure (IDR)	288,380,120	308,733,730	+7.1%
Number of JKN participants at period-end (people)	33,489	34,390	+2.7%
Monthly patient visits (people)	4,609	5,421.5	+17.6%

Source: Talise Community Health Center BLUD Evaluation Report 2026, revenue, expenditure, and service data sheets (processed by the authors). End-of-period participant numbers refer to May and September 2026. This comparison does not compare equivalent periods across different years and does not control for seasonal effects

Average monthly BLUD revenue after relocation was IDR 289,724,421, compared with IDR 246,250,922 before relocation (+17.7%); average capitation revenue increased by 6.7%. Average monthly patient visits increased from 4,609 to 5,421.5. JKN participants numbered 33,489 in May 2026 and 34,390 in September 2026, an increase of 901. The increase in participants from December 2025 (31,350) to May 2026 (33,489), amounting to 2,139 people (6.8%), had already occurred before relocation. Average monthly operating expenditure increased by 18.6%, while average monthly capital expenditure declined because capital spending was concentrated in April–June, immediately before and during the move.

Discussion

Revenue Risk Mitigation and Effectiveness

The strategies described by the Treasurer and the Head of the Community Health Center setting annual targets based on historical data and realistic potential and monitoring actual results monthly are consistent with the principles of risk identification, monitoring, and treatment in SNI ISO 31000:2018. Liwang et al. (2024) discussed the application of SNI ISO 31000:2018-based risk management in local government agencies. Irianto and Amirya (2024) described challenges in implementing risk management in local governments. Bracci et al. (2021) positioned risk management as part of public-sector management practices. Revenue effectiveness of 102.87% in 2025 and 111.32% against the prorated target in 2026 indicates that realized revenue exceeded the relevant comparison targets. However, these results cannot be attributed entirely to mitigation strategies. JKN capitation is the main revenue source, and the number of registered participants increased during the observation period; therefore, enrollment also influenced revenue. The ratios should be interpreted as indicators of financial performance, not as proof that mitigation was the sole cause of revenue achievement.

The financial data also show how risks identified by informants appear in the figures. First, the risk of setting targets too low is evident in non-capitation revenue and service charges in 2025, whose actual amounts substantially exceeded their targets. This suggests that targets based on historical data may be conservative for fluctuating revenue items. Cooperation revenue should be interpreted differently: it appeared in 2025 without a budget because, according to informant RM, this source began to be billed in accordance with local regulations only after BLUD implementation. This item is better understood as the formalization of a revenue source rather than merely a conservative target. Second, fluctuations in non-capitation revenue, including the absence of receipts in May 2026, are consistent with the risk of delayed claims payments, although financial data alone cannot establish the cause. Third, in terms of cash flow, the BLUD cash balance of IDR 94,279,270 as of September 2026 was equivalent to approximately 0.32 months of average monthly expenditure (IDR 297,426,169), while monthly capitation was around IDR 222,390,232. After SiLPA was used, the liquidity buffer became thin, making delays in BPJS payments more consequential. The relationship between revenue achievement and fund utilization is consistent with Retnosari et al. (2022), who found that the effectiveness and efficiency of BLU budget planning are closely associated with financial performance, particularly operating revenue and operating costs. At Talise Community Health Center, this relationship is reflected in revenue exceeding its target in 2025, while expenditure exceeded revenue in 2026 and was covered by SiLPA. The context differs because the earlier study concerned a central general hospital, whereas Talise adopted the BLUD model only in 2025 and faced relocation-related needs.

Mitigating Planning and Budgeting Risks and Improving Efficiency

In 2025, total expenditure absorption of 88.86% of the RBA left an unspent budget of IDR 305,838,161, comprising IDR 180,257,521 in operating expenditure and IDR 125,580,640 in capital expenditure. Together with the revenue surplus, this contributed to year-end 2025 SiLPA of IDR 380,962,495, including IDR 126,905,048 carried forward from 2024 into 2026. This is consistent with the Treasurer's account that part of the revenue surplus was retained to support relocation needs. Nevertheless, low budget absorption does not automatically indicate greater efficiency, as it may also reflect activities or expenditures that have not been implemented. Fitrah and Handayati (2022) examined budget efficiency measurement in government agencies with BLU status. Retnosari et al. (2022) studied budget management effectiveness and efficiency in a hospital, while Pappa et al. (2023) analyzed the effectiveness and efficiency of local government expenditure implementation. Financial ratios should therefore be interpreted alongside budget realization and the context in which activities are carried out.

The 2026 expenditure-to-revenue ratio above 100% indicates that expenditure through September exceeded revenue realized during the same period. This does not necessarily demonstrate waste because some expenditure was financed using SiLPA accumulated for relocation needs. However, using SiLPA also reduces the cash buffer available for subsequent periods. Managers should therefore ensure that routine expenditure and future service needs remain financeable and account for new costs that will become the BLUD's responsibility.

