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PHILHEALTH CIRCULAR
No. 2024 - 0011

TO : **HEALTH CARE PROVIDER NETWORKS, HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES, LOCAL HEALTH INSURANCE OFFICES, LOCAL GOVERNMENT UNITS, AND ALL OTHERS CONCERNED**

SUBJECT : **PhilHealth Prospective Payment Mechanisms (3PM) for Health Care Provider Networks**

I. RATIONALE

PhilHealth currently pays its accredited health facilities primarily by way of reimbursements. Claims processing of these reimbursements naturally results in some lag in the turnaround time in payment. Its effect consequently results in delays in cash flow, and potential fiscal constraints and losses. Furthermore, the current benefit landscape has limited containment mechanisms in place, which potentially leads to unnecessary admissions and irrational fund utilization.

Republic Act (RA) No. 11223, otherwise known as the Universal Health Care (UHC) Act, aims to address these recurring issues by mandating PhilHealth to "shift to paying providers using performance-driven, closed-end, prospective payments..." enabling them to strategize how to utilize funds efficiently within a fixed budget.[1] Prospective payments facilitate less administrative burden by making health spending more predictable, and by reducing the number of transactions between PhilHealth and its contracted health facilities and health care provider networks (HCPN).

The key features and components of prospective payments must be defined and understood by all stakeholders involved to maximize its implementation.

II. OBJECTIVES

This PhilHealth Circular aims to establish policy on how PhilHealth implements provider payment mechanisms, in line with the UHC Act

[1] Republic Act No. 11223 (Universal Health Care Act), Section 18(b).

(Republic Act No. 11223) and the National Health Insurance Act of 2013 (Republic Act No. 7875, as amended by Republic Act No. 10606). This policy shall be referenced by all succeeding benefits that will be designed and implemented as prospective payments.

III. SCOPE

This PhilHealth Circular encompasses the implementing policy for the Prospective Provider Payment Mechanisms (3PM) which details:

A. Prospective payments for reference of public, private, or mixed health care provider networks (HCPN), health facilities, national government agencies, and local government units (LGU); and

B. Preparation, utilization, recording, and auditing of prospective payments.

IV. DEFINITION OF TERMS

For the purpose of this PhilHealth Circular, the operational definitions of terms used in this issuance are the following:

A. Capitation - a provider payment mechanism where providers are paid a fixed amount prospectively to provide a defined set of goods and services for each enrolled individual for a fixed period of time, regardless of the goods and services actually provided which is influenced by particular characteristics of individuals that influence their health as part of the estimation of the payment.[2]

B. Case-based Payment – a provider payment mechanism where providers are paid a fixed amount per episode of care, based on clinical condition/s.[3]

C. Contracting – a process where providers and networks are engaged to commit and deliver quality health services at agreed cost, cost sharing and quantity in compliance with prescribed standards.[4]

D. Efficiency gains - the increase in profit following a reduction in cost whereby health facilities generate surplus revenues which they can use for continuous quality improvements, such as upgrading facilities, procurement of additional supplies or equipment, or augmenting health human resources with the goal of ensuring client satisfaction.

[2] PhilHealth Circular No. 2022-0032 (Governing Policies of the Konsulta+), Section IV(A).
[3] *Ibid.*, Section IV(B).
[4] UHC Act Implementing Rules and Regulations, Rule 4.7.

Thus, the surplus generated by HFs through efficiency gains shall not be interpreted as overpayments.[5]

E. Front-loaded Payment – a method of paying providers prospectively wherein there is advanced provision of funds for the anticipated delivery of medical goods or services, that forms part of the total contract amount.

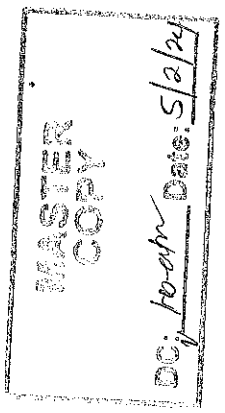
F. Global Budget (GB) – a prospective payment method where the insurer pays a fixed amount for a specified period to cover aggregate expenditures to provide an agreed-upon set of services.[6]

G. Health Care Provider Network (HPCN) – a group of primary to tertiary care providers, either public or private, offering people-centered and comprehensive care in an integrated and coordinated manner with the primary care facility acting as the navigator and coordinator of health care within the network.[7] The terms HCPN and Network are used interchangeably in these guidelines.

