PENN TREATY AMERICAN CORP
Form 10-K
April 02, 2008
UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

x Annual Report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934
For the fiscal year ended **December 31, 2006**

or

o Transition Report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934

For the transition period from ___________to _________

Commission file number: 001-14681

PENN TREATY AMERICAN CORPORATION

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization	23-1664166 (I.R.S. Employer Identification No.)
3440 Lehigh Street, Allentown, Pennsylvania (Address of principal executive offices)	18103 (Zip Code)

Registrant's telephone number, including area code **(610) 965-2222**

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, par value $.10 per share,

Listed on the New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 402 of the Securities Act.

Yes o No x

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

Yes o No x

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes o No x

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (section 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See

definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o Accelerated filer x Non-accelerated filer o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No. x

Based upon the last sale price of the registrant's Common Stock on June 30, 2006, the aggregate market value of the outstanding shares of voting stock held by non-affiliates of the registrant was $170,564,833.

As of March 28, 2008, 23,290,712 shares of the registrant's Common Stock were issued and outstanding.

Documents Incorporated by Reference: None.

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Explanatory Note

This is our Annual Report on Form 10-K for the year ended December 31, 2006. In this document we present our 2006 financial statements and Management's Discussion and Analysis of Financial Condition and Results of Operations. Throughout the document we have also included 2007 information where appropriate and available.

On February 15, 2008 we filed a Form 8-K, that included all of the sections and items of this Form 10-K for the fiscal year ended December 31, 2006, except for Quarterly Data, Item 9A-Controls and Procedures, the Reports of Independent Registered Public Accounting Firm, Management's Report on Internal Control Over Financial Reporting, and the Report of Independent Registered Public Accounting Firm on Internal Control Over Financial Reporting. The exhibit list was also omitted.

The audited financial statements in this Form 10-K differ from the unaudited financial statements in the Form 8-K filed on February 15, 2008 in that we increased claim reserves by an additional $9.6 million ($6.2 million net of taxes) which increased our net loss to $33.2 million and decreased our book value per share to $8.91 as of December 31, 2006.

On March 26, 2007, we filed our Form 10-K for the fiscal year ended December 31, 2005. The Company has not filed Quarterly Reports on Form 10-Q for the quarters ended March 31, 2006, June 30, 2006, September 30, 2006, March 31, 2007, June 30, 2007 and September 30, 2007. These reports will be filed after the completion of the 2007 Annual Report on Form 10-K.

The initial reason for the late filings is that in October 2006 we requested an interpretation of an accounting rule from the staff of the Securities and Exchange Commission and consequently, all of the Company s periodic reports were delayed while such request was pending. The interpretation pertained to the prospective unlocking of assumptions employed in the Company s policyholder benefit reserve liability and unamortized deferred acquisition cost asset. Although this matter had not been concluded, the Company had filed its Annual Report on Form 10-K for the year ended December 31, 2005 utilizing its most recent locked in factors in computing its results of operations. As a result of the request, we did not file our Form 10-K for the year ended December 31, 2005 until March 26, 2007. It has come to our attention that on February 28, 2008, in a response to another company, the SEC staff expressed their view that prospective unlocking of policyholder benefit reserve and deferred acquisition cost assumptions was not in accordance with generally accepted accounting principles. The audited financial statements in this Form 10-K were prepared utilizing our locked in factors and we are no longer considering prospective unlocking for the year ended December 31, 2007. However, we may pursue this issue again with the SEC in the future.

Subsequent to filing our Form 10-K for the year ended December 31, 2005, we discovered certain financial statements errors. These errors are not material to either the year ended December 31, 2005 or prior years. However, an error related to our actuarial assumptions did have a material impact on each of the quarters of 2005, and therefore, we have determined that a restatement of the financial statements for the year ended December 31, 2005 is needed. The 2005 financial statements included herein have been restated to correct the errors. There was no adjustment to years prior to 2005. As a result of the restatement shareholders' equity decreased $526,000 from the previously filed financial statements.

PART I

Forward-Looking Statements

Certain statements made by us in this filing may be considered forward-looking within the meaning of the Private Securities Litigation Reform Act of 1995. Although we believe that our expectations are based on reasonable assumptions within the bounds of our knowledge of our business and operations, there can be no assurance that our actual results of operations will not differ materially from our expectations. Factors which could cause actual results to differ from expectations include, among others, those described in Risk Factors beginning on page 24.

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Available Information

The public may read and copy any materials we file with the SEC at the SEC s Public Reference Room located at 100 F Street N.E, Washington, D.C., 20549. In order to obtain information about the operation of the Public Reference Room, you may call the SEC at 1-800-732-0330. The SEC also maintains a site on the Internet that contains reports, proxy and information statements and other information regarding issuers that file electronically with the SEC. The SEC s website is http://www.sec.gov.

The address for our internet website is https://www.penntreaty.com. We make available, free of charge, through our website, our annual report on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, and all amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC.

We provide access through our website to current information relating to corporate governance. Copies of our Audit Committee Charter, our Nominating and Corporate Governance Committee Charter, our Code of Ethics for the Chief Executive Officer and Senior Financial Executives, our Corporate Governance Guidelines, our Code of Business Conduct and Ethics for all employees, our Compensation Committee Charter and other matters impacting our corporate governance program are accessible on our website. Copies of these documents may also be obtained free of charge by contacting Penn Treaty American Corporation, 3440 Lehigh Street, Allentown, PA 18103, Attention: Corporate Secretary. We intend to post on our website any amendments to, or waivers from, our Code of Ethics for the Chief Executive Officer and Senior Financial Executives, which are required to be disclosed by applicable law, rule or regulation. Information contained on Penn Treaty s website is not part of this document.

Item 1. **Business**

(a) **The Company and the Long-term Care Insurance Industry**

Penn Treaty American Corporation

We are a provider of long-term care insurance in the United States. Our principal products are individual, defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care. Our policies are designed to provide benefits if and when the insured is no longer capable of functioning independently. Although long-term care policies accounted for approximately 97% of our total annualized issued premium as of December 31, 2007 and 2006, we also sell Medicare supplement policies. Our total long-term care in-force premiums were approximately $295 million and $307 million at December 31, 2007 and 2006, respectively. We also own insurance agencies that sell senior-market insurance products issued by us as well as other insurers.

We introduced our first long-term nursing home insurance product in 1972 and our first home health care insurance product in 1983. Since then, we have developed several new products designed to meet the changing needs of our customers. Our primary product offerings currently are:

- The Personal Freedom® policy, which provides comprehensive coverage for facility and home health care;
- The Secured Risk® product, which is a limited benefit policy designed for applicants who would not otherwise qualify for traditional long-term care products due to their current health condition;
- The Assisted Living Plus® policy, which provides coverage for all levels of facility care and includes an optional home health care rider;
- The Independent Living® policy, which provides coverage for home and community-based care furnished by licensed care providers, as well as unlicensed caregivers and includes an optional facility rider; and
- Simple LTC Solution^{SM}, which offers a simplified and more affordable approach to long-term care insurance and provides coverage for facility and home health care services.

Corporate Background

Penn Treaty American Corporation (Penn Treaty) is registered and approved as a holding company under the Pennsylvania Insurance Code. Penn Treaty was incorporated in Pennsylvania on May 13, 1965 under the name Greater Keystone Investors, Inc. and changed its name to Penn Treaty American Corporation on March 25, 1987. Our primary business is the sale of long-term care insurance, which we conduct through the following subsidiaries:

- Penn Treaty Network America Insurance Company (PTNA) a Pennsylvania-domiciled insurance company;
- American Network Insurance Company (ANIC) a Pennsylvania-domiciled insurance company; and
- American Independent Network Insurance Company of New York a New York-domiciled insurance company.

We also conduct insurance agency operations through the following subsidiaries:

- United Insurance Group Agency, Inc. a Michigan-based consortium of insurance agencies;
- Network Insurance Senior Health Division a Florida-based insurance agency brokerage; and
- Senior Financial Consultants Company a Pennsylvania-based insurance agency brokerage.

The Long-Term Care Insurance Industry

Based on the 2006 and 2007 Annual Surveys by LIMRA International:

- Industry-wide individual long-term care insurance sales in 2007 grew by approximately 3% over 2006 levels, reversing a trend of reductions of 8% and 5% in 2006 and 2005, respectively. Approximately $633 million in new annual policy premiums were issued in 2007 compared to $614 million in 2006 and $661 million in 2005.
- The total number of individual in-force policies at the end of 2007 exceeded 4.6 million, compared to 4.5 million at the end of 2006, with in-force annualized premium reaching $8.1 billion in 2007, compared to $7.7 billion in 2006.

We believe the potential for future growth in the long-term care industry remains significant. According to a 2000 U.S. Census Bureau report, the population of senior citizens (people age 65 and over) in the United States is projected to grow from an estimated level of approximately 35 million in 2002 to approximately 70 million by 2030. Furthermore, health and medical technologies are improving life expectancy and, by extension, increasing the number of people requiring some form of long-term care. The projected growth of the target population indicates a substantial growth opportunity for companies providing long-term care insurance products. We believe that the rising cost of nursing home and home health care services, along with the increasing strain these services are having on the state and federally financed Medicaid system (which is the largest payer of long-term care services) makes long-term care insurance an attractive means to pay for these services. According to reports by the Centers for Medicare and Medicaid Services, the combined cost of home health care and nursing home care was $20.0 billion in 1980. By 2001, this cost rose to $134.9 billion. In 2003 the cost was $150 billion. In 2005, national spending on long-term care totaled $207 billion according to the Health Policy Institute, Georgetown University. The proportion of spending on home and community based care continues to grow, accounting for 37% of total long-term care spending in 2005, compared with 19% ten years earlier.

While long-term care insurance has been sold by our Company for over 35 years, recent changes in legislation, aging demographics and consumer education have increased awareness of the product. The Deficit Reduction Act, signed into law in February 2006, promotes the utilization of long-term care insurance in three distinct ways. The primary provision includes the expansion of long-term care partnership programs to all states by filing Medicaid state plan amendments. These partnership programs allow for asset protection equal to the amount of long-term care insurance benefits used without affecting their eligibility for Medicaid. Other key long-term care provisions include Medicaid reform by states and a promotion effort aimed at educating the consumer on long-term care issues. These

three areas - partnership expansion, revision of Medicaid eligibility and consumer education - are expected to raise consumer awareness of long-term care issues and long-term care insurance as a financing tool. Implementation will require coordination between the states and federal agencies. We are unable to predict the impact this will have on our future sales.

According to the U.S. Census Bureau, the aging demographic continues to expand this market segment as nearly eight thousand of the 78 million Baby Boomers turn 60 every day (Press Release January 3, 2006). The Baby Boomers are learning about long-term care issues as they deal with aging parents - many without adequate resources for the care, medications and choices that face them

Our Strategy

Our vision for the future is to be a leading provider of long-term care insurance solutions, with related services and products, which offer our customers and their families security through asset and income protection and the preservation of choice of eligible care providers. Our value proposition incorporates stratification of underwriting risk, innovative product development, efficient and effective underwriting, improved claims adjudication processes, wellness programs and an individualized service culture for agents and policyholders. We believe we can achieve this goal through profitable sales growth, diligent management of our in-force policies and ongoing service enhancements.

We have retained Friedman, Billings, Ramsey & Co., Inc. ("FBR") to assist our Board of Directors in the review of strategic alternatives to enhance shareholder value. These alternatives could include, but are not limited to, capital structure review, strategic partnerships, business combination transactions or the sale of certain assets. There can be no assurance that our review of strategic alternatives will result in any specific transaction. We do not expect to disclose any further developments with respect to the exploration of strategic alternatives unless and until our Board of Directors has approved a transaction or other strategic alternative.

We will be continuing with all of our previously planned sales and marketing efforts throughout the review of strategic alternatives, including seeking to identify an even stronger financial platform from which distribution partners and financial advisors can promote and increase the sale of our long-term care insurance policies.

Sales

We provide an individualized service culture for agents and policyholders and we also have the ability to underwrite applicants not considered for coverage by our competitors due to their current health condition. We are able to issue policies on a high percentage of applications because of our ability to stratify the risks we are presented into five underwriting classes and appropriately price for insurance coverage in each class. This core competency allows agents representing Penn Treaty to reach out to a broader segment of the population and ultimately be more productive.

Sales of new products are expected to be a driving force in generating profits in the future. In 2007 our issued annualized long-term care premium was approximately $16.1 million which is 8.5% below 2006 sales. In 2006, sales of our current generation of long-term care insurance products totaled approximately $17.6 million on an issued annualized premium basis, 12% below the sales level of 2005. We believe the decreases in 2007 and 2006 were due to the uncertainty created by the late filing of our 2006 and 2005 Form 10-K, the amount of time we were prohibited from selling new business in the state of Florida, the focus by a number of our independent agents on the new Medicare Part D and fee for service products, and the impact on current and potential new distribution from negative press regarding Penn Treaty and the long-term care industry in general.

While the performance and related loss ratio of our business issued prior to 2002 continues to reflect volatility and profitability below our expectations, our new business issued since January 1, 2002 has performed better than our expectations. These polices constitute approximately 18% of our annualized premiums in force as of December 31, 2007. During the early duration of these policies, incurred losses have been approximately one third of the amount we projected. We cannot guarantee that this performance will continue as these policies become more seasoned.

We primarily market our long-term care insurance products through Field Marketing Organizations (FMOs), which are generally large, independent, multi-agent networks utilized for the purpose of recruiting agents and developing networks of agents in various states. FMOs retain a portion of the commissions we pay on business written in return for recruiting, training and motivating independent agents to place business with Penn Treaty. Approximately $15.1 million or 94% of our 2007 long-term care sales were generated by FMOs. Approximately $17.1 million or 97% of our 2006 long-term care sales were generated by FMOs.

In 2008, we introduced our LTCi QuickPass^{SM} program, which we believe will simplify the approach to selling long-term care policies for our FMOs. The traditional long-term care sale is generally accomplished by the agent meeting face-to-face with a potential applicant, completing a lengthy application with numerous benefit calculations, obtaining a signature and collecting an initial premium check prior to submitting the application to us.

With the LTCi QuickPass program, we have modified this process. A one page form can now be completed in the potential applicant's home or over the phone. If the answer is "no" to the five health questions on the form, the agent submits the form to us. There are no complicated rate calculations and no need to collect premium at this stage in the process.

Once the form is submitted, a nurse from an outside agency will contact the potential applicant to schedule an interview and gather additional health information for the underwriting process. If the applicant qualifies for a policy they will be given a proposal, which is guaranteed for 30 days, subject to financial suitability requirements.

Agents can use the LTCi QuickPass program to submit all of their business or they can utilize it as an alternative insurer option at the point of sale. We believe that this will enable new agents to learn the long-term sales process more quickly. We also believe that this simplified program will streamline the application process so as to allow agents to spend more time on generating additional sales. Through February 29, 2008, we have received more than 700 LTCi QuickPass submissions.

Distribution opportunities are expanding for long-term care insurance, with the product increasingly being recognized as a valuable tool for wealth advisors involved in financial planning and lifestyle programs. For financial advisors who have not typically sold long-term care insurance to their clients, we believe the product is a cross-selling and asset-retention vehicle. We have been exploring this and other distribution channels to maximize growth opportunities in the coming years. In February 2007, we introduced our PersonaLTC® platform specifically designed to help financial advisors deliver long-term care insurance solutions to their clients. This platform includes:

- A new simplified application process.
- The use of our underwriting capabilities to help reduce the number of declined applications experienced by financial advisors.
- A national co-sales specialist network that utilizes our FMOs.

From the beginning of the second quarter of 2007 through the filing of this document, we have signed distribution contracts with 17 financial advisor organizations and continue the development of the wholesaling, training and support infrastructure to facilitate sales growth. As of the time of this filing, no material sales have been generated from this distribution channel. However, we expect sales to materialize in 2008, as our efforts change from recruiting financial advisor organizations to training them and supporting them in their sales efforts of our products.

There are a myriad of chronic health conditions that exist in various population segments in the United States. Advances in wellness, diagnostics and pharmacology have allowed many people to live active and stable lives despite these health conditions. Hypertension, diabetes, osteoarthritis, obesity and cancer are examples of prevalent co-morbid conditions that we evaluate for long-term care insurance in our physically impaired risk product line. Early diagnosis and excellent management of conditions are evaluated by our underwriters. We offer five different underwriting classes based on an applicant s health and overall risk. Significant surcharges are added to our base rate so that we are able to offer coverage to individuals with varying degrees of risks. Although this approach is common in other lines of insurance such as life and disability, we believe our approach is unique to the long-term care insurance marketplace and that our underwriting breadth distinguishes us from our competition, allowing our agents to offer coverage to many additional applicants.

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Management of In-Force Policies

As a leading provider of long-term care insurance with over 35 years of issued polices and historical long-term care data, we currently manage multiple product generations (new and revised products introduced at different times in our history), including facility only, home health care only, comprehensive, tax-qualified and non tax-qualified business. Our in-force policies written before December 31, 2001 have demonstrated a high degree of volatility, requiring recurrent evaluations and multiple rounds of premium rate increases. All of our in-force policies are reviewed at least quarterly in order to identify any trends that are different than previously anticipated. If negative trends are identified, we take action to correct these trends. These actions include requesting authority from state regulators to permit premium rate increases or a voluntary reduction of the level of benefits in exchange for a reduced premium rate increase or no premium rate increase. In addition to premium rate increases, we also manage our in-force policies through improvements to our claims adjudication processes, general and administrative expense management and recently introduced wellness programs.

We launched a wellness program for our policyholders that will provide them with a host of important health related information long before they require long-term care services. The wellness program is expected to include a comprehensive menu of interactive, educational, and reference based wellness resources that we believe promote and support the inherent desire of all persons to maintain their cognitive health and functional independence well into their senior years. This initiative will deliver a coordinated series of community and web based medical, psychological and social support, education, information and referral services, lifestyle coaching, and an emergency responder service for our policyholders that live alone.

The cognitive health programs and critical disease screening programs have been introduced to some of our policyholders. The cognitive component, the brain fitness program from PositScience , is a computer based cognitive health and fitness program that is designed to provide our policyholders with the opportunity to take a proactive approach to managing their cognitive health. Dementia related impairments such as Alzheimer's Disease, are among the leading causes of claims in the long-term care insurance industry. If the results of the brain fitness program among our policyholder population mirror the positive results shown in the scientific research that has been conducted on this program, there may be a significant benefit to both our policyholders and to Penn Treaty.

(b) Insurance Products

Since 1972, we have developed, marketed and sold defined benefit accident and health insurance policies designed to be responsive to changes in:

- the characteristics and needs of the senior insurance market;
- governmental regulations and governmental benefits available for senior citizens; and
- the health and long-term care delivery systems.

We evaluate input from both our independent agents and our policyholders with respect to the changing needs of the long-term care market. In addition, our representatives regularly attend regulatory meetings, industry consortiums and seminars to monitor significant trends in the long-term care industry.

The following table sets forth, at the dates indicated, information related to our policies in force:

	(annualized premiums in $000's) December 31, 2007		2006		2005	
Long-term care:						
Annualized premiums	$ 295,384	97.4%	$ 307,045	96.6%	$ 316,785	95.7%
Number of policies	147,836		153,597		160,700	
Average premium per policy	$ 1,998		$ 1,999		$ 1,971	
Disability insurance:						
Annualized premiums	$ 160	0.1%	$ 208	0.1%	$ 248	0.1%
Number of policies	495		704		819	
Average premium per policy	$ 323		$ 295		$ 303	
Medicare supplement:						
Annualized premiums	$ 7,506	2.5%	$ 8,467	2.6%	$ 11,472	3.4%
Number of policies	3,618		4,415		5,975	
Average premium per policy	$ 2,075		$ 1,918		$ 1,920	
Life insurance:						
Annualized premiums	$ -	0.0%	$ 2,027	0.6%	$ 2,245	0.7%
Number of policies	-		3,748		4,086	
Average premium per policy	$ -		$ 541		$ 549	
Other insurance:						
Annualized premiums	$ 131	0.0%	$ 148	0.1%	$ 166	0.1%
Number of policies	1,269		1,395		1,554	
Average premium per policy	$ 103		$ 106		$ 107	
Total annualized premiums in force	$ 303,181	100.0%	$ 317,895	100.0%	$ 330,916	100.0%
Total Policies	153,218		163,859		173,134	

Our long-term care insurance policies provide benefits for care provided in a long-term care facility, care received at home or both. Policies that include coverage for long-term care facilities provide benefits for confinement to nursing facilities as well as assisted living facilities. Our policies generally require that the insured need assistance with at least two activities of daily living or have cognitive impairment that makes it unsafe for them to live unsupervised in order to be eligible for benefits. Most of our non-tax-qualified policies (deemed such because they do not meet the requirements for tax-qualified policies established by HIPAA) also provide benefits for care prescribed by a physician.

Benefits paid for long-term care facility confinement are generally paid on an expense-incurred basis, subject to a daily maximum selected at the time the policy was issued, ranging from $60 to $300 per day. Some of our older policies pay the policy s full daily maximum as an indemnity benefit without regard to the expense incurred. Benefits are paid for as long as the insured remains under the policy requirements, or until the policy s maximum benefit period has been exhausted. Benefit periods range from one to 10 years or are unlimited. Effective January 1, 2007, we no longer offer policies with an unlimited benefit period. The maximum benefit period we now offer is seven years.

Many policies also offer benefits for home health care services. Nurses, home health aides and certified nursing assistants are typically covered for the care/services they provide in the insured s home. Some policies also cover private, unlicensed caregivers and family members, subject to our pre-approval. Home health care benefits are paid on an expense-incurred basis and are generally subject to the same requirements and limitations as facility benefits, such as the daily maximum and maximum benefit period described above.

Our long-term care insurance policies may also cover other long-term care providers and services, such as adult day care and hospice care. Most policies include waiver of premium benefits that waive the premiums payable for the duration of the claim once the insured has received benefits for 90 days and restoration of benefits features that permit the benefits of the policy to be replenished after the insured has recovered and remained independent of the need for care for a specified period of time. Many policies also include an inflation feature, purchased as a rider to the base policy, which is intended to allow the benefit amounts purchased to keep pace with the rising cost of care.

Our current product offerings include the following:

Personal Freedom policy. Our Personal Freedom policy (offered since 1996) provides comprehensive coverage in that it covers both facility care and home health care. Personal Freedom® policies represented 43% and 46% of our policies issued in 2007 and 2006, respectively.

Secured Risk policy. Our Secured Risk policy (offered since 1998) provides limited facility care benefits to people who would not, due to health conditions, qualify for the more traditional long-term care insurance policy. An optional home care rider, offering limited coverage, is also available to those who qualify. This policy includes limitations not required in our other policies, such as waiting periods for pre-existing conditions, elimination periods (deductibles) of at least 100 days and maximum benefit periods of no more than three years. It excludes some of the features found in our other policies, such as waiver of premium benefits and restoration of benefits. Secured Risk policies represented 45% and 37% of our policies issued in 2007 and 2006, respectively.

Assisted Living policy. The Assisted Living policy (offered since 1999) provides facility coverage only and is a lower-priced alternative to the Personal Freedom policy. When coupled with an optional home health care rider, the Assisted Living® policy offers benefits similar to those of the Personal Freedom policy. Assisted Living policies represented 5% and 7% of our policies issued in 2007 and 2006, respectively.

Independent Living policy. The Independent Living® policy (offered since 1994) provides coverage for all levels of home health care. Independent Living policies represented 6% and 7% of our policies issued in 2007 and 2006, respectively.

Simple LTC Solution policy. The Simple LTC Solution policy (offered since 2005) provides a simplified, more affordable approach to long-term care insurance. This policy covers facility and home health care, but does not include many of the additional features found in our Personal Freedom policy. It includes cost-controlling features such as an automatic deductible, an ongoing policyholder co-payment, and limited benefit dollars that do not restore. Simple LTC Solution policies represented 1% of our policies issued in 2007 and 2006.

Riders. We offer numerous optional riders to our base policies, including home health care coverage, inflation protection, shared care (which allows spouses to share benefits) and a non-forfeiture benefit (which guarantees certain paid-up benefits in the event the policy lapses in the future).

Tax qualified and non-qualified policies. Following the enactment of HIPAA, we began offering a tax qualified policy, which allows for certain income tax deductions for premium payments and provides benefit payments that are not subject to tax. We continue to offer both tax-qualified and non-tax-qualified policies, with the non-tax-qualified policies generally offering access to benefits at lower levels of disability, while not offering the same preferential tax treatment as tax-qualified policies. Tax qualified policies represented approximately 93% and 90% of our policies issued in 2007 and 2006, respectively.

We employ the use of multiple risk underwriting classes that permit us to offer coverage to individuals who are considered healthy, as well as those with significant medical conditions. This tiered approach requires the policyholder to pay a premium that correlates with his/her health at the time of application and the risk associated therewith. Our Secured Risk policy is reserved for those in the highest-risk class.

In 2006, we modified the benefits offered within our Secured Risk policy, extending coverage on newly issued policies up to three years. In 2007, we also modified the benefits offered within the Secured Risk policy, increasing the

daily maximum to $150. We periodically evaluate new product opportunities that seek to match consumer attitudes for new coverage design. Our future product development efforts are designed to expand the distribution of long-term care insurance coverage, rather than competing with existing products. We seek to do so through the development of products that will attract applicants who could qualify for, but may not be interested in currently available products, and through the further expansion of our strategy to provide policies to those who do not qualify for traditional long-term care insurance products due to health conditions.

(c) Marketing

Historically, our business has been concentrated in a few key states. During 2007 and 2006, approximately 39% and 40%, respectively, of our direct premium revenue came from sales of policies in California, Florida and Pennsylvania. In 2001, we ceased new policy sales nationwide as a result of our statutory surplus levels until we formulated the Corrective Action Plan (the Plan) with the Commonwealth of Pennsylvania Department of Insurance (the Department). Upon the Department s approval of the Plan in February 2002, we recommenced new policy sales in 23 states, including Pennsylvania. We have now recommenced new policy sales in 21 additional states, including California and Florida (however, we are currently suspended from new sales in Florida, effective June 4, 2007). We are working with the remaining six states to recommence new policy sales.

The following table summarizes our sales of new long-term care and Medicare supplement policies in the periods indicated (in thousands):

	2007	2006	2005
Number of new policies sold	7	8	9
Annualized premiums	$16,268	$17,906	$21,018

Markets. The following chart shows premium revenues by state (dollar amounts in thousands):

	Year	Year Ended December 31,			Current Year %
State	Entered	2006	2005	2004	of Total
Arizona	1988	$ 12,446	$ 13,190	$ 13,671	4%
California	1992	41,013	43,826	46,585	14%
Florida	1987	44,931	49,090	50,435	15%
Illinois	1990	16,791	17,341	17,535	6%
North Carolina (2)	1990	7,989	8,775	9,430	3%
Ohio	1989	8,167	8,677	9,248	3%
Pennsylvania	1972	32,971	35,143	39,392	11%
Texas	1990	15,037	15,469	15,742	5%
Virginia	1989	21,983	21,789	22,477	7%
Washington	1993	9,846	9,995	10,270	3%
All Other States (1)(2)		83,593	86,221	85,100	29%
All States		$294,767	$309,516	$319,885	100%

(1) Includes all states with premiums of less than three percent of total premiums in 2006.

(2) We have not recommenced new policy sales in North Carolina or in five other states, which are included in *All Other States*.

Distribution Partners. We primarily market our long-term care insurance products through FMOs, which are generally large, independent, multi-agent networks utilized for the purpose of recruiting agents and developing networks of agents in various states. FMOs retain a portion of the commissions we pay on business written in return for recruiting, training and motivating independent agents to place business with Penn Treaty. Approximately 94% of the 2007 long-term care sales were generated by FMOs. At December 31, 2005, we had contracts to sell our products with approximately 75 FMOs. The number of FMOs decreased in 2005 from approximately 140 at December 31, 2004 as FMOs that did not meet certain production levels were transferred under other FMOs or ceased new sales with Penn

Treaty. The number of FMOs was further reduced to approximately 55 at December 31, 2006. The reduction in the number of FMOs allows us to focus our resources on FMOs that are more likely to increase production with respect to Penn Treaty products in the future. Beginning in 2006, we also began to recruit new FMOs that are interested in selling our products. We recruited four new FMOs in 2007 and five in 2006. As of December 31, 2007 we had 52 FMOs.

The remaining sales in both 2007 and 2006 were generated through strategic alliances with other long-term care insurance providers. These coordinated ventures offer our competitors captive sales agents access to our long-term care insurance products and underwriting breadth.

In February 2007, we introduced our PersonaLTC® platform specifically designed to help financial advisors deliver long-term care insurance solutions to their clients. This platform includes:

- A new simplified application process.
- The use of our physically impaired underwriting capabilities to help reduce the number of declined applications experienced by financial advisors.
- A national co-sales specialist network that utilizes our FMOs.

