MICARE PLAN, INC.

FINANCIAL STATEMENTS AND INDEPENDENT AUDITORS' REPORT

YEAR ENDED SEPTEMBER 30, 2005

MICARE PLAN, INC.

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Year Ended September 30, 2005

Deloitte.

Deloitte & Touche LLP
361 South Marine Corps Drive
Tamuning, GU 96913-3911
USA

Tel: +1 671 646 3884
Fax: +1 671 649 4932
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

Chairman
Board of Directors
MiCARE Plan, Inc.:

We have audited the accompanying statement of net assets of the MiCare Plan, Inc. (the "Plan"), a component unit of the Federated States of Micronesia National Government, as of September 30, 2005, and the related statements of revenues, expenses, and changes in net assets and of cash flows for the year then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audit.

Except as discussed in the following paragraph, we conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

Because of the inadequacy of accounting records, we were unable to form an opinion regarding medical claims payable amounting to $438,968 and $30,864, respectively, for two related parties as of September 30, 2005. We were unable to satisfy ourselves as to the fairness of these amounts by means of other auditing procedures.

In our opinion, except for the effects of such adjustments, if any, as might have been determined to be necessary had medical claims been supported, the financial statements referred to in the first paragraph present fairly, in all material respects, the financial position of the MiCare Plan, Inc. as of September 30, 2005, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

The accompanying financial statements have been prepared assuming that the Plan will continue as a going concern. As discussed in note 7 to the financial statements, the Plan has incurred substantial losses from operations. This condition raises substantial doubt about its ability to continue as a going concern. Management's plans concerning this matter are also described in note 7. The financial statements do not include any adjustments that might result from the outcome of this uncertainty.

The Management's Discussion and Analysis on pages 3 - 5 is not a required part of the basic financial statements but is supplementary information required by the Governmental Accounting Standards Board. This supplementary information is the responsibility of the Plan's management. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit such information and we do not express an opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our report dated June 30, 2006, on our consideration of the Plan's internal control over financial reporting and our tests of its compliance with certain laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Deloitte & Touche LLP

June 30, 2006

MICARE PLAN, INC.

Management's Discussion and Analysis
Year Ending September 30, 2005

The following discussion and analysis of the financial performance and activity of MiCare is to provide an introduction and understanding of the basic financial statements of MiCare for the year ended September 30, 2005. This discussion has been prepared by the management and should be read in conjunction with the financial statements and notes thereto, which follow this section.

MiCare formerly known as the FSM National Government Employees' Health Insurance Plan (FSMNGEHIP) was established by the Federated States of Micronesia Public Law 3-82 enacted December 26, 1984 for the purpose of establishing a fund to pay for eligible members' certain medical expenses both on-island and off-island.

Participation is optional for employees and employers both public and private in the Federated States of Micronesia. Premium contributions are paid on a fixed bi-weekly rate for the three plan options - basic, supplemental resident, and supplemental non-resident plans.

FSM Public Law 12-77 transferred the operation of MiCare from the Department of Finance and Administration to an independent Board of Directors to oversee the Plan's fund. The Board of Directors consist of four (4) member representatives from each state government, one (1) from the National Government and one (1) member representing private sector, all of which are appointed by the President and confirmed by the FSM Congress. The seventh member of the board is the Administrator who is appointed by the Board of Directors and serves as an ex-officio member.

Fiscal year 2005 was another difficult and challenging year for the Plan in terms of profitability due to an increase of medical utilization both on-island and off-island. The increase of medical utilization was attributed mainly by the increase in the number of referrals off-island and the increase of cost of medical and non-medical services like medicines, supplies and airfare. With all these factors combined, the Plan takes most of the sacrifices in keeping the country's health care system providing assistance to our members for their health care needs.

The following table summarizes the financial condition and operations of MiCare for FY 2005 and FY 2004:

	2005	2004
Assets:		
Current assets	$ 1,642,366	$ 1,476,604
Noncurrent assets	15,427	29,185
	$ 1,657,793	$ 1,505,789
Liabilities and Net Assets:		
Current liabilities	$ 3,098,333	$ 2,389,068
Net Assets	(1,440,540)	(883,279)
	$ 1,657,793	$ 1,505,789
Revenues, Expenses and Changes in Net Assets:		
Operating revenues	$ 5,511,587	$ 4,132,265
Operating expenses	6,091,735	5,335,443
Net operating loss	(580,148)	(1,203,178)
Investment income and others	22,887	13,314
Decrease in net assets	$ (557,261)	$ (1,189,864)

2005 Significant Financial Events

The most remarkable financial event occurring during fiscal year 2005 was the implementation of $2.00 premium increase for all options to offset ever increasing medical utilization costs. The new premium rate had increased the plan's cash flow and allowed the plan to continue paying its previous years debts.

Other notable financial event for the year is the increase of medical referrals off-island by 13% (157 patients) for both basic and supplemental options and the coverage of Genesis Hospital for inpatient care on January 2005. The opening of in-patient care at Genesis hospital promotes quality health care service to members and at the same time allowed the Plan to continue incurring expenses.

Operating Revenue

Insurance premiums for fiscal year 2005 of $5,506,315 were 33% higher than the $4,132,265 earned in fiscal year 2004. As compared to fiscal year 2004, total premium contributions from Governments and agencies increased by $1,045,405 while premium contributions from private businesses increased by $328,645 for a total increase for the year of $1,374,050. The result of the increase in operating revenue is the premium increase applied for both basic and supplemental options that took effect October 1, 2004.

Operating Expense

Operating expenses for fiscal year 2005 of $6,091,735 was 14% more than the $5,335,443 incurred in fiscal year 2004. As compared to fiscal year 2004, total medical expenses increased by $741,396 while general and administrative expenses increased by $14,896 for an overall increase for the year of $756,292. The increase was largely due to increase of medical expenses from local private providers, off-island providers and patients' airfare tickets.