1. **Mixed Network** – a network of providers, which may be composed of health service providers from both the public and private sector, represented by a self-assembled entity of both public and private sector as the Managing Board, supported by a document establishing its juridical personality (e.g., Securities and Exchange Commission-Articles of Incorporation, Articles of Partnership, Joint Venture Agreement).

2. **Private Network** – a network of providers, which may be composed of health service providers from both the public and private sector, represented by a private entity as the Managing Board, supported by a document establishing its juridical personality (e.g., Securities and Exchange Commission-Articles of Incorporation, Articles of Partnership, Joint Venture Agreement).

3. **Public Network** – a network of providers, which may be composed of health care providers from both the public and private sector, represented by the Local Health Board (LHB) as the Managing Board.
   a. The Public Network may refer to a city-wide health system (CWHS) or province-wide health system (PWHS) as respectively defined in Sections III.A and III.O of DOH-DBM-DOF-DILG-PHIC Joint Memorandum Circular (JMC) No. 2021-0001.



[5] PhilHealth Circular No. 2024-0001 (Rules for Adjusting Case Rates), Section IV(I).
[6] PhilHealth Circular No. 2024-0004 (Implementation of an All Case Rates-Based Global Budget in Health Care Provider Network Demonstration Sites), Section IV(E).
[7] *Ibid.*, Section 4(l).

b. The LHB is the board created in every province, city, and municipality pursuant to Section 102 of RA No. 7160 or the Local Government Code of 1991. In addition, the UHC Act provides for the additional members and functions of LHB in Provinces, Highly Urbanized Cities, and Independent Component Cities.[8]

H. Health Facility – previously referred to as Health Care Institution (HCI), which may be public or private, devoted primarily to the provision of services for health promotion, prevention, diagnosis, treatment, rehabilitation, and palliation of individuals suffering from illness, disease, injury, disability or deformity or in need of obstetrical or other medical and nursing care.[9]

I. Human Resources for Health (HRH) – medical professionals, allied health professionals and other health service delivery personnel (eg. barangay health workers, nurse aide, barangay nutrition scholars, etc) who are essential to the performance of health service delivery. They include workers in the different domains of the health systems, including preventive, curative, rehabilitative, and palliative care services.

J. Individual-based Health Services – services which can be accessed within a health facility or remotely that can be definitively traced back to one (1) recipient, has limited effect at a population level and does not alter the underlying cause of illness such as ambulatory and inpatient care, medicines, laboratory tests and procedures, among others.[10]

K. Inpatient Payments – PhilHealth benefit payouts for services provided in an inpatient setting as defined by the guidelines of the specific benefit, including, but not limited to, payments through All Case Rates (ACR) and Diagnosis-Related Groups (DRG).

L. Managing Board – governing body that provides oversight function to healthcare provider network(s), such as Local Health Board for public network, a private board for private network, and a self-assembled board composed of both public and private entities for mixed network.

M. Memorandum of Agreement (MOA) - instrument between parties that sets the obligations and commitments towards the payment of benefits by PhilHealth to a healthcare provider network. It shall include a service-level agreement as an annex.

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[8] DOH-DBM-DOF-DILG-PHIC Joint Memorandum Circular No. 2021-0001 (Guidelines on the Allocation, Utilization, and Monitoring of, and Accountability for the Special Health Fund), Section III(J).
[9] Republic Act No. 11223 (Universal Health Care Act), Section 4(k)(1).
[10] Republic Act No. 11223 (Universal Health Care Act), Section 4(p).

N. **Outpatient Payments** – PhilHealth benefit payouts for services provided in an outpatient setting as defined by the guidelines of the specific benefit, including, but not limited to, payments for the PhilHealth Outpatient Drug Benefit (ODB) Package.

O. **PhilHealth Prospective Payments** – allocation of resources to a healthcare provider to deliver the covered package of health care goods, services, and interventions to the covered population in which rates are set in advance and/or providers are paid before services are delivered.[11]

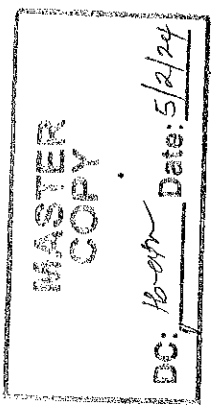
P. **PhilHealth Provider Payment Mechanisms**– a method that PhilHealth pays its providers for the provision of healthcare services as stipulated within the benefit packages of the Corporation.