From the beginning of the second quarter of 2007 through the filing of this document, we have signed distribution contracts with 17 financial advisor organizations. As of the time of this filing there are no material sales yet generated from this distribution channel. However we expect sales to materialize in 2008, as our efforts change from recruiting financial advisor organizations to training them and supporting them in their sales efforts of our products.

(d) Administration

Underwriting

We have offered long-term care insurance products for over 35 years and we believe we have benefited significantly from our longstanding focus on this specialized line. Through our experience, we have been able to establish a system of underwriting designed to permit us to process our new business and assess the risks presented with new applications effectively and efficiently. This experience has also enabled us to devise a risk stratification system whereby we can accept a broad array of risks with correspondingly appropriate premium levels.

Applicants for long-term care insurance are required to complete applications and answer detailed medical questions about their health history, medications and other personal information. Additionally, each applicant must complete a telephonic or face-to-face interview conducted by an employee of our underwriting department or a nurse through an outside agency. These interviews are used to verify the information provided on the application, as well as obtain additional insight into an applicant s physical abilities, activity level, living situation and cognitive functioning.

As part of these interviews, all applicants are screened for cognitive impairment, a major contributor to the need for long-term care services. For those under age 65, the Delayed Word Recall screen is utilized. For those 65 and older, the Minnesota Cognitive Acuity Screen (MCAS) is performed. Unless the underwriting department determines that an in-home assessment is required, the MCAS is generally conducted telephonically for applicants between 65 and 74 years of age. For those ages 75 and over, an in-home assessment incorporating the MCAS is required. Depending on the applicant s health history, copies of an applicant s medical records are also frequently required. Our underwriting evaluation process not only assesses the risk the applicant currently represents, but also takes into account how existing health conditions and risk factors are likely to progress and affect an applicant s level of independence as he or she ages.

We use multiple rate classifications as a means to approve a greater number of applicants by obtaining the appropriate premiums for additional risk levels. Applicants are placed in different risk classes for acceptance and premium calculation based on medical conditions and level of activity. We have an underwriting points-based scoring system, which provides consistent underwriting and rate classification for applicants with similar medical histories and conditions. We currently offer Preferred, Premier, Select and Standard risk classifications. We are able to offer the

equivalent of a fifth underwriting class through our Secured Risk product, which allows us to accept applicants who would not otherwise qualify for traditional long-term care insurance products.

Claims

Our long-term care insurance policies provide coverage for a full continuum of long-term care services including home health care, assisted living facilities and skilled nursing home services. Consumers may purchase policies that cover services in one of these settings with a stand alone policy, or they may purchase a comprehensive policy which provides benefits for services received in any of these health care settings.

Our long-term care insurance claims are processed by interdisciplinary teams of claim examiners and registered nurse case managers. New claims are assigned to both a claim examiner and a registered nurse case manager for the lifecycle of that claim. This allows the examiner and case manager to become well acquainted with the circumstances of the claim, the provider(s) being utilized, the plan of care development and compliance and the claimant s progress toward achieving rehabilitative milestones.

Our registered nurse case managers conduct a preliminary medical review of new claims and work with the policyholder, care providers and attending physicians in developing an appropriate and effective plan of care for each individual policyholder. The registered nurse case managers utilize a frequency review protocol which incorporates policyholder demographics, diagnosis and medical condition acuity.

Our evaluation process for determining benefit eligibility for new claims, as well as re-evaluating continued eligibility for existing claims, includes the use of our internally developed, face-to-face functional and cognitive assessment tool. Registered nurses, employed by external vendors, use our assessment tool to capture important medical, functional and cognitive needs information. The use of our internally developed assessment tool serves to standardize the format and enhance the consistency, quality and relevance of the information we receive from each of the external vendors we utilize.

We believe the addition of a consulting Medical Director to our claim/case management operation, together with the continuing expansion of our preferred provider network and broadening claim audit and fraud investigation departments, will help us to continue to better manage costs associated with claim payments.

Systems Operations

We maintain our own computer system for most aspects of our operations, including policy issuance, billing, claims processing, commissions, premiums and general ledger. We are working on developing new business process management techniques and practices designed to improve quality control, reduce operating expense and institutionalize our intellectual capital.

In addition, to effectively leverage our core operating strengths and support new distribution channels, we plan to implement technologies that will enable us to deliver high service level standards and claims processing efficiencies. We are investing in technology solutions designed to leverage our existing infrastructure and prepare us for future business process and service level efficiencies critical to our core competencies.

We have an outsourcing agreement with a computer services vendor providing for the daily operations of our systems and future program development.

(e) Premiums

Our long-term care policies provide for guaranteed renewability, at the option of the policyholder, at then current premium rates. The policyholder may elect to pay premiums on a monthly, quarterly, semi-annual or annual basis.

Premium rates for all lines of insurance are subject to state regulations, which vary across jurisdictions. Premium rates for our insurance policies are established by our actuarial staff with the assistance of our actuarial consultants and after consultation with executive management. At the time of the filing of this document, there is no in-house actuarial staff for product pricing. While we are currently searching to fill actuarial staff positions, we continue to utilize our consulting actuaries for all work related to pricing and premium rate increases. All premium rates, including changes to previously approved premium rates, must be approved by the insurance regulatory authorities in each state. However, regulators may not approve the premium rate increases we request, may approve them only with respect to certain types of policies, or may approve increases that are smaller than those we request.

In the past, we have filed with and received approval from certain state insurance departments to increase policy premium rates. These premium rate increases have resulted from a) claims experience that has differed from our expectations at the time of the original policy issuance and b) development of alternative forms of facility care (assisted living centers) that were not contemplated at the time of the original policy issuance, but for which we have frequently made payment under the terms of our existing facility-based policy forms.

We have filed and implemented premium rate increases on the majority of our policies sold prior to 2002 and are continuing to do so. We do not currently anticipate the need to file for premium rate increases on any policies issued after 2001. When we file for premium rate increases, we assume that an increased number of policies will lapse due to the premium rate increases and that anti-selection will occur as a result of the premium rate increases. Anti-selection is the lapsation of policies held by healthier policyholders, leading to a higher expected ratio of claims to premiums in future periods.

The premium rate increases we file may be consistent within a policy form or may vary by the policy type, benefit period, underwriting class and age of the policyholder. The timing of state approvals for premium rate increases, where required, varies. Some states will approve requested premium rate increases within several months while other states will take more than a year or may only approve a portion of the increase requested. In those situations, we generally will file for additional premium rate increases at a later date in order to obtain the remaining portion of the premium rate increase, so long as it is still actuarially justified. Therefore, fully implementing planned premium rate increases, may take several years.

Long-term care insurance has fixed annual premiums that can be adjusted only upon approval of the insurance departments of the states where the policies were written. The process for filing for premium rate increases requires us to demonstrate to the insurance departments that expected claims experience is anticipated to exceed original assumptions. The approval of premium rate increases is at the discretion of the insurance departments.

In 2005, we settled a national class action suit brought against us as a result of premium rate increases. A significant component of this settlement was the addition of a contingent non-forfeiture benefit to many of our existing policyholders. This benefit may enable participating policyholders to receive a paid-up benefit in the event of lapse in the future following additional premium rate increases that surpass threshold levels established in the settlement agreement.

(f) Future Policy Benefits, Claims Reserves and Deferred Acquisition Costs

Our insurance policies are accounted for as long duration contracts. As a result, there are two components of policyholder liabilities. The first is a policy reserve liability for future policyholder benefits, represented by our estimate of the present value of future benefits less future premium collection. These reserves are calculated based on assumptions that include estimates for mortality, morbidity, interest rates, premium rate increases, expenses and persistency. The assumptions are based on industry experience, our historical results and recent trends.

The second is a reserve for claims which have already been incurred, whether or not they have yet been reported. The amount of reserves relating to claims incurred is determined by periodically evaluating statistical information with respect to the number and nature of historical claims. We regularly review our claims reserves, and any adjustments to previously established claims reserves are recognized in operating income in the period that the need for such adjustments becomes apparent.

In connection with the sale of our insurance policies, we defer and amortize the policy acquisition costs over the related premium paying periods throughout the life of the policy. Deferred costs are costs that are directly related to, and vary with, the acquisition of new premiums. These costs include the variable portion of commissions, which are defined as the first year commissions less ultimate renewal commissions, and variable general and administrative expenses related to policy sales, underwriting and issuance. Deferred costs are amortized over the life of the policy based upon actuarial assumptions, including persistency of policies in-force. In the event that a policy lapses prematurely due to death or termination of coverage, the remaining unamortized portion of the deferred amount is immediately recognized as expense in the current period.

We assess the recoverability of our unamortized deferred acquisition cost (DAC) asset on a quarterly basis through actuarial analysis. To determine recoverability, the present value of anticipated future premiums less future costs and claims are added to current reserve balances. If this amount is greater than the current unamortized DAC then the DAC is deemed recoverable. If this amount is less than the current unamortized DAC then we impair our DAC and record a charge in our current period results of operations. The DAC recoverability analysis includes our most recent assumptions for persistency, morbidity, interest rates, expenses and premium rate increases, all or any of which may be different than the assumptions utilized in establishing our benefit reserves.

Although we believe that our reserves are adequate to cover all policy liabilities, we cannot be certain that our reserves are adequate or that future claims experience will be similar to, or accurately predicted by, our past or current claims experience.

(g) Reinsurance

We contract for reinsurance to increase the number and size of the policies we may underwrite and as a tool to manage statutory surplus strain associated with new business growth. Reinsurance is utilized by insurance companies to insure their liability under policies written to their policyholders. By transferring, or ceding, certain amounts of premium (and the risk associated with that premium) to reinsurers, we can limit our exposure to risk. However, if a reinsurance company becomes insolvent or otherwise fails to honor its obligations under any reinsurance agreements, we would remain fully liable to the policyholder.

Reinsurance Agreement with Imagine International Reinsurance Limited

Effective June 30, 2005, we entered into an agreement to reinsure, on a 100% quota share basis, substantially all of our long-term care insurance policies in-force as of December 31, 2001 with Imagine International Reinsurance Limited (the 2001 Imagine Agreement). This agreement does not qualify for reinsurance treatment in accordance with Accounting Principles Generally Accepted in the United States of America (GAAP) because it does not result in the reasonable probability that the reinsurer may realize a significant loss. This is due to a number of factors related to the agreement, including an experience refund provision, expense and risk charges due to the reinsurer that escalate over the life of the agreement and an aggregate limit of liability. Therefore, the agreement is being accounted for in accordance with deposit accounting for reinsurance contracts. However, the agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules, which requires a reinsurance agreement to transfer risk to the reinsurer, but does not require the reasonable probability of a significant loss required under GAAP.

The 2001 Imagine Agreement allows us to withhold all funds due to the reinsurer as a funds withheld liability, which is only recorded for statutory accounting purposes. In addition, the agreement allows us to recapture the reinsured policies on any January 1, commencing January 1, 2008. In the event we elect to commute the agreement and recapture the reinsured policies, we will be entitled to an experience refund equal to the funds withheld liability (except as further described below). For deposit accounting purposes, the experience refund and the funds withheld liability are offset as a net deposit amount.

The funds withheld liability and the corresponding experience refund are comprised of:

1. an initial premium of approximately $1.039 billion, equal to the statutory reserves for the reinsured policies at the effective date plus

2. future investment income plus
3. future premiums less
4. future losses paid less
5. an initial ceding commission of $60 million less
6. future expense allowances less
7. future expense and risk charges.

The expense allowance from the reinsurer, limited to a maximum of 25% of premiums collected, is equal to:

1. Renewal commissions paid to our agents, not to exceed 10.5% of premiums collected; plus
2. 9.2% of premiums collected; plus
3. 4.0% of paid claims.

The quarterly expense and risk charge is equal to the sum of (1) 0.25% of total ceded statutory reserves at the end of a quarter and (2) 0.50% of the value of the combination of any letters of credit or funds deposited in trust by the reinsurer as of the beginning of the quarter. In addition, we paid the reinsurer an initial expense and risk charge of $2.92 million, which is being amortized to expense over 42 months, the initial estimated life of the agreement.

The 2001 Imagine Agreement contains an aggregate limit of liability, which limits the ultimate liability for paid claims of the reinsurer. The aggregate limit of liability is equal to:

1. $100 million plus
2. the initial premium less
3. the initial ceding allowance plus
4. the cumulative premiums collected after the effective date less
5. the cumulative expense allowances reimbursed after the effective date plus
6. the cumulative investment income after the effective date.

As noted above, the 2001 Imagine Agreement contains commutation provisions and allows us to recapture the reinsured policies as of January 1, 2008, or on January 1 of any year thereafter. Additionally, the agreement contains certain covenants and conditions that, if breached, could result in our decision to ultimately commute the agreement or else forego any future opportunity to commute. We were in compliance with these covenants as of and for the period ended December 31, 2006 and as of the date of the filing of this document.

In the event we do not commute the 2001 Imagine Agreement on or before January 1, 2009, the expense and risk charge paid to the reinsurer will increase by 50 percent. In the event we do not commute the agreement on or before January 1, 2011, but commute at a later date, the experience refund will not exceed the statutory reserves as of the date of commutation, resulting in our forfeiture of any accumulated statutory profits to which we otherwise may have been entitled.

In order to commute the agreement and remain in compliance with requisite minimum regulatory standards, we will need to have a risk based capital ratio (RBC) of at least 200%. Our current modeling and actuarial projections suggest that our RBC ratio should be at or slightly above 200% and therefore we may be able to commute the 2001 Imagine Agreement on January 1, 2010. We also believe that we should have an additional margin for any adverse development in order to recapture the block of business. These projections include assumptions related to premiums (new sales, persistency and the timing of the collection of premium rate increases by 2011), investment income, expense levels, incurred claims (paid claims plus change in claim reserves) and changes in our future policyholder benefits. Because our current projections show that we are unable to commute the 2001 Imagine Agreement until January 1, 2010, we have included additional expense and risk charges in our DAC recoverability analysis. Our DAC is still recoverable with these additional expense and risk charges. We are considering alternatives that may allow us to either commute the 2001 Imagine Agreement prior to January 1, 2010 or reduce the expense and risk charges that escalate as a result of not commuting on January 1, 2009. We believe that alternatives such as modifications to the current reinsurance agreement, new reinsurance agreements, additional capital issuances or a transaction that is completed as a result of our current review of strategic alternatives are available to allow us to

commute the 2001 Imagine Agreement on January 1, 2009. We may not be able to commute the 2001 Imagine Agreement on January 1, 2010, as planned, which could have a material adverse affect on our financial condition and results of operations. In the event we determine that commutation of the Imagine Agreement is unlikely on or before January 1, 2010, but likely at some future date, we will include additional annual expense and risk charges in our unamortized DAC recoverability analysis. As a result, we could impair the value of our DAC asset and record the impairment in our financial statements at that time.

Pursuant to the Plan with the Department, which requires the pre-approval of new or modified reinsurance agreements, we have requested and received approval to modify the 2001 Imagine Agreement. The approved modification would waive an increase in the expense and risk charges that would be payable to the reinsurer if the ceded policies are not recaptured and the Agreement is not commuted on or before January 1, 2009 and allow Penn Treaty, in its sole discretion, to recapture approximately 1/3 of the reinsured business in each of the years 2009, 2010 and 2011, with no escalation in the expense and risk charges. The modification would give us additional latitude in deciding the economics of commuting the agreement via other capital alternatives. At the time of the filing of this document, the modified agreement has not been signed by the reinsurer or us.

The agreement further requires that we maintain our financial position in good standing, including covenants regarding our financial strength ratings and risk-based capital ratios. Under the agreement the reinsurer may require the immediate repayment of the funds withheld liability in the event of a deterioration of our financial strength. As a result of such deterioration, our expense and risk charges could be increased by 25 percent, although any additional expense and risk charges would be refunded, with interest, upon commutation of the agreement if on or before January 1, 2010.

Our agreement requires us to file premium rate increases within 30 days of our determination of need for these increases. Failure to file such rate increases within the prescribed time is defined in the agreement as a Material Breach Event, which, if uncorrected, would ultimately lead to a reduction in the reinsurer s liability to reimburse claims made in the future under the agreement. Although we filed our premium rate increases more than 30 days after our determination of need in 2006, the Reinsurer considered our filings to be sufficient to cover our obligations under the agreement and has not reduced the aggregate limit of liability.

2005 Reinsurance Agreement with Imagine International Reinsurance Limited

Effective October 1, 2005, we entered into an agreement to reinsure, on a 75% quota share basis, our long-term care insurance policies issued between October 1, 2005 and September 30, 2006 with Imagine International Reinsurance Limited (the 2005 Imagine Agreement). This agreement has been amended to cover long-term care insurance policies issued through September 30, 2008. This agreement does not qualify for reinsurance treatment in accordance with GAAP because it does not result in the reasonable probability that the reinsurer may realize a significant loss. This is due to a number of factors related to the agreement, including an experience refund provision, expense and risk charges due to the reinsurer that escalate over the life of the agreement and an aggregate limit of liability. Therefore, the agreement is being accounted for in accordance with deposit accounting for reinsurance contracts. However, the agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules, which requires a reinsurance agreement to transfer risk to the reinsurer, but does not require the reasonable probability of a significant loss required under GAAP.

The 2005 Imagine Agreement allows us to withhold all funds due to the reinsurer as a funds withheld liability, which is only recorded for statutory purposes. In addition, the agreement allows us to recapture the reinsured policies on any September 30, commencing on September 30, 2008. In order to recapture any policies reinsured under the 2005 Imagine Agreement, we are required to first recapture policies reinsured under the 2001 Imagine Agreement for polices issued December 31, 2001 or prior. Since we did not recapture the policies reinsured under the 2001 Imagine Agreement on January 1, 2008, and current projections show the Company is unable to commute the 2001 Imagine Agreement until January 1, 2010, we will not be able to recapture any new policies reinsured under the 2005 Imagine Reinsurance Agreement prior to September 30, 2010.

Other Reinsurance

We have a reinsurance agreement with General Re Life Corporation with respect to home health care policies with benefit periods exceeding 36 months. No new policies have been reinsured under this agreement since 1998. We also have a reinsurance agreement with General Re Life Corporation with respect to certain home health and nursing home claims. The claims ceded are either in excess of 60 months, $250,000 or $350,000 depending on the policy type. There have been no new policies reinsured under this agreement since 2001.

We have an agreement with Lincoln Heritage Life Insurance Company to cede 100% of certain whole life and deferred annuity policies on an assumption basis effective December 31, 2002. Upon approval from state insurance departments in which the policies were issued, or policyholder approval as may be prescribed by state regulation, we will no longer record these policies in our financial statements.

On January 1, 2006, we ceded all of our remaining life policies to Liberty Bankers Life Insurance Company on a 100% quota share assumption basis. Upon approval from state insurance departments in which the policies were issued, or policyholder approval as may be prescribed by state regulation, we will no longer record these policies in our financial statements. At December 31, 2007 state insurance department approvals had been obtained in states comprising over 90% of the ceded business.

The following table shows our historical use of reinsurance:

Company	A.M. Best Rating	Reinsurance Recoverable December 31, 2006	December 31, 2005
		(in thousands)	
General Re Life Corporation	A++	$ 28,892	$27,322
Liberty Bankers Life Insurance Company	B	10,390	-
Constitution Life	B++	303	-
Lincoln Heritage Life Insurance Company	A-	2,464	2,623
Other (1)		77	87

(1) Reinsurance recoverables of less than $100 are combined.

(h) Investments

We have categorized all of our investment securities as available for sale because they may be sold in response to changes in interest rates, prepayments and similar factors. Investments in this category are reported at their current market value with net unrealized gains and losses, net of the applicable deferred income tax effect, being added to or deducted from total shareholders equity on the balance sheet. As of December 31, 2006, shareholders equity was decreased by $30.1 million due to unrealized losses of $46.8 million in the investment portfolio. The amortized cost and estimated market value of our available for sale investment portfolio as of December 31, 2006 and 2005 are as follows (amounts in thousands):

	December 31, 2006			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Market Value
U.S. Treasury securities and obligations of U.S. Government authorities and agencies	$ 220,952	$ 180	$ (10,675)	$ 210,457
Mortgage backed securities	192,745	208	(3,970)	188,983
Municipal Bonds	24,542	-	(1,239)	23,303
Foreign	616	-	(13)	603
Corporate securities	591,861	105	(30,888)	561,078
	$1,030,716	$ 493	$ (46,785)	$ 984,424

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	December 31, 2005			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Market Value
U.S. Treasury securities and obligations of U.S. Government authorities and agencies	$ 222,346	$ 49	$ (3,057)	$ 219,338
Mortgage backed securities	138,161	20	(3,151)	135,030
Municipal Bonds	24,547	-	(497)	24,050
Corporate securities	639,491	55	(17,911)	621,635
	$1,024,545	$ 124	$ (24,616)	$1,000,053

Our investment portfolio consists primarily of investment grade fixed income securities. Income generated from this portfolio is largely dependent on prevailing levels of interest rates at the time of original purchase. Due to the duration of our investments (approximately 10 years), investment income does not immediately reflect changes in market interest rates.

On December 29, 2006, we acquired for $5 million a 10% beneficial interest in a trust consisting of commission renewal rights. The trust is collateralized by future cash flows from commission renewals of life insurance policies from A+ rated insurers. The commissions paid to the trust have actuarial and credit risk and are payable for the life of the underlying insurance policies. The purchase price was based on discounting anticipated future commissions using a discount rate equal to the internal rate of return of 9.9%. We began receiving monthly distributions from the trust in January 2007 and will record the investment income using the prospective interest method. The investment is categorized as available-for-sale.

Our funds are invested by professional investment management firms under the direction of our management team in accordance with investment guidelines approved by the Investment Committee of the Board of Directors. Although our investment guidelines stress diversification of risks and conservation of principal and liquidity, our investments are subject to market risks, as well as risks inherent to individual securities. Investment losses could significantly decrease our book value, thereby affecting our ability to conduct business.

We do not match the duration of assets and liabilities, which could subject us to interest rate risk from the investment of new cash flows that are inadequate to meet our future claims payments. In addition, we are limited by the Corrective Action Plan with the Pennsylvania Insurance Department (see page 23) as to the types of new investments that we may purchase. We are also limited by our statutory surplus in terms of the level of realized loss we can incur in connection with the sale of existing assets and purchase of new investments. This could, and has, limited our ability to realign the duration of our investment portfolio and to maximize our investment yield. Our future earnings could be restricted as a result of these limitations.

Our operating results are affected by the performance of our investment portfolio. Our investment portfolio contains fixed income investments and may be adversely affected by changes in interest rates. Volatility in interest rates could also have an adverse effect on our investment income and operating results. For example, if interest rates decline, funds reinvested will earn less than the maturing investment.

Interest rates are highly sensitive to many factors, including monetary and fiscal policies and domestic and international political conditions. Although we take measures to manage the risks of investing in a changing interest rate environment, we may not be able to effectively mitigate interest rate sensitivity. Our mitigation efforts include maintaining a high quality portfolio to reduce the effect of interest rate changes on book value. A significant increase in interest rates could have a material adverse effect on our book value.

(i) Selected Financial Information: Statutory Basis

The following table shows certain ratios derived from our insurance regulatory filings with respect to our accident and health policies presented in accordance with accounting principles prescribed or permitted by insurance regulatory authorities, which differ from the presentation under GAAP and which also differ from the presentation under statutory accounting rules for purposes of demonstrating compliance with statutorily mandated loss ratios.

	Year ended December 31,		
	2007	2006	2005
Loss Ratio (1) (4)	68.2%	48.5%	177.6%
Expense ratio (2) (4)	67.9%	66.8%	(78.6)%
Combined loss and expense ratio	136.1%	115.3%	99.0%
Persistency (3)	93.2%	91.9%	88.8%

(1) Loss ratio is defined as incurred claims and increases in policy reserves divided by collected premiums.

(2) Expense ratio is defined as commissions and expenses, net of ceding allowances from reinsurers, divided by collected premiums.

(3) We measure persistency as the continuation of a benefit unit, or an increment of $10 of coverage per day offered under a policy, that remains in-force from one year to the next.

(4) The 2007, 2006 and 2005 loss ratios and expense ratios are significantly affected by the statutory accounting for reinsurance agreements. The 2007 rations are impacted by the 2001 and 2005 Imagine Agreements. The 2006 ratios are impacted by our 2001 and 2005 Imagine Agreements and an assumption reinsurance agreement related to our life insurance policies. The 2005 ratios are impacted by the commutation of two reinsurance agreements with Centre Solutions (Bermuda) Limited and the subsequent entry into the 2001 Imagine Agreement. The expense ratio is negative in 2005 due to a ceding allowance of $60 million received upon entering the 2001 Imagine Agreement, which is netted against expenses as described in note (2) above. The loss ratio in 2005 was higher than in 2007 or 2006 because the premium we ceded to Imagine International Reinsurance Limited exceeded the amount we received upon commutation of the two reinsurance agreements with Centre Solutions (Bermuda) Limited, resulting in a smaller numerator being utilized in the ratio.

Statutory accounting practices. State insurance regulators require our insurance subsidiaries to have statutory surplus at a level sufficient to support existing policies and new business growth. Under statutory accounting rules, we charge costs associated with sales of new policies against earnings as such costs are incurred. These costs, together with required reserves, generally exceed first year premiums and, accordingly, cause a reduction in statutory surplus during periods of increasing first year sales. The commissions paid to agents are generally higher for new policies than for renewing policies. Because statutory accounting requires commissions to be expensed as paid, growth in first year policies generally results in higher expense ratios.

(j) Insurance Industry Rating Agencies

The financial strength ratings assigned to our insurance company subsidiaries by A.M. Best Company, Inc. and Standard & Poor s Insurance Rating Services, two independent insurance industry rating agencies, affect our ability to expand and to attract new business. A.M. Best s ratings for the industry range from A++ (superior) to F (in liquidation). Standard & Poor s ratings range from AAA (extremely strong) to CC (extremel weak). A.M. Best and Standard & Poor s insurance company ratings are based upon factors of concern to policyholders and insurance agents and are not directed toward the protection of investors. Our subsidiaries that are rated have A.M. Best ratings of B (negative outlook) and Standard & Poor s ratings of B- (stable outlook) . In July 2006, both A.M. Best and Standard & Poor s assigned our ratings to credit watch, with negative outlook . In August 2007, Standard & Poor's reduced the financial strength rating of the Company's subsidiary, Penn Treaty Network America Insurance Company to "B- (stable outlook)". In February 2008, A.M. Best reduced the financial strength rating of the Company's subsidiaries to "B (negative outlook)". We believe that a further downgrade of either of these ratings would have an adverse effect upon our ability to sell new policies, including, but not limited to, the potential for certain key states to suspend our ability to write new business in those states, including Florida, which specifically cites a rating agency downgrade in our consent order as a reason for suspension.

Certain distributors will not sell our products unless we have a more favorable financial strength rating. Similarly, certain prospective customers may decline to purchase new policies because of a perceived risk of non-payment of policy benefits due to our financial condition. Our inability to achieve improved ratings could have a material adverse effect on our financial condition and results of operations.

In addition, our 2001 Imagine Agreement allows our assets withheld and payable to the Reinsurer to be transferred to the Reinsurer in the event that our Standard and Poor s rating falls below B-.

(k) Competition

We operate in a highly competitive industry. We believe that competition is based on a number of factors, including service, products, premiums, commission structure, financial strength, industry ratings, name recognition and distribution channels. We compete with a large number of national insurers which offer similar products through similar distribution channels, smaller regional insurers and specialty insurers, many of whom have considerably greater financial resources, larger and more diverse networks of agents and higher financial strength ratings than we do. We also are subject to competition resulting from changes in the Medicare and Medicaid benefit plans, especially as it relates to home and community based services and long-term care facility coverage.

We also actively compete in an intense market that is developing combination products with life insurance, annuity and other financial plans. The expansion of these product features outside of the traditional insurance arena has brought increased competition and pressure to develop alternate business and product lines for long-term care insurance. We also may be adversely affected if we do not seek appropriate affiliations and are required to compete with other financial institutions. Our ability to compete in the long-term care insurance arena will be dependent on our ability to develop new products and necessary affiliations.

Our products are distributed through networks of agents and financial advisors who independently sell our products. We compete with other insurance companies in product offerings, commission rates, underwriting, claim adjudication and service. Our business may suffer if we are unable to recruit and retain independent agents, networks of agents or develop alternative distribution channels.

We continue to compete in an industry that is changing. New regulations and products continue to be introduced for the funding of long-term care services. In order to keep pace with any new developments, we may need to expend significant capital to offer new products, develop partnerships, expand distribution channels and train our agents and employees to sell and administer our products and services.