Type of Claims	2005	2004
Local State Hospitals	$ 390,248	$ 395,289
Local Private providers	1,703,611	1,222,043
Off-island Hospitals	2,970,896	2,810,983
Airfare Ticket	585,805	461,021
Stipend	12,210	31,040
Other	-	998
Total Medical Claims	$ 5,662,770	$ 4,921,374

For fiscal year 2005, medical claims from local private providers significantly increased by $481,568 or 39% from the prior year. The increase was due primarily to more members prefer treatment at the private clinics over the state hospitals. The second major cost to the Plan is that for the health care provided off-island. In the past, majority of these services were provided in Guam and Hawaii but there has been a shift toward health care provided in Manila for services provided under basic referrals. In fiscal year 2005, there are 625 basic referral patients sent off-island and 669 supplemental referrals. Compared to last year figure, medical expenses from off-island providers in 2005 were $ 2,970,896, a 6% increase from $2,810,983 in 2004. The slight increase of off-island cost was due to strict implementation of the new policy for basic referrals to go to Manila. The third major cost to the Plan is the payment of patient's airfare cost. Payment for airfare significantly increased in 2005 by $124,784 or 27% to $585,805 from $461,021 in 2004. The increase was due to increase of number of basic referrals and the uncontrolled cost of airfare due to worldwide increase of fuel cost.

Administrative Expenses and Fixed Assets Purchases

Net administrative expenses of $389,344 and fixed asset purchases of $7,245 were paid during fiscal year 2005. This was 3% less than the approved budget of $406,287. The biggest administrative expenses were salaries in the amount of $256,479, travel in the amount of $ 46,997 and communication in the amount of $27,652.

Investment

The Plan received fixed income of $22,887 in fiscal year 2005 from its U.S. Treasury note investment account. Bank of Hawaii, Investment Services Group manages this investment with the assistance of FSM Finance, Investment Division. As of September 30, 2005, the market value of this investment stood at $1,071,844, with the remaining balance of $87,078 maintained in a money market account.

Plan of Action for 2006

The ultimate goal of the Plan must be to remain financially viable in order to continue to provide quality, limited, health care to its members. The following are the course of actions that will be taken in Fiscal Year 2006.

1. Continue to negotiate for reductions in the amounts paid to the private providers for services rendered to its members and to carefully review and control member's utilization cost.

2. Work closely with State Hospitals to implement strict screening of referral patients sent off-island and to introduce joint partnership with State Hospitals and Private Clinics to purchase diagnostic equipment to decrease the dependence on off-island care.

3. Reexamine the current premium and consider increasing premium to head off any further deficits of the Plan.

4. Recommend to FSM Congress to consider reinstating limitations on coverage for pre-existing conditions for new members.

5. Aggressive collections of receivables, promote members' awareness on their healthcare benefits and improve public relations to government officials and members.

6. Continue to provide training to employees to enhance competence level and knowledge to develop work efficiency and productivity.

7. Continue to improve the existing database by investing to a more unified computerization system for better tracking of medical cases and expenses, as well as the production of detailed reports needed to insure efficient operation.

MICARE PLAN, INC.

Statement of Net Assets
September 30, 2005

ASSETS

Current assets:	
Cash and cash equivalents	$ 48,857
Investments	1,158,922
Premiums receivable	137,340
Accounts receivable, net	33,945
Prepaid expenses	263,302
Total current assets	1,642,366
Noncurrent assets:	
Fixed assets, net	15,427
Total assets	$ 1,657,793

LIABILITIES AND NET ASSETS

Current liabilities:	
Accounts payable	$ 3,098,333
Total liabilities	3,098,333
Commitments and contingencies	
Net assets:	
Invested in fixed assets	15,427
Unrestricted	(1,455,967)
Total net assets	(1,440,540)
Total liabilities and net assets	$ 1,657,793

See accompanying notes to financial statements.

MICARE PLAN, INC.

Statement of Revenues, Expenses, and Changes in Net Assets
Year Ended September 30, 2005

Operating revenues:	
Insurance premiums	$ 5,506,315
Miscellaneous	5,272
Total operating revenues	5,511,587
Operating expenses:	
Medical claims	5,662,770
Personnel services	256,479
Travel	46,997
Communication	27,652
Depreciation	21,003
Provision for doubtful accounts	18,618
Rent	14,029
Supplies	12,441
Printing	7,480
Utilities	6,993
Repairs and maintenance	3,585
Contractual services	3,190
Insurance	1,386
Miscellaneous	9,112
Total operating expenses	6,091,735
Loss from operations	(580,148)
Non-operating revenues:	
Net increase in the fair value of investments	22,887
Change in net assets	(557,261)
Net assets at beginning of year	(883,279)
Net assets at end of year	$ (1,440,540)

See accompanying notes to financial statements.

MICARE PLAN, INC.

Statement of Cash Flows
Year Ended September 30, 2005

Cash flows from operating activities:	
Premiums received	$ 5,368,975
Medical claims and benefits paid	(4,964,952)
Cash paid to suppliers and employees	(389,429)
Other cash received	5,272
Net cash provided by operating activities	19,866
Cash flows from capital and related financing activites:	
Acquisition of fixed assets	(7,245)
Net cash used for capital and related financing activities	(7,245)
Cash flows from investing activities:	
Net change in investments	(23,941)
Investment income	22,887
Net cash used for investing activities	(1,054)
Net change in cash and cash equivalents	11,567
Cash and cash equivalents at beginning of year	37,290
Cash and cash equivalents at end of year	$ 48,857
Reconciliation of operating loss to net cash provided by operating activities:	
Loss from operations	$ (580,148)
Adjustment to reconcile loss from operations to net cash provided by operating activities:	
Depreciation	21,003
Bad debts	18,533
(Increase) decrease in assets:	
Premiums receivable	(137,340)
Accounts receivable	1,457
Prepaid expenses	(12,904)
Increase in liabilities:	
Accounts payable	709,265
Net cash provided by operating activities	$ 19,866

See accompanying notes to financial statements.