Q. **Pooled Fund for Health** – pool of financial resources used by private or mixed networks to finance individual-based health services, health system operating costs, capital investments, and maintenance and other operating expenses.

R. **Primary Care Facility (PCF)** – the institution that primarily delivers primary care services which shall be licensed or registered by the DOH.[12]

S. **Primary Care Payments** – PhilHealth benefit payouts for services provided in a primary care setting as defined by the guidelines of the specific benefit, including, but not limited to, payments for the PhilHealth Konsulta Package, Konsulta+, and Konsulta + SDG benefits.

T. **Provincial/City-Wide Health Systems (P/CWHS)** – integrated local health system in which health care providers deliver continuous and integrated health services to individuals and/or communities in a well-defined catchment area.[13]



U. **Service-level Agreement (SLA)** – an annex of the Memorandum of Agreement between the contracting parties that stipulates volume of services, total prospective payment amounts and allocations, and other terms.

V. **Special Health Fund (SHF)** - a pool of financial resources at the P/CWHS intended to finance population-based and individual-based health services, health system operating costs, capital investments, and remuneration of additional health workers and incentives for all health workers.[14]

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[11] DOH-DBM-DOF-DILG-PHIC Joint Memorandum Circular No. 2021-0001 (Guidelines on the Allocation, Utilization, and Monitoring of, and Accountability for the Special Health Fund), Section III(N).
[12] UHC Act Implementing Rules and Regulations, Rule 4.26.b.
[13] Department of Health Administrative Order No. 2020-0021 (Guidelines on Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)), Section VI.
[14] *Ibid.*, Section III(R).

W. Unutilized Funds - residual cash in the front-loaded amount that was not spent due to the lower volume of health services provided as compared to the negotiated volume of services.

X. Volume of Services - the quantity of unique individuals forming a catchment for provision of primary care services, or the quantity of individual cases or episodes of care for inpatient services.

V. POLICY STATEMENTS

A. Prospective Payment General Guidelines

1. PhilHealth shall recognize all prospective payments as receivables (Due from Local Government Units) upon fund transfer to the Network, and as members' benefits (an expense account) upon utilization.[15]

2. The Network shall recognize all prospective payments as liabilities to PhilHealth (Due to GOCCs) upon fund receipt and as income upon utilization.[16]

3. The Network shall qualify for prospective payments once contracted by PhilHealth for the delivery of individual-based health services. The entity that manages the Network, referred to as the Managing Board, shall determine its type:

    a. A Public Network shall be managed by the Local Health Board (Provincial/City Health Board) of the province-/city-wide health system (P/CWHS), as authorized by a Sanggunian Resolution.

    b. A Private Network shall be managed by a board of private entities, supported by a document establishing its juridical personality i.e., Security and Exchange Commission-approved Articles of Incorporation, Articles of Partnership, or Joint Venture Agreement.

    c. A Mixed Network shall be managed by a board composed of both public and private entities, supported by a document establishing its juridical personality e.g., Security and Exchange Commission-approved Articles of Incorporation, Articles of Partnership, or Joint Venture Agreement.

[15] COA Circular No. 2023-003 (Accounting and Reporting Guidelines for the Special Health Fund (SHF) for Province-wide/City-wide Health Systems (P/CWHS) pursuant to Section 20 of the Implementing Rules and Regulations (IRR) of the Republic Act (RA) No. 11223, the Universal Health Care (UHC) Act approved on February 20, 2019), Annex A.
[16] *Ibid.*

4. PhilHealth prospective payments to the Network shall be coursed through the Special Health Fund (SHF) for Public Networks, and through the Pooled Fund for Health (PFH) for Private and Mixed Networks.

   a. Public Networks shall establish their SHF through a Local Health Board Resolution, endorsed by a Sanggunian Resolution, in accordance with DOH-DBM-DOF-DILG-PHIC JMC No. 2021-0001. The Public Network, through its Provincial or City Treasurer, shall create and maintain a depository account in the name of the respective LGU with an authorized government depository bank. The Public Network's depository bank account shall be created in accordance with the existing Department of Finance-Bureau of Local Government Finance Guidelines on Authorized Government Depository Banks and other relevant issuances.

   b. Private and Mixed Networks shall establish their PFH through a Board Resolution or an equivalent instrument. Private and Mixed Networks shall create and maintain a depository bank account in the name of the Network.