(l) Government Regulation

General

Insurance companies are subject to supervision and regulation in all states in which they transact business. Penn Treaty is registered and approved as a holding company under the Pennsylvania Insurance Code. Our insurance company subsidiaries are chartered in the states of Pennsylvania and New York.

State Regulations

The extent of regulation of insurance companies varies, but generally derives from state statutes which delegate regulatory, supervisory and administrative authority to state insurance departments. Although many states insurance laws and regulations are based on models developed by the National Association of Insurance Commissioners (NAIC), and are therefore similar, variations among the laws and regulations of different states are common.

The NAIC is a voluntary association of all of the state insurance commissioners in the United States. The primary function of the NAIC is to develop model laws on key insurance regulatory issues that can be used as

guidelines for individual states in adopting or enacting insurance legislation. While the NAIC model laws are accorded substantial deference within the insurance industry, these laws are not binding on insurance companies unless adopted by states, and variation from the model laws by states is common. The NAIC initiated the Long-Term Care Working Group which reports directly to the Life B Committee and is responsible for the development of Model Act and Regulation for long-term care and gives guidance to members of the NAIC on long-term care issues. Throughout 2007, the NAIC sought to streamline its meeting schedule and consolidated the LTC Working Group into the Senior Issues Task Force which also reports directly to the Life B Committee. We believe that this is an important function and we maintain an active presence through committee representation and NAIC meetings.

Most states mandate minimum benefit standards and policy lifetime loss ratios for long-term care insurance policies and for other accident and health insurance policies. A significant number of states, including Pennsylvania, have adopted the NAIC model regulation that requires new business rates to contain a margin for moderately adverse experience. Certain states, including New Jersey and New York, have adopted a minimum loss ratio of 65% for long-term care. The states in which we are licensed have the authority to change these minimum ratios, the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced. There is no minimum loss ratio for policies issued after a state has adopted the NAIC model regulation that requires new business rates to contain margin for moderately adverse experience.

In December 1986, the NAIC adopted the Long-Term Care Insurance Model Act (the Model Act) to promote the availability of long-term care insurance policies, to protect applicants for such insurance and to facilitate flexibility and innovation in the development of long-term care coverage. The Model Act establishes standards for long-term care insurance, including provisions relating to disclosure and performance standards for long-term care insurers, incontestability periods, non-forfeiture benefits, severability, penalties and administrative procedures. Model regulations were also developed by the NAIC to implement the Model Act. Some states have also adopted standards relating to agent compensation for long-term care insurance.

Some state legislatures have, since 2000, adopted NAIC proposals to limit significant premium rate increases on long-term care insurance products. These states have required that new long-term care policies sold after the adoption of the NAIC proposals include an additional margin for a moderately adverse deviation in claims expectations. This additional margin included in the original pricing of policies is designed to partially protect policyholders from future premium rate increases. In the past, we have been generally successful in obtaining premium rate increases when necessary. We currently have premium rate increases on file with various state insurance departments. If we are unable in the future to obtain premium rate increases, or in the event of legislation further limiting premium rate increases, we believe it would have a material adverse impact on our financial condition, results of operations and future earnings.

The Pennsylvania Insurance Department and the New York Insurance Department and the insurance regulators in other jurisdictions have broad administrative and enforcement powers relating to the granting, suspending and revoking of licenses to transact insurance business, the licensing of agents, the regulation of premium rates and trade practices, the content of advertising material, the form and content of insurance policies and financial statements and the nature of permitted investments. In addition, regulators have the power to require insurance companies to maintain certain deposits, capital and surplus and reserve levels calculated in accordance with prescribed statutory standards. The NAIC has developed minimum capital and surplus requirements utilizing certain risk-based factors associated with various types of assets, credit, underwriting and other business risks. This calculation, commonly referred to as Risk-Based Capital ("RBC"), serves as a benchmark for the regulation of insurance company solvency by state insurance regulators. The primary purpose of such supervision and regulation is the protection of policyholders, not investors.

We are also subject to the insurance holding company laws of Pennsylvania and of the other states in which we are licensed to do business. These laws generally require insurance holding companies and their subsidiary insurers to register and file certain reports, including information concerning their capital structure, ownership, financial condition and general business operations. Further, states often require prior regulatory approval of changes in control of an insurer and of inter-company transfers of assets within the holding company structure. The Pennsylvania Insurance Department and the New York Insurance Department must approve the purchase of more than 10% of the outstanding shares of our common stock by one or more parties acting in concert, and may subject such party or parties

to the reporting requirements of the insurance laws and regulations of Pennsylvania and New York, and to the prior approval and/or reporting requirements of other jurisdictions in which we are licensed. In addition, our officers and directors and those of our insurance subsidiaries and our 10% shareholders are subject to the reporting requirements of the insurance laws and regulations of Pennsylvania and New York, as the case may be, and may be subject to the prior approval and/or reporting requirements of other jurisdictions in which they are licensed.

On October 25, 2007, Elkhorn Partners Limited Partnership, (the "Partnership") filed a Schedule 13D/A with the Securities and Exchange Commission. The general partner of the Partnership is Parsow Management LLC, and the sole manager of Parsow Management LLC is Alan S. Parsow. The Schedule 13D/A disclosed that the Partnership is asking the Pennsylvania Insurance Department to (1) approve any purchases of additional Penn Treaty common stock by the Partnership (increasing its ownership by 10% to 20%) and any election of Mr. Parsow to the Penn Treaty Board of Directors and (2) conclude that these proposed actions will not result in the Partnership's acquisition of control of Penn Treaty. This request has been approved by the Department.

States also restrict the dividends our insurance subsidiaries are permitted to pay. Dividend payments will depend on profits arising from the business of our insurance company subsidiaries, computed according to statutory formulae. Under the insurance laws of Pennsylvania and New York, where our insurance subsidiaries are domiciled, insurance companies can pay ordinary dividends only out of earned surplus. In addition, under Pennsylvania law, our Pennsylvania insurance subsidiaries (including our primary insurance subsidiary) must give the Department at least 30 days advance notice of any proposed extraordinary dividend and cannot pay such a dividend if the Department disapproves the payment during that 30-day period. For purposes of that provision, an extraordinary dividend is a dividend that, together with all other dividends paid during the preceding twelve months, exceeds the greater of 10% of the insurance company s surplus as shown on the company s last annual statement filed with Department or its statutory net income as shown on that annual statement. Statutory earnings are generally lower than earnings reported in accordance with generally accepted accounting principles due to the immediate or accelerated recognition of all costs associated with premium growth and benefit reserves. Additionally, our Plan requires the Department to approve all dividend requests made by PTNA, regardless of normal statutory requirements for allowable dividends. We believe that the Department is unlikely to consider any dividend request in the foreseeable future as a result of PTNA s current statutory surplus position. Although not stipulated in the Plan, this requirement is likely to continue until such time as PTNA meets normal statutory allowances, including reported net income and positive cumulative earned surplus.

Under New York law, our New York insurance subsidiary (American Independent Network Insurance Company of New York) must give the New York Insurance Department 30 days advance notice of any proposed dividend and cannot pay any dividend if the regulator disapproves the payment during that 30-day period. In addition, our New York insurance company must obtain the prior approval of the New York Insurance Department before paying any dividend that, together with all other dividends paid during the preceding twelve months, exceeds the lesser of 10% of the insurance company s surplus as of the preceding December 31 or its adjusted net investment income for the year ended the preceding December 31.

PTNA and ANIC did not pay any dividends to Penn Treaty in 2004, 2005, 2006 or 2007 and are unlikely in the foreseeable future to be able to make dividend payments due to insufficient statutory surplus and anticipated earnings. The New York subsidiary has not paid any dividends in 2004, 2005, 2006 or 2007.

State Regulatory Actions

Our insurance subsidiaries are regulated by various state insurance departments. In its ongoing effort to improve solvency regulation, the NAIC has adopted RBC requirements for insurance companies to evaluate the adequacy of statutory capital and surplus in relation to investment and insurance risks, such as asset quality, mortality and morbidity, asset and liability matching, benefit and loss reserve adequacy and other business factors. The RBC formula is used by state insurance regulators as an early warning tool to identify, for the purpose of initiating regulatory action, insurance companies that potentially are inadequately capitalized. In addition, the formula defines minimum capital standards that an insurer must maintain. Regulatory compliance is determined by a ratio of the enterprise s regulatory Total Adjusted Capital to its Authorized Control Level RBC, as defined by the NAIC. Companies below specific trigger points or ratios are classified within certain levels, each of which may require specific corrective action depending upon the insurer s state of domicile.

Our insurance subsidiaries, PTNA, ANIC and American Independent Network Insurance Company of New York (representing approximately 90%, 8% and 2% of our in-force premium in both 2006 and 2005, respectively), are each required to hold statutory surplus that is above a certain required level. If the statutory surplus of either of our Pennsylvania subsidiaries falls below such level, the Department may be required to place such subsidiary under regulatory control, leading to rehabilitation or liquidation. At December 31, 2000, PTNA had Total Adjusted Capital below the Regulatory Action level. As a result, it was required to file the Plan with the Department. On February 12, 2002, the Department approved the Plan by way of a Corrective Order.

The Corrective Order requires PTNA and ANIC to comply with certain requirements, including, but not limited to:

- Limit new investments to NAIC 1 or 2 rated securities;
- Increase statutory reserves by an additional $125 million by December 31, 2004, which has been completed;
- Enter into a reinsurance treaty with Centre Solutions (Bermuda) Limited through which PTNA and ANIC reinsure 100% of their individual long term care insurance business in effect on December 31, 2001. This treaty was commuted effective May 24, 2005 and we entered into a new reinsurance agreement with Imagine International Reinsurance Limited effective June 30, 2005;
- File with the Department monthly statements of the balance of the trust account required under the trust agreement among them, Imagine International Reinsurance Limited and The Bank of New York within five days of receipt of any such statement;
- Compute contract and unearned premium reserves using the initial level net premium reserve methodology;
- Submit to the Department all filings made by Penn Treaty with the Securities and Exchange Commission and all press releases issued by Penn Treaty, PTNA or ANIC;
- Not enter into any new reinsurance contract or treaty, or amend, commute or terminate any existing reinsurance treaty without the prior written approval of the Department, such approval not to be unreasonably withheld;
- Not make any new special deposits or make any changes to existing special deposits without the prior written approval of the Department, such approval not to be unreasonably withheld; and
- Not enter into any new agreements or amend any existing agreements with Penn Treaty or any affiliate in excess of $100,000 or make any dividends or distributions to Penn Treaty or any affiliate without the prior written approval of the Department, such approval not to be unreasonably withheld.

We are in compliance with all terms of the Corrective Order as of the date of this filing. If we fail to continue to comply with the terms of the Corrective Order, the Department could take action to suspend our ability to continue to write new policies, or impose other sanctions on us.

The Florida OIR issued a Consent Order dated July 30, 2002, as amended, reinstating PTNA s Certificate of Authority in Florida as a foreign insurer. The Consent Order sets forth the following obligations which PTNA must satisfy to maintain its Certificate of Authority in Florida:

- Maintain compliance with Florida laws that establish the minimum surplus required for health and life insurers;
- Submit monthly financial statements to the Department of Insurance;
- Maintain compliance with Florida laws governing investments in subsidiaries and related corporations; and;;
- Submit quarterly reports to the Department of Insurance demonstrating all claims that have been assumed by Imagine International Reinsurance Limited.

In August 2006, PTNA agreed to temporarily suspend new sales of Florida insurance policies pending the filing and review by the Florida Office of Insurance Regulation (OIR) of its 2005 statutory audit report. Florida represented approximately 6% of new business applications prior to the temporary suspension. In November 2006, PTNA entered into a revised voluntary consent agreement with the Florida OIR to recommence sales. We anticipate that the terms of the voluntary consent agreement will adequately accommodate our expected growth plans for the foreseeable future. The major provisions of the voluntary consent agreement, with which PTNA must comply in order to continue writing new policies in Florida include, but are not limited to, the following:

- PTNA continuing to file monthly financial reports, as it has since 2002, with the Florida OIR.
- PTNA limiting total Florida premium to current levels of approximately $48 million as of June 30, 2006, allowing for new business growth equal to lapses of existing policies. This base amount may increase as a result of any future premium rate increases on existing policies.
- PTNA seeking approval of the Florida OIR before commencing or terminating any new reinsurance agreements.
- PTNA maintaining a risk-based capital ratio in excess of 250%. PTNA s reported ratio as of December 31, 2006 and 2005 was approximately 869% and 714%, respectively.

In the event that PTNA fails to maintain compliance with Florida laws or the above requirements, the Florida OIR will notify PTNA and could require it to take corrective action. If the Florida OIR determines that the corrective action is not timely, PTNA s Certificate of Authority could be suspended and it could be required to cease writing new direct business in Florida until such time as it took any required corrective action. The voluntary consent agreement may be modified by the Florida OIR in the event of deteriorating financial performance on the part of PTNA. In addition PTNA may seek removal of the conditions of the voluntary consent agreement in the future if its financial strength or its ratings with either A.M. Best Company or Standard and Poor s improves.

In June 2007, the Florida OIR suspended PTNA s certificate of authority to conduct business in Florida for a period of at least twelve months because PTNA did not file its 2006 audited statutory financial report on or before June 1, 2007, as is required by Florida statute. PTNA filed its 2006 audited financial report on June 30, 2007. PTNA filed an appeal with the Florida OIR, as prescribed by statute, for consideration before an administrative law judge which was denied. PTNA has continued to actively work with the Florida OIR in an effort to reach a resolution.

In addition, in December 2006, we entered into a purchase agreement to acquire Southern Security Life Insurance Company ("Southern Security"), a Florida-domiciled shell insurance company. The purchase price for Southern Security consisted of $400,000 plus the capital and surplus of Southern Security as of December 31, 2006, which was $3,861,363, plus all investment income and interest on the capital and surplus accruing between December 31, 2006 and the date of final distributions from escrow. The purchase agreement required the approval of the Pennsylvania Insurance Department, which was obtained, and the Florida Office of Insurance Regulation by December 21, 2007. Because the Florida Office of Insurance Regulation did not complete its review by that date, the seller exercised its right to terminate the purchase agreement and the escrowed purchase price is pending distribution. We are making no further attempt to consummate the transaction.

In January 2003, PTNA received approval from the Illinois Department of Insurance to recommence the sale of new policies. As a condition of recommencement, PTNA agreed to provide a second actuarial asset adequacy review on a biannual basis.

In March 2003, we received approval from the California Insurance Department to recommence sales in California subject to certain conditions to be met prior to recommencement of sales and in order to continue to write new policies in the future. The conditions included:

- The additional certification of the Company s reserves for 2002, and annually thereafter by May 1, to be performed by an independent actuary of the California Insurance Department s choice.
- The Company s commitment that if an unqualified actuarial opinion is not received as of any subsequent year-end, it will voluntarily discontinue writing new business in California until that condition is corrected.

In May 2005, we received approval from the Ohio Insurance Department to recommence sales in Ohio subject to certain conditions contained in a Memorandum of Understanding. We agreed that all new long-term care insurance policies written by PTNA would be reinsured to ANIC on a 100% quota share basis. In addition, we agreed to provide estimated monthly statutory reporting of our financial condition and our Management s Discussion and Analysis as and upon filing with the Securities and Exchange Commission.

We are in compliance with all conditions established by the Illinois Department of Insurance, the California Insurance Department and the Ohio Insurance Department as of the date of this filing.

Federal Regulation

In February 2006, Congress passed the Deficit Reduction Act, which has significant implications for Medicaid and long-term care insurance. Medicaid, with both federal and state funds, has traditionally been the largest payer for long-term care facilities. The Deficit Reduction Act seeks to tighten eligibility access, and in turn further promotes the use of long-term care insurance as a vehicle for individual financing of these costs. Three distinct areas that will impact the potential market for long-term care insurance include 1) Medicaid eligibility restrictions, 2) expansion of state sponsored long-term care partnership programs and 3) education regarding the benefits of long-term care insurance through state sponsored long-term care websites and federally funded long-term care awareness campaigns. Many states have begun implementation and we are participating.

Compliance with multiple Federal and state privacy laws may affect our profits. Congress enacted the Gramm-Leach-Bliley Financial Services Modernization Act (GLB) in 1999 and HIPAA in 1996. GLB was effective November 13, 2000 with full compliance required by July 1, 2001. The United States Department of Health and Human Services adopted privacy rules under HIPAA to protect the privacy and confidentiality of consumer s protected health information. The HIPAA privacy rules took effect April 14, 2003. Subsequently, additional rules were adopted addressing security standards for protection of electronic health information with compliance required by April 20, 2005. States were encouraged by the preemption provisions of these laws to enact their own privacy rules and regulations. In addition, the NAIC adopted the Insurance Information and Privacy Model Act as a model for states to follow in enacting their own privacy laws and regulations. While many states had enacted privacy laws and regulations prior to the advent of GLB and HIPAA, a majority of states have enacted new laws and regulations following passage of GLB and HIPAA to be consistent with or more stringent than the NAIC model act and those provided for under federal law. Compliance with different laws in states where we are licensed could prove to be costly.

Under HIPAA, premiums paid for eligible long-term care insurance policies are treated as deductible medical expenses for federal income tax purposes. The deduction is limited to a specified dollar amount with the amount of the deduction increasing with the age of the taxpayer. In order to qualify for the deduction, the insurance contract must, among other things, provide for limitations on pre-existing condition exclusions, prohibitions on excluding individuals from coverage based on health status and guaranteed renewability of health insurance coverage. Although we offer tax-deductible policies, we continue to offer a few non-deductible policies as well. We have long-term care policies that qualify for tax exemption under HIPAA in all states in which we are currently selling new policies.

Periodically, the federal government has considered adopting a national health insurance program. The passage of such a program could have a material impact on our operations. In addition, other legislation enacted by Congress could impact our business. As with any pending legislation, it is possible that any laws finally enacted will be substantially different from the current proposals. Accordingly, we are unable to predict whether the impact of any such legislation on our business and operations would be positive or negative.

In May 2007, the U. S. House Committee on Energy and Commerce requested information from long-term care insurance companies, including our Company, regarding their practices and protocols for assessing, paying and denying claims. We cooperated fully in supplying the requested information within the time frame requested. In addition, in September 2007, the minority leader of the U.S. Senate Committee on Finance requested information about long-term care insurance procedures from the leading long-term care industry carriers. We cooperated fully in supplying the requested information within the time frame requested. In October 2007, the office of the Attorney General of the state of New York issued subpoenas to all long-term care insurance carriers issuing policies in New

York. We are cooperating fully and have been providing information in response on a continuing basis. The National Association of Insurance Commissioners and certain state Insurance Departments also conducted industry-wide regulatory inquiries during 2007. In January 2008, we were informed that the U.S. Government Accountability Office has requested information from the leading long-term care industry carriers, including our Company, to evaluate oversight of the long-term care insurance industry in the areas of rate setting and claims settlement practices. We intend to cooperate fully in supplying the requested information in the time frame requested. We do not know if these reviews will have an impact on our financial condition or results of operations.

(m) Employees

As of December 31, 2007 and 2006, we had 362 and 322 full-time employees, respectively. The increase in 2007 is primarily due to additional employees that were hired to reinforce the finance division, improve claims management and processing, expand our sales and marketing initiatives and at our agency subsidiaries to increase sales levels. We are not a party to any collective bargaining agreements.

Item 1A. Risk Factors

The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties that we do not currently know about or currently believe are immaterial are not specifically identified below, but may nevertheless adversely affect our business. If any of the risks actually occur, our business, financial condition or future results of operations could be materially and adversely affected.

We may not have enough statutory capital and surplus to continue to write business

Our continued ability to write business is dependent on maintaining adequate levels of statutory capital and surplus to support the policies we write. Our new business writing typically results in net losses on a statutory basis during the early years of a policy. The resulting reduction in statutory surplus limits our ability to seek new business due to statutory restrictions on premium to surplus ratios and statutory surplus requirements. If we cannot generate sufficient statutory surplus to maintain minimum statutory requirements through increased statutory profitability, reinsurance or other capital generating alternatives, we will be limited in our ability to realize additional premium revenue from new business writing, which could have a material adverse effect on our financial condition and results of operations or, in the event that our statutory surplus is not sufficient to meet minimum premium to surplus and risk based capital ratios in any state, we could be prohibited from writing new policies in such state.

Our reserves for current and future claims may be inadequate and any increase to such reserves could have a material adverse effect on our financial condition and results of operations.

We calculate and maintain reserves for current and future claims using assumptions about numerous variables, including our estimate of the probability of a policyholder making a claim, the severity and duration of such claim, the mortality rate of our policyholders, the persistency or renewal of our policies in-force and the amount of interest we expect to earn from the investment of premiums. The adequacy of our reserves depends on the accuracy of our assumptions. We cannot be certain that our actual experience will not differ from the assumptions used in the establishment of reserves. Any variance from our assumptions could have a material adverse effect on our financial condition and results of operations.

Our unamortized deferred policy acquisition cost asset may not be fully recoverable, which would result in an impairment charge and could materially adversely affect our financial condition and results of operations.

In connection with the sale of our insurance policies, we defer and amortize the policy acquisition costs over the related premium paying periods throughout the life of the policy. These costs include all expenses that are directly related to, and vary with, the acquisition of the policy, including commissions, underwriting and other policy issue expenses. The amortization of DAC is determined using the same persistency and discount rate assumptions utilized in computing policy reserves. We review the assumptions underlying DAC and our policy reserves on at least a quarterly basis to determine their continued adequacy given current observed trends and expectations. If, based on that review we

determine that our DAC is not fully recoverable, we would impair the value of our DAC and would fully expense the impaired amount. As a result, our financial condition and results of operations could be materially adversely affected.

Our reinsurance agreements with Imagine International Reinsurance Limited are subject to an aggregate limit of liability, which, if exceeded, could adversely affect our financial condition and results of operations.

Our reinsurance agreements with Imagine International Reinsurance Limited are subject to certain coverage limitations and an aggregate limit of liability. The aggregate limit of liability may be reduced if we do not use best efforts to obtain premium rate increases deemed necessary under the provisions of the agreements and if certain other events occur. If the aggregate limit of liability is expected to be exceeded in the future, we would establish a contingent deficiency reserve for the expected shortfall, resulting in the reduction of our statutory surplus.

Our reinsurance agreements also limit the amount of security to be provided by the reinsurer in order for us to gain full statutory credit for the cession of our reserves. This security is generally in the form of a letter of credit issued for our benefit. This letter of credit cannot exceed $100 million plus the aggregate of all expense and risk charges paid to the reinsurer since inception of the agreement. If our letter of credit requirements exceeded this limit, our ability to take full credit for the ceded reserves would be limited.

In the event that (1) the reinsurer s limit of liability is reduced or exceeded, (2) our ability to take full credit for ceded reserves is limited, (3) the reinsurance agreements are cancelled due to lack of premium payments or (4) the reinsurer is not able to satisfy its obligations to us our financial condition and results of operations could be materially adversely affected.

We may have insufficient capital and surplus to commute our reinsurance agreement with Imagine International Reinsurance Limited, which could adversely affect our financial condition and results of operations.

We are entitled to commute (i.e., recapture the statutory reserve liabilities on the underlying policies) our reinsurance agreement with Imagine International Reinsurance Limited on January 1, 2008 or any January 1 thereafter. To be able to do so, we would be required to have amounts of statutory capital and surplus which would support recapturing the statutory liability for such policies. We do not currently have enough statutory capital and surplus to do so.

In order to commute the agreement and remain in compliance with requisite regulatory minimum standards, we will need to have a risk based capital ratio of at least 200%. Our current modeling and actuarial projections suggest that our RBC ratio should be at or slightly above 200% and therefore we may be able to commute the 2001 Imagine Agreement on January 1, 2010. We also believe that we should have an additional margin for any adverse development in order to recapture the block of business. These projections include assumptions related to premiums (new sales, persistency and the timing of premium rate increases), investment income, expense levels, incurred claims (paid claims plus change in claim reserves) and changes in our future policyholder benefits. Because our current projections show that we are unable to commute the 2001 Imagine Agreement until January 1, 2010, we have included additional expense and risk charges in our DAC recoverability analysis. Our DAC is still recoverable with these additional expense and risk charges. We are considering alternatives that may allow us to either commute the 2001 Imagine Agreement prior to January 1, 2010 or reduce the expense and risk charges that escalate as a result of not commuting on January 1, 2009. We believe that alternatives such as modifications to the current reinsurance agreement, new reinsurance agreements, additional capital issuances or a transaction that is completed as a result of our current review of strategic alternatives are available to allow us to commute the 2001 Imagine Agreement on January 1, 2009. We may not be able to commute the 2001 Imagine Agreement on January 1, 2010, as planned, which could have a material adverse affect on our financial condition and results of operations. In the event we determine that commutation of the Imagine Agreement is unlikely on or before January 1, 2010, but likely at some future date, we will include additional annual expense and risk charges in our unamortized DAC recoverability analysis. As a result, we could impair the value of our DAC asset and record the impairment in our financial statements at that time.

Pursuant to the Plan with the Department, which requires the pre-approval of new or modified reinsurance

agreements, we have received approval to modify the 2001 Imagine Agreement. The modification would waive an increase in the expense and risk charges, which would be payable to the Reinsurer if the ceded policies are not recaptured and the Agreement is not commuted on or before January 1, 2009, and allow Penn Treaty, in its sole discretion, to recapture approximately 1/3 of the reinsured business in each of the years 2009, 2010 and 2011, with no escalation in the expense and risk charges. The modification would give us additional latitude in deciding the economics of commuting the agreement via other capital alternatives. At the time of the filing of this document, the modified Agreement has not been signed by the reinsurer or by us.

Our reinsurers may not satisfy their obligations to us, which could materially adversely affect our financial condition and results of operations.

We obtain reinsurance from unaffiliated reinsurers, in addition to Imagine International Reinsurance Limited, on certain of our policies. Although each reinsurer is liable to us to the extent the risk is transferred to such reinsurer, reinsurance does not relieve us of liability to our policyholders. Accordingly, we bear credit risk with respect to all of our reinsurers. We cannot assure you that our reinsurers will pay all of our reinsurance claims or that they will pay our reinsurance claims on a timely basis. The failure of our reinsurers to make such payments could have a material adverse effect on our financial condition and results of operations.

We could suffer a loss if our premium rates are not adequate and we are unable to obtain necessary state approvals for premium rate increases.

We set our premium rates for both new and existing policies based on assumptions about numerous variables, including our estimate of the probability of a policyholder making a claim, the severity and duration of such claim, the mortality rate of our policyholders, the persistency or renewal of our policies in-force, the expenses associated with administering our policies and the amount of interest we expect to earn from the investment of premiums. In setting premium rates, we consider historical claims information, industry statistics and other factors.

Based on our recent studies, we believe that the policies we currently sell are priced to provide a satisfactory profit margin. However, those studies also demonstrate that certain of our older policies are only marginally profitable and some are unprofitable. As a result, we commenced efforts to obtain premium rate increases on such polices, which include policies for which we previously received premium rate increases. If our actual experience related to either the pricing on our new policies or the premium rates on our existing policies proves to be less favorable than we assumed, our financial condition and results of operations could be materially adversely affected.

We generally cannot raise our premium rates in any state unless we first obtain the approval of the insurance regulator in that state. We cannot assure you that we will be able to obtain approval for premium rate increases from existing requests or requests filed in the future, especially in light of the magnitude of past premium rate increases and consumer sentiment. If we are unable to raise our premium rates because we fail to obtain approval for a premium rate increase in one or more states, our financial condition and results of operations could be materially adversely affected.

In 2005, we settled a class action based on past premium rate increases in which we were the defendant. As part of the settlement, many existing policyholders elected a contingent non-forfeiture benefit, which could entitle them to a paid-up benefit upon lapse following future premium rate increases that exceed certain age-dependent thresholds. While we release reserves to income for lapsing policyholders, the effect of the settlement could lead to higher than expected lapses, future benefit payments for non-premium paying policyholders and anti-selection of remaining policyholders. Although we include an assumption for anti-selection in our policyholder reserves, anti-selection could cause our actual claims experience to exceed our expectations based on the higher risk of the remaining policyholders. As a result, our financial condition and results of operations could be materially adversely affected.

Our failure to timely file periodic reports with the Securities and Exchange Commission (SEC) could result in enforcement action by the SEC, stock exchange delisting actions or shareholder lawsuits.

We have failed to file timely periodic reports since the third quarter of 2005. This could result in enforcement action by the SEC, delisting of our common stock by the New York Stock Exchange or shareholder lawsuits. If any of these were to happen, our financial condition and results of operations could be materially adversely affected.

Legal and regulatory investigations are increasingly common in the insurance business and may result in financial losses and harm our reputation.

We are subject to various regulatory inquiries, such as information requests, subpoenas and books and record examinations, from state and federal regulators and other authorities. Recently, the long-term care insurance industry has become the focus of increased scrutiny by regulatory and other authorities concerning certain practices within the industry.