The expenditure data reinforce the planning risks identified by informants. Informant RM's strategy of preparing a rational RBA, conducting rapid evaluations, and setting priorities allows adjustments when needs change. On the other hand, deviations in medicine and office supply expenditure, together with actual spending on several items that were not initially budgeted, indicate the need to examine budget-reallocation documents and the reasons for changing needs. Herawati et al. (2022) discussed community health centers' readiness to adopt BLUD status. Sulistyowati and Sunaningsih (2023) examined their financial management after obtaining BLUD status. Sutaryo et al. (2024) evaluated the implementation of the PPK-BLUD financial management model at community health centers. Rohilah et al. (2025) discussed

community health center financial management to improve budget-use efficiency and effectiveness. These studies provide points of comparison regarding the importance of planning, flexibility, and accountability. Because the budget-reallocation documents have not been reviewed comprehensively, the deviations are treated as findings requiring clarification, not as evidence of violations.

Looking ahead, informant RM's account indicates risks that are not yet fully reflected in the 2026 figures. Electricity costs, which were not charged to the BLUD in 2026, will begin to be funded in the following year. For comparison, electricity expenditure at the old building in 2025 was IDR 59,410,240, although the needs of the new air-conditioned building may differ. At the same time, SiLPA has been used (the 2026 SiLPA estimate in the evaluation worksheet was approximately IDR 140,144,284, down from IDR 380,962,495), the capital expenditure ceiling is nearly exhausted, and most doctors remain contracted. This combination indicates funding pressures for 2027 that should be anticipated when preparing the RBA.

Fraud, Expenditure, and Procurement Risks

Mitigation in the expenditure and procurement categories is administrative and preventive. The identified measures include tiered review of accountability reports (SPJ) by the Treasurer and the Head of the Community Health Center, checking the consistency of supporting documents and photographs, periodic reconciliation, and monthly reporting deadlines. These mechanisms help maintain transaction traceability and accountability. Liwang et al. (2024) examined SNI ISO 31000:2018-based risk management in the Kaimana Regency Government. Islami et al. (2025) found a positive relationship between risk management, the Government Internal Control System (SPIP), and local government financial performance. Qamariyyah et al. (2025) found that the capability of government internal supervisory apparatus (APIP) and risk-management maturity were positively associated with the effectiveness of corruption control. Weyha et al. (2025) reported that risk management was associated with fewer local government audit findings. Nevertheless, this study found no evidence that Talise Community Health Center had a formal risk register.

The Treasurer's account identified four potential forms of fraud risk: failure to deposit all receipts, fictitious expenditures, price mark-ups, and procurement that does not match actual needs. These should be understood as risk scenarios requiring prevention, not as proven incidents of fraud at Talise Community Health Center. The available interview and documentary data do not show that these practices actually occurred. Relevant controls therefore include matching receipts against cash records and bank accounts, verifying transaction evidence and accountability reports, checking price reasonableness, and assessing whether procurement matches planned needs. Periodic reconciliation and internal and external oversight can also help detect discrepancies. Irianto and Amirya (2024) described challenges in implementing risk management in local government, while Fadhlurrhman and Sari (2026) reviewed risk management for mitigating public-sector budget fraud. These sources provide comparative context, not direct evidence of fraud at Talise Community Health Center. Thus, the findings indicate a need to strengthen the identification and control of potential fraud risks, rather than concluding that fraud has occurred.

Facility Relocation as a Contextual Factor

The new facility, which began operating on 1 June 2026, changed the community health center's risk profile. During preparation, the main risks concerned budget execution: activity funds were reallocated, SiLPA was accumulated, and the capital expenditure ceiling was used for facilities, infrastructure, accreditation, and credentialing. The data show that capital expenditure absorption reached 86.2% by the ninth month and that capital spending was concentrated from April to June. After relocation, the risk shifted toward revenue sustainability because the Head of the Community Health Center and the Treasurer were concerned that the

greater distance of the new building might reduce enrollment and revenue. Informant RM's strategy was to attract patients through more comfortable services and a larger number of doctors, while the Program Officer reported increased visits in the Tondo area. Suryawati et al. (2023) discussed local fiscal risk mitigation, while Kristanto and Lisdiono (2025) examined risk management practices in regional hospitals with BLUD status. These studies provide comparative context; the Talise relocation is analyzed using this study's interviews and financial data.