5. The Managing Board shall assume full responsibility for the management of the SHF and PFH, subject to existing pertinent budgeting, accounting, and auditing rules and regulations.

   a. For Public Networks, the Management Support Unit (MSU) shall serve as the administrative secretariat of the LHB. The MSU, together with the Local Budget Officer, Treasurer, Accountant, and Health Officer, shall provide fund management support functions to the LHB, as outlined in the DOH-DBM-DOF-DILG-PHIC JMC No. 2021-0001.

   b. For Private and Mixed Networks, an administrative secretariat may be created to assist with the management functions of their Managing Board.

6. The estimation of prospective payments shall follow the formulae prescribed in the circulars for the different benefit packages.

   a. Estimation shall be designed appropriate to the nature of their covered individual-based health services and desired incentives.

   b. Estimated rates may be adjusted using relevant factors, such as but not limited to: the age and sex of the population served, geographic location, facility ownership, and inflation.

B. Budget Preparation for Prospective Payments

1. Budget Preparation of PhilHealth for Prospective Payment

   a. Prospective payment amounts shall be estimated based on the aggregation of estimated payout for primary care facilities, inpatient facilities, and standalone outpatient facilities, as applicable.

   b. The estimated payout amount shall be the basis for the budget of the benefit payouts of each PhilHealth Regional Office (PRO) for the following fiscal year.

   c. PhilHealth and the Network may negotiate the volume of services and contract amounts, as applicable.

   d. PhilHealth and the Network shall execute a memorandum of agreement (MOA) with an attached service-level agreement (SLA). The SLA shall indicate the agreed-upon volume of services and its corresponding contract amount. The MOA and SLA shall be signed and notarized not later than 30th of November every year. The SLA between the Network and its member health facilities shall then indicate their own agreed-upon volume of services and its corresponding payments for the delivery of health services, based on the commitment of the Network to PhilHealth.

2. Budget Release of PhilHealth for Prospective Payment

   a. The Budget Release Order (BRO) shall be issued by the PhilHealth Central Office, following the relevant standard operating procedures of the Corporation.

   b. The PRO shall release the prospective payment in tranches to the Network's recognized depository account. All fund releases to the network shall be made through the mode authorized by PhilHealth, and shall be accompanied by appropriate documentary requirements.

   c. The tranches of prospective payment to the Network shall reference the applicable benefit packages. The first tranche to the Network shall be released within the first 10 calendar days of January.

   d. For prospectively paid benefits that allow the request of supplementary budgets, the maximum supplementary budget amount for the network shall be accounted for in computing the contract amount.

C. Utilization of Prospective Payment

1. The Network shall be entitled to receive PhilHealth payments based on the following:

   a. Payment for primary care shall be released by PhilHealth to the Network in accordance with rules set forth by the indicated benefit policies.

   b. Other payment releases for prospectively paid packages shall be front-loaded to the Network following the given schedule:

Tranche	Amount	Schedule
1	60% of the contract amount	January
2	30% of the contract amount	Conditions for frontloading indicated in the specific benefit packages.
3	10% of the contract amount	

Table 1: Payment Release Schedule

   c. Packages with specific bundles of services paid through reimbursement shall be given directly to the concerned health facilities. The same health facilities shall also have full liberty to utilize the said funds, following rules specified under these benefits.

2. The Network shall ensure the frontloading of PhilHealth payment to member facilities in accordance with the SLA between the Network and member facility and facility performance. PhilHealth payment shall be released to member facilities within ten (10) working days after the fulfillment of condition/s stipulated in relevant benefit packages (e.g., percentage utilization of the preceding tranche).

3. The utilization of prospective payments for the delivery of health services shall be based on the predetermined rate set forth in the benefit packages for primary care, standalone, and inpatient facilities.

   a. Primary Care Capitation - successful completion of mandatory health risk assessment and/or provision of primary care services;

   b. Inpatient Case-Based Rate - full episode of care within a hospitalization period as evidenced by a good claim; and

c. Standalone Case-Based Rate - the provision, administration, or dispensing of covered health services as prescribed in the benefit package.