(1) Nature of Operations and Summary of Significant Accounting Policies

Reporting Entity

The MiCare Plan (the Plan) was created in 2003 by Public Law 12-77 of the Twelfth Congress of the Federated States of Micronesia. The MiCare Plan, Inc. began its operations in 1984. The purpose of the MiCare Plan is to provide, arrange for, pay for, or reimburse the costs of medical, dental and vision treatment and care, hospitalization, surgery, prescription drugs, medicine, prosthetic appliances, out-patient care, and other medical care benefits, in cash or the equivalent in medicines and supplies.

The Plan is a discretely presented component unit of the FSM National Government. The financial statements in this report do not represent the financial position, results of operations or cash flows of the FSM National Government as a whole. The financial statements of the Plan are not obligations of the FSM National Government unless specifically authorized by the FSM National Government. To date, no such authorizations have been made. Until October 1, 2004, the Plan was accounted for as a proprietary fund type of the FSM National Government, which created a Board of Directors comprised of seven members appointed by the President, with the consent of Congress, to administer the Plan's affairs. The Board became responsible for the Plan's administration, effective October 1, 2004.

The accounting policies of the Plan conform to accounting principles generally accepted in the United States of America as applicable to governmental entities, specifically proprietary funds. Governmental Accounting Standards Board (GASB) Statement No. 20, "Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities that Use Proprietary Fund Accounting," requires that proprietary activities apply all applicable GASB pronouncements as well as Statements and Interpretations issued by the Financial Accounting Standards Board (FASB), Accounting Principle Board Opinions and Accounting Research Bulletins of the Committee on Accounting Procedures issued on or before November 30, 1989. The Plan has implemented GASB 20 and elected not to apply FASB Statements and Interpretations issued after November 30, 1989.

The Plan has adopted GASB Statement No. 34, "Basic Financial Statements and Management's Discussion and Analysis for State and Local Governments" (GASB 34) as amended by GASB Statement No. 37, "Basic Financial Statements – Management's Discussion and Analysis for State and Local Governments: Omnibus" and GASB Statement No. 38, "Certain Financial Statement Disclosures" and applied those standards on a retroactive basis. GASB Statement No. 34 establishes standards for external financial reporting for state and local governments and requires that resources be classified for accounting and reporting purposes into the following four net asset categories:

- Invested in capital assets, net of related debt:

  Capital assets, net of accumulated depreciation and outstanding principal balances of debt attributable to the acquisition, construction or improvement of those assets.

(1) Nature of Operations and Summary of Significant Accounting Policies, Continued

Reporting Entity, Continued

- Restricted:

  - Nonexpendable – Net assets subject to externally imposed stipulations that require the Plan to maintain them permanently. For the year ended September 30, 2005, the Plan does not have nonexpendable net assets.

  - Expendable – Net assets whose use by the Plan is subject to externally imposed stipulations that can be fulfilled by actions of the Plan pursuant to those stipulations or that expire by the passage of time.

- Unrestricted:

  Net assets that are not subject to externally imposed stipulations. Unrestricted net assets may be designated for specific purposes by action by management or the Board of Directors or may otherwise be limited by contractual agreements with outside parties.

Basis of Accounting

Proprietary funds are accounted for on a flow of economic resources measurement focus. With this measurement focus, all assets and liabilities associated with the operation of the fund are included in the statements of net assets. Proprietary fund operating statements present increases and decreases in net total assets. The accrual basis of accounting is utilized by proprietary funds. Under this method, revenues are recorded when earned and expenses are recorded at the time liabilities are incurred.

Proprietary funds distinguish operating revenues and expenses from nonoperating items. Operating revenues and expenses generally result from providing services and producing and delivering goods in connection with a proprietary fund's principal ongoing operations. All other revenues are reported as nonoperating. Operating expenses includes the cost of sales and services, administrative expenses, and depreciation on capital assets. Expenses not meeting this definition are reported as nonoperating expenses.

Revenue Recognition

Health care premiums from enrolled members of the Plan are reported as revenue in the period such becomes due.

Premiums Receivable

Premiums receivable are primarily due from the FSM National Government.

The Plan establishes an allowance for doubtful accounts receivable based on the credit risk of specific customers, historical trends and other information.

(1) Nature of Operations and Summary of Significant Accounting Policies, Continued

Cash and Cash Equivalents

For the purposes of the statements of net assets and of cash flows, cash and cash equivalents are defined as cash in bank checking and savings accounts, and commercial paper with original maturities of three months or less from the date of acquisition.

Investments

Investments and related investment earnings are recorded at fair value. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in a forced or liquidation sale.

Fixed Assets

Fixed assets are stated at cost, less accumulated depreciation. Depreciation is based on the straight-line method over the estimated useful lives of the respective assets. All of the assets have an estimated useful life of three to five years. The Plan capitalizes assets with individual values of $1,000 and over. Assets with a value below $1,000 are expensed in the year of purchase.

New Accounting Standards

During fiscal year 2005, the Plan implemented GASB Statement No. 40, *Deposit and Investment Risk Disclosures (an amendment of GASB Statement No. 3)*. GASB Statement No. 40 addresses common deposit and investment risks related to credit risk, concentration of credit risk, interest rate risk, and foreign currency risk. As an element of interest risk, GASB Statement No. 40 requires certain disclosures of investments that have fair values that are highly sensitive to changes in interest rates.