In this regard, in May 2007, the U. S. House Committee on Energy and Commerce requested information from long-term care insurance companies, including our Company, regarding their practices and protocols for assessing, paying and denying claims. We cooperated fully in supplying the requested information within the time frame requested. In addition, in September 2007, the minority leader of the U.S. Senate Committee on Finance requested information about long-term care insurance procedures from the leading long-term care industry carriers. We cooperated fully in supplying the requested information within the time frame requested. In October 2007, the office of the Attorney General of the state of New York issued subpoenas to all long-term care insurance carriers issuing policies in New York. We are cooperating fully and have been providing information in response on a continuing basis. The National Association of Insurance Commissioners and certain state Insurance Departments also conducted industry-wide regulatory inquiries during 2007. In January 2008, we were informed that the U.S. Government Accountability Office has requested information from the leading long-term care industry carriers, including our Company, to evaluate oversight of the long-term care insurance industry in the areas of rate setting and claims settlement practices. We intend to cooperate fully in supplying the requested information in the time frame requested.

We cannot ensure that the current investigations and proceedings will not have a material adverse effect on our business, financial condition or results of operations. In addition, it is possible that related investigations may be commenced in the future, and we could become subject to further investigations and have lawsuits filed against us. In addition, increased regulatory scrutiny and any resulting investigations or proceedings could result in new legal precedents and industry-wide regulations or practices that could adversely affect our business, financial condition and results of operation. A significant regulatory action or a substantial legal liability against us could have a material adverse effect on our business, financial condition and results of operations. Moreover, even if we ultimately prevail in any related litigation, regulatory action or investigation, we could suffer significant reputational harm, which could have a material adverse effect on our business, financial condition and results of operations, including our ability to attract new customers and retain our current customers.

We may suffer reduced income if governmental authorities change the regulations applicable to the insurance industry.

Our insurance subsidiaries are subject to comprehensive regulation by state insurance regulatory authorities. The laws of the various states establish insurance departments with broad powers with respect to such things as licensing companies to transact business, licensing agents, prescribing accounting principles and practices, admitting statutory assets, mandating certain insurance benefits, regulating premium rates, approving policy forms, regulating unfair trade, regulating market conduct and claims practices, establishing statutory reserve requirements and solvency standards, limiting dividends, restricting certain transactions between affiliates and regulating the types, amounts and statutory valuation of investments. The primary purpose of such regulation is to protect policyholders, not shareholders.

State legislatures, state insurance regulators and the NAIC continually reexamine existing laws and regulations, and may impose changes in the future that materially adversely affect our financial condition and results of operations and could make it difficult or financially impracticable to continue doing business. Some states limit premium rate increases on long-term care insurance products and other states have considered doing so. Because insurance premiums are our primary source of income, our financial condition and results of operations could be negatively affected by any of these changes.

Certain legislative proposals could, if enacted, adversely affect our financial condition and results of operations. These include the implementation of minimum consumer protection standards for inclusion in all long-term care policies, including: guaranteed premium rates; protection against inflation; limitations on waiting periods for pre-existing conditions; setting standards for sales practices for long-term care insurance; and guaranteed consumer access to information about insurers, including lapse and replacement rates for policies and the percentage of claims denied. In addition, recent Federal financial services legislation requires states to adopt laws for the protection of consumer privacy. Compliance with various existing and pending privacy requirements also could result in significant additional costs to us.

Our business could be materially adversely affected if our financial strength ratings are downgraded; we may not be able to compete successfully with insurers that have greater financial resources or better financial strength ratings.

We sell our products in highly competitive markets. We compete with large national insurers, smaller regional insurers and specialty insurers. Many insurers are larger than we are and many have greater resources and better financial strength ratings than we do. Most insurers also have not experienced the regulatory problems we have faced. In addition, we are subject to competition from insurers with broader product lines. In addition a significant portion of our sales come from our willingness to underwrite physically impaired risks. Currently no other major carrier is competing with us in the underwriting of physically impaired risks. We also may be subject, from time to time, to new competition resulting from changes in Medicare benefits, as well as from insurance carriers introducing products similar to those offered by us or by new carriers entering the long-term care insurance marketplace. If we are unable to remain competitive for any of these reasons it could have a material adverse effect on our financial condition and results of operations.

The financial strength ratings assigned to our insurance company subsidiaries by A.M. Best Company, Inc. and Standard & Poor s Insurance Rating Services, two independent insurance industry rating agencies, affect our ability to expand and to attract new business. A.M. Best s ratings for the industry range from A++ (superior) to F (in liquidation). Standard & Poor s ratings range from AAA (extremely strong) to CC (extremel weak). A.M. Best and Standard & Poor s insurance company ratings are based upon factors of concern to policyholders and insurance agents and are not directed toward the protection of investors. Our subsidiaries that are rated have A.M. Best ratings of B (negative outlook) and Standard & Poor s ratings of B- (stable outlook) . In July 2006, both A.M. Best and Standard & Poor s assigned our ratings to credit watch, with negative outlook . In August 2007, Standard & Poor's reduced the financial strength rating of the Company's subsidiary, Penn Treaty Network America Insurance Company to "B- (stable outlook)". In February 2008, A.M. Best reduced the financial strength rating of the Company's insurance subsidiaries to "B (negative outlook)". We believe that a further downgrade of either of these ratings would have an adverse effect upon our ability to sell new policies, including, but not limited to, the potential for certain key states to suspend our ability to write new business in those states, including Florida, which specifically cites a rating agency downgrade in our consent order as a reason for suspension, all of which would have a material adverse effect on our business, financial condition and results of operations.

Certain distributors will not sell our products unless we have a more favorable financial strength rating. Similarly, certain prospective customers may decline to purchase new policies because of a perceived risk of non-payment of policy benefits due to our financial condition. Our inability to achieve improved ratings could have a material adverse effect on our financial condition and results of operations.

In addition, our reinsurance agreement with Imagine International Reinsurance Limited, allows our assets withheld and payable to the reinsurer to be transferred to the reinsurer in the event, that our Standard and Poor s rating falls below B-.

Our business could be materially adversely affected if we were unable to continue selling policies in key states.

Historically, our business has been concentrated in a few key states. During 2007 and 2006, approximately 39% and 40%, respectively, of our direct premium revenue was in California, Florida and Pennsylvania. Although we have recommenced new policy sales in 44 states, including California, Florida and Pennsylvania, we are currently

suspended from new sales in Florida and we have not yet recommenced new policy sales in six other states. We are working with the remaining states to recommence sales in all jurisdictions. Florida represented approximately 6% of new applications for insurance prior to the suspension of new sales at June 4, 2007.

We have agreed to conditions for the recommencement of business in California, Florida (prior to the current suspension), Illinois, Ohio and Pennsylvania. If we were found not to be in compliance with these conditions, we could be forced to stop new policy sales. Each state insurance department may impose its own conditions on our recommencing or continuing new policy sales in its state. If we are unable to continue selling new policies in our key states, our financial condition and results of operations could be materially adversely affected.

Our success depends on our ability to attract and retain qualified, experienced personnel.

We have in the past experienced, and we expect to experience in the future, difficulty in hiring and retaining employees with appropriate qualifications. Because long-term care insurance is a very specialized segment of the insurance industry, we face significant competition in recruiting talented personnel. The location of our corporate offices outside of a major metropolitan area also makes it difficult to recruit personnel. We might not be successful in our efforts to recruit and retain the required personnel. Failure to recruit new personnel or failure to retain our current personnel could have a material adverse effect on our financial condition and results of operations because it could impact our ability to complete actuarial and financial analyses in a timely manner.

We may not complete any transaction as a result of our evaluation of strategic alternatives.

We retained Friedman, Billings, Ramsey & Co., Inc. ("FBR") to assist us in the review of strategic alternatives to enhance shareholder value. These alternatives could include, but are not limited to, capital structure review, strategic partnerships, business combination transactions or the sale of certain assets. There can be no assurance that our review of strategic alternatives will result in any specific transaction or if we engage in a transaction that it will be on terms favorable to our shareholders. If we are unable to complete a transaction, it could limit our ability to increase sales growth, which could have a material adverse effect on our financial condition and results of operations.

If demand for long-term care insurance continues to decline, we will not be able to execute our strategy of strengthening our position as a leading provider of long-term care insurance.

We have devoted significant resources to developing our long-term care insurance business, and our growth strategy relies upon continued growth of the sale of this product. In recent years, however, industry sales of individual long-term care insurance have declined. Annualized first-year premiums for individual long-term care insurance achieved a historical high in 2002 at approximately $1.0 billion but have decreased to $614 million in 2006, according to LIMRA International. We believe this decrease was due primarily to decisions by several providers to cease offering long-term care insurance, to raise premiums on in-force policies and/or to introduce new products with higher prices. These actions resulted in decreased purchases of long-term care insurance products and have caused some distributors to reduce their sales focus on these products. If the market for long-term care insurance continues to decline, we may be unable to realize our growth strategy and our financial condition and results of operations could be adversely affected.

We may not be able to compete successfully if we cannot recruit and retain insurance agents.

We distribute our products principally through independent agents that we recruit and train to market and sell our products. We also engage FMOs to recruit independent agents and develop networks of agents in various states. We compete vigorously with other insurance companies for productive independent agents, primarily on the basis of our financial position, support services, compensation and product features. When we ceased new policy sales in 2001, many of our agents began selling more long-term care insurance products issued by our competitors. We may not be able to attract (or in the case of agents who have begun writing long-term care products for our competitors, to re-engage) and retain independent agents to sell our products, including if we are unable to obtain permission to recommence new policy sales in the six states where we are currently not permitted to offer new policies. In addition, we believe that the willingness of independent agents to represent our Company is hindered by delays in financial

reporting, ratings, and unfavorable Company and industry reports issued by the media or reviewed by governmental bodies. Because our future profitability depends greatly on new policy sales, our business and ability to compete would suffer if we are unable to recruit and retain insurance agents or if we lose the services provided by our FMOs.

Litigation may result in financial losses or harm our reputation and may divert management resources.

Current and future litigation may result in financial losses, harm our reputation and require the dedication of significant management resources. We are regularly involved in litigation. The litigation naming us as a defendant ordinarily involves our activities as an insurer. In recent years, many insurance companies, including us, have been named as defendants in class actions relating to market conduct issues, sales practices and premium rate increases. See Item 3 Legal Proceedings for a description of current legal proceedings.

Significant litigation could materially adversely affect our financial condition due to defense costs, settlements or adverse decisions.

Our investment performance may affect our financial results and ability to conduct business

Our funds are invested by professional investment management firms under the direction of our management team in accordance with investment guidelines approved by the Investment Committee of the Board of Directors. Our investments are subject to market risks, as well as risks inherent to individual securities. Investment losses could significantly decrease our book value, thereby affecting our ability to conduct business.

We do not match the duration of assets and liabilities, which could subject us to interest rate risk from the investment of new cash flows that are inadequate to meet our future claims payments. In addition, we are limited by the Plan with the Department as to the types of new investments that we may purchase. We are also limited by our statutory surplus in terms of the level of realized loss we can incur in connection with the sale of existing assets and purchase of new investments. This could, and has, limited our ability to realign the duration of our investment portfolio and to maximize our investment yield. Our future earnings could be restricted as a result of these limitations.

We may be adversely affected by interest rate changes.

Our operating results are affected by the performance of our investment portfolio. Our investment portfolio contains fixed income investments and may be adversely affected by changes in interest rates. Volatility in interest rates could also have an adverse effect on our investment income and operating results. For example, if interest rates decline, funds reinvested will earn less than the maturing investment.

Interest rates are highly sensitive to many factors, including monetary and fiscal policies and domestic and international political conditions. We may not be able to effectively mitigate interest rate sensitivity. A significant increase in interest rates could have a material adverse effect on our book value.

Certain anti-takeover provisions in state law and our Articles of Incorporation may make it more difficult to acquire us and thus may depress the market price of our common stock.

Our Restated and Amended Articles of Incorporation, the Pennsylvania Business Corporation Law of 1988, as amended, and the insurance laws of states in which our insurance subsidiaries do business contain certain provisions which could delay or impede the removal of incumbent directors and could make a merger, tender offer or proxy contest involving us difficult, even if such a transaction would be beneficial to our shareholders, or discourage a third party from attempting to acquire control of us. In particular, the classification and three-year terms of our directors could have the effect of delaying a change in control. Insurance laws and regulations of Pennsylvania and New York, our insurance subsidiaries states of domicile, prohibit any person from acquiring control of us, and thus indirect control of our insurance subsidiaries, without the prior approval of the insurance commissioners of those states.

The exercise of our outstanding stock options and any future issuances of new shares of our common stock may result in significant dilution to our existing shareholders.

We anticipate that to finance the growth of our business adequately and to support our liquidity needs, we may offer and sell additional shares of common stock or convertible debt in private or public offerings in the future. The occurrence of any or all of the foregoing may result in significant additional dilution to our existing shareholders.

Our computer systems may fail or their security may be compromised, which could damage our business and adversely affect our financial condition and results of operations.

Our business is highly dependent upon the uninterrupted operation of our computer systems. We rely on these systems throughout our business for a variety of functions, including processing claims and applications, providing information to customers and distributors, performing actuarial analyses and maintaining financial records. Despite the implementation of security measures, our computer systems may be vulnerable to physical or electronic intrusions, computer viruses or other attacks, programming errors and similar disruptive problems. The failure of these systems for any reason could cause significant interruptions to our operations, which could result in a material adverse effect on our business, financial condition or results of operations.

We retain confidential information in our computer systems, and we rely on sophisticated commercial technologies to maintain the security of those systems. Anyone who is able to circumvent our security measures and penetrate our computer systems could access, view, misappropriate, alter or delete any information in the systems, including personally identifiable customer information and proprietary business information. In addition, an increasing number of states and foreign countries require that customers be notified if a security breach results in the disclosure of personally identifiable customer information, which could damage our reputation in the marketplace, deter people from purchasing our products, subject us to significant civil and criminal liability and require us to incur significant technical, legal and other expenses.

Item 1B. **Unresolved Staff Comments**

None.

Item 2. **Properties**

Our principal offices in Allentown, Pennsylvania occupy two buildings owned by the Company, totaling approximately 37,000 square feet of office space in a 40,000 square foot building and all of a 16,879 square foot building. We also own and lease additional office space for ancillary operations of our agency subsidiaries and New York staff.

Item 3. **Legal Proceedings**

The Company and its subsidiaries are involved in various legal actions generally arising in the normal course of their business, in which claims for compensatory and punitive damages are asserted. The amounts sought in certain of these actions are often large and indeterminate and the ultimate outcome of certain actions is difficult to predict. Additionally, pleading practices in the United States permit considerable variation in the assertion of monetary damages or other relief. Jurisdictions may permit claimants not to specify the monetary damages sought or may permit claimants to state only that amount sought is sufficient to invoke the jurisdiction of the trial court. In addition, jurisdictions may permit plaintiffs to allege monetary damages in amounts well exceeding reasonable possible verdicts in the jurisdiction for similar matters. In our experience, monetary relief sought by plaintiffs against the Company often bears little relevance to the merits or disposition value of the legal action.

Although there can be no assurance, at the present time the Company does not anticipate that the ultimate liability from either pending or threatened legal actions is likely to have a material adverse effect on the overall financial condition or operation results of the Company.

Item 4. Submission of Matters to a Vote of Stockholders

A Special Meeting of Shareholders was held on December 28, 2007. At this meeting, the following matters were voted upon by the shareholders, receiving the number of affirmative, negative and withheld votes, as well as abstentions and broker non-votes, set forth below for each matter.

1. To ratify and approve the grant of stock options to Patpatia & Associates, Inc.

For	Against	Abstentions	Broker Non-Votes
13,290,441	1,577,198	59,469	0

2. To ratify and approve the grant of stock options to Bradley Management Services, LLC.

For	Against	Abstentions	Broker Non-Votes
13,252,480	1,611,897	62,731	0

3. To transact other business that properly comes before the Special Meeting and any and all adjournments and postponements thereof.

For	Against	Abstentions	Broker Non-Votes
6,586,685	8,244,697	95,726	0

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Our common stock is traded on the New York Stock Exchange under the symbol PTA.

As of March 28, 2008, there were 141 record holders of our common stock. The following table indicates the high and low closing sale prices of our common stock as reported on the New York Stock Exchange during the periods indicated.

	High	Low
2007		
1st Quarter	$ 8.23	$ 6.05
2nd Quarter	6.21	5.56
3rd Quarter	6.02	5.20
4th Quarter	6.60	5.66
2006		
1st Quarter	$ 10.94	$ 8.75
2nd Quarter	9.10	7.30
3rd Quarter	7.87	6.33
4th Quarter	7.69	6.64
2005		
1st Quarter	$ 10.20	$ 8.04
2nd Quarter	9.84	8.24
3rd Quarter	10.77	8.23
4th Quarter	10.15	8.08

We have never paid any cash dividends on our common stock and do not intend to do so in the foreseeable future. It is our present intention to retain any future earnings to support the continued growth and ongoing operations of our business. Any future payment of dividends is subject to the discretion of the board of directors and is dependent, in part, on any dividends we may receive from our subsidiaries. The payment of dividends by our subsidiaries is dependent on a number of factors, including their respective earnings and financial condition, business needs and capital and surplus requirements, and is also subject to certain regulatory restrictions and the effect that such payment would have on their financial strength ratings. See Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources, Business Insurance Industry Rating Agencies and Business Government Regulation.

The following graph compares the cumulative total shareholder return on the Company's Common Stock with the cumulative total return of the Standard & Poor s 500 Composite Stock Index and the Standard and Poor's Insurance Composite for the period December 31, 2001 through December 31, 2006, assuming an initial investment of $100 and that dividends are reinvested annually.

PENN TREATY AMERICAN CORPORATION
Performance Graph

	2001	2002	2003	2004	2005	2006
PTA STOCK	$ 100.00	$ 31.34	$ 28.98	$ 32.91	$ 39.53	$ 30.28
S&P 500	$ 100.00	$ 76.63	$ 96.85	$ 105.56	$ 108.73	$ 123.54
S&P INSURANCE INDEX	$ 100.00	$ 108.21	$ 129.20	$ 136.85	$ 154.03	$ 168.45

(1) Assumes an $100 investment on December 31, 2001 in the Company's common stock, and in each of the indices shown. The total return assumes reinvestment of all dividends.

Recent sales of Unregistered Securities

During the year ended December 31, 2007, we issued securities without registration under the Securities Act of 1933 on the terms and circumstances described below.

On May 10, 2007, the Company entered into an Option Agreement with Patpatia & Associates, Inc. (Patpatia) which provided for a grant to Patpatia of an option to purchase 600,000 shares of the Company s common stock, subject to shareholder approval. The Company and Patpatia are also parties to a Consulting Agreement pursuant to which Patpatia provides consulting services to the Company with the objective of increasing the distribution of the Company s long-term care insurance and other complementary offerings to current and potential customers. The options were granted as additional compensation for the consulting services provided under the Consulting Agreement.

On June 1, 2007, the Company entered into an Option Agreement with Bradley Management Services, LLC (BMS) which provided for a grant to BMS of an option to purchase 200,000 shares of the Company s common stock, subject to shareholder approval. The Company and BMS are also parties to a Consulting and Marketing Agreement pursuant to which BMS will provide consulting services to the Company in connection with various executive management, information technology and marketing projects. The options were granted as additional compensation for the services provided under the Consulting and Marketing Agreement.

The option grants to Patpatia and BMS were approved by the Company s shareholders on December 28, 2007. Patpatia and BMS are accredited investors as defined in Rule 501 under the Securities Act of 1933, as amended (the Act), and the option grants are private placement exempt from registration under Rule 506 under the Act. Under both Option Agreements, the exercise price is $6.48, which is equal to the closing price of the Company s common stock on the New York Stock Exchange as of December 28, 2007, the date the option grants were approved by the Company s

shareholders. The options will vest over five years based on the achievement of certain sales and performance objectives.

Item 6. Selected Financial Data

The following selected consolidated statement of operations data and balance sheet data as of and for the years ended December 31, 2006, 2005, 2004, 2003 and 2002 have been derived from our Consolidated GAAP Financial Statements.

	2006	2005 Restated	2004	2003	2002
Statement of Income and Comprehensive Income Data:					
Revenues:					
Total premiums	$294,767	$309,516	$319,885	$ 321,946	$ 333,643
Net investment income	53,059	50,833	46,839	43,273	40,107
Net realized capital (losses) gains	(1,812)	(1,134)	167	237	15,663
Market gain (loss) on experience account (1)	-	48,799	39,749	(9,494)	56,555
Change in preferred interest on early conversion liability (2)	-	1,403	2,237	(981)	-
Federal excise tax recoverable (3)	8,079	-	-	-	-
Other income	11,882	8,847	5,864	9,082	11,585
Total revenues	365,975	418,264	414,741	364,063	457,553
Benefits and expenses:					
Benefits to policyholders (4)	298,385	283,667	232,698	247,822	374,085
Commissions	35,735	38,121	39,115	40,800	45,741
Net acquisition costs amortized	4,601	8,746	11,578	10,243	8,615
General and administrative expenses (5)	63,219	60,185	52,970	58,588	46,472
Impairment of goodwill (6)	-	-	13,376	-	-
Litigation expense (7)	-	1,437	4,150	-	-
Impairment of property and equipment (8)	337	2,337	-	522	-
Commutation expense (9)	-	18,300	-	-	-
Reinsurance warrant expense (9)	-	7,267	-	-	-
Expense and risk charges and excise tax	13,325	12,457	14,199	14,138	17,227
Interest expense (10)	1,264	8,070	10,443	8,112	5,733
Total benefits and expenses	416,866	440,587	378,529	380,225	497,873
(Loss) income before federal income taxes and cumulative effect of accounting change (11)	(50,891)	(22,323)	36,212	(16,162)	(40,320)
Benefit (provision) for federal income taxes	17,723	8,917	(15,676)	2,992	13,728
Net (loss) income before cumulative effect of accounting change (11)	$(33,168)	$(13,406)	$ 20,536	$(13,170)	$(26,592)
Net (loss) income	$(33,168)	$(14,913)	$ 20,536	$(13,170)	$(31,743)
Basic earnings per share before cumulative effect of accounting change (11)	$ (1.42)	$ (0.92)	$ 2.16	$ (2.52)	$ (5.52)
Diluted earnings per share before cumulative effect of accounting change (11)	$ (1.42)	$ (0.92)	$ 1.20	$ (2.52)	$ (5.52)
Basic earnings per share (12)	$ (1.42)	$ (1.02)	$ 2.16	$ (2.52)	$ (6.60)
Diluted earnings per share (12)	$ (1.42)	$ (1.02)	$ 1.20	$ (2.52)	$ (6.60)
Weighted average shares outstanding (12) (13)	23,281	14,569	9,430	5,243	4,810
Weighted average diluted shares outstanding (12) (14)	23,281	14,569	21,577	5,243	4,810

	2006	2005 Restated	2004	2003	2002
GAAP Ratios:					
Loss ratio	101.2%	91.6%	72.7%	77.0%	112.1%
Expense ratio	40.1%	38.6%	36.8%	38.6%	35.4%
Combined ratio (15)	141.3%	130.2%	109.5%	115.6%	147.5%
Return on average equity (16)	(14.4)%	(6.6)%	12.0%	(9.0)%	(18.9)%
Balance Sheet Data:					
Total investments (17)	$ 989,424	$1,000,409	$ 59,509	$ 44,141	$ 28,692
Total assets	1,314,848	1,289,214	1,244,677	1,145,494	1,079,843
Total debt (18)	-	-	85,167	88,467	76,245
Shareholders' equity	207,558	254,404	197,370	144,079	148,342
Book value per share (12) (13)	$ 8.83	$10.82	$18.28	$23.32	$30.56
Selected Statutory Data:					
Net premiums written (19)	$51,977	$ 25,954	$ 29,888	$ 27,008	$ 22,440
Statutory surplus (beginning of period)	$35,876	$ 38,834	$ 30,638	$ 34,234	$ 35,551
Ratio of net premiums written to statutory surplus	1.45x	0.67x	0.98x	0.79x	0.63x

Notes to Selected Financial Data (amounts in thousands):

(1) In accordance with the 2001 Centre reinsurance agreement which was commuted on May 24, 2005, the reinsurer maintained a notional experience account for our benefit in the event of commutation. The notional experience account received an investment credit, derived from the separate components of the notional experience account. This gain represented the income from the embedded derivative portion of our notional experience account, similar to that of an unrealized gain or loss on a bond.

(2) Holders of our convertible subordinated notes were entitled to convert their notes into shares of our common stock before October 2005 and receive a discounted amount of interest that they would have otherwise received until that date. We had determined that this feature is an embedded derivative as defined in Statement of Financial Accounting Standards No. 133 Accounting for Derivative Instruments and Hedging Activities. As a result of this determination, we had separately valued and bifurcated the embedded derivative from the host contract. At each balance sheet date, the embedded derivative was recorded at fair value, with any change in fair value recognized in current operations.

(3) In June 2007, we received notification that the Internal Revenue Service had accepted a claim for refund of excise taxes related to premiums that had been paid to Centre during the years 2002 to 2005. The estimated amount of the refund is $9,003 which included interest of $924. As a result the Company recorded $8,079 as Federal excise tax revenue for the year ended December 31, 2006 and recorded $924 of net investment income for the year ended December 31, 2006.

(4) Based on retrospective tests on the development of claims incurred on or before December 31, 2006, we have increased our claim reserves approximately $34.6 million above the amounts produced by the reserving methodology we employed, which utilized the continuance curves completed in 2006. The retrospective tests were based on the development of all claims incurred on or before December 31, 2006, and the increase was based on the development of these claims through December 31, 2007. We believe that this increase was needed because the duration of

claims is longer than we previously estimated. We believe that the claims reserves at December 31, 2006, represent our best estimate based on all information available through December 31, 2007. However, if these estimates are not accurate it could have a material adverse effect on our financial condition and results of operations.

During the fourth quarter of 2005, we revised our assumption related to the length of time a policyholder will stay on claim once they have been on claim in excess of three years. Primarily as a result of increasing our assumption for the duration of these claims we increased our claim reserves by approximately $42,000. During the third quarter of 2002, we determined to refine certain of our processes and assumptions in the establishment of our reserves for current claims. As a result of this change, we increased our claim reserves by approximately $83,000.

(5) We accrued additional expenses related to accounting, actuarial, legal and consulting fees in 2006 and 2005. These fees were incurred due to work related to our increase in claim reserves in 2006 and in the fourth quarter of 2005, the settlement of litigation, cost associated with the development of the financial advisor distribution channel, our written submission to the SEC related to prospective unlocking, the delay in filing our 2005 and 2006 Form 10-K and the restatement of our 2005 financial statements.

(6) We test for impairment of goodwill on an annual basis unless an event occurs or circumstances change that would more likely than not indicate that an impairment has occurred. During our impairment test in 2004, we determined that goodwill related to our agency subsidiaries was impaired. This impairment was a result of declining sales, which led to lower than planned net income at the reporting unit level.

(7) In 2005 we recorded $1,437 of litigation expense related to the settlement of four lawsuits, three of which had been accrued for in the prior year. In 2004 we recorded $4,150 of litigation expense related to the settlement of one lawsuit and the anticipated settlement of two other lawsuits. There were no material litigation accruals in 2006, 2003 or 2002.

(8) In late 2005, we determined that the new administrative system that we were in the process of installing would not yield the benefits and efficiencies to operations that were originally intended. As a result of this determination we impaired its capitalized value through a charge to income of $2,337 in 2005 and 337 in 2006.

(9) The 2001 Centre Agreement was commuted in May 2005. We recorded a termination fee of $18,300 in 2005 related to the early commutation of this agreement and $7,267 for warrants that were forfeited.

(10) In November 2005, the remaining balance of the convertible debt due in 2008 mandatorily converted to 6,649 shares of our common stock. As a result of the conversion, 2006 and 2005 interest expense declined from 2004.

(11) In 2002, we determined that the goodwill associated with our insurance subsidiaries was impaired and recognized an impairment charge of $5,151, net of related tax effect, which we recorded as a cumulative effect of change in accounting principle.

In January 2005, we discovered errors related to prior period financial statements for the years 1999-2004 that on a cumulative basis total $2,318 on a pre-tax basis and $1,507 net of federal income taxes. The entire amount relates to return of premium benefits that should have been paid to policyholders in prior years but due to an error in our process of identifying which policyholders should be paid, not all of the policyholders were properly identified. This process has been corrected. The following table summarizes the impact on net income for prior years and the amount of $1,507, net of related tax effect, which was recorded as a cumulative effect of a change in accounting principle.