4. The aggregation of benefit payouts shall constitute the utilized funds and shall be deducted from the total front-loaded amount. Utilized funds shall be recognized by the Network as "Income." Utilized funds shall be spent for the improvement of health services, especially primary care services.

5. In the case of the SHF, expenditure items stipulated in the DOH-DBM-DOF-DILG-PHIC JMC No. 2021-0001 Section VI(D) shall not be charged against the SHF and shall be charged against the LGU mandatory counterpart funding.

6. The actual charges for rendered services that are covered by a benefit package shall be deducted from the predetermined rate of the relevant package. Any remaining amount shall constitute efficiency gains. The aggregation of all remaining amounts from utilized funds shall constitute the total efficiency gains of the provider.

7. A proportion of utilized funds, which are already recognized as income, may be pooled to the Network.

   a. Any transfer of income to the pooled fund shall be accompanied by documentary requirements.

   b. The pooled funds shall be used for allowable expenses under individual-based health services, health system operating costs, capital investment, remuneration of additional human resources for health (HRH), and incentives for all HRH indicated in the DOH-DBM-DOF-DILG-PHIC JMC No. 2021-0001.

   c. The pooled fund is recommended to be used for the following purposes:
      c.1. Operations of the Managing Board and its administrative secretariat;
      c.2. Pooled procurement of medical commodities;
      c.3. Remuneration of additional HRH for sharing among member facilities within the HCPN;
      c.4. Incentives for all HRH and backend managerial offices (e.g., health office) within the territorial jurisdiction of the Network;

c.5. Capital investment, particularly infrastructure for primary care, ambulance and patient transport vehicles, subject to existing guidelines.

d. The allocation of pooled funds shall be decided upon by the Managing Board, and shall be reflected in the applicable investment and operational plan.

e. Utilization of the pooled fund shall be subject to applicable tax rules and regulations.

8. The amount after the deduction of utilized funds from the total front-loaded payment shall be considered as unutilized funds, and shall be returned back to PhilHealth at the end of the contract period.

9. Applicable taxes shall be applied to prospective payment upon utilization based on applicable issuances of National Government Agencies.

10. Reconciliation shall be conducted after the engagement period to determine the provider performance, unutilized funds, and efficiency gains.

a. Provider performance shall reference specific benefit packages to be implemented in the Network.

b. Unutilized funds shall be returned to the relevant PRO through the prevailing payment recovery mechanism of the Corporation.

c. In the event that the Network is contracted for another year of implementation or instances of multi-year contracts, the Network may request PhilHealth, through a letter addressed to its President and Chief Executive Officer (PCEO), to retain the unutilized funds which will be deducted from the receivable contract amount for the succeeding engagement. Such a request shall be subject to the approval of the PCEO. shall be subject to the approval of the PCEO.

11. Cost-sharing rules outlined in a separate PhilHealth Circular and specific benefit packages shall be followed.

12. Health facilities that plan to disengage with the Network shall return back all unutilized funds directly to the Network. Health facilities directly contracted by PhilHealth that have a contract terminated for any reason shall return all unutilized funds to

PhilHealth. The payment recovery mechanisms set by the Corporation may apply.

13. Misuse of prospective payments as well as other violations listed in Section 38 of RA No. 11223 may be used as grounds for contract termination.

D. Recording of Prospective Payment

1. The Network shall create and maintain appropriate recording mechanisms on the flow and utilization of funds. All fund transfers within the Network (e.g., fund to facilities, fund to the component LGUs) shall be accompanied by appropriate documentary requirements.

    a. Public Network within PWHS
        a.1. The Provincial Accountant shall create and maintain a separate SHF book of accounts with complete financial reporting obligations. Subsidiary ledgers shall be created for PhilHealth payment. When there are more than one (1) HPCN in the PWHS, the Provincial Accountant shall create a subsidiary ledger for each Network.
        a.2. The Provincial Accountant shall create a subsidiary ledger for each hospital operated by the Provincial Government.
        a.3. The fund allocation for the component LGU shall be transferred to their Trust Fund. The Component LGU Accountant shall create and maintain a subsidiary ledger for primary care payments, inpatient payments, and outpatient payments.