For fiscal year 2006, the Plan will be implementing GASB Statement No. 42, *Accounting and Financial Reporting for Impairment of Capital Assets and for Insurance Recoveries*, GASB Statement No. 44, *Economic Condition Reporting: The Statistical Section, an amendment to NCGA Statement 1* and GASB Statement No. 47, *Accounting for Termination Benefits*. GASB Statement No. 42 establishes standards for impairment of capital assets when its service utility has declined significantly and unexpectedly. GASB Statement No. 44 improves the understandability and usefulness of statistical section information and adds information from the new financial reporting model for state and local governments required by GASB Statement No. 34. GASB Statement No. 47 establishes guidance for state and local governmental employers on accounting and financial reporting for termination benefits. These benefits include incentives for voluntary terminations (e.g., early retirement window programs) and severance payments with respect to involuntary terminations. Management does not believe that the implementation of these statements will have a material effect on the financial statements of the Plan.

In April 2004, GASB issued Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*. GASB Statement No. 43 establishes uniform financial reporting for other postemployment benefit plans by state and local governments. The provisions of this Statement are effective for periods beginning after December 15, 2007. Management does not believe that the implementation of this statement will have a material effect on the financial statements of the Plan.

(1) Nature of Operations and Summary of Significant Accounting Policies, Continued

New Accounting Standards, Continued

In July 2004, GASB issued Statement No. 45, *Accounting and Financial Reporting by Employers for Post employment Benefits Other Than Pensions*. GASB Statement No. 45 establishes standards for the measurement, recognition, and display of other post employment benefits expense/expenditures and related liabilities, note disclosures, and, if applicable, required supplementary information in the financial reports of state and local governmental employers. The provisions of this Statement are effective for periods beginning after December 15, 2008. Management does not believe that the implementation of this statement will have a material effect on the financial statements of the Plan.

In December 2004, GASB issued Technical Bulletin No. 2004-2, *Recognition of Pension and Other Postemployment Benefit Expenditures/Expense and Liabilities by cost-Sharing Employers*. GASB Technical Bulletin No. 2004-2 clarifies the requirements of GASB Statement Nos. 27 and 45 for recognition of pension and other postemployment benefit expenditures/expense and liabilities by cost-sharing employers. Management does not believe the implementation of this pronouncement will have a material effect on the financial statements of the Plan.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. A material estimate that is particularly susceptible to significant change in the near term relates to the determination of unbilled medical claims.

(2) Deposits and Investments

GASB Statement No. 40 addresses common deposit and investment risks related to credit risk, concentration of credit risk, interest rate risk and foreign currency risk. As an element of interest rate risk, disclosure is required of investments that have fair values that are highly sensitive to changes in interest rates. GASB Statement No. 40 also requires disclosure of formal policies related to deposit and investment risks.

A. Deposits:

GASB Statement No. 3 previously required government entities to present deposit risks in terms of whether the deposits fell into the following categories:

Category 1 — Deposits that are federally insured or collateralized with securities held by the Plan or its agent in the Plan's name;

Category 2 — Deposits that are uninsured but fully collateralized with securities held by the pledging financial institution's trust department or agent in the Plan's name; or

(2) Deposits and Investments, Continued

A. Deposits, Continued:

Category 3 Deposits that are collateralized with securities held by the pledging financial institution's trust department or agent but not in the Plan's name and non-collateralized deposits.

GASB Statement No. 40 amended GASB Statement No. 3 to in effect eliminate disclosure for deposits falling into categories 1 and 2 but retained disclosures for deposits falling under category 3. Category 3 deposits are those deposits that have exposure to custodial credit risk. Custodial credit risk is the risk that in the event of a bank failure, the Plan's deposits may not be returned to it. Such deposits are not covered by depository insurance and are either uncollateralized, or collateralized with securities held by the pledging financial institution or held by the pledging financial institution but not in the depositor-government's name. The Plan does not have a deposit policy for custodial credit risk.

As of September 30, 2005, the carrying amount of the Plan's total cash and cash equivalents was $48,857 and the corresponding bank balance was $121,970, which is primarily maintained in financial institutions subject to Federal Deposit Insurance Corporation (FDIC) insurance. As of September 30, 2005, bank deposits in the amount of $116,557 were FDIC insured. The Plan does not require collateralization of its cash deposits; therefore, deposit levels in excess of FDIC insurance coverage are uncollateralized. Accordingly, these deposits are not exposed to custodial credit risk. Management's confidence in the financial strength of their banking institutions was the basis of the decision to not require collateralization. No losses as a result of this practice were incurred for the year ended September 30, 2005.

B. Investments:

GASB Statement No. 3 previously required government entities to present investment risks in terms of whether the investments fell into the following categories:

Category 1 Investments that are insured or registered, or securities held by the Plan or its agent in the Plan's name;

Category 2 Investments that are uninsured and unregistered for which the securities are held by the counterparty's trust department or agent in the Plan's name; or

Category 3 Investments that are uninsured and unregistered, with securities held by the counterparty, or by its trust department or agent but not in the Plan's name.

GASB Statement No. 40 amended GASB Statement No. 3 to in effect eliminate disclosure for investments falling into categories 1 and 2, and provided for disclosure requirements addressing other common risks of investments such as credit risk, interest rate risk, concentration of credit risk, and foreign currency risk. GASB Statement No. 40 did retain and expand the element of custodial credit risk in GASB Statement No. 3.

(2) Deposits and Investments, Continued

B. Investments, Continued:

As of September 30, 2005, investments at fair value are as follows:

Fixed income securities:	
Domestic fixed income	$ 1,071,844
Other investments:	
Money market funds	87,078
	$ 1,158,922

As of September 30, 2005, the Plan's fixed income securities had the following maturities:

	Less Than 1 Year	1 to 5 Years	6 to 10 Years	Greater Than 10 Years	Fair Value
U.S. Treasury obligations	$ 1,071,844	$ -	$ -	$ -	$ 1,071,844
	$ 1,071,844	$ -	$ -	$ -	$ 1,071,844

Credit risk for investments is the risk that an issuer or other counterparty to an investment will not fulfill its obligations.