	Cumulative prior to January 1, 2003	Year Ended December 31, 2003	2004	Adjustment Recorded as of January 1, 2005
Accounts payable and other liabilities	$1,440	$393	$485	$2,318
Federal income taxes receivable or payable	(503)	(138)	(170)	(811)
Impact on net income	$937	$255	$315	
Retained earnings				$1,507

(12) A one-for-four reverse stock split for current holders of our common stock became effective July 11, 2005. The basic and diluted earning per share amounts, the average shares outstanding and our book value per share for 2004, 2003 and 2002 have been restated to reflect the impact of the reverse stock split.

(13) In 2002, we issued approximately 143 new shares through a direct equity placement. In 2003, approximately $2,000 of convertible debt due 2003 was exchanged for new convertible debt due 2008. In addition, we issued approximately $33,000 in new convertible debt due 2008 and used a portion of the proceeds to retire approximately $9,000 in convertible debt due 2003. During 2003, holders of approximately $8,000 of the convertible debt due 2008 converted their debt for approximately 1,250 shares of our common stock. During 2004, holders of approximately $29,500 of the convertible debt due 2008 converted their debt for approximately 4,625 shares of our common stock. During 2005, holders of $40,049 of the convertible debt due 2008 converted their debt for approximately 5,790 shares of our common stock. In 2005, $46,544, the remaining balance of the convertible debt due 2008, mandatorily converted to 6,649 shares of our common stock.

(14) Diluted shares outstanding include shares issuable upon the conversion of our convertible debt and exercise of options outstanding in 2004. They are excluded for 2006, 2005, 2003 and 2002 since inclusion of such shares would be anti-dilutive.

(15) We measure our GAAP combined ratio as the total of all expenses, including benefits to policyholders, related to policies in-force divided by premium revenue. This ratio provides an indication of the portion of premium revenue that is devoted to the coverage of policyholder related expenses. We depend on our investment returns to offset the amounts by which our combined ratio is greater than 100%. For 2006, 2005 and 2002, see note 4 above. Expenses considered in the expense ratio and combined ratio calculations are benefits to policyholders, commissions, net acquisition costs amortized, general and administrative expenses and expense and risk charges and excise tax.

(16) Return on average equity, which is the ratio of net income or losses to average shareholders equity, measures the current period return provided to shareholders on invested equity. New or existing shareholders could be dissuaded from future investment in our common stock and may choose to sell their common stock if they are not satisfied with our return on equity.

(17) As a result of our reinsurance agreement with Centre Solutions (Bermuda) Limited, effective December 31, 2001, we transferred substantially all of our investable assets to the reinsurer. We received back our investable assets upon commutation of the reinsurance agreement in May 2005.

(18) In November 2005, the remaining balance of the convertible debt due 2008, $46,544, mandatorily converted to 6,649 shares of our common stock.

(19) Under statutory accounting principles, ceded reinsurance reserves are accounted for as offsetting negative benefits and negative premium. The premium amounts are significantly reduced each year due to the ceding of all of our long-term care premiums for business written prior to December 31, 2001.

Quarterly Data

Our unaudited quarterly data have been derived from unaudited financial statements and include all adjustments, which we consider necessary for a fair presentation of the results of operations for such periods.

	2006			
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Premium revenue	$ 76,647	$ 74,893	$ 72,216	$ 71,011
Net investment income	13,664	13,094	11,963	14,338
Net realized capital (losses) gains	(1,420)	(566)	(15)	189
Benefits to policyholders	111,684	65,831	62,452	58,418
Commissions and operating expenses	30,660	28,730	27,726	29,764
Net (loss) income	(32,652)	(2,444)	(3,209)	5,137
Basic earnings per share from net (loss) income	(1.40)	(0.10)	(0.14)	0.22
Diluted earnings per share from net (loss) income	(1.40)	(0.10)	(0.14)	0.22

	2005 (Restated)			
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Premium revenue	$ 79,812	$78,482	$76,066	$ 75,156
Net investment income	12,335	12,757	12,580	13,161
Net realized capital (losses) gains	(1)	(82)	(341)	(710)
Benefits to policyholders	65,400	70,780	56,085	91,402
Commissions and operating expenses	29,534	28,649	25,586	34,991
Net (loss) income before cumulative effect of change in accounting principle	(3,705)	10,355	4,932	(24,988)
Net (loss) income	(5,212)	10,355	4,932	(24,988)
Basic earnings per share from net (loss) income before cumulative effect of change in accounting principle	(0.26)	0.71	0.34	(1.71)
Basic earnings per share from net (loss) income	(0.36)	0.71	0.34	(1.71)
Diluted earnings per share from net (loss) income before cumulative effect of change in accounting principle	(0.26)	0.71	0.34	(1.71)
Diluted earnings per share from net (loss) income	(0.36)	0.71	0.34	(1.71)

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Item 7. **Management s Discussion and Analysis of Financial Condition and Results of Operations**

Restatement (amounts in thousands)

In connection with the preparation and audit of the financial statements for the year ended December 31, 2006, we discovered certain financial statements errors. These errors are not material to either the year ended December 31, 2005 or prior years. However, an error related to our actuarial assumptions did have a material impact on each of the quarters of 2005, and therefore, we have restated the previously issued financial statements for the year ended December 31, 2005. There was no adjustment to years prior to 2005. As a result of the restatement, shareholders' equity decreased $526 at December 31, 2005 compared to the previously issued financial statements.

The errors related to four areas as follows:

Reserving Factors:

We use various actuarial assumptions in the determination of our reserves for policyholders and in the establishment of our deferred acquisition cost asset. We incorrectly applied a future modifier, which is an assumption that reduces the total in-force population in future periods for policyholders that are assumed to already be on claim. The effect for each of the quarters in 2005 was considered to be material, which is the primary reason that we have determined to restate the 2005 financial statements. The total cumulative impact of the restatement for the change in assumptions that affected shareholders equity as of December 31, 2005 was an increase in shareholders equity and net income of $731. There was no adjustment to years prior to 2005.

Return of Premium Benefit:

We offer a Return of Premium Benefit in some of our policies, which generally requires that a portion of the premium paid be returned to the policyholder if no claims have been incurred after a certain number of years or upon lapse of the policy or death of the policyholder. Due to an error in our process for identifying which policyholders should be paid, not all required payments were made when due. Further, we determined that, under the terms of the policies, interest on the unpaid balance was due to the policyholder as well. The total cumulative impact of the restatement for this error that affected shareholders equity as of December 31, 2005 was a decrease in shareholders equity and net income of $1,102. There was no adjustment to years prior to 2005.

In connection with the adoption of SAB 108 in 2005, we recorded a cumulative effect adjustment in 2005 for return of premium benefits that should have been paid to policyholders in prior years. The adjustment above corresponds to additional items not considered when the SAB 108 adjustment was made in 2005.

Beneficial Conversion Feature of Notes Payable

A beneficial conversion feature exists when convertible debt is issued with a non-detachable conversion feature and when the conversion price is lower than the fair market value of the common stock at the time of issuance. In November 2004, we issued convertible debt and followed the guidance of the Emerging Issues Task Force of the Financial Accounting Standards Board in EITF 98-5 calculating the value of the beneficial conversion feature using the intrinsic value methodology. EITF 98-5 also required that the beneficial conversion feature be expensed over the period to the earliest conversion date. Since our convertible debt was convertible immediately upon issuance, the total value was expensed in 2004. At that time, there was also proposed guidance in EITF 00-27 that directly impacted the accounting treatment of the beneficial conversion feature. The first difference was that the beneficial conversion feature should have been amortized to the maturity of the debt. In addition, EITF 00-27 required that any discounts associated with the convertible debt be considered in determining the value of the beneficial conversion feature. Applying this methodology increased the value of the beneficial conversion feature recognized for the November 2004 issue and required the recognition of a beneficial conversion feature for the February 2004 issuance of convertible debt. In February 2005, a consensus was reached on EITF 00-27, but we did not properly adopt it for our financial statements. The total cumulative impact of the restatement for this as of December 31, 2005 was a decrease in retained earnings

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and net income of $439 and an increase in additional paid-in capital of $439. There was no adjustment to years prior to 2005.

Sale Leaseback:

During 2006, we discovered that the amortization tables developed internally and used to amortize the lease obligation for a sale leaseback transaction were incorrect because the implicit interest rates and the payment streams used were incorrect. New amortization tables were prepared with the correct data. Lease obligation balances at December 31, 2005, derived from the new tables are higher than recorded balances, and conversely, interest expense for the year was lower. The total cumulative impact of the restatement for this error that as of December 31, 2005 was a decrease in retained earnings and net income of $155.

Restatement of Financial Statements for 2005

The consolidated financial statements for the years ended December 31, 2005 reflect the effects of the restatements described previously on net policy acquisition costs amortized and its effect on unamortized deferred policy acquisition costs, benefits to policyholders expense and its effect on policy reserves and claim reserves, interest expense and its effect on notes payable and additional paid-in capital, the Federal income tax benefit and its effects on income taxes payable and deferred income taxes, and basic and fully diluted earnings per share. A summary of the effects of the restatement for all errors on reported amounts for the year ended December 31, 2005 is presented below.

	Amounts Reported in the Consolidated Balance Sheet		
	December 31, 2005		
	As Previously Reported	Adjustment	As Restated
Unamortized deferred policy acquisition costs	$ 143,700	$ (3,266)	$140,434
Policy reserves (accident and health)	618,128	(4,391)	613,737
Claim reserves	363,059	870	363,929
Accounts payable and other liabilities	35,796	1,064	36,860
Long-term debt	-	-	-
Federal income tax payable	2,605	(84)	2,521
Deferred income taxes	5,306	(199)	5,107
Additional paid-in capital	226,922	439	227,361
Retained earnings	48,283	(965)	47,318

Consolidated Statement of Income and Comprehensive Income	Amounts Reported in the		
	December 31, 2005		
	As Previously Reported	Adjustment	As Restated
Benefits to policyholders	$ (287,188)	$ 3,521	$ (283,667)
Net policy acquisition costs amortized	(5,480)	(3,266)	(8,746)
Interest expense	(6,567)	(1,503)	(8,070)
Federal income tax benefit	8,634	283	8,917
Net loss before cumulative effect of change in accounting principle	(12,441)	(965)	(13,406)
Cumulative effect of change in accounting principle	(1,507)	-	(1,507)
Net loss	(13,948)	(965)	(14,913)
Basic earnings per share from net loss before cumulative effect of change in accounting principle	$ (0.85)	$ (0.07)	$ (0.92)
Basic earnings per share from net loss	$ (0.96)	$ (0.06)	$ (1.02)
Diluted earnings per share from net loss before cumulative effect of change in accounting principle	$ (0.85)	$ (0.07)	$ (0.92)
Diluted earnings per share from net loss	$ (0.96)	$ (0.06)	$ (1.02)

The restatement did not have any impact on total cash flows from operations, investing or financing activities.

Critical Accounting Estimates

(amounts in thousands)

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America (GAAP) requires management to make estimates and assumptions that affect the reported amounts and related disclosures. Such estimates and assumptions significantly affect various reported amounts of assets and liabilities. Management discusses the development, selection and disclosure of these estimates and assumptions with the audit committee. Management has made estimates in the past that we believed to be appropriate but which were subsequently revised to reflect actual experience. If our future experience differs materially from these estimates and assumptions, our financial condition and results of operations could be affected. Management considers an accounting estimate to be critical if:

It requires assumptions to be made that were uncertain at the time the estimate was made; and

Changes in the estimate or different estimated amounts that could have been selected could have a material impact on our financial condition or results of operations.

Other than Temporary Impairment of Investments

We assess whether declines in market value for debt and equity securities held as investments are other than temporary. Securities are evaluated considering factors such as financial condition, near-term and long-term prospects of the issuer, as well as underlying factors such as specific events or circumstances that may influence the operations of the issuer, the financial condition and prospects for the issuer s geographic region and industry, the duration and extent to which the market value has been less than cost and our ability and intent to hold these investments for a period of time sufficient for them to recover in value. Upon such determination, we will impair the security s amortized cost and record an impairment charge to results of operations.

Policy Reserves and Deferred Acquisition Costs

Our policies are accounted for as long duration policies. As a result, there are two components of the liabilities associated with our policies. The first is a liability for future policyholder benefits, represented by the present value of future benefits less the present value of future premium collections. In calculating these reserves we utilize assumptions, including estimates for persistency (policies that do not terminate), morbidity (claims expectations), interest rates, expenses and premium rate increases. These assumptions are estimated in the year a policy is issued. Once the assumptions are established, we continue to utilize those assumptions unless our assessment of deferred acquisition costs (DAC) indicates that the current unamortized DAC asset is not recoverable in future periods. Any variance from the assumptions established in the year a policy is issued could have a material adverse impact on our financial condition and results of operations.

The significant assumptions utilized in setting our reserves for future policyholder benefits are:

- The use of a voluntary lapse rate that ranges from 1.5% to 43%, depending on the age of the policyholder, the number of years the policy has been in-force and other characteristics. The high end of the lapse rate range is 43%, which is utilized for our more recently issued policies in their first year of issue at policyholder ages of 80 and above. A significant majority of our policyholders are between the ages of 60 to 79 at the time of issuance of a policy. The lapse rates for these ages range from a high of 30% in the first year a policy is issued down to 2.5% in the later durations.
- Morbidity based upon past Company experience and industry data. We also include an estimate for improving morbidity trends in the general population.
- The use of the 1990-1995 Select and Ultimate, Sex Distinct, actuarial table for mortality.
- For policies issued in 2002 through 2005, we use a 4.5% interest rate to discount future experience. For policies issued prior to 2002, we use a 5.7% interest rate to discount future experience.
- We also include an estimate of premium rate increases for certain policies issued prior to 2002, based on the premium rate increases we estimated as of September 30, 2002. This is the last time we revised our assumptions and recorded an impairment to our DAC. We have achieved 100% of these premium rate increases as of September 30, 2005.
- Consideration of the terms and expected recapture timing of the 2001 Centre Agreement.

Our assumptions remain unchanged in future periods regardless of actual experience unless we impair our DAC due to an expected loss in future periods using updated assumptions for all of the above. However, when actual experience differs from our expectations, the incremental difference between actual and expected results is recognized in the current period.

In connection with the sale of our insurance policies, we defer and amortize a portion of the policy acquisition costs over the related premium paying periods of the life of the policy. These costs include all expenses that are directly related to, and vary with, the acquisition of the policy, including commissions, underwriting and other policy issue expenses. We defer 27% of new premiums for the general and administrative expenses related to issuing a policy. The premium paying periods of the life of the policy are the same assumptions utilized for persistency in the future benefit reserves.

We assess the recoverability of our unamortized DAC asset on a quarterly basis, through actuarial analysis. To determine recoverability, the present value of anticipated future premiums less future costs and claims are added to current reserve balances. If this amount is greater than the current unamortized DAC, then the DAC is deemed recoverable. If this amount is less than the current unamortized DAC, then we impair our DAC and record a charge in our current period results of operations.

The DAC recoverability analysis includes our most recent assumptions for persistency, morbidity, interest rates, expenses and premium rate increases, all or any of which may be different than the assumptions utilized in establishing our benefit reserves.

The significant assumptions utilized in the DAC recoverability analysis that differs from our current assumptions for policy reserves and DAC include:

- Use of new claim costs based on a recent analysis of claims experience from 1993 to 2006.
- An investment income rate of 5.37% initially, grading to the 6.59% for newly investable funds by 2036.
- An estimate that claims expense will improve beyond the assumptions we utilized in our locked-in estimates due to the expected results from recently implemented and future planned improvements to our claims adjudication procedures.
- Recognition of actual premium rate increases achieved as well as an estimate related to premium rate increases that we began filing in November of 2006. Our assumption is that the premium rate increases will be implemented beginning in the second half of 2007 and most of them will be approved by 2010, although we also assume that some of the premium rate increases will be implemented in 2011. There is also an assumption related to an increased number of people lapsing due to the premium rate increases and therefore an assumption related to anti-selection as a result of the premium rate increases. Anti-selection is the lapsation of policies held by healthier policyholders, leading to a higher expected ratio of claims to premiums in future periods.
- Mortality assumptions based on a study completed in September 2005 which measured our actual mortality experience, considering underwriting class as well as age and gender.
- Voluntary lapse rates based on a new study completed in November of 2006, which indicate that policies are lapsing at a slower rate than we previously assumed
- Consideration of the terms and expected recapture timing of the Imagine Agreement.

The premium rate increases we are seeking may be consistent by policy form or may vary by the policy type, benefit period, underwriting class and the age of the policyholder. The aggregate average increase is approximately 55%, although the policy forms for which we have filed premium rate increase requests have an average increase ranging from 3.2% to 99.1%, depending on the mix of business within a particular state. The timing of state approvals for premium rate increases varies. Some states will approve the amount we filed within several months of the receipt of the filing, while other states will take up to a year or may only approve a portion of the amount we filed. In those situations, we will file for additional premium rate increases at a later date in order to obtain the remaining portion of the premium rate increase, so long as it is still actuarially justified. Therefore, to implement 100% of the premium rate increases, if ultimately approved, may take several years. We have submitted 100% of our requests for premium rate increases. We have received approval to implement premium rate increases on 68% of the policies for which we have sought increases. The average premium rate increase approved on these policies is approximately 27%. Therefore, as of the time of this filing, we have received rate increases of approximately 18% compared to the 55% we have requested.

Long-term care insurance has fixed annual premiums that can be adjusted only upon approval of the insurance departments of the states where the premiums were written. The process for filing for premium rate increases requires us to demonstrate to the insurance department that expected claims experience is anticipated to exceed original assumptions. The approval of premium rate increases is at the discretion of the insurance department.

We base our premium rate increase assumptions on our past experience and our expectations of the amounts of actual rate increases that we will be able to achieve. If we are unsuccessful in obtaining the assumed level of premium rate increases, we could recognize an impairment in the future, which could have a material adverse effect on our financial condition and results of operations.

Changes in one or a combination of these assumptions can produce significant volatility in the recoverability of DAC.

Claim Reserves

The second component of the liabilities associated with our policies is a reserve we establish for incurred, either reported or not yet reported, claims. This amount represents the benefits to be paid in the future for our current claims. The significant assumptions utilized in establishing claim reserves are expectations about the duration, cost of

care being reimbursed, the interest rate utilized to discount the claim reserves, claims that have been incurred but not yet reported, claims that have been closed but are expected to reopen and assumptions about which claims that are currently in their eligibility review stage will eventually become claims that have payments associated with them. We establish our claim reserves in each period based upon our most currently available information and assumptions.

A significant majority of our claims do not go beyond three years in duration. Due to the relatively large amount of data we have on claims in these early durations, the assumption about the length of claims in these durations is primarily based on our own past experience. The expected duration of claims is derived through continuance studies. We completed a new continuance study in 2006, which was utilized in establishing reserves throughout 2006. Continuance studies determine our assumption about the probability of a claim continuing once it has reached a certain point. The continuance studies are done by segments of similar claims which include categories such as policy type (nursing home, home health care, or comprehensive), medical condition causing the claims (which is categorized as short-term, intermediate, long-term or cognitive impairment), the age of the claimant at time of claim and gender. There is no guarantee that past performance is an indicator of future performance. If our assumptions about continuance are incorrect and individuals stay on claim longer than expected, it could have a material adverse affect on our financial condition and results of operations

Both our experience and the industry s experience with claims that last longer than three years is much more limited due to the relatively small number of claims that go past the third year. A majority of our policies were written in the late 1990 s through 2001 and therefore there are only a limited number of claims on which to base any conclusions. Therefore, we rely on a combination of our experience and studies performed by the Society of Actuaries or other sources for claims in the later durations. Due to the limited amount of data, there is a higher likelihood of variance related to this assumption and any variance could have a material affect on our financial condition and results of operations. In the fourth quarter of 2005, we changed our assumption related to claims that lasted longer than three years, resulting in a revised assumption that once a claim lasted longer than three years, it would last longer than we previously assumed. As a result of this change in assumptions, we increased claim reserves approximately $42,000 in the fourth quarter of 2005. As part of continuance assumptions, we also try to reflect anticipated changes in mortality of disabled lives and recovery rates of people on claim. Reviewing past experience is a partial guide, but changes in the future may not follow past patterns.

Based on retrospective tests on the development of claims incurred on or before December 31, 2006, we have increased our claim reserves approximately $34.6 million above the amounts produced by the reserving methodology we employed which utilized the continuance curves completed in 2006. The retrospective tests were based on the development of all claims incurred on or before December 31, 2006, and the increase was based on the development of these claims through December 31, 2007. We believe that this increase was needed because the duration of claims is longer than we previously estimated. We believe that the claims reserves at December 31, 2006, represent our best estimate based on all information available through December 31, 2007, however if these estimates are not accurate it could have a material adverse effect on our financial condition and results of operations.

The cost of care being utilized is also based on our historical experience. In general, a significant portion of our older polices reimburse claimants that are receiving care in a facility on an indemnity basis, meaning that we pay 100% of the maximum daily benefit regardless of the cost of the care provided. Our newer generations of products pay facility claims on a cost incurred basis, meaning that we only reimburse for the cost of care provided up to the maximum daily benefit. However, all of our home health care benefits are paid on a cost incurred basis regardless of when the policy was issued. If our assumptions related to the percentage of the maximum daily benefit that we will pay on claims are higher than anticipated, it could have a material adverse affect on our financial condition and results of operations.

Because our claim payments are made over a period of time, we utilize a discount rate of 5.1% for claim reserves in order to determine the present value of future expected payments. This discount rate approximates the current yield to maturity of our assets supporting this future liability.

We make an assumption that there have been a number of claims that have been incurred but not yet reported. This assumption is based on historical studies related to the number of claims that are reported after the date of the

financial statements that have been incurred prior to the date of financial statements. This assumption also reflects recent patterns relating to incidence rates.

There are also assumptions related to claims that are closed but are expected to reopen. These are typically claims where we have requested information that has not been received and therefore close the claim and receive the requested information subsequent to closing the claim. The assumption related to these claims is also based on our historical experience.

The other significant assumption we make is for the likelihood of a reported claim that has not yet had a payment, because it is in its initial eligibility assessment, becoming a claim with payments in the future. This assumption is also based on our past experience.

As part of our monitoring of claims reserves, we compare actual results to our expectations. Any deviation from our expectations is recorded in the period in which the deviation occurs. Any changes in our estimates in the future may have a material adverse impact on our financial condition and results of operations.

Litigation and Contingencies

We are involved in legal proceedings relating to our operations. We recognize an estimated loss for contingencies when we believe it is probable that a loss has occurred and the amount of loss can be reasonably estimated. However, it is difficult to measure the actual loss that might be incurred related to litigation and contingency matters. As time passes and additional facts and circumstances become known, our estimation of the probability of loss as well as our ability to reasonably estimate a loss may change. The ultimate outcome of litigation and other contingencies could have a material adverse impact on our financial condition and results of operations.

Imagine Reinsurance Agreements

The Imagine reinsurance agreements (the 2001 Imagine Agreement and the 2005 Imagine Agreement) are being accounted for using deposit accounting for reinsurance contracts. We are using deposit accounting because we believe the reinsurance contracts do not result in the reasonable possibility that the reinsurer will suffer a significant loss. We assessed these long duration reinsurance contracts using the reasonable possibility of significant loss criteria due to certain contract provisions that limit the risk to the reinsurer, including an aggregate limit of liability for the reinsurer, experience refund provisions and expense and risk charges provided to the reinsurer. We also entered into the reinsurance agreements with the intent of commuting the agreements in the future. However, the agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules, which requires a reinsurance agreement to transfer risk to the reinsurer, but does not require the reasonable probability of a significant loss required under GAAP.

As noted above, the 2001 Imagine Agreement contains commutation provisions and allows us to recapture the reinsured policies as of January 1, 2008, or on January 1 of any year thereafter. Additionally, the agreement contains certain covenants and conditions that, if breached, could result in our decision to ultimately commute the agreement or else forego any future opportunity to commute.

In the event we do not commute the 2001 Imagine Agreement on or before January 1, 2009, the expense and risk charge paid to the reinsurer will increase by 50 percent. In the event we do not commute the agreement on or before January 1, 2011, but commute at a later date, the experience refund will not exceed the statutory reserves as of the date of commutation, resulting in our forfeiture of any accumulated statutory profits to which we otherwise may have been entitled.

In order to commute the agreement and remain in compliance with requisite minimum regulatory standards, we will need to have a risk based capital ratio (RBC) of at least 200%. Our current modeling and actuarial projections suggest that our RBC ratio should be at or slightly above 200% and therefore we may be able to commute the 2001 Imagine Agreement on January 1, 2010. We also believe that we should have an additional margin for any adverse development in order to recapture the block of business. These projections include assumptions related to premiums (new sales, persistency and the timing of the collection of premium rate increases by 2011), investment income, expense levels, incurred claims (paid claims plus change in claim reserves) and changes in our future

policyholder benefits. Because our current projections show that we are unable to commute the 2001 Imagine Agreement until January 1, 2010, we have included additional expense and risk charges in our DAC recoverability analysis. Our DAC is still recoverable with these additional expense and risk charges. We are considering alternatives that may allow us to either commute the 2001 Imagine Agreement prior to January 1, 2010 or reduce the expense and risk charges that escalate as a result of not commuting on January 1, 2009. We believe that alternatives such as modifications to the current reinsurance agreement, new reinsurance agreements, additional capital issuances or a transaction that is completed as a result of our current review of strategic alternatives are available to allow us to commute the 2001 Imagine Agreement on January 1, 2009. We may not be able to commute the 2001 Imagine Agreement on January 1, 2010, as planned, which could have a material adverse affect on our financial condition and results of operations. In the event we determine that commutation of the Imagine Agreement is unlikely on or before January 1, 2010, but likely at some future date, we will include additional annual expense and risk charges in our unamortized DAC recoverability analysis. As a result, we could impair the value of our DAC asset and record the impairment in our financial statements at that time.

Pursuant to the Plan with the Insurance Department, which requires the pre-approval of new or modified reinsurance agreements, we have requested and received approval to modify the 2001 Imagine Agreement. The approved modification would waive an increase in the expense and risk charges that would be payable to the Reinsurer if the ceded policies are not recaptured and the entire Agreement is not commuted on or before January 1, 2009 and allow, Penn Treaty, in its sole discretion to recapture approximately 1/3 of the reinsured business in each of the years 2009, 2010 and 2011, with no escalation in the expense and risk charges. The modification would give us additional latitude in deciding the economics of commuting the treaty via other capital alternatives. At the time of the filing of this document, the modified Agreement has not been signed by the reinsurer or us.

Our agreement requires us to file premium rate increases within 30 days of our determination of need for these increases. Failure to file such rate increases within the prescribed time is defined in the agreement as a Material Breach Event, which, if uncorrected would ultimately lead to a reduction in the reinsurer s liability to reimburse claims made in the future under the agreement. Although we filed our premium rate increases more than 30 days after our determination of need in 2006, thereby creating a Material Breach Event, the Reinsurer considers our ultimate filings to be sufficient to cover our obligations under the agreement and has not reduced the aggregate limit of liability.

Goodwill

Our goodwill relates to the purchase of our insurance agencies, United Insurance Group Agency, Inc. (UIG) and Network Insurance Senior Health Division (NISHD). We test for impairment of goodwill on an annual basis unless an event occurs or circumstances change that would more likely than not indicate that an impairment has occurred. During 2004, we performed our impairment test on a quarterly basis due to declining sales. The test is done at the reporting unit level, which combines the operations of UIG and NISHD. UIG and NISHD are both insurance agencies that sell senior market insurance products, and therefore have similar economic characteristics.

During our quarterly impairment test as of December 31, 2004, we determined that the goodwill was impaired. This impairment was a result of declining sales, particularly in the fourth quarter of 2004, which led to lower than planned net income at the reporting unit level. The decline in sales is attributable to a decline in sales across the long-term care industry during 2004 as a result of higher priced policies and the negative impact of premium rate increases that have been implemented on previously issued policies. The fair value of the reporting unit is determined utilizing the present value of cash flows, which includes assumptions for future growth in sales. During the impairment test, we lowered the assumptions related to future sales growth and as a result recognized an impairment of $13,376 in 2004. There was no impairment in 2006 or 2005.

The significant assumptions in our impairment test include future growth in sales of insurance policies, the persistency of the renewal commission stream and estimated future expenses. The projection encompasses a 20 year period, and we utilized a 15% discount rate. We assume that our agencies are capable of future growth from both the sale of our products and from the sale of other carriers products.

Our future growth assumptions ranged from 15% in the first years and stabilized at 5% in the later years of our analysis. The growth rates in the early years are dependent upon the ability of our agencies to execute on recently signed agreements with unaffiliated insurance companies and to sell policies underwritten by our insurance

subsidiaries. The renewal commission stream is based on the contracts that the agencies have with various insurance carriers and historical patterns of persistency.