    b. Public Network within CWHS
        b.1. The City Accountant shall create and maintain a separate SHF book of accounts with complete financial reporting obligations. Subsidiary ledgers shall be created for PhilHealth payments. When there are more than one (1) Network in the CWHS, the City Accountant shall create a subsidiary ledger for each Network.
        b.2. The City Accountant shall create and maintain a subsidiary ledger for primary care payments, inpatient payments, and outpatient payments.

    c. Private and Mixed Network
        c.1. The Network shall create and maintain a separate book of accounts and subsidiary ledgers for PFH.

c.2. The recognized accountant shall create and maintain subsidiary ledgers for primary care payments, inpatient payments, and outpatient payments.

E. Audit of Prospective Payment

1. The Commission on Audit (COA) shall reserve the right to conduct audits for PhilHealth-related payments, whether for public, private, or mixed Networks, based on the guidelines set forth in this PhilHealth Circular and auditing guidelines on prospective payment.

2. PhilHealth reserves the right to inquire regarding the utilization of funds based on this Circular during periods of monitoring, reconciliation, and/or contract re-entry at the level of each facility and at the Network level. Unjustified large variations in fund use may be subject to sanctions and penalties as PhilHealth deems necessary.

3. The auditing of prospective payments shall allow both PhilHealth and COA the capacity to observe the SHF through transactions of their depository account.

4. All Networks shall submit quarterly utilization reports, annual utilization reports, and financial reports to the relevant PhilHealth Regional Office.
   a. These reports shall include benefit-specific utilization reports, SHF Financial Performance Report (Annex A), and SHF Budget and Utilization Report (Annex B).
   b. Quarterly reports shall be submitted not later than the 20th day after the end of each quarter, while annual utilization reports and financial reports shall be submitted to PhilHealth not later than the 15th day of February of the following year.

5. The Local Health Board shall post the utilization reports in the website of the P/CWHS and involved LGUs, and/or in at least three (3) conspicuous public places in compliance with the Full Disclosure Policy of the Department of Interior and Local Government.

6. The existing rules on claims submission, as applicable to the All Case Rates-based Global Budget (ACR-GB) through the eClaims, shall remain in effect.

F. Monitoring and Evaluation

This policy shall be regularly reviewed by the UHC Surge Team and enhanced as necessary.

G. Annexes

1. Annex A.1: SHF Financial Performance Report (Target Vs. Actual Income/Expenditures)

2. Annex A.2: SHF Financial Performance Report (Target Vs. Actual Cash Receipts/Disbursements)

3. Annex B: SHF Budget and Utilization Report

VI. TRANSITORY CLAUSE

A. This policy shall be initially implemented for one (1) calendar year in Public Networks within the HCPN Demonstration Sites. The following benefit packages shall be implemented:

   1. Konsulta with Sustainable Development Goals-related Benefits (Konsulta+SDG), in accordance with PhilHealth Circular No. 2023-0019, and its succeeding revisions, as applicable;

   2. ACR-GB, in accordance with PhilHealth Circular No. 2024-0004, and its succeeding revisions, as applicable; and

   3. PhilHealth Outpatient Drug Benefit (ODB) Package, in accordance with PhilHealth Circular No. 2023-0029, and its succeeding revisions, as applicable.

B. Expansion of the application of this Circular to private and mixed networks shall be subject to the approval of the PhilHealth Board.

C. Existing benefit packages, including but not limited to Z benefits and other standalone case-based benefits outside the PhilHealth Konsulta with SDG Benefits Package, shall be paid directly to the facility following existing engagement agreements.

VII. PENALTY CLAUSE

Any violation of this PhilHealth Circular, terms and conditions of the Performance Commitment and/or Contracts, and all existing related PhilHealth Circulars shall be dealt with and penalized in accordance with the pertinent provisions of RA No. 7875, as amended by RA Nos. 9241 and

10606 (National Health Insurance Act of 2013), and RA No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, and other pertinent laws and rules.

VIII. SEPARABILITY CLAUSE

If, for any reason, any part of this PhilHealth Circular is declared invalid or unconstitutional, any part or provision not affected thereby shall remain in full force and effect.

IX. REPEALING CLAUSE

All previous issuances that are inconsistent with any provisions of this Circular are hereby amended, modified, or repealed accordingly.