The Plan's exposure to credit risk at September 30, 2005, was as follows:

Moody's Rating	Total
Aaa	$ 1,071,844

Custodial credit risk for investments is the risk that in the event of the failure of the counterparty to the transaction, the Plan will not be able to recover the value of investment or collateral securities that are in the possession of an outside party. The Plan's investments are held and administered by trustees. Based on negotiated trust and custody contracts, all of these investments were held in the Plan's name by the Plan's custodial financial institutions at September 30, 2005.

Concentration of credit risk for investments is the risk of loss attributed to the magnitude of an entity's investment in a single issuer. GASB Statement No. 40 requires disclosure by issuer and amount of investments in any one issuer that represents five percent (5%) or more of total investments for the Plan. As of September 30, 2005, the Plan did not hold an investment in any one issuer that represented more than 5% of the Plan's total investments.

Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of debt instruments. The Plan does not have a formal investment policy that limits investment maturities as a means of managing its exposure to fair value losses arising from increasing interest rates.

(3) Accounts Receivable

A summary of loans receivable at September 30, 2005 follows:

Accounts receivable	$ 101,563
Allowance for doubtful account	(67,618)
	$ 33,945

(4) Fixed Assets

A summary of fixed assets as of September 30, 2005, is as follows:

	Beginning Balance October 1, 2004	Additions	Deletions	Ending Balance September 30, 2005
Office furniture, fixtures and equipment	$ 48,232	$ 7,245	$ (5,607)	$ 49,870
Vehicles	64,438	-	-	64,438
	112,670	7,245	(5,607)	114,308
Less accumulated depreciation	(83,485)	(21,003)	5,607	(98,881)
Net fixed assets	$ 29,185	$ (13,758)	$ -	$ 15,427

(5) Related Party Transactions

As of September 30, 2005, the Plan has recorded expenses of $241,447 and $838,109, respectively, related to claims by Pohnpei State Hospital and Genesis Island Family Clinic and Hospital. Management of these entities are on the Plan's Board of Directors. These medical claims are made under similar terms and conditions as exist with other health care providers. The Plan has recorded estimated payables to Pohnpei State Hospital and Genesis Island Family Clinic and Hospital of $123,450 and $438,965, respectively, as of September 30, 2005, but has not received underlying billing support from these entities. Accordingly, resolution of these liabilities could occur at an amount that materially varies from these estimates and such differences, if any, will be accounted for prospectively.

(6) Commitments and Contingencies

Litigation

The Plan is a party to various legal proceedings, the ultimate impact of which is not currently predictable. Therefore, no liability has been recorded in the accompanying financial statements due to management's inability to predict the ultimate outcome of these proceedings.

Self Insurance

The Plan carries vehicle insurance to cover its potential risks. The Plan is substantially self-insured for all other risks. Management is of the opinion that no material losses have been sustained as a result of this practice.

(6) Commitments and Contingencies, Continued

Lease Commitments

The Plan has six operating leases as of September 30, 2005. Two are residential real estate leases for contract employees. Four represent leases for the branch offices in each state (one with a lease term of two years, two for five years and one for fifteen years). All leases have an attached option allowing the Plan to renew the lease upon expiration of the current term. It is likely that these options will be utilized by the Plan and the leases renewed. The approximate future minimum annual lease payments payable by the Plan are as follows:

Fiscal year ending September 30,	Total
2006	$ 17,832
2007	17,832
2008	17,832
2009	17,832
2010	17,832
2011 - 2015	89,160
2016 - 2020	89,160
2021 - 2025	89,160
2026 - 2030	89,160
	$ 445,800

(7) Going Concern

As of September 30, 2005, the Plan has incurred a net asset deficiency of approximately $1.4 million. Continuation of the Plan as a going concern is dependent on its ability to increase premiums, to reduce covered benefits and to obtain support, if necessary, from the FSM National Government. Management's plans to address this matter include: (1) continued negotiation for reductions in the amounts paid to the private providers for services rendered to its members and to carefully review and control member's utilization cost; (2) work closely with State Hospitals to implement strict screening of referral patients sent off-island and to introduce joint partnership with State Hospitals and Private Clinics to purchase diagnostic equipment to decrease the dependence on off-island care; (3) reexamine the current premium rates and consider increasing premiums to head off any further deficits of the Plan; (4) recommend to the FSM Congress to consider reinstating limitations on coverage for pre-existing conditions for new members; (5) aggressive collections of receivables, promote members' awareness on their healthcare benefits and improve public relations to government officials and members; (6) continue to provide training to employees to enhance competence level and knowledge to develop work efficiency and productivity; and (7) continue to improve the existing database by investing to a more unified computerization system for better tracking of medical cases and expenses, as well as the production of detailed reports needed to insure efficient operation.

Deloitte.

Deloitte & Touche LLP
361 South Marine Corps Drive
Tamuning, GU 96913-3911
USA

Tel: +1 671 646 3884
Fax: +1 671 649 4932
www.deloitte.com

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

The Board of Directors
MiCare Plan, Inc.:

We have audited the financial statements of the MiCare Plan, Inc. (the "Plan"), as of and for the year ended September 30, 2005, and have issued our report thereon dated June 30, 2006, which was qualified due to the inadequacy of accounting records regarding medical claims payable. Except as discussed in the preceding sentence, we conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Plan's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Plan's ability to record, process, summarize and report financial data consistent with the assertions of management in the financial statements. Reportable conditions are described in the accompanying Schedule of Findings (pages 19 through 27) as items 2005-1 through 2005-13.

A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we believe that none of the reportable conditions described above is a material weakness.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Plan's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

This report is intended solely for the information and use of the Board of Directors and management of the Plan and is not intended to be and should not be used by anyone other than those specified parties.

Deloitte & Touche LLP

June 30, 2006

MICARE PLAN, INC.