Results of Operations

Twelve Months Ended December 31, 2006 and 2005 (Restated)

(amounts in thousands)

Premium revenue. Total premium revenue earned in the twelve months ended December 31, 2006, decreased 4.8% to $294,767, compared to $309,516 in the same period in 2005.

Total first year premium revenue earned in 2006 decreased 4.5% to $11,549, compared to $12,095 in 2005. First year long-term care premiums earned in 2006 decreased 2.6% to $11,538, compared to $11,842 in 2005. We believe that this decrease was due to the uncertainty created by the late filing of our audited statutory financial statements, the uncertainty created by the late filing of our 2005 Form 10-K, the amount of time that we were prohibited from selling new business in the state of Florida during 2006 and the focus by a number of our independent agents on the new Medicare Part D and fee for service products.

Total renewal premium revenue earned in 2006 decreased 4.8% to $283,218, compared to $297,421 in 2005. Renewal long-term care premiums earned in 2006 decreased 3.6% to $274,696, compared to $284,840 in 2005. The decrease in renewal premium revenue is due to the lapsation of existing policies. We anticipate that we will continue to experience reduced levels of renewal premium revenue until such time as the combination of an increased level of new premiums and the implementation of premium rate increases on policies issued prior to 2002 is sufficient to offset the lapsation of existing policies. Our persistency was 91.9% and 88.8% for the 2006 and 2005 periods, respectively. The increase in persistency in 2006 is primarily due to the lower level of premium rate increases implemented in 2006 compared to 2005. In general, policyholders have a higher likelihood of voluntarily lapsing or canceling their policy after receiving a premium rate increase.

Net investment income. Net investment income earned in 2006 increased 4.4% to $53,059 from $50,833 in 2005.

Our average yield on invested assets at cost, including cash and cash equivalents, was 5.18% and 5.02% in 2006 and 2005, respectively. The increase in 2006 was primarily due to the sale of lower yielding securities and the purchase of higher yielding securities. Our net investment income included an investment income component from our 2001 Centre agreement notional experience account prior to May 24, 2005. The investment income component of our notional experience account investment credit generated $18,859 in 2005. The notional experience account yielded a fixed return based upon the yield to maturity of the underlying benchmark indices, which were comprised of U.S. Treasury strips, government agencies and investment grade corporate bonds with weightings of approximately 25%, 15% and 60%, respectively, and had a duration of approximately 14 years. The average yield on the notional experience account was 5.26% in 2005. We commuted the 2001 Centre agreement in May of 2005 and received investments of approximately $950 million as a result of the commutation. We have gradually reduced the duration of this portfolio to approximately 10 years at December 31, 2006 by selling long duration U.S. Treasury strips and purchasing medium duration mortgage backed securities.

Market gain on notional experience account. We recorded a gain on our notional experience account of $48,799 in 2005. Following the commutation of our 2001 Centre agreement in May 2005, we no longer record gains or losses attributable to a notional experience account.

Federal excise tax recoverable. In June 2007, we received notification that the Internal Revenue Service has accepted a claim for refund that the Company had filed related to returned premiums associated with the commutation of the reinsurance transaction with Centre Solutions (Bermuda) LTD. (Centre). The excise taxes related to premiums

that had been paid to Centre as part of a reinsurance agreement the Company had with Centre during the years 2002-2005. The estimated amount of the refund is $9,003, which includes interest of $924.

Other income. We recorded $11,882 in other income in 2006, as compared to $8,847 in 2005. The commission income related to our agency subsidiaries increased to $11,321 in 2006 compared to $5,359 in 2005. The increase in commission income was primarily related to the sale of Medicare Private Fee for Service and Part D Medicare products by our agency subsidiaries.

Benefits to policyholders. Total benefits to policyholders in 2006 increased 5.2% to $298,385 compared to $283,667 in 2005. Our loss ratio, or policyholder benefits to premiums, was 101.2% in 2006, compared to 91.6% in 2005. In 2006 our long-term care claim reserves increased approximately $42,600 compared to an increase of approximately $39,800 in 2005. Based on retrospective tests on the development of claims incurred on or before December 31, 2006, we have increased our claim reserves approximately $34,600 above the amounts produced by the reserving methodology we employed which utilized the continuance curves completed in 2006. The retrospective tests were based on the development of all claims incurred on or before December 31, 2006, and the increase was based on the development of these claims through December 31, 2007. We believe that this increase was needed because the duration of claims is longer than we previously estimated. We believe that the claims reserves at December 31, 2006, represent our best estimate based on all information available through December 31, 2007. However, if these estimates are not accurate it could have a material adverse effect on our financial condition and results of operations.

The increased amount in 2005 was primarily a result of an adjustment to our assumption related to the length of time a claim will stay open after it has been open for more than three years along with a change in the discount rate used to set our claim reserves from 5.9% to 5.1%, based on the yield of our portfolio at December 31, 2005. The remaining variance in the loss ratio is due to lower premium revenue in 2006 compared to 2005.

As our block of policies in-force ages, we generally anticipate an increase in our loss ratio. Because we have collected premiums over the life of these policies, and invested the premiums in investment securities, a greater portion of our income comes from interest income each year, which is not reflected in the loss ratio. In addition, if we remain locked in to our assumption in our future policy benefit reserves, we anticipate loss ratios similar to those experienced in 2006 and 2005 until such time as enough premium rate increases are implemented.

We establish reserves for current claims based upon current and historical experience of our policyholder benefits, including an expectation of claims incidence and duration, as well as the establishment of a reserve for claims that have been incurred but are not yet reported (IBNR). We continuously monitor our experience to determine the best estimate of reserves to be held for future payments of these claims. As a result, we periodically refine our process to incorporate the most recent known information in establishing these reserves.

Claims experience can differ from our expectations due to numerous factors, including mortality rates, duration of care and type of care utilized. The amount of reserves relating to reported and unreported claims incurred is determined by periodically evaluating historical claims experience and statistical information with respect to the probable number and nature of such claims. We compare actual experience with estimates and adjust reserves on the basis of such comparisons.

Commissions. Commissions to agents decreased 6.3% to $35,735 in 2006, compared to $38,121 in 2005. These totals exclude commissions paid to our subsidiaries, which are eliminated in consolidation.

First year commissions on accident and health business in 2006 decreased 0.3% to $7,681 compared to $7,703 in 2005. Although first year premiums decreased 4.5% in 2006 compared to 2005, the first year commissions only decreased 0.3%. This is due to modifications in our commission structure, which resulted in higher first year and lower renewal commissions. The ratio of first year accident and health commissions to first year accident and health premiums was 66.5% in 2006 and 63.7% in 2005. Both the first year commissions total and the ratio of first year commissions to first year premiums include the commissions paid to our subsidiaries.

Renewal commissions on accident and health business in 2006 decreased 7.2% to $30,383, compared to $32,732 in 2005, primarily due to the decrease in renewal accident and health premiums. The ratio of renewal accident and health commissions to renewal accident and health premiums was 10.7% in 2006 and 11.1% in 2005. We have implemented premium rate increases on a majority of policies written prior to December 31, 2002. We do not pay commissions on the additional premium collected as a result of a premium rate increase, which reduces the ratio of renewal commissions to renewal premium revenue. We anticipate that this ratio will continue to decline until all premium rate increases are fully implemented. Both the renewal commissions total and the ratio of renewal commissions to renewal premiums include the commissions paid to our subsidiaries.

Net policy acquisition costs amortized. The net deferred policy acquisition costs amortized in 2006 decreased to $4,601, compared to $8,746 in 2005.

Deferred costs are typically all costs that are directly related to, and vary with, the acquisition of new premiums. These costs include the variable portion of commissions, which are defined as the first year commissions less ultimate renewal commissions, and variable general and administrative expenses related to policy sales, underwriting and issuance. Deferred costs are amortized over the life of the policy based upon actuarial assumptions, including persistency of policies in-force. In the event that a policy lapses prematurely due to death or termination of coverage, the remaining unamortized portion of the deferred amount is immediately recognized as expense in the current period.

The net amortization of deferred policy acquisition costs is affected by new business generation, imputed interest on prior reserves and policy persistency. The amortization of deferred costs is generally offset largely by the deferral of costs associated with new premium generation. However, the level of new premium sales during the 2006 and 2005 periods produced less expense deferral than needed to offset amortized costs.

General and administrative expenses. General and administrative expenses in 2006 increased 5.0% to $63,219, compared to $60,185 in 2005. The ratio of total general and administrative expenses to premium revenues was 21.4% in 2006, compared to 19.4% in 2005.

The increase in 2006 was primarily related to additional costs related to accounting, actuarial, legal and consulting fees. These fees increased due to work related to the actuarial study of claim reserves, the settlement of litigation, and the restatement of our 2005 financial statements. There were also additional expenses in 2006 related to our start-up in the financial advisor distribution channel. In addition, the general and administrative expenses at our agency subsidiaries increased in 2006, corresponding with their increase in other income.

Loss due to impairment of property, plant and equipment. Subsequent to December 31, 2005, we determined that the new administrative system that we were in the process of installing would not yield the benefits and efficiencies to operations that were originally intended. As a result of this determination we decided not to continue to pursue this project and impaired its capitalized value through a charge to income of $337 in 2006 and $2,337 in 2005.

Expense and risk charges on reinsurance. In 2006 and 2005, we incurred expense and risk charges of $13,325 and $11,708, respectively. Our Imagine Agreements provide the reinsurer an expense and risk charge equal to the sum of (1) 0.25% of total ceded statutory reserves at the end of a quarter and (2) 0.50% of the value of the combination of any letters of credit or funds deposited in trust by the reinsurer as of the beginning of the quarter. Our 2001 Centre Agreement provided the reinsurer with expense and risk charges. The annual charge consisted of a fixed cost and a variable component based upon reserve and capital levels needed to support the reinsured business.

Interest expense. Interest expense in 2006 was $1,264, compared to $8,070 in 2005. Interest expense incurred in 2006 is primarily related to our capital lease obligation and interest due to our policyholders. We paid our policyholders interest due to the late payment of return of premium benefits that should have been paid in prior years. The interest expense in 2005 was primarily related to our convertible subordinated notes, which bore interest at an annual rate of 6.25%. We incurred additional interest expense related to the conversion of our convertible subordinated notes prior to October 15, 2005. Holders of our convertible subordinated notes were entitled to convert their notes into shares of our common stock before October 15, 2005 and receive a discounted amount of interest that they would have otherwise received through October 15, 2005 had they not converted the notes. We incurred $691 of interest expense

from the conversion of $40,049 in convertible subordinated notes during 2005.

Benefit for federal income taxes. In 2006 and 2005, we recorded a benefit for Federal income taxes of $17,723 and $8,917 respectively. The effective tax rate was 34.8% in 2006 compared to 39.9% in 2005.

Permanent differences in 2006 were not significant. In 2005, the effective tax rate utilized to record our benefit for Federal income taxes was higher than our statutory tax rate of 35% primarily due to the release of $1,197 of contingency reserves related to tax positions taken in the past for which the tax years are no longer open to audit.

Twelve Months Ended December 31, 2005 (Restated) and 2004

(amounts in thousands)

Premium revenue. Total premium revenue earned in the twelve months ended December 31, 2005, decreased 3.2% to $309,516, compared to $319,885 in the same period in 2004.

Total first year premium revenue earned in 2005 increased 8.1% to $12,095, compared to $11,186 in 2004. First year long-term care premiums earned in 2005 increased 14.3% to $11,842, compared to $10,358 in 2004. We believe that the increase in first year premiums is due to (1) the recommencement of sales in additional states, (2) the engagement of additional independent agents that had not previously sold our policies, and (3) the introduction of our new products, which have higher annual premiums than our previously sold products. While many of our new products are sold at higher premium levels than previous products with similar benefits, a portion of the higher premium is attributable to an additional margin for future adverse claims deviation, as required by many states. While these products yield increased profits due to the additional margin, future premium rate increases, if needed, may be more difficult to achieve due to the revised state insurance department rules regarding these increases.

Total renewal premium revenue earned in 2005 decreased 3.7% to $297,421, compared to $308,699 in 2004. Renewal long-term care premiums earned in 2005 decreased 3.8% to $284,840, compared to $295,959 in 2004. The decrease in renewal premium revenue is due to the lapsation of existing policies. We anticipate that we will continue to experience reduced levels of renewal premium revenue until such time as the combination of an increased level of new premiums and the implementation of premium rate increases on policies issued prior to 2002 is sufficient to offset the lapsation of existing policies. Our persistency was 88.8% and 88.7% for the 2005 and 2004 periods, respectively.

Net investment income. Net investment income earned in 2005 increased 8.5% to $50,833 from $46,839 in 2004.

Our average yield on invested assets at cost, including cash and cash equivalents, was 5.02% and 5.17% in 2005 and 2004, respectively. Our net investment income included an investment income component from our 2001 Centre agreement notional experience account prior to May 24, 2005 and for all of 2004. The investment income component of our notional experience account investment credit generated $18,859 and $46,172 in 2005 and 2004, respectively. The notional experience account yielded a fixed return based upon the yield to maturity of the underlying benchmark indices, which were comprised of U.S. Treasury strips, government agencies and investment grade corporate bonds with weightings of approximately 25%, 15% and 60%, respectively, and had a duration of approximately 14 years. The average yield on the notional experience account was 5.26% and 5.65% in 2005 and 2004, respectively. We commuted the 2001 Centre agreement in May of 2005 and received investments of approximately $950 million as a result of the commutation. We have gradually reduced the duration of this portfolio to approximately 11 years at December 31, 2005 by selling long duration U.S. Treasury strips and purchasing medium duration mortgage backed securities.

Market gain on notional experience account. We recorded a gain on our notional experience account of $48,799 and $39,749 in 2005 and 2004, respectively. Following the commutation of our 2001 Centre agreement in May 2005, we no longer record gains or losses attributable to a notional experience account.

During the period of January 2005 through May 2005 the interest rates on the underlying investments in the benchmark indices supporting our notional experience account declined resulting in a market gain. During 2004, the interest rates on the underlying investments in the benchmark indices supporting our notional experience account were lower at the end of the year compared to the beginning of the year, resulting in a market gain.

The total return of the Lehman Brothers US Aggregate Bond Index was 2.4% and 4.3% in 2005 and 2004, respectively. The total return on our notional experience account, which generated the majority of our net investment income through May 2005 and throughout 2004, was 7.35% and 10.51% for the five months of 2005 and all of 2004, respectively. We attribute the favorable return achieved from the notional experience account in 2005 and 2004 to the impact of declining market interest rates upon the long duration of the underlying benchmark indices.

Following the commutation of our 2001 Centre Agreement in May 2005, we invested our assets in instruments similar to the benchmark indices underlying our notional experience account. From July through December 2005, this portfolio had a total loss of 2.66%. We believe that this loss in total return is consistent with the observed increase in market interest rates for the period, the duration of the portfolio, and the yields imbedded in the portfolio compared to comparable investment vehicles available for purchase in the market during that time.

Change in preferred interest on early conversion. We recorded a gain of $1,403 on the change in preferred interest on early conversion or our convertible debt in 2005 as compared to a gain of $2,237 in 2004. The fair value of the embedded derivative decreased to zero in October 2005, the date the offer ended for the additional shares of our common stock. As a result, a gain of $1,403 was recorded for 2005. The gain in 2004 was a result of $29,499 of conversions and the decrease in the value of the interest we would pay upon the conversion due to the shortening of the time period between the date of conversion and October 2005. All of our outstanding convertible debt was converted to our common stock in November 2005.

Other income. We recorded $8,847 in other income in 2005, as compared to $5,864 in 2004. The increase is attributable to a number of items, including the recognition of a deferred gain from the 2001 sale of our disability business. The sale was done as a 100% quota share agreement, in contemplation of a subsequent assumption of the business, where actual ownership of the policies would change. For 2005, the process to complete the remaining policyholder assumptions was completed and we recorded $1,714 as other income. We recorded a gain of $815 as a result of the commutation of the 2002 Centre Agreement. The commission income related to our agency subsidiaries increased to $5,359 in 2005 compared to $4,979 in 2004. The increase in commission income was related to the sale of Medicare Private Fee for Service and Part D Medicare products by our agency subsidiaries.

Benefits to policyholders. Total benefits to policyholders in 2005 increased 21.9% to $283,667 compared to $232,698 in 2004. Our loss ratio, or policyholder benefits to premiums, was 91.6% in 2005, compared to 72.7% in 2004. In 2005 our long-term care claim reserves increased approximately $39,791 compared to a decrease of approximately $17,200 in 2004. The increase in 2005 was primarily a result of an adjustment to our assumption related to the length of time a claim will stay open after it has been open for more than three years along with a change in the discount rate used to set our claim reserves from 5.9% to 5.1%, based on the yield of our portfolio at December 31, 2005. The decrease in 2004 is attributable to:

(1) Refinements to the model we utilized to calculate claim reserves, including the addition of diagnosis code data, payment frequency data, and further delineation of policy forms for purposes of evaluation of existing continuance tables. As a result claims reserves were reduced by approximately $6,000.

(2) An increase in the discount rate used for claim reserves from 5.7% to 5.9%, reflecting our improved investment portfolio performance, which reduced reserves by approximately $1,000.

(3) During 2004, fewer claims that were closed as of December 31, 2003 reopened than we had estimated, resulting in a reduction of approximately $4,500; and

(4) Claim reserve adjudication process improvements implemented in the second half of 2003 and throughout 2004.

We establish reserves for current claims based upon current and historical experience of our policyholder benefits, including an expectation of claims incidence and duration, as well as the establishment of a reserve for claims that have been incurred but are not yet reported (IBNR). We continuously monitor our experience to determine the best estimate of reserves to be held for future payments of these claims. As a result, we periodically refine our process to incorporate the most recent known information in establishing these reserves.

Claims experience can differ from our expectations due to numerous factors, including mortality rates, duration of care and type of care utilized. The amount of reserves relating to reported and unreported claims incurred is determined by periodically evaluating historical claims experience and statistical information with respect to the probable number and nature of such claims. We compare actual experience with estimates and adjust reserves on the basis of such comparisons.

We evaluate our prior year assumptions by reviewing the development of reserves for the prior period. During 2005, reserve amounts relating to December 31, 2004 and prior had an unfavorable development of $30,696. These changes to prior year reserve amounts (particularly when calculated as a percentage of the prior year-end reserve balance) provide a relative measure of deviation in actual performance as compared to our initial assumptions. The adjustments to reserves for claims incurred in prior periods are primarily attributable to claims incurred from our long-term care insurance policies, which represent approximately 96% of our premium in-force. The unfavorable development in 2005 is attributable to the change in our assumption related to the mortality of policyholders that are on claim in excess of three years.

Commissions. Commissions to agents decreased 2.5% to $38,121 in 2005, compared to $39,115 in 2004.

First year commissions on accident and health business in 2005 increased 18.0% to $7,703 compared to $6,530 in 2004, primarily due to the increase in first year accident and health premiums. The ratio of first year accident and health commissions to first year accident and health premiums was 63.7% in 2005 and 58.4% in 2004. This increase was due to the first year commission paid to one FMO that is paid a higher first year commission and lower renewal commissions than our traditional structure. We collected $1,032 of premium for this FMO and paid first year commissions of $1,217. This arrangement was not material in 2004. The ratio of first year accident and health commission to first year accident and health premiums would have been 58.6% in 2005 without this arrangement.

Renewal commissions on accident and health business in 2005 decreased 5.7% to $32,732, compared to $34,708 in 2004 primarily due to the decrease in renewal accident and health premiums. The ratio of renewal accident and health commissions to renewal accident and health premiums was 11.1% in 2005 and 11.3% in 2004. We have implemented premium rate increases on a majority of policies written prior to December 31, 2002. We do not pay commissions on the additional premium collected as a result of a premium rate increase, which reduces the ratio of renewal commissions to renewal premium revenue. We anticipate that this ratio will continue to decline until all premium rate increases are fully implemented.

Net policy acquisition costs amortized. The net deferred policy acquisition costs amortized in 2005 decreased to $8,746, compared to $11,578 in 2004.

Deferred costs are typically all costs that are directly related to, and vary with, the acquisition of new premiums. These costs include the variable portion of commissions, which are defined as the first year commissions less ultimate renewal commissions, and variable general and administrative expenses related to policy sales, underwriting and issuance. Deferred costs are amortized over the life of the policy based upon actuarial assumptions, including persistency of policies in-force. In the event that a policy lapses prematurely due to death or termination of coverage, the remaining unamortized portion of the deferred amount is immediately recognized as expense in the current period.

The net amortization of deferred policy acquisition costs is affected by new business generation, imputed interest on prior reserves and policy persistency. The amortization of deferred costs is generally offset largely by the deferral of costs associated with new premium generation. However, the level of new premium sales during the 2005 and 2004 periods produced less expense deferral than needed to offset amortized costs.

General and administrative expenses. General and administrative expenses in 2005 increased 13.6% to $60,185, compared to $52,970 in 2004. The ratio of total general and administrative expenses to premium revenues was 19.4% in 2005, compared to 16.6% in 2004.

The increase in 2005 was primarily related to additional costs related to accounting, actuarial and consulting fees. These fees increased due to work related to our increase in claim reserves in the fourth quarter of 2005, our written submission to the SEC related to prospective unlocking and the delay in filing our 2005 Form 10-K. In addition the general and administrative expenses at our agency subsidiaries increased in 2005, corresponding with their increase in other income.

Litigation Accrual Expense. During 2005, we accrued $737 for the final resolution of the two lawsuits related to the sale of long-term care policies. In addition we accrued $700 related to the final resolution of two additional lawsuits in 2005. During 2004, we accrued $3,000 related to the anticipated resolution of two lawsuits related the sale of long-term care policies. In addition, we accrued $1,150 in 2004 related to the settlement of a separate lawsuit.

Loss due to impairment of property, plant and equipment. Subsequent to December 31, 2005, we determined that the new administrative system that we were in the process of installing would not yield the benefits and efficiencies to operations that were originally intended. As a result of this determination we have decided not to continue to pursue this project and have impaired its capitalized value through a charge to income of $2,337.

Commutation expense. The 2001 Centre Agreement was commuted effective May 24, 2005. We recorded a termination fee of $18,300 in 2005 related to the early commutation of this agreement.

Reinsurance warrants expense. As part of the 2001 Centre Agreement, the reinsurer was granted four tranches of warrants to purchase shares of non-voting convertible preferred stock. The warrants were forfeited as part of the early commutation of the agreement. The remaining value of $7,267 was recorded as an expense in 2005.

Expense and risk charges on reinsurance. In 2005 and 2004, we incurred expense and risk charges of $11,708 and $11,230, respectively. Our Imagine Agreements provide the reinsurer an expense and risk charge equal to the sum of (1) 0.25% of total ceded statutory reserves at the end of a quarter and (2) 0.50% of the value of the combination of any letters of credit or funds deposited in trust by the reinsurer as of the beginning of the quarter. Our 2001 Centre Agreement provided the reinsurer with expense and risk charges. The annual charge consisted of a fixed cost and a variable component based upon reserve and capital levels needed to support the reinsured business.

Excise tax expense. We were subject to an excise tax for premium payments made to a foreign reinsurer under the 2001 Centre Agreement equal to one percent of the net premium revenue ceded to the foreign reinsurer. We recorded $749 and $2,969 for excise tax expenses in 2005 and 2004, respectively. The amount decreased in 2005 due to the commutation of the 2001 Centre Agreement effective May 24, 2005. There are no excise taxes related to the Imagine Agreements.

Interest expense. Interest expense in 2005 decreased 22.7% to $8,070, compared to $10,443 in 2004. The interest expense in 2005 and 2004 is primarily related to our convertible subordinated notes, which bore interest at an annual rate of 6.25%. We incurred additional interest expense related to the conversion of our convertible subordinated notes prior to October 15, 2005. Holders of our convertible subordinated notes were entitled to convert their notes into shares of our common stock before October 15, 2005 and receive a discounted amount of interest that they would have otherwise received through October 15, 2005 had they not converted the notes. We incurred $691 of interest expense from the conversion of $40,049 in convertible subordinated notes during 2005. We incurred $2,809 of interest expense from the conversion of $29,499 in convertible subordinated notes during 2004.

In addition, interest expense decreased due to a reduction in outstanding notes as a result of the conversions. The 2008 Notes automatically converted to shares of the Company s common stock on November 4, 2005. The conversion occurred under the terms of the Notes because the

average closing price of the Company s common stock on the fifteen trading days following October 15, 2005 was greater than 110% of the conversion price of $7.00. There was $46,544 of 2008 Notes outstanding on November 4, 2005. Immediately after the conversion on November 7, 2005, there were 23,269 shares of common stock issued and outstanding.

Benefit (Provision) for federal income taxes. In 2005, we recorded a benefit for Federal income taxes of $8,917 compared to a provision for Federal income taxes of $15,676 in 2004. The effective tax rate was 39.9% in 2005 compared to 43.3% in 2004.

In 2005, the effective tax rate utilized to record our benefit for Federal income taxes was higher than our statutory tax rate of 35% primarily due to the release of $1,197 of contingency reserves related to tax positions taken in the past for which the tax years are no longer open to audit. In 2004, the effective tax rate utilized to record our provision for Federal income taxes was higher than our statutory tax rate of 35% primarily due to the impairment charge recorded against the goodwill of UIG, which is not deductible for Federal income tax purposes.

Liquidity and Capital Resources

(amounts in thousands)

Capital resources:

We carefully manage our capital resources to minimize our cost of capital while maintaining appropriate claims-paying resources of our insurance subsidiaries. Our capital resources include our total investments, cash and cash equivalents and accrued investment income. At December 31, 2006 and 2005, our capital resources were $1,015,049 and $1,031,887, respectively. Our ongoing capital requirements depend on many factors, including our in-force long-term care policies and regulatory and rating agency capital requirements. To the extent that our existing capital is insufficient to pay benefit obligations or meet regulatory requirements, we may need to raise additional funds through financings or curtail our insured exposure. Any debt or equity financing, if available at all, may be on terms that are not favorable to us. If we cannot obtain adequate capital on favorable terms or at all, our business, operating results and financial condition could be adversely affected.

During the past two years, we have not been profitable due to higher than expected expenses, claims payments, reserve increases and lower than expected new sales. We have financed our insurance operations through operating cash flow and, to a lesser extent, equity financing that occurred in 2004. We have implemented and are further seeking premium rate increases sufficient to return us to profitable operations in the near future. We have no material commitments for capital expenditures and do not anticipate capital expenditures to significantly increase above historic levels.

We have also engaged Friedman, Billings, Ramsey & Co., Inc. to assist us in the review of strategic alternatives. These strategic alternatives, include, but are not limited to, capital structure review, strategic partnerships, business combination transactions or the sale of certain assets. An objective of this effort is to identify a stronger financial platform from which distribution partners and financial advisors can promote and increase the sale of our products, which would also help return us to profitable operations. There can be no assurance that this effort will result in any specific transaction or that any such transaction will be on terms favorable to us.

Liquidity:

Our consolidated liquidity requirements have historically been met from the operations of our insurance subsidiaries, from our agency subsidiaries and from funds raised in the capital markets. Our primary sources of cash from insurance operations are premiums, investment income and maturities of investments. We have obtained, and may in the future obtain, cash through public and private placements of our common stock, the exercise of stock options and other capital market activities including the sale of debt and equity securities. Our primary uses of cash are policy acquisition costs (principally commissions), claim payments to policyholders, investment purchases, debt service and general and administrative expenses. We believe that our insurance subsidiaries have sufficient liquidity and capital resources to meet their short-term and long-term obligations

We had $14,732 in cash and cash equivalents at December 31, 2006. Cash and cash equivalents decreased by $5,511 during 2006, down from $20,243 as of January 1, 2006. The decrease in cash and cash equivalents was mainly used for (i) net investment purchases of $8,224, (ii) proposed acquisition of a shell life insurance company of $4,209, (iii) property and equipment additions of $3,628 and (iv) repayment of its capital lease obligation of $1,541. The use of cash was offset by cash provided from operations of $9,950, primarily from premium revenues.

Our cash and cash equivalents increased $4,947 in 2005 primarily due to $7,133 from operations, the receipt of $972,656 from the commutation of the 2001 Centre Agreement and the sale of $192,008 of bonds. The major source of cash from operations was premiums received. The principal use of cash in 2005 was for the purchase of $1,158,625 in bonds.

Our cash and cash equivalents increased $2,488 in 2004 primarily due to $26,000 in additional funds generated from the issuance of convertible subordinated debt. This was supplemented by $30,076 from operations and the sale of $34,177 of bonds. The major source of cash from operations was premium received. Cash decreased in 2004 primarily due to payments made to our reinsurer of $43,354 and the purchase of $51,469 in bonds.