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall be published in any newspaper of general circulation and shall take effect after fifteen (15) days of its publication. Further, this PhilHealth Circular shall also be deposited thereafter with the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EMMANUEL R. LEDESMA JR.
President and Chief Executive Officer

Date signed: 04/29/2024

MASTER COPY
DC: Date: 5/2/24

Annex A.1: SHF Financial Performance Report (Target Vs. Actual Income/Expenditures)

SHF FINANCIAL PERFORMANCE REPORT
(TARGET VS. ACTUAL INCOME/EXPENDITURES)
As of _____

NETWORK: _____
Address: _____
Contract Number: _____

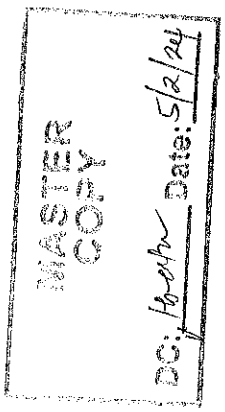
PARTICULAR	TARGET	ACTUAL (INCOME/ EXPENDITURES)	VARIANCE	% OF PERFORMANCE
REVENUE				
Financial Grants and Subsidies from National Government Agencies				
Income from PhilHealth Payments				
Other Donations and Financial Grants				
Other Fund Sources				
Contribution from the LGU Health Fund (General Fund)				
Contribution from the Component LGUs				
Other Sources				
TOTAL				
LESS: EXPENDITURES				
Population-based health services				
Individual-based health services				
Health system operating costs				
Capital investments				
Remuneration of additional health workers				
Incentives for all health workers				
TOTAL				
BALANCE				

Prepared by:

_____

Certified Correct by:

_____
Network Recognized Accountant



Annex A.2: SHF Financial Performance Report (Target vs. Actual Cash Receipts/Disbursements)

SHF FINANCIAL PERFORMANCE REPORT
(TARGET VS. ACTUAL CASH RECEIPTS/DISBURSEMENTS)
As of _____

NETWORK: _____
Address: _____
Contract Number: _____

PARTICULAR	TARGET	ACTUAL (CASH RECEIPTS/ DISBURSEMENTS)	VARIANCE	% OF PERFORMANCE
REVENUE				
Financial Grants and Subsidies from National Government Agencies				
Income from PhilHealth Payments				
Other Donations and Financial Grants				
Other Fund Sources				
Contribution from the LGU Health Fund (General Fund)				
Contribution from the Component LGUs				
Other Sources				
TOTAL				
LESS: EXPENDITURES				
Population-based health services				
Individual-based health services				
Health system operating costs				
Capital investments				
Remuneration of additional health workers				
Incentives for all health workers				
TOTAL				
BALANCE				

Prepared by:

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Certified Correct by:

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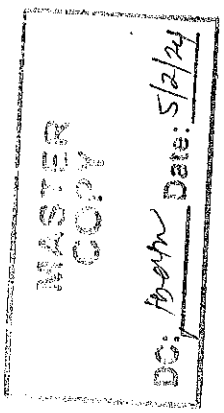
Network Recognized Accountant



SHF BUDGET AND UTILIZATION REPORT

(BY USES OF FUNDS EXPENSE CLASS, OBJECT OF EXPENDITURES)

As of _____

NETWORK: _____

Address: _____

Contract Number: _____

PARTICULAR	AMOUNT				PERCENTAGE					
	APPROPRIATION	ALLOTMENT	OBLIGATION (EXPENSES)	DISBURSEMENT	ALLOTMENT VS. APPROPRIATION	OBLIGATION VS. APPROPRIATION	DISBURSEMENT VS. APPROPRIATION	OBLIGATION VS. ALLOTMENT	DISBURSEMENT VS. ALLOTMENT	DISBURSEMENT VS. OBLIGATION
1. Population-based health services										
MOOE										
Sub-Total										
2. Individual-based health services										
MOOE										
Sub-Total										
3. Health system operating costs										
MOOE										
Sub-Total										
4. Capital investment										
CAPITAL OUTLAY										
Sub-Total										
5. Remuneration of additional health workers										
PERSONNEL SERVICES										
Sub-Total										
6.Incentives for all workers										
PERSONNEL SERVICES										
Sub-Total										
TOTAL										

Prepared by:

Certified Correct by:

Network Recognized Accountant