Schedule of Findings
Year Ended September 30, 2005

Finding No.: 2005-01
Area: Issuance of Cash Receipts

Criteria: As per entity's policy, there shall be no cash receipt issued if the check is post dated to prevent early recording of cash.

Condition: For 1 of 25 (4%) transactions tested, the cash receipt was issued for payment of a post-dated check.

Cause: The internal control over issuances of cash receipts appears to be weak.

Effect: This condition has no known material effect on the financial statements. However, cash and receivable accounts may be misstated at balance sheet date because of early recording of cash. Also, the entity is non-compliant with its policy.

Recommendation: We recommend that MiCare ensure implementation of its policy.

Auditee Response: This situation occurred when the Plan started receiving payments for health insurance premium allotments from the Social Security Administration, representing premium deductions from the individual members receiving monthly social security benefits. In this instance, the cashier, who received the payment, immediately issued a receipt, dating it to the date of the receipt. The following day, while preparing the deposit slip, the cashier realized that the check was postdated. The cashier then directly consulted the immediate supervisor, and was advised to deposit the check based on the issuance date to avoid paying bank penalty fee. This prompted the management to remind staffs again, particularly the cashier involved, to exercise due care in making sure that any receipt for postdated checks is issued properly.

Finding No.: 2005-02
Area: Voided Cash Receipts

Criteria: As per entity's policy, all three copies of the cash receipts must be retained whenever a cash receipt is voided.

Condition: For 1 of 25 (4%) transactions tested, we noted that white copy of the cash receipt was not retained by the entity.

Cause: Internal control over cancellation and retention of CR appears to be weak.

Effect: The condition has no known material effect to the financial statements. However, the entity is non-compliant with its policy.

Recommendation: We recommend that MiCARE strengthen its internal control over cancellation of CR.

Auditee Response: Existing policy requires that all three copies of the cash receipts be retained whenever a cash receipt is voided. In this particular instance, a white copy of the voided receipt was missing, which is not in compliance with the policy. The staffs particularly the cashier involved in issuing payment receipts were reminded of the policy and to ensure strict compliance to existing policy.

Finding No.: 2005-03
Area: Timeliness of Deposits

Criteria: Per entity's policy, all collections during the day must be deposited into the Plan's depository bank account on the day received or immediately on the following working day to prevent misappropriation of cash collected.

Condition: For 10 of 25 (40%) transactions tested, we noted that cash collected was deposited after two or more working days.

Cause: Internal controls over the timely deposit of cash collected appears to be weak.

Effect: The condition has no known material effect to the financial statements. However, there is a risk that cash collected could be misappropriated. Also, the entity is non-compliant with its policy.

Recommendation: We recommend that MiCARE strengthen its internal controls over the timely deposit of cash collections.

Auditee Response: The policy requires that all collections during the day must be deposited into the Plan's depository bank account on the day received or immediately on the following working day to avoid misappropriation or disappearance of cash collected. The subject audit finding was discussed with and among individuals who are tasked and who are involved in making deposit of payment collection. Management reminded the individual employee who is assigned the responsibility to deposit cash collections to be mindful of the existing policy and to ensure strict compliance with the policy and procedure in place for cash deposits. Cash and payment collections received during the day should either be deposited the same day they were received, or immediately on the following working day.

Finding No.: 2005-04
Area: Unsupported Cash Receipts

Criteria: As per US GAAP, revenue should be recognized when earned. As such, revenue should be properly supported by contracts or billing statements in order to determine the amount of revenue earned during the year.

Condition: For all transactions tested, we noted that insurance contracts and/or billing statements were not available.

Cause: The root cause of the weakness is lack of control over recordkeeping.

Effect: There is a risk of recording the revenue in the wrong period. Revenue earned in FY 2005 that was collected in FY 2006 may be recorded as revenue of FY 2006.

Recommendation: We recommend that MiCARE should obtain insurance contracts for all its participating members.

Finding No.: 2005-04, Continued
Area: Unsupported Cash Receipts

Auditee Response: As a sound standard practice, revenue should be recognized when earned. As such, revenue should be properly supported by contracts or billing statements in order to clearly determine what specific periods the payment represents. The payment received should be recorded properly to reflect amount of revenue actually earned during the year. There is a logging system that is kept internally, to monitor timely payment due, and to flag out any payments due that remained outstanding. There is really no contract per se, between the Plan and the participating agency. By practice, the payment should always be filed with a list showing specifically, the premium due and paid for each member by pay periods. The management discussed the findings, and agreed that there should be clear and definitive requirement to make sure that all cash receipts are supported accordingly.

Finding No.: 2005-05
Area: Independent Checks

Criteria: The entity has only one staff in each of their field offices in Chuuk, Kosrae, and Yap. Cash collection reports are not being reviewed.

Condition: The entity has only one staff in each of their field offices in Chuuk, Kosrae, and Yap. Cash collection reports are not being reviewed.

Cause: The entity appears to be understaffed in its field offices.

Effect: The condition has no known material effect to the financial statements. However, the risk of cash collection being misappropriated is high.

Recommendation: We recommend that MiCare have independent checks of cash collected from each of their field offices or inquire if such collections can occur at the FSM National Government Revenue offices.