The data in Table 6 do not indicate a decline after relocation: average monthly revenue, capitation, and patient visits from June to September were higher than from January to May. However, these increases cannot be directly attributed to relocation. Most of the increase in JKN participants occurred before the move, although participant numbers continued to rise afterward. Capitation is calculated based on registered participants, so changes in enrollment may only be reflected in receipts after some time. The before-and-after comparison also does not control for seasonal effects or factors other than relocation. Retnosari et al. (2022) examined budget effectiveness and efficiency in healthcare organizations. Karina and Ramadhani (2022) assessed the financial performance of a community health center BLUD using the value-for-money concept, as did Prasetyo et al. (2022). Therefore, data through September 2026 do not show that concerns about declining revenue materialized, but four months after relocation is too short a period for a firm conclusion. Monitoring during the fourth quarter of 2026 and throughout 2027 is needed.

Overall, the findings show that financial risk mitigation at Talise Community Health Center is implemented through needs-based budgeting and prioritization, periodic monitoring, transaction verification, reconciliation, and internal and external oversight. These control practices coexist with different budget outcomes: revenue effectiveness was high in 2025 and, on a period-matched basis, in January–September 2026, while the expenditure-to-revenue ratio shifted from efficient in 2025 to less efficient in January–September 2026. The latter result needs to be interpreted in light of relocation-related spending and the use of SiLPA. The findings therefore indicate that mitigation provides a framework for managing financial uncertainty, but the available data do not establish a direct causal effect of mitigation strategies on the measured ratios. The study's contribution lies in examining qualitative financial controls together with financial performance ratios during the simultaneous BLUD transition and facility relocation, providing a context-specific account of the relationship between financial risk management and budget performance at a community health center.

CONCLUSION AND SUGGESTIONS

Conclusion

This study shows that budget management at Talise Community Health Center, Palu City, faces financial risks associated with revenue uncertainty, adjustments to budget planning and priorities, expenditure control, and the completeness of transaction accountability records. Mitigation strategies include preparing budgets based on needs and priorities, monitoring realized revenue and expenditure, checking transaction evidence, reconciliation, and internal and external oversight. In terms of effectiveness, realized revenue in 2025 reached 102.87% of the revenue target, while the January–September 2026 figure reached 111.32% of the prorated target. In terms of efficiency, the expenditure-to-revenue ratio was 90.57% in 2025, classified as efficient, whereas the ratio of 111.99% for January–September 2026 was classified as less efficient under the study criteria. The 2026 results should be interpreted in light of the use of prior-year budget surpluses and relocation-related expenditure needs; therefore, the ratio cannot be taken directly as evidence of waste. This study contributes by linking financial risk identification and mitigation with budget performance measurement in the context of the transition to regional public service agency financial management and facility relocation.

However, the available data do not establish that the mitigation strategies directly caused changes in budget effectiveness or efficiency.

Limitations

This study is limited to Talise Community Health Center in Palu City; therefore, its findings are context-specific and cannot be directly generalized to all community health centers. The data were obtained through interviews with four informants and analysis of financial documents, covering 2025 and January–September 2026. This period limits the assessment of long-term changes in budget performance, particularly following the adoption of the regional public service agency financial management model and relocation to a new building. In addition, measurements of effectiveness and efficiency depend on the availability and completeness of the financial documents obtained, which do not fully explain all factors affecting changes in budget ratios. The study also cannot establish that financial risk mitigation strategies directly caused changes in budget management effectiveness and efficiency. The findings should therefore be interpreted within the scope of the research setting, observation period, informants, and available data.

Recommendations

Talise Community Health Center should strengthen periodic monitoring of realized revenue and expenditure, set revenue targets based on historical data and realistic revenue potential, and review budget needs in light of the new building's operating costs. The use of prior-year budget surpluses should be planned carefully so that relocation needs do not undermine the ability to fund routine services in subsequent periods. Controls should also be strengthened through documentation of budget changes, verification of transaction evidence, periodic reconciliation, and more structured risk mapping, including fraud as a potential risk to be anticipated rather than an established occurrence. Post-relocation evaluation should continue using revenue, expenditure, patient-visit, and enrollment data over a longer period. Future studies could include several community health centers, extend the observation period, and add relevant financial and service indicators to analyze the relationship between risk mitigation and budget performance more comprehensively.

Author Contributions

The first author was responsible for conceptualizing the study, collecting and analyzing data, interpreting the findings, and preparing the manuscript draft. The second author contributed to developing the theoretical framework, formulating the conceptual framework, and reviewing and revising the manuscript. The third author contributed to data processing, interpretation of the findings, and suggestions for improving the manuscript. The fourth author contributed to critical review, editing, and refinement of the article before submission for publication. All four authors have read and approved the final version of the manuscript submitted for publication.

Statement on the Use of Artificial Intelligence (AI)

During the preparation of this manuscript, the authors used ChatGPT (OpenAI) to assist with language editing and manuscript revision. The authors reviewed and edited the resulting text and take full responsibility for the accuracy, interpretation, and final content of the article.

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