We invest in securities and other investments authorized by applicable state laws and regulations and follow an investment policy designed to maximize yield to the extent consistent with liquidity requirements and preservation of assets. As of December 31, 2006 and 2005, shareholders equity was decreased by $30,090 and $15,920, respectively, due to net unrealized losses of $46,292 and $24,492, respectively, in the investment portfolio. As of December 31, 2004, shareholders equity was increased by $147 due to unrealized gains of $226 in the investment portfolio.

The maturities of our principal contractual cash obligations at December 31, 2006, are as follows (amounts in thousands):

	2007	2008	2009	2010	2011	thereafter	Total
On Balance Sheet:							
Pension and post-retirement benefits	$ 116	$ 117	$ 118	$ 117	$ 116	$ 571	$ 1,155
Capital lease obligations	3,099	2,414	2,258	1,097	-	-	8,868
Insurance liabilities (1)	219,634	209,032	187,199	176,271	164,743	4,641,319	5,598,198
Off-Balance Sheet:							
Operating leases	714	495	223	61	3	-	1,496
Vendor contracts	2,514	2,799	2,555	872	91	-	8,831
Total	$226,077	$214,857	$192,353	$178,418	$164,953	$4,641,890	$ 5,618,548

(1) Insurance liabilities consist of future policy benefits and unpaid claims relating to the Company s insurance products. Substantially all of the amounts contained in this table with respect to such liabilities consist of estimates by the Company s management based on various actuarial and other assumptions relating to morbidity, mortality and persistency. In accordance with GAAP, a substantial portion of such liabilities are carried on a discounted basis on the consolidated balance sheet, however, the amounts contained in the table are presented on an undiscounted basis. The actual payments relating to these liabilities will differ, both in amount and timing, from indicated in the table.

Parent Company Operations

(amounts in thousands)

As a holding company, the Parent Company s ability to meet its ongoing cash requirements (including debt service payments or other expenses and dividends on its common shares, if and when declared) will depend upon its ability to obtain cash dividends or loans from its operating subsidiaries. The payments of cash dividends from its insurance subsidiaries are subject to regulatory restrictions, and as of December 31, 2006 and December 31, 2007, are limited. As a result, there can be no assurance that our insurance subsidiaries will be able to pay us dividends. Our insurance agency subsidiaries, however, are able to pay dividends and advance cash if needed. We currently have enough cash at our agency subsidiaries to meet the Parent Company's ongoing cash requirements.

Historically, we have engaged in external debt or equity financing to meet our operating expenses. However, we did not engage in financing activities in 2006 and 2005. In 2004, we issued $26,000 in debt instruments that were converted to common shares in 2005. The net proceeds were used to supplement Parent Company liquidity and working capital and to supplement our insurance subsidiaries statutory surplus.

We have never paid and do not anticipate paying any dividends from the Parent Company to our shareholders in the foreseeable future due to restrictions on the ability of our insurance subsidiaries to pay dividends to the Parent Company.

Subsidiary Operations

Liquidity at our insurance subsidiaries is mainly used to pay their claims, ceded reinsurance premiums and operating expenses and from time to time make capital investments. The subsidiaries principal sources of liquidity are their portfolio of liquid assets and their net operating cash flow. Liquidity can be affected by changes in interest rates and the amount and timing of claim payments. We believe that our operating subsidiaries have sufficient liquidity and capital resources to meet their short-term and long-term obligations.

The majority of our insurance subsidiaries cash flow results from our existing long-term care policies, which have been ceded to the reinsurer under reinsurance agreements. Our subsidiaries ability to meet additional liquidity needs and cover fixed expenses in the future is highly dependent upon our ability to issue new policies and to control expense growth. Our future growth and new policy issuance is dependent upon our ability to continue to expand our historical markets, retain and expand our network of agents and effectively market our products and our ability to fund our marketing and expansion while maintaining minimum statutory levels of capital and surplus required to support such growth.

Our insurance subsidiaries are regulated by various state insurance departments. The National Association of Insurance Commissioners (NAIC) has Risk-Based Capital (RBC) requirements for insurance companies to evaluate the adequacy of statutory capital and surplus in relation to investment and insurance risks, such as asset quality, mortality and morbidity, asset and liability matching, benefit and loss reserve adequacy, and other business factors. The RBC formula is used by state insurance regulators as an early warning tool to identify, for the purpose of initiating regulatory action, insurance companies that potentially are inadequately capitalized. In addition, the formula defines minimum capital standards that an insurer must maintain. Regulatory compliance is determined by a ratio of the enterprise s regulatory Total Adjusted Capital, to its Authorized Control Level RBC, as defined by the NAIC. Companies below specific trigger points or ratios are classified within certain levels, each of which may require specific corrective action depending upon the insurer s state of domicile.

States also restrict the dividends our insurance subsidiaries are permitted to pay. Dividend payments will depend on profits arising from the business of our insurance company subsidiaries, computed according to statutory formulae. Under the insurance laws of Pennsylvania and New York, where our insurance subsidiaries are domiciled, insurance companies can pay ordinary dividends only out of earned surplus. In addition, under Pennsylvania law, our Pennsylvania insurance subsidiaries (including our primary insurance subsidiary) must give the Department at least 30 days advance notice of any proposed extraordinary dividend and cannot pay such a dividend if the Department disapproves the payment during that 30-day period. For purposes of that provision, an extraordinary dividend is a dividend that, together with all other dividends paid during the preceding twelve months, exceeds the greater of 10% of the insurance company s surplus as shown on the company s last annual statement filed with Department or its statutory net income as shown on that annual statement. Statutory earnings are generally lower than earnings reported in accordance with generally accepted accounting principles due to the immediate or accelerated recognition of all costs associated with premium growth and benefit reserves. Additionally, our Corrective Action Plan requires the Commonwealth of Pennsylvania Department of Insurance to approve all dividend requests made by PTNA, regardless of normal statutory requirements for allowable dividends. We believe that the Department is unlikely to consider any dividend request in the foreseeable future as a result of PTNA s current statutory surplus position. Although not stipulated in the Plan, this requirement is likely to continue until such time as PTNA meets normal statutory allowances, including reported net income and positive cumulative earned surplus.

Under New York law, our New York insurance subsidiary (American Independent Network Insurance Company of New York) must give the New York Insurance Department 30 days advance notice of any proposed dividend and cannot pay any dividend if the regulator disapproves the payment during that 30-day period. In addition, our New York insurance company must obtain the prior approval of the New York Insurance Department before paying any dividend that, together with all other dividends paid during the preceding twelve months, exceeds the lesser of 10% of the insurance company s surplus as of the preceding December 31 or its adjusted net investment income for the year ended the preceding December 31.

PTNA and ANIC have not paid any dividends to Penn Treaty in 2006, 2005 or 2004 and are unlikely in the foreseeable future to be able to make dividend payments due to insufficient statutory surplus and anticipated earnings. However, our New York subsidiary, which is not subject to the Plan has not paid any dividends in 2006, 2005 or 2004.

New Accounting Principles

In December 2004, the Financial Accounting Standards Board (FASB) issued FASB Statement No. 123(R) (SFAS 123(R)) Share-Based Payment . SFAS 123(R) replaces SFAS 123, Accounting for Stock-Based Compensation, and supersedes APB Opinion 25, Accounting for Stock Issued to Employees. SFAS 123(R) requires that the cost of share-based payment transactions (including those with employees and non-employees) be recognized in the financial statements. SFAS 123(R) applies to all share-based payment transactions in which an entity acquires goods or services by issuing (or offering to issue) its shares, share options, or other equity instruments or by incurring liabilities (1) in amounts based (even in part) on the price of the entity s shares or other equity instruments, or (2) that require (or may require) settlement by the issuance of an entity s shares or other equity instruments. We have adopted the provisions of SFAS 123(R) on January 1, 2006, and we have recorded an expense of $359 during the year ended December 31, 2006. See Note 13 "Stock options Plans".

In June of 2006, the Emerging Issues Task Force (EITF) of the Financial Accounting Standards Board (FASB) reached a consensus on EITF Issue No, 06-5 Accounting for Purchases of Life Insurance Determining the Amount that Could Be Realized in Accordance with FASB Technical Bulletin No. 85-4 (EITF 06-5). EITF 06-5 relates to accounting for corporate-owned life insurance (COLI). The Company owns a COLI policy, which is utilized to fund the future payment of employee benefit expenses. The EITF reached a consensus that a policyholder should consider any additional amounts included in the contractual terms of the policy in determining the amount that could be realized under the insurance contract. The EITF also reached a consensus that a policyholder should determine the amount that could be realized under the life insurance contract assuming the surrender of an individual-life by individual-life policy (or certificate by certificate in a group policy). EITF 06-5 is effective for fiscal years beginning after December 15, 2006. The Company has adopted EITF 06-5 on January 1, 2007 and it had no effect on the determination or reporting of the Company's financial results.

In September, 2005, the American Institute of Certified Public Accountants (AICPA) issued Statement of Position (SOP) No. 05-1 Accounting by Insurance Enterprises for Deferred Acquisition Costs in Connection with Modifications or Exchanges of Insurance Contracts , effective for internal replacements occurring on fiscal years beginning after December 15, 2006. The SOP provides guidance on accounting by insurance enterprises for deferred acquisition costs on internal replacements of certain insurance and investment contracts. An internal replacement is a modification in product benefits, features, rights or coverages that occurs by the exchange of a contract for a new contract, or by amendment, endorsement, or rider to a contract, or by the election of a feature or coverage within a contract. Contract modifications meeting the conditions of the SOP result in a replacement contract that is substantially unchanged from the replaced contract band should be accounted for as a continuation of the replaced contract. An internal replacement that is determined to result in a replacement contract that is substantially changed from the replaced contract should be accounted for as an extinguishment of the replaced contract. Unamortized deferred acquisition costs, unearned revenue liabilities, and deferred sales inducement assets from the replaced contract in an internal replacement transaction that results in a substantially changed contract should not be deferred in connection with the replacement contract. The Company is currently evaluating the effect the adoption of SOP 05-1 will have on its financial statements.

In February 2006, the FASB issued SFAS No. 155, "Accounting for Certain Hybrid Financial Instruments" ("SFAS 155"), which amends SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS

133") and SFAS No. 140, "Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities" ("SFAS 140"), and addresses issues raised in SFAS 133 Implementation Issue No. D1, "Application of Statement 133 to Beneficial Interests in Securitized Financial Assets." The primary objectives of SFAS 155 are: (i) with respect to SFAS 133, to address the accounting for beneficial interests in securitized financial assets and (ii) with respect to SFAS 140, to eliminate a restriction on the passive derivative instruments that a qualifying special purpose entity may hold. SFAS 155 is effective for all financial instruments acquired or issued after the beginning of an entity's first fiscal year that begins after September 15, 2006. The Company has adopted SFAS 155 on January 1, 2007 and it had no effect on the determination or reporting of the Company's financial results.

In July 2006, the FASB issued FASB Interpretation No. 48, Accounting for Uncertainty in Income Taxes-an Interpretation of FASB Statement 109 (FIN 48). FIN 48 prescribes a comprehensive model for how a company should recognize, measure, present, and disclose in its financial statements uncertain tax positions that the company has taken or expects to take on a tax return. The interpretation requires public companies to recognize the tax benefits of uncertain tax positions only where the position is more likely than not to be sustained assuming examination by tax authorities. The amount recognized would be the amount that represents the largest amount of tax benefit that is greater than 50% likely of being realized upon ultimate settlement with the taxing authority. A liability would be recognized for any benefit claimed, or expected to be claimed, in a tax return in excess of the benefit recorded in the financial statements, along with any interest and penalty (if applicable) on the excess. FIN 48 will require a tabular reconciliation of the change in the aggregate unrecognized tax benefits claimed, or expected to be claimed, in tax returns and disclosure relating to accrued interest and penalties for unrecognized tax benefits. Discussion will also be required for those uncertain tax positions where it is reasonably possible that the estimate of the tax benefit will change significantly in the next 12 months. FIN 48 is effective for fiscal years beginning after December 15, 2006. The Company is currently evaluating the impact of adopting FIN 48.

In September 2006, the FASB issued SFAS No. 157, "Fair Value Measurements" ("SFAS 157") which defines fair value, establishes a framework for measuring fair value in generally accepted accounting principles, and expands disclosures about fair value measurements. This Statement is applicable in conjunction with other accounting pronouncements that require or permit fair value measurements, where the FASB previously concluded in those accounting pronouncements that fair value is the relevant measurement attribute. Accordingly, this Statement does not require any new fair value measurements. SFAS No. 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within these fiscal years. The Company is currently evaluating the effect the adoption of SFAS 157 will have on its financial statements.

In September 2006, the FASB issued SFAS No. 158, "Employer s Accounting for Defined Benefit Pension and Other Post Retirement Plan - an amendment of FASB Statements No. 87, 88, 106 and 132(R) ("SFAS 158"). SFAS 158 requires an entity to recognize in its balance sheet an asset for a defined benefit post-retirement plan s over funded status or a liability for a plan s under funded status and additional disclosures. The Company has previously recorded its post-retirement defined benefit obligations through earnings and currently maintains a pay-as-you-go funding of defined benefits. On December 31, 2006, the Company adopted the recognition and funding provisions of SFAS 158, which did not have a significant impact on the determination or reporting of our financial results. See Note 12 "Employee Benefits".

In February 2007, the FASB issued SFAS 159, "The Fair Value Option for Financial Assets and Financial Liabilities." SFAS 159 provides the Company an irrevocable option to report selected financial assets and liabilities at fair value with changes in fair value recorded in earnings. The option is applied, on a contract-by-contract basis, to an entire contract and not only to specific risks, specific cash flows or other portions of that contract. Upfront costs and fees related to a contract for which the fair value option is elected shall be recognized in earnings as incurred and not deferred. SFAS 159 also establishes presentation and disclosure requirements designed to facilitate comparisons between companies that choose different measurement attributes for similar types of assets and liabilities. SFAS 159 is effective for fiscal years beginning after November 15, 2007. The Company is currently evaluating the effect the adoption of SFAS 159 will have on its financial statements.

In September 2006, the staff of the Securities and Exchange Commission (SEC) issued Staff Accounting Bulletin (SAB) No. 108, Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in Current Year Financial Statements. The interpretations in this SAB express the staff s views regarding the process of

quantifying financial statement misstatements. Specifically, the SEC staff believes that registrants must quantify the impact on current period financial statements of correcting all misstatements, including both those occurring in the current period and the effect of reversing those that have accumulated from prior periods. This SAB should be applied beginning with the first fiscal year ending after November 15, 2006, with early adoption encouraged. The Company has elected to adopt SAB No. 108 early, and it is therefore effective for the Company s financial statements for the year ended December 31, 2005.

SAB No. 108 permits companies to initially apply its provision either by (1) restating prior financial statements or (2) recording the cumulative effect of initially applying the methodology for quantifying errors described in SAB No. 108 as adjustments to the carrying values of assets and liabilities as of January 1, 2005. The Company elected to record the effects of applying SAB No. 108 using the cumulative effect transition method. Accordingly, as of January 1, 2005, the Company recorded a cumulative effect of accounting principle in the amount of $1,507. The following table summarizes the effects of applying the guidance in SAB No. 108:

	Cumulative prior to January 1, 2003	Year Ended December 31, 2003	Year Ended December 31, 2004	Adjustment Recorded as of January 1, 2005
Accounts payable and other liabilities	$1,440	$393	$485	$2,318
Federal income taxes receivable or payable	(503)	(138)	(170)	(811)
Impact on net income	$937	$255	$315	
Retained earnings				$1,507

As of January 1, 2005, the Company discovered errors related to prior period financial statements for the years 1999-2004 that on a cumulative basis total $2,318 on a pre-tax basis and $1,507 net of federal income taxes. The entire amount relates to return of premium benefits that should have been paid to policyholders in prior years but due to an error in the Company s process of identifying which policyholders should be paid, not all of the policyholders were properly identified. This process has been corrected for 2005. Although these individual errors are immaterial to the prior periods, the cumulative amount is material to the 2005 financial statements because of the adoption of SAB No. 108 as mentioned above.

Forward Looking Statements

Certain statements made by us in this report may be considered forward looking within the meaning of the Private Securities Litigation Reform Act of 1995. Although we believe that our expectations are based upon reasonable assumptions within the bounds of our knowledge of our business and operations, there can be no assurance that actual results of our operations will not differ materially from our expectations. An investment in our securities includes certain risks, which may be specific to us or to the long-term care insurance industry. Factors which could cause actual results to differ from expectations include, among others, our ability to comply with the Corrective Action Plan, the Florida Consent Order, the orders or directives of other states in which we do business or any special provisions imposed by states in connection with the resumption of writing new business, our ability to commute our reinsurance agreement and to recapture our reinsured policies, whether our Corrective Action Plan will be accepted and approved by all states, our ability to secure premium rate increases, our ability to meet our future risk-based capital goals, the adverse financial impact of suspending new business sales, our ability to raise adequate capital to meet regulatory requirements and to support anticipated growth, the cost associated with recommencing new business sales, liquidity needs and debt obligations, the adequacy of our loss reserves and the recoverability of our DAC asset, our ability to sell insurance products in certain states, our ability to resume generating new business in all states, our ability to comply with government regulations and the requirements which may be imposed by state regulators as a result of our capital and surplus levels, the ability of senior citizens to purchase our products in light of the increasing costs of health care, our ability to defend ourselves against adverse litigation, the results of the SEC review of our request related to prospective unlocking of future policyholder benefits and our ability to recapture, expand and retain our network of productive independent agents, especially in light of the suspension of new business.

Item 7a. **Quantitative and Qualitative Disclosures about Market Risk**

Interest rate risk:

We invest in securities and other investments authorized by applicable state laws and regulations. We follow an investment policy designed to maximize yield to the extent consistent with liquidity requirements and preservation of assets. A significant portion of our investments are financial instruments, which are subject to the market risk of potential losses from adverse changes in market rates and prices. Our primary market risk exposures relate to interest rate risk on fixed rate domestic medium-term instruments and, to a lesser extent, domestic short-term and long-term instruments. We currently do not use derivative financial instruments in our investment portfolio.

Our financial instruments are held as available-for-sale investments and for purposes other than trading. Our portfolio does not contain any significant concentrations in single issuers (other than U.S. treasury and agency obligations), industry segments or geographic regions. Although sufficient assets to support our statutory reserve liabilities are secured by trust accounts and irrevocable letters of credit with major United States financial institutions, the accumulated profits of our reinsured business are susceptible to credit risk of the reinsurer.

As of December 31, 2006 and 2005, we had $46,292 and $24,492, respectively of unrealized losses related to fixed income securities that have been in an unrealized loss position. The hypothetical effects of changes in market rates or prices on the fair values of our financial instruments as of December 31, 2006 and 2005, excluding insurance liabilities and reinsurance receivables on unpaid losses, would have been as follows:

If interest rates had increased by 100 basis points at December 31, 2006, there would have been a decrease of approximately $135 million in the net fair value of our investment portfolio. A 200 basis point increase in market rates at December 31, 2006 would have resulted in a decrease of approximately $214 million in the net fair value. If interest rates had decreased by 100 basis points, there would have been a net increase of approximately $55 million in the net fair value of our total investments.

If interest rates had increased by 100 basis points at December 31, 2005, there would have been a decrease of approximately $122 million in the net fair value of our investment portfolio. A 200 basis point increase in market rates at December 31, 2005 would have resulted in a decrease of approximately $206 million in the net fair value. If interest rates had decreased by 100 basis points, there would have been a net increase of approximately $90 million in the net fair value of our total investments.

Item 8. Audited Financial Statements and Supplementary Data

Refer to Consolidated Financial Statements and notes thereto attached to this report.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Shareholders

Penn Treaty American Corporation

Allentown, PA

We have audited the accompanying consolidated balance sheets of Penn Treaty American Corporation and subsidiaries (the Company) as of December 31, 2006 and 2005 and the related consolidated statements of income and comprehensive income, shareholders equity, and cash flows for each of the two years in the period ended December 31, 2006. These financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (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 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.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Penn Treaty American Corporation at December 31, 2006 and 2005, and the results of its operations and its cash flows for each of the two years in the period ended December 31, 2006**,** in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 4 to the consolidated financial statements, the Company changed its method of accounting for share-based compensation in 2006, as a result of adopting Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment.*

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Penn Treaty American Corporation s internal control over financial reporting as of December 31, 2006, based on criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) and our report dated March 31, 2008 expressed an adverse opinion thereon.

/s/ BDO Seidman, LLP

BDO Seidman, LLP

Philadelphia, PA

March 31, 2008

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Shareholders

of Penn Treaty American Corporation:

In our opinion, the accompanying consolidated statements of income and comprehensive income, of shareholders' equity and of cash flows for the year ended December 31, 2004 present fairly, in all material respects, the results of operations and cash flows of Penn Treaty American Corporation and its subsidiaries for the year ended December 31, 2004, in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit of these statements in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtainable assurance about whether the financial statements are free of material misstatement. An audit 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, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

/s/ PricewaterhouseCoopers LLP

April 29, 2005

PENN TREATY AMERICAN CORPORATION AND SUBSIDIARIES
Consolidated Balance Sheets
(amounts in thousands, except per share information)

	December 31, 2006	December 31, 2005 Restated
ASSETS		
Investments:		
Bonds, available for sale at market (cost of $1,030,716 and $1,024,545, respectively) (1)	$ 984,424	$ 1,000,053
Securitized investment trust, at market (cost of $5,000)	5,000	-
Policy loans	-	356
Total investments	989,424	1,000,409
Cash and cash equivalents (1)	14,732	20,243
Property and equipment, at cost, less accumulated depreciation of $9,621 and $12,521, respectively	18,482	17,477
Unamortized deferred policy acquisition costs	135,833	140,434
Accrued investment income	10,893	11,235
Receivable from reinsurers	42,126	30,032
Federal excise tax recoverable	9,003	-
Corporate owned life insurance	49,579	51,395
Federal income tax recoverable	6,877	-
Net deferred tax asset	16,877	-
Escrow account	4,209	-
Goodwill	6,985	6,985
Other assets	9,828	11,004
Total assets	$ 1,314,848	$ 1,289,214
LIABILITIES		
Policy reserves:		
Accident and health	$ 655,793	$ 613,737
Life	12,396	12,656
Claim reserves	406,493	363,929
Accounts payable and other liabilities	32,608	36,860
Federal income tax payable	-	2,521
Net deferred tax liability	-	5,107
Total liabilities	1,107,290	1,034,810
Commitments and contingencies (Note 14)	-	-
SHAREHOLDERS' EQUITY		
Preferred stock, par value $1.00; 1,250 shares authorized, none outstanding	-	-
Common stock, par value $.10; 37,500 shares authorized, 23,519 and 23,502 shares issued, respectively	2,352	2,350
Additional paid-in capital	227,851	227,361
Accumulated other comprehensive loss	(30,090)	(15,920)
Retained earnings	14,150	47,318
	214,263	261,109
Less 229 common shares held in treasury, at cost	(6,705)	(6,705)
Total shareholders' equity	207,558	254,404
Total liabilities and shareholders' equity	$ 1,314,848	$ 1,289,214

(1) Cash and investments of $960,993 and $960,056, are restricted as to use as of December 31, 2006 and 2005, respectively (See Note 5).
See accompanying notes to consolidated financial statements.

PENN TREATY AMERICAN CORPORATION AND SUBSIDIARIES
Consolidated Statements of Income and Comprehensive Income
for the Years Ended December 31, 2006, 2005 and 2004
(amounts in thousands, except per share information)

	2006	2005 Restated	2004
Revenues:			
Premium revenue	$ 294,767	$ 309,516	$ 319,885
Net investment income	53,059	50,833	46,839
Net realized capital (losses) gains	(1,812)	(1,134)	167
Market gain on notional experience account	-	48,799	39,749
Change in preferred interest on early conversion liability	-	1,403	2,237
Federal excise tax recoverable	8,079	-	-
Other income	11,882	8,847	5,864
	365,975	418,264	414,741
Benefits and expenses:			
Benefits to policyholders	298,385	283,667	232,698
Commissions	35,735	38,121	39,115
Net policy acquisition costs amortized	4,601	8,746	11,578
General and administrative expense	63,219	60,185	52,970
Impairment of goodwill	-	-	13,376
Litigation accrual expense	-	1,437	4,150
Impairment of property and equipment	337	2,337	-
Commutation expense	-	18,300	-
Reinsurance warrant expense	-	7,267	-
Expense and risk charges on reinsurance	13,325	11,708	11,230
Excise tax expense	-	749	2,969
Interest expense	1,264	8,070	10,443
	416,866	440,587	378,529
(Loss) income before federal income taxes and cumulative effect of change in accounting principle	(50,891)	(22,323)	36,212
Federal income tax benefit (provision)	17,723	8,917	(15,676)
Net (loss) income before cumulative effect of change in accounting principle	(33,168)	(13,406)	20,536
Cumulative effect of change in accounting principle	-	(1,507)	-
Net (loss) income	$ (33,168)	$ (14,913)	$ 20,536
Other comprehensive (loss) income:			
Change in unrealized loss	(23,612)	(25,852)	(527)
Income tax benefit from change in unrealized loss	8,264	9,048	185
Reclassification of losses (gains) included in net income	1,812	1,134	(167)
Income tax (benefit) provision from reclassification	(634)	(397)	58
Comprehensive (loss) income	$ (47,338)	$ (30,980)	$ 20,085
Basic earnings per share from net (loss) income before cumulative effect of change in accounting principle (1)	$ (1.42)	$ (0.92)	$ 2.16
Basic earning per share from net (loss) income	$ (1.42)	$ (1.02)	$ 2.16
Diluted earnings per share from net (loss) income before cumulative effect of change in accounting principle (1)	$ (1.42)	$ (0.92)	$ 1.20
Diluted earnings per share from net (loss) income (1)	$ (1.42)	$ (1.02)	$ 1.20
Weighted average number of shares outstanding (1)	23,281	14,569	9,430
Weighted average number of shares and share equivalents (1)	23,281	14,569	21,577

(1) 2004 adjusted to reflect impact of reverse stock split (See Note 2).
See accompanying notes to consolidated financial statements.

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PENN TREATY AMERICAN CORPORATION AND SUBSIDIARIES
Consolidated Statements of Shareholders' Equity
for the Years Ended December 31, 2006, 2005 and 2004
(amounts in thousands)

	Common Stock		Additional Paid-In	Accumulated Other Comprehensive	Retained	Treasury	Total Shareholders'
	Shares	Amount	Capital	Income (Loss)	Earnings	Stock	Equity
Balance, December 31, 2003 (1)	6,411	641	107,850	598	41,695	(6,705)	144,079
Net income	-	-	-	-	20,536	-	20,536
Change in unrealized gain	-	-	-	(451)	-	-	(451)
Shares issued as compensation for services (1)	25	2	211	-	-	-	213
Interest expense for debt issued with beneficial conversion feature	-	-	686	-	-	-	686
Shares issued for conversion and interest (1)	4,587	459	31,848	-	-	-	32,307
Balance, December 31, 2004 (1)	11,023	1,102	140,595	147	62,231	(6,705)	197,370
Net loss as restated	-	-	-	-	(14,913)	-	(14,913)
Change in unrealized loss	-	-	-	(16,067)	-	-	(16,067)
Shares issued as compensation for services (1)	27	3	241	-	-	-	244
Shares issued for employee options	13	1	81	-	-	-	82
Interest expense for debt issued with beneficial conversion feature	-	-	439	-	-	-	439
Shares issued for conversion and interest (1)	12,439	1,244	86,005	-	-	-	87,249
Balance, December 31, 2005 Restated (1)	23,502	$ 2,350	$ 227,361	$ (15,920)	$ 47,318	$ (6,705)	$ 254,404
Net loss	-	-	-	-	(33,168)	-	(33,168)
Change in unrealized loss	-	-	-	(14,170)	-	-	(14,170)
Shares issued as compensation for services	17	2	131	-	-	-	133
Stock based compensation	-	-	359	-	-	-	359
Balance, December 31, 2006	23,519	$ 2,352	$ 227,851	$ (30,090)	$ 14,150	$ (6,705)	$ 207,558

(1) Adjusted to reflect impact of reverse stock split (See Note 2).

See accompanying notes to consolidated financial statements.