Auditee Response: The audit finding recommending for additional staff at the field offices in Chuuk, Kosrae and Yap, for purposes of reviewing and certifying premium payment at ach respective field offices to avoid or reduce the risk of misappropriation, is well taken. The finding was discussed and considered, however, it is not quite feasible at this time due to the small amount of transactions being handled at the field office. There is a monitoring mechanism in place now, but it is being done at the Central Office in Pohnpei. At the moment, the Fiscal Officer is tasked to closely monitor the field offices' collection and to reconcile accounts on a daily basis to ensure that all collections are deposited to the Plan's depository bank account. Confirmation of payment to the Plan's account with all participating entities will continue to be done on a regular manner to avoid the risk of misappropriations of the Plan's funds. The recommendation to have independent checks on cash collected is a sound management policy. While the management will continue to explore ways to improve the current practice, or explore other options to ensure independent checks, assigning the task to FSM National Revenue Offices in each of the State at this time is not quite workable in our view. While the current law requires that the health insurance fund be kept, and managed separate from the general fund, and FSM National Revenue Office collecting taxes, and revenues going to the general fund, there is a fear that if collections are co-mingled, there is a risk in assigning payments to the general fund. Even program like Social Security is doing their own collections, independent of the Revenue Office.

Finding No.: 2005-05, Continued
Area: Independent Checks

Auditee Response, Continued:

Assigning the payment collection to National Revenue Office may add unnecessary delay in remitting the proceeds to the Plan for its use to meet obligations necessary. The cash flow situation with the Plan at this time requires immediate availability of cash to pay outstanding obligations. Despite all these, the issue of independent checks will continue to be explored, and improved upon to avoid misappropriation of payment of premium collections.

Finding No.: 2005-06
Area: Medical Claims Review

Criteria: As per entity's policy, billings, vendor's invoices and claim forms should be properly reviewed by the utilization officer to ensure that all medical claims are covered by the Plan.

Condition: For 1 of 25 (4%) transactions tested, we noted that billings, vendor's invoices, and claim forms were not reviewed by the utilization department.

Cause: The root cause of the weakness is inadequate review of the disbursement documents by the utilization officer.

Effect: The condition has no known material effect to the financial statements. However, there is a risk that some of the medical claims are not covered by the Plan.

Recommendation: We recommend that all medical claims be properly reviewed by the utilization officer.

Auditee Response: The audit finding claimed that, tests on some transactions showed that billings, vendor's invoices and claim forms were not reviewed by the utilization department. the Plan's current organization has three departments' administration, utilization and accounting. Each of these departments have assigned duties and responsibilities. In the Utilization Department at the Central Office in Pohnpei, we have 5 staffs responsible for reviewing medical claims. During the period subject to this audit, the Plan had a medical doctor heading the utilization department, with a title "Utilization Manager", who oversaw the utilization of benefits in reviewing all claims submitted for payments, and to make sure that all claims are properly reviewed. However, if the utilization manager is unavailable due to outside travel, etc., the responsibility in overseeing the utilization reviews is normally delegated to another staff to act on his behalf. However, when more in depth review on more complicated cases are required, they usually are held pending the doctor's review. This practice is followed so operations and processing of claims will not be delayed, while the more complicated ones requiring more in depth reviews are held pending the doctor's review. But to suggest that some claims were paid without utilization review, is a more serious problem that needs immediate corrections. I reviewed the current procedures and have yet to come across any claims that may otherwise by-passed the screening review.

Finding No.: 2005-06, Continued
Area: Medical Claims Review

Auditee Response, Continued:

However, staffs are reminded to make sure that claims are properly reviewed and in order for payment before they are submitted to the accounting department for payment. Subsequent to the audit period, the position for the utilization manager has been vacant, however, the selection has recently been finalized, and in matter of days, she will come on board. In the meantime, the utilization department has been instructed by management to review claims and process for payments, medical bills and others which are legitimate and in order. Those requiring further review by the doctor, will be either sent to other individual assisting the Plan now or until the utilization manager is hired. Management has directed all departments to purchase appropriation stamps for their department use, including one with "REVIEWED" to be stamped on claims which received and reviewed by the utilization department before payments are made.

Finding No.: 2005-07
Area: Missing Signatures

Criteria: As per the entity's policy, the preparer, controller, and administrator are required to sign the disbursement voucher upon verifying the accuracy and completeness of the attachments.

Condition: For 1 of 25 (4%) transactions tested, the disbursement voucher did not have the required signatures.

Cause: The persons required to sign the disbursement voucher did not perform their assigned task.

Effect: The condition has no known material effect to the financial statements. However, the entity is non-compliant with its policy.

Recommendation: We recommend that the responsible persons ensure that required tasks are carried out.

Auditee Response: Management acknowledged this oversight in not securing the required signatures on disbursement voucher. The management reminded the department involved to make sure that all requirements are met before any subsequent actions is done. Before any checks are prepared for payments, disbursement vouchers should be properly checked to make sure they are approved with proper and required signatories. Disbursements voucher process is in place, and those individuals required to review or sign the voucher documents are reminded to do their assigned task properly.

Finding No.: 2005-08
Area: Overpayment of Medical Claims

Criteria: All expenditure should be adequately supported by underlying documents such as vendor's invoices, allotment advices, etc.

Condition: For 2 of 25 (8%) transactions tested, the payments exceed the invoice amount.

Finding No.: 2005-08, Continued
Area: Overpayment of Medical Claims

Cause: The root cause of the weakness is inadequate review of vendor invoices.

Effect: The entity overpaid the vendor by $ 1,070.04. Also, medical claims expense is overstated by this amount.

Recommendation: We recommend that all medical claims be properly reviewed to ensure payments are adequately supported by vendor invoices.

Auditee Response: Management acknowledged the findings, however, the adjustment in correcting the mistake was done with the particular vendor's account subsequently. The subject vendor's subsequent claim was adjusted and was offset against the vendor's account by the amount overpaid. Management has directed the Accounting staff to be extra careful and to carefully double check all claims adjusted by Manila Office.

Finding No.: 2005-09
Area: Patient's Share Miscalculation

Criteria: Patient's share should be properly calculated to ensure that medical bills are correctly shared by the entity and the covered person.

Condition: For 1 of 25 (4%) transactions tested, we noted a systematic error in calculating the patient's share.

Cause: The root cause of this weakness is that the formula used for calculating the patient's share was incorrect.

Effect: The condition has no known material effect to the financial statements. However, there is a risk that the entity's members are paying more than their share of the medical bills.

Recommendation: We recommend that MiCARE ensure that the formula being used for calculating patient's share is correct.

Auditee Response: There has been established policies promulgated in the Rules, designating patient's responsibility in sharing cost of medical treatments, e.t.c. Likewise, there are established formula calculation placed and should be used and be consulted constantly in determining the patient's share of medical cost. The staffs are again reminded to make sure that established formula calculation is followed correctly and consistently. Management discussed the findings with the staffs and emphasized the need to compute co-payment accurately. In addition to management's reminder to staff to follow right formula for calculating shares between the Plan and the patient, a sample of correct calculation to determine the patient's share was devised and was given to employees involved with such calculation.

Finding No.: 2005-10
Area: Late Posting

Criteria: For best practice, transactions should be recorded at least on a monthly basis to reflect the correct balances on a timely manner.

Condition: Based on work performed and inquiry with the entity, cash receipts are being posted on a quarterly basis.

Cause: The root cause of this weakness is inappropriate policy over posting of cash receipts.

Effect: The condition has no known material effect to the financial statements. However, there is a risk that cash receipts would not be recorded because cash receipts were lost. Also, the correct balances of cash and receivable are not reflected on a timely manner.

Recommendation: We recommend that MiCARE record cash receipts at least on a monthly basis.

Auditee Response: The audit finding appear to address weakness in "inappropriate policy" over posting of each receipt for account receivable, audit finding suggests that cash receipt on account receivable should be recorded at least on a monthly basis. MiCare's current practice requires that cash receipts posting are to be done on a daily basis. However, the cash receipt for account receivables are posted on a quarterly basis. Management will adhere to the recommendation to post payment for account receivable accounts on a monthly basis.

Finding No.: 2005-11
Area: IBNR Deficiency

Criteria: A formal IBNR system should be utilized to project medical bills incurred, but not received.

Condition: The entity does not have a formal IBNR process wherein it estimates associated medical referrals and then tracks the actual results against the estimates. Rather, it relies on after the fact reporting by hospitals and others and a very long time period in which it waits to obtain underlying invoices. Therefore, without such a time period available to it, the entity will not be able to project its actual liability at any point in time.

Cause: The cause of this condition is that a formal IBNR system has not been initiated.

Effect: The impact of this matter is that incorrect financial data is maintained during the year.

Recommendation: A full lag-analysis supported IBNR system should be developed and implemented.

Auditee Response: We agree with the finding that the Plan as of now, does not have a formal IBNR process in place. We further concur with and support the recommendations to develop and to implement an IBNR system, one that will enable management to set aside and monitor financial obligations as they incur. Management fully agrees that it would be a good and sound management policy to obligate certain amount based on estimate when a referral is made, then when actual costs are reported, they will be offset against the estimate. The Plan will continue to make efforts by advising all participating providers on-island and off-island to submit their billings in a timely manner.

Finding No.: 2005-12
Area: Claims Review

Criteria: Claims are to be reviewed by the utilization department. This practice was designed to ensure that all medical claims are covered by the Plan.

Condition: In 1 of 115 (1%) transactions tested, the claim # 05-0070 for $15,447.88 was not reviewed by the utilization department.

Cause: The root cause of this condition is that controls over the review of medical claims were not effective in this instance.

Effect: The condition has no known material effect on the financial statements. However, the risk of medical claims being paid that are not covered by the plan increases due to the absence of a review.

Recommendation: We recommend that MiCARE ensure that medical claims be properly reviewed by the utilization department, which will ensure that claims are subject to appropriate coverage.

Auditee Response: As an office procedure, all claims must be reviewed by Utilization Department before payment is made. The above subject finding was happened when there was an offsetting made by Honolulu Medical Group against MiCare Trust account on delinquent accounts. We agree on this finding and the management has instructed the Accounting and Utilization staff to be extra careful and to properly examine all claims before offsetting is done to ensure that only eligible charges are being paid by the Plan. There is a need also to review and amend the existing service provider contract to include some restrictions or limitations on withdrawal of accounts making sure that both parties agrees on the amount subject for offsetting.

Finding No.: 2005-13
Area: Facilitation

Criteria: Documentation should be on file to substantiate contractual relationships.

Condition: The entity transacts with one provider` through a facilitator. Billings from and payments to the provider go through the facilitator before being forwarded to the provider. We were unable to locate a contract for this service and could not determine the manner in which the facilitator was selected.

Cause: The entity may have inadequate documentation to support its relationship with the facilitator.

Effect: The condition has no known material effect on the financial statements. However, we were unable to determine the reason for the use of this facilitator.

Recommendation: We recommend that MiCARE examine the basis for the use of the facilitator and document the attendant rationale in writing.

Auditee Response: We acknowledge this finding. This arrangement was made when the Plan was not successful to have a Memorandum of Agreement with Philippine Heart Center (PHC) due to numerous requirements such as SEC Registration and Business License, which the Plan was not able to comply. However, because of the interest of the Plan to get PHC as one of the main providers in Manila for cardiac cases patients, the Plan has made an oral arrangement with Dr. Saavedra to represent MiCare on his behalf. With the help of Dr. Saavedra's office, the Plan was able to use PHC for MiCare patients.

Finding No.: 2005-13, Continued
Area: Facilitation

Auditee Response, Continued:

The Plan processed payments on all claims from PHC, however, payments are sent directly to Dr. Saavedra's office. Because of the risk exist on this transaction; management has instructed the Accounting Department to make direct payments to the hospital instead of Dr. Saavedra. Subsequent to the audit period, while the Plan still in the process of reviewing the renewal contract, a letter was received from PHC agreeing to send payments direct to the hospital. Management has also directed the administration department to review all providers' contracts and to make sure the Plan's relationship is legal, binding and transparent.