PENN TREATY AMERICAN CORPORATION AND SUBSIDIARIES
Consolidated Statements of Cash Flows
for the Years Ended December 31, 2006, 2005 and 2004
(amounts in thousands)

	2006	2005 Restated	2004
Net cash flow from operating activities:			
Net (loss) income	$ (33,168)	$ (14,913)	$ 20,536
Non-cash items and adjustments to reconcile net (loss) income to net cash from operating activities:			
Depreciation and amortization expense	3,182	13,233	6,461
Change in preferred interest on early conversion liability	-	(1,403)	(2,237)
Accretion of securities discounts, net	(4,778)	(4,741)	-
Impairment of long-lived assets	337	2,337	-
Net realized capital loss (gain)	1,812	1,134	(167)
Notional experience account due from reinsurer	-	(59,365)	(73,236)
Impairment of goodwill	-	-	13,376
Other, net	34	379	2,488
Decrease (increase) in assets:			
Policy acquisition costs, net	4,601	8,746	11,578
Accrued investment income	342	(10,347)	(284)
Receivable from reinsurers	(12,094)	(5,993)	122
Federal excise tax recoverable	(9,003)	-	-
Federal income tax recoverable	(6,878)	-	-
Deferred tax asset	(16,877)	-	-
Other, net	433	489	330
Increase (decrease) in liabilities:			
Policy reserves	42,152	43,897	50,797
Claim reserves	42,564	39,791	(16,843)
Accounts payable and other liabilities	(2,711)	8,869	2,843
Federal income taxes payable	(2,521)	1,976	545
Deferred income taxes	2,523	(15,830)	14,101
Other, net	-	(1,126)	(334)
Cash provided by operations	9,950	7,133	30,076
Cash flow from investing activities:			
Proceeds from sales of bonds	108,653	192,008	34,177
Maturities of investments	6,543	4,624	960
Purchase of securitized investment trust	(5,000)	-	-
Purchases of bonds	(118,420)	(1,158,625)	(51,469)
Proceeds from commutation	-	972,656	-
Change in policy loans	-	(18)	(50)
Death benefits received from corporate owned life insurance	2,141	-	8,564
Escrow deposit for acquisition of life insurance company	(4,209)	-	-
Deposits to notional experience account due from reinsurer	-	(11,923)	(43,354)
Proceeds from sale of property and equipment	-	5,232	308
Purchases of property and equipment	(3.628)	(5,067)	(2,724)
Cash used in investing	(13,920)	(1,113)	(53,588)
Cash flow from financing activities:			
Proceeds from exercise of stock options	-	82	-
Issuance of long-term debt	-	-	26,000
Sale leaseback payments	(1,541)	(1,155)	-
Cash (used in) provided by financing	(1,541)	(1,073)	26,000
Increase (decrease) in cash and cash equivalents	(5,511)	4,947	2,488
Cash balances:			
Beginning of period	20,243	15,296	12,808
End of period (1)	$ 14,732	$ 20,243	$ 15,296
Non-cash transactions:			
Equity issued for long-term debt conversions and related interest	$ -	$ 87,249	$ 29,499
Equity issued as compensation for services performed by third parties	133	244	213
Supplemental disclosures of cash flow information:			
Cash paid during the year for interest	$ 477	$ 4,933	$ 5,393
Cash paid during the year for federal income taxes	(6,030)	(4,126)	(1,055)

(1) Includes $12,015, $12,294 and $2,308 of cash and cash equivalents restricted as to use as of December 31, 2006, 2005 and 2004, respectively.
See accompanying notes to consolidated financial statements.

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PENN TREATY AMERICAN CORPORATION AND SUBSIDIARIES

Notes to Consolidated Financial Statements

(amounts in thousands, except per share information)

1. Basis of Presentation and Nature of Operations:

Basis of Presentation:

The accompanying consolidated financial statements of Penn Treaty American Corporation and its Subsidiaries (the Company) have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) and include Penn Treaty Network America Insurance Company (PTNA), American Network Insurance Company (ANIC), American Independent Network Insurance Company of New York (AIN), United Insurance Group Agency, Inc. (UIG), Network Insurance Senior Health Division (NISHD) and Senior Financial Consultants Company (SFCC). Intercompany transactions and balances have been eliminated in consolidation.

Nature of Operations:

The Company currently sells accident and health insurance through its wholly owned subsidiaries. The Company s principal lines of business are long-term care products including facility care and home health care products. The Company distributes its products principally through independent agents, independent field marketing organizations and agents employed by UIG. The Company operates its home office in Allentown, Pennsylvania, with subsidiary agency offices throughout the country, whose principal functions include marketing new business.

The Company is licensed in all states and receives renewal premiums from policyholders, but is currently restricted from issuing new policies in six states. Although the Company is approved for sales in Florida, it is currently restricted from issuing new business. See Note 11- Statutory Information . Sales in Florida, California and Pennsylvania (subject to Corrective Action Plans or Letter Agreements), accounted for approximately 15%, 14% and 11%, respectively, of the Company s direct premium revenue for the year ended December 31, 2006. No other state s sales accounted for more than 10% of the Company s direct premium revenue for the year ended December 31, 2006.

2. Reverse Stock Split:

A one-for-four reverse stock split for current holders of the Company s common stock became effective July 11, 2005. The consolidated financial statements and notes related to the year ended December 31, 2004 have been restated to reflect the impact of the reverse stock split.

3. Restatement

In connection with the preparation and audit of the financial statements for the year ended December 31, 2006 management discovered errors related to prior period financial statements. These prior year errors are not material to either the year ended December 31, 2005 or prior years. However, an error related to our actuarial assumptions did have a material impact on each of the quarters of 2005, and therefore, the Company has restated its previously issued financial statements for the year ended December 31, 2005. There was no adjustment to years prior to 2005. The total cumulative impact of the restatement for all errors that affected shareholders equity as of December 31, 2005 was a decrease of $526.

The errors related to four areas as follows:

Reserving Factors:

Calculation of the Company s benefit reserves requires the application of various actuarial assumptions to the population of policies in-force. Due to an error in the application of a certain assumption used to calculate benefit reserves, policy reserves and deferred acquisition costs were calculated incorrectly. The incorrect assumption was the future modifier factor, which is an assumption that reduces the total in-forcer population in future periods for policyholders that are assumed to already be on claim. The effect for each of the quarters in 2005 was considered to be material, which is the primary reason that the Company has determined to restate the 2005 financial

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statements. The total cumulative impact of the restatement for the change in assumptions that affected shareholders equity as of December 31, 2005 was an increase in shareholders equity and net income of $731. There was no adjustment to years prior to 2005.

Return of Premium Benefit:

The Company offers a Return of Premium Benefit in some of its policies which generally requires that a portion of the premium paid be returned to the policyholder if no claims have been incurred after a certain number of years or upon lapse of the policy or death of the policyholder. Due to an error in the Company s process for identifying which policyholders should be paid not all required payments were made when due. Further, the Company determined that, under the terms of the policies, interest on the unpaid balance was due to the policyholder as well. The process was subsequently corrected. The total cumulative impact of the restatement for this error that affected shareholders equity as of December 31, 2005 was a decrease in shareholders equity and net income of $1,102. There was no adjustment to years prior to 2005.

In connection with the adoption of SAB 108 in 2005, the Company recorded a cumulative effect adjustment in 2005 for return of premium benefits that should have been paid to policyholders in prior years. The adjustment above corresponds to items not considered when the SAB 108 adjustment was made in 2005.

Beneficial Conversion Feature of Notes Payable

A beneficial conversion feature exists when convertible debt is issued with a non-detachable conversion feature and conversion price is lower than the fair market value of the common stock at the time of issuance. In November 2004 the Company issued convertible debt and followed the guidance in EITF 98-5 calculating the value of the beneficial conversion feature using the intrinsic value methodology. EITF 98-5 also required that the beneficial conversion feature be expensed over the period to the earliest conversion date. Since the notes were convertible immediately upon issuance, the total value was expensed in 2004. At that time there was also a proposed guidance in EITF 00-27 which directly impacted the accounting treatment of the beneficial conversion feature. The first difference was that the beneficial conversion feature should be amortized to the maturity of the debt. In addition, EITF 00-27 required that any discounts associated with the convertible debt be considered in determining the value of the beneficial conversion feature. Applying this methodology increased the value of the beneficial conversion feature recognized for the November 2004 issuance and required the recognition of a beneficial conversion feature for the February 2004 issuance of convertible debt. In February 2005, a consensus was reached on EITF 00-27 and the Company did not properly adopt it for its financial statements for the year ended December 31, 2004 which had not been issued at that time. The total cumulative impact of the restatement for this error that affected shareholders equity as of December 31, 2005 was a decrease in retained earnings and net income of $439 and an increase in additional paid-in capital of $439. There was no adjustment to years prior to 2005.

Sale Leaseback:

During 2006, the Company discovered that the amortization tables developed internally and used to amortize the lease obligation were incorrect because the implicit interest rates and the payment streams used were incorrect. New amortization tables were prepared with the correct data. Lease obligation balances at December 31, 2005 derived from the new tables are higher than recorded balances and conversely, interest expense for the year was lower. The total cumulative impact of the restatement for this error that affected shareholders equity as of December 31, 2005 was a decrease in retained earnings and net income of $155.

Restatement of Financial Statements for 2005

The consolidated financial statements for the years ended December 31, 2005 reflect the effects of the restatements described previously on net policy acquisition costs amortized and its effect on unamortized deferred policy acquisition costs, benefits to policyholders expense and its effect on policy reserves and claim reserves, interest expense and its effect on notes payable and additional paid-in capital, the Federal income tax benefit and its effects on income taxes payable and deferred income taxes, and basic and fully diluted earnings per share. A summary of the effects of the restatement for all errors on reported amounts for the year ended December 31, 2005 is presented below.

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	Amounts Reported in the Consolidated Balance Sheet		
	December 31, 2005		
	As Previously Reported	Adjustment	As Restated
Unamortized deferred policy acquisition costs	$ 143,700	$ (3,266)	$140,434
Policy reserves (accident and health)	618,128	(4,391)	613,737
Claim reserves	363,059	870	363,929
Accounts payable and other liabilities	35,796	1,064	36,860
Federal income tax payable	2,605	(84)	2,521
Deferred income taxes	5,306	(199)	5,107
Additional paid-in capital	226,922	439	227,361
Retained earnings	48,283	(965)	47,318

Consolidated Statement of Income and Comprehensive Income	Amounts Reported in the		
	December 31, 2005		
	As Previously Reported	Adjustment	As Restated
Benefits to policyholders	$ (287,188)	$ 3,521	$ (283,667)
Net policy acquisition costs amortized	(5,480)	(3,266)	(8,746)
Interest expense	(6,567)	(1,503)	(8,070)
Federal income tax benefit	8,634	283	8,917
Net loss before cumulative effect of change in accounting principle	(12,441)	(965)	(13,406)
Cumulative effect of change in accounting principle	(1,507)	-	(1,507)
Net loss	(13,948)	(965)	(14,913)
Basic earnings per share from net loss before cumulative effect of change in accounting principle	$ (0.85)	$ (0.07)	$ (0.92)
Basic earnings per share from net loss	$ (0.96)	$ (0.06)	$ (1.02)
Diluted earnings per share from net loss before cumulative effect of change in accounting principle	$ (0.85)	$ (0.07)	$ (0.92)
Diluted earnings per share from net loss	$ (0.96)	$ (0.06)	$ (1.02)

The restatement did not have any impact on total cash flows from operations, investing or financing activities

4. Summary of Significant and New Accounting Policies:

Use of Estimates:

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent liabilities and the reported amounts of revenues and expenses. Management believes that the estimates used are reasonable, although

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actual results could differ from those estimates and the differences could have a material impact on the consolidated financial statements. The Company s principal estimates include:

- Bonds, available for sale
- Other than temporary impairment of investments
- Unamortized deferred policy acquisition costs
- Goodwill
- Policy reserves
- Claim reserves
- The valuation allowance for deferred income taxes
- Income taxes
- Stock based compensation
- Preferred interest on early conversion
- Commitments and contingencies

Investment in Bonds:

The Company categorizes its investments in bonds as available-for-sale since they may be sold in response to changes in interest rates, prepayments and similar factors. Investments in this classification are reported at the current market value with net unrealized gains or losses, net of the applicable deferred income tax effect, as components of other comprehensive income.

Realized investment gains and losses, including provisions for market declines considered to be other than temporary, are included in income. Gains and losses on sales of investment securities are computed on the specific identification method. Purchases and sales of securities are recorded on the trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.

Debt securities are regularly evaluated to determine if market values below amortized cost are as a result of credit quality, performance or general market decline. If market value declines are determined to be other than temporary, the amortized cost is adjusted to the market value of the security, with the loss recognized in the current period. Any future increases to the market value of a security that has been written down due to an other than temporary impairment is recorded as an unrealized gain in other comprehensive income.

Amortization of discount or premium is recorded under the interest method and is included in investment income. The Company is subject to credit risk and to interest rate risk to the extent that its investment portfolio cash flows are not matched to its insurance liabilities. The Company does not match the duration of assets and liabilities, which could subject it to interest rate risk from the investment of new cash flows that are inadequate to meet our future claims payments. In addition, the Company is limited by the Corrective Action Plan with the Pennsylvania Insurance Department as to the types of new investments that it may purchase. The Company is also limited by its statutory surplus in terms of the level of realized loss it can incur in order to sell existing assets and purchase new investments. This could, and has, limited its ability to realign the duration of its investment portfolio and to maximize its investment yield.

Investment in Securitized Trust:

The Company categorizes its investment in securitized trust as available-for-sale since it may be sold in response to changes in interest rates, prepayments and similar factors. Investments in this classification are reported at the current market value with net unrealized gains or losses, net of the applicable deferred income tax effect, as components of other comprehensive income.

Policy Loans:

Policy loans are stated at the aggregate unpaid principal balance.

Cash and Cash Equivalents:

Cash equivalents are highly liquid investments with an original maturity of 90 days or less.

Concentrations of Credit Risk:

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of cash, cash equivalents and short-term investments. The Company places its cash, cash equivalents and short-term investments with high quality financial institutions, and attempts to limit the amount of credit exposure to any one institution. However, at December 31, 2006, and at other times during the year, amounts in any one institution exceeded the Federal Deposit Insurance Corporation limits. The Company is also a party to certain reinsurance transactions whereby the Company remains ultimately liable for claims exposure under ceded policies in the event the assuming reinsurer is unable to meet its commitments due to default or insolvency.

Fair Value of Financial Instruments:

Fair values are based on quoted market prices. If market prices are not available, they are estimated based on the present value of future cash flows. Those techniques are significantly affected by the assumptions used, including the discount rate and estimates of future cash flows. The fair value amounts presented do not purport to represent and should not be considered representative of the underlying value of the Company.

The methods and assumptions used to estimate the fair values of each class of the financial instruments described below are as follows:

Investments The fair values of fixed maturities are based on quoted market prices. Fair values of securitized trust investments are computed using present values of future cash flows. Fair value of policy loans are not computed because such loans are not separately transferable and are often repaid by reductions to benefits and surrenders.

Cash and cash equivalents The carrying value approximates fair value.

Property and Equipment:

Property and equipment are stated at cost, less accumulated depreciation and amortization. Expenditures for improvements, which materially increase the estimated useful life of the asset, are capitalized. Expenditures for repairs and maintenance are charged to operations as incurred. Depreciation is provided principally on a straight-line basis over the related asset s estimated life. Upon sale or retirement, the cost of the asset and the related accumulated depreciation are removed from the accounts and the resulting gain or loss, if any, is included in operations.

The Company accounts for its internally developed software in accordance with Statement of Position 98-1 Accounting for the Costs of Computer Software Developed or Obtained for Internal Use. All costs incurred during the preliminary project stage are expensed as they are incurred. Costs incurred to develop the internal-use software during the application development stage are capitalized with the exception of certain data conversion costs, which are expensed as incurred. Training costs and maintenance costs are expensed as incurred.

Unamortized Deferred Policy Acquisition Costs (DAC):

The costs primarily related to and varying with the acquisition of new business, principally commissions, underwriting and policy issue expenses, have been deferred. These deferred costs are amortized over the related premium-paying periods utilizing the same projected premium assumptions, related to persistency, used in computing reserves for future policy benefits.

The Company regularly assesses the recoverability of DAC through actuarial analysis. To determine recoverability, the present value of future premiums less future costs and claims are added to current reserve balances. If this amount is greater than current DAC, the unamortized amount is deemed recoverable. The Company utilizes its most recent assumptions in the recoverability calculation including an assumption for premium rate increases. If premium rate increases are not approved, the Company will expense, as impaired, the attributed portion of the DAC in the current period. If the Company concludes that DAC is impaired, the Company will record an impairment loss and a reduction in the DAC. In the event of an impairment, the Company will also utilize its most recent assumptions for policy reserves and DAC to reflect current experience (referred to as unlocking) going forward. The primary assumptions include persistency, morbidity (claims expectations), investment yields, expenses and premium rate increases. Recoverability of DAC is highly dependent upon the Company s ability to obtain future premium rate increases. While the Company has been successful in obtaining premium rate increases on existing policies in the past, the ability to obtain these

increases is subject to regulatory

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approval, and is not guaranteed. Management believes the current assumptions and other considerations used to estimate and evaluate the recoverability of DAC are appropriate.

The significant assumptions utilized in the DAC recoverability analysis that differ from the current assumptions for policy reserves and DAC include:

- Use of new claim costs based on a recent analysis of claims experience from 1993 to 2006.
- An investment income rate of 5.37% initially, grading to the 6.59% for newly investable funds by 2036.
- An estimate that claims expense will improve beyond the assumptions utilized in the locked-in estimates due to the expected results from recently implemented and future planned improvements to claims adjudication procedures.
- Recognition of actual premium rate increases achieved as well as an estimate related to premium rate increases that the Company began filing in November of 2006. The assumption is that these premium rate increases will be implemented beginning in the second half of 2007 and most of them will be approved 2010, although the Company also assumes that some of the premium rate increases will be implemented in 2011. There is also an assumption related to an increased number of people lapsing due to the premium rate increases and therefore an assumption related to anti-selection as a result of the premium rate increases. Anti-selection is the lapsation of policies held by healthier policyholders, leading to a higher expected ratio of claims to premiums in future periods.
- Mortality assumptions based on a study completed in September 2005 which measured the Company s actual mortality experience, considering underwriting class as well as age and gender.
- Voluntary lapse rates based on a new study completed in November of 2006, which indicate that policies are lapsing at a slower rate than the Company previously assumed
- Consideration of the terms and expected recapture timing of the Imagine Agreement.

The premium rate increases the Company is filing may be consistent by policy form or may vary by the policy type, benefit period, underwriting class and the age of the policyholder. The aggregate average increase is approximately 55%, although the policy forms for which the Company has filed premium rate increase requests have an average increase ranging from 3.2% to 99.1%, depending on the mix of business within a particular state. The timing of state approvals for premium rate increases varies. Some states will approve the amount we filed within several months of the receipt of the filing, while other states will take up to a year and may only approve a portion of the amount the Company filed. In those situations, the Company will file for additional premium rate increases at a later date in order to obtain the remaining portion of the premium rate increase, so long as it is still actuarially justified. Therefore, to implement 100% of the premium rate increases, if ultimately approved, may take several years. We have received approval to implement premium rate increases on 68% of the policies for which we have sought increases. The average premium rate increase approved on these policies is approximately 27%. Therefore, as of the time of this filing, we have received rate increases of approximately 18% compared to the 55% we have requested.

Long-term care insurance has fixed annual premiums that can be adjusted only upon approval of the insurance departments of the states where the premiums were written. The process for filing for premium rate increases requires the Company to demonstrate to the insurance department that expected claims experience is anticipated to exceed original assumptions. The approval of premium rate increases is at the discretion of the insurance department.

The Company bases its premium rate increase assumptions on its past experience and its expectations of the amounts of actual premium rate increases that it will be able to achieve. If the Company is unsuccessful in obtaining the assumed level of premium rate increases, it could recognize an impairment in the future, which could have a material adverse effect on the Company s financial condition and results of operations.

Changes in one or a combination of these assumptions can produce significant volatility in the recoverability of DAC.

Goodwill:

The goodwill on the Company s Consolidated Balance Sheets at December 31, 2006 and 2005 relates to the purchase of the Company s insurance agencies, UIG and NISHD. The Company tests for impairment of goodwill

on an annual basis unless an event occurs or circumstances change that would more likely than not indicate that an impairment has occurred. In 2004, due to declining sales, the Company recorded an impairment of $13,376 in the fourth quarter of 2004. There was no impairment for the years ended December 31, 2005 and 2006.

The impairment test is done at a reporting unit level. UIG and NISHD are combined to form a reporting unit. UIG and NISHD are both insurance agencies that sell senior market insurance products, and therefore have similar economic characteristics.

Receivable from Reinsurers:

Premium revenue, benefits, and operating expenses are reported net of the amounts relating to reinsurance ceded to other companies. Amounts due from reinsurers for incurred and estimated future claims are reflected in the reinsurance recoverable asset. The cost of reinsurance is accounted for over the terms of the related treaties using assumptions consistent with those used to account for the underlying reinsured policies.

The Company applies deposit accounting for reinsurance agreements that do not meet the risk transfer criteria in Statement of Financial Accounting Standards No. 113 Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts.

Deposit Accounting for Reinsurance Agreements:

Effective June 30, 2005, the Company entered into an agreement to reinsure, on a 100% quota share basis, substantially all of its long-term care insurance policies in-force as of December 31, 2001 with Imagine International Reinsurance Limited (the Imagine Agreement). This agreement does not qualify for reinsurance treatment in accordance with GAAP because it does not result in the reasonable probability that the reinsurer may realize a significant loss. This is due to a number of factors related to the agreement, including an experience refund provision, expense and risk charges due to the reinsurer that escalate over the life of the agreement and an aggregate limit of liability. Therefore, the agreement is being accounted for in accordance with deposit accounting for reinsurance contracts. However, the agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules, which requires a reinsurance agreement to transfer risk to the reinsurer, but does not require the reasonable probability of a significant loss required under GAAP.

Effective October 1, 2005, the Company entered into an agreement to reinsure, on a 75% quota share basis, its long-term care insurance policies issued between October 1, 2005 and September 30, 2006 with Imagine International Reinsurance Limited (the 2005 Imagine Agreement). This agreement has been extended through September 30, 2008. This agreement does not qualify for reinsurance treatment in accordance with GAAP because it does not result in the reasonable probability that the reinsurer may realize a significant loss. This is due to a number of factors related to the agreement, including an experience refund provision, expense and risk charges due to the reinsurer that escalate over the life of the agreement and an aggregate limit of liability. Therefore, the agreement is being accounted for in accordance with deposit accounting for reinsurance contracts. However, the agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules, which requires a reinsurance agreement to transfer risk to the reinsurer, but does not require the reasonable probability of a significant loss required under GAAP.

Corporate Owned Life Insurance:

The Company purchased corporate owned life insurance (COLI) totaling $50,000 to fund the future payment of employee benefit expenses. No additional purchases were made in 2006 or 2005. The COLI, which is invested in investment grade corporate bonds and equity indexes, is recorded at cash surrender value. Increases in the cash surrender value are recorded as other income. When a covered employee dies, the Company receives cash equal to the death benefit. No income or expense is recorded as a result.

Notional Experience Account:

The 2001 reinsurance agreement with Centre Solutions (Bermuda) Limited (Centre) (as described in Note 15) included a provision for the maintenance of a notional experience account for the Company s benefit in the event of future commutation of the agreement. This agreement was commuted on May 24, 2005, at which time the investments held in the notional experience account were transferred back to the Company.

In accordance with SFAS No. 133, the Company accounted for the investment credit received on the notional experience account as follows:

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The fixed debt host yielded a fixed return based on the yield to maturity of the underlying benchmark indices. The return on the fixed debt host was reported as investment income in the Consolidated Statement of Income and Comprehensive Income.
The change in fair value of the embedded derivative represented the percentage change in the underlying indices applied to the notional experience account, similar to that of an unrealized gain/loss on a bond. The change in the fair value of the embedded derivative was reported as a market (loss) gain on the notional experience account in the Consolidated Statement of Income and Comprehensive Income.

Other Assets:

Other assets consist primarily of deferred reinsurance premiums, premiums due but not yet collected, prepaid assets, receivables due to our agency subsidiaries from other insurance companies, and a deposit account.

The deferred reinsurance premium represents the initial expense and risk charge paid to Imagine International Reinsurance Limited, which is being amortized over 42 months, the estimated life of the agreement.

Premiums due but not collected are recorded as premium revenue when due.

Prepaid assets are expensed over the period to which the related services are provided.

UIG and NISHD record receivables for amounts due from other insurance companies related to the sale of the other companies insurance products.

Policy Reserves and Claim Reserves:

There are two components to the Company s policyholder liabilities. The first is a policy reserve for future policy benefits and the second is a claim reserve for incurred claims, either reported or unreported.

Policy Reserves

The policy reserve liability is determined using the present value of estimated future policy benefits to be paid to, or on behalf of policyholders, less the present value of estimated future premiums to be collected from policyholders, including anticipated premium rate increases. This liability is recognized concurrent with and as a portion of premium revenue. Policy reserves are computed based on assumptions, including estimates of expected investment yield, mortality, morbidity (claims expectations), persistency and expenses, applicable at the time insurance contracts are effective. The assumptions utilized to determine the policy reserves are established at year of policy issuance and are locked in for the future development of reserves (See Unamortized Deferred Policy Acquisition Costs). Also see Note 9 for a description of the significant assumptions utilized in establishing the policy reserves.

Claim Reserves

The liability for claim reserves represents the amount needed to provide for the estimated ultimate cost of settling claims relating to insured events that have occurred on or before the end of the respective reporting period. The estimated liability includes requirements for future payments of (a) claims that have been reported to the insurer, (b) claims related to insured events that have occurred but that have not been reported to the insurer as of the date the liability is estimated, and (c) claim adjustment expenses. Claim adjustment expenses include costs incurred in the claim settlement process such as legal fees and costs to record, process, and adjust claims. The Company discounts all claims, which involve fixed periodic payments extending beyond one year. See Note 9 Policy and Claim Reserves for a description of the significant assumptions utilized in establishing the claim reserves.

The Company considers the liability for claim reserves provided to be satisfactory to cover the losses that have occurred. The Company monitors actual experience, and where circumstances warrant, will revise its assumptions. The methods of determining such estimates and establishing the reserves are reviewed continuously and any

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adjustments are reflected in operations in the period in which they become known. Future developments may result in losses and loss expenses greater or less than the liability for claim reserves.

Accounts Payable and Other Liabilities:

Accounts payable and other liabilities consist primarily of amounts payable to agents, reinsurers and vendors, capitalized lease obligations, accrued post retirement benefits, as well as deferred income items.

Income Taxes:

Income taxes consist of amounts currently due plus deferred tax expense or benefits. Deferred tax assets and liabilities result from temporary differences between the amounts recorded in the consolidated financial statements and the tax bases of the Company s assets and liabilities. Such temporary differences are primarily due to the difference in allowable deductions for deferred acquisition costs, the deposit accounting for the Company s reinsurance agreements, and tax benefits of net operating loss carryforwards. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. A valuation allowance against deferred tax assets is recorded if it is more likely than not that all, or some portion, of the benefits related to deferred tax assets will not be realized.

Revenue Recognition:

Premiums on long duration accident and health insurance, the majority of which is guaranteed renewable, and life insurance are recognized when due. Estimates of premiums due but not yet collected are accrued.

Commission revenue that the Company s agencies receive from unaffiliated insurers is included in other income when the commission from the underlying policy premium is due, net of an allowance for unissued or cancelled policies.

Earnings per Share:

Basic earnings per share (EPS) excludes dilution and is computed by dividing net income available to common stockholders by the weighted-average number of common shares outstanding for the period. Diluted EPS reflect the potential dilution that could occur if securities or other contracts to issue common stock were exercised or converted into common stock. Anti-dilutive effects are not included. As such, the Company has not included securities of 631, 159 and 4,286 for 2006, 2005 and 2004, respectively, which could potentially dilute basic earnings per share in the future. A reconciliation of the numerator and denominator of the basic earnings per share computation to the numerator and denominator of the diluted earnings per share computation follows.

	For the Periods Ended December 31,		
	2006	2005 Restated	2004
Net (loss) income before cumulative effect of change in accounting principle	$ (33,168)	$ (13,406)	$20,536
Weighted average common shares outstanding (2)	23,281	14,569	9,430
Basic earning per share from net (loss) income before cumulative effect of change in accounting principle (2)	$ (1.42)	$ (0.92)	$ 2.16
Net (loss) income before cumulative effect of change in accounting principle	$ (33,168)	$ (13,406)	$20,536
Cumulative effect of change in accounting principle	-	(1,507)	-
Net (loss) income	$ (33,168)	$ (14,913)	$20,536
Basic earnings per share from net (loss) income (2)	$ (1.42)	$ (1.02)	$ 2.16
Adjustments net of tax:			
Interest expense on convertible debt (3)	$ -	$ -	$ 6,514
Amortization of debt offering costs (3)	-	-	607
Gain on preferred interest (3)	-	-	(1,454)
Diluted net (loss) income before cumulative effect of change in accounting principle	$ (33,168)	$ (13,406)	$26,203
Diluted net (loss) income	$ (33,168)	$ (14,913)	$26,203
Weighted average common shares outstanding (2)	23,281	14,569	9,430
Common stock equivalents due to dilutive			