KAPSTONE PAPER & PACKAGING CORP
Form SC 13G/A
February 07, 2014

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

SCHEDULE 13G

Under the Securities Exchange Act of 1934

(Amendment No: 5)

KAPSTONE PAPER & PACKAGING CORP.

(Name of Issuer)

Common Stock

(Title of Class of Securities)

48562P103

(CUSIP Number)

January 31, 2014

(Date of Event Which Requires Filing of this Statement)

Check the appropriate box to designate the rule pursuant to which this Schedule is filed:

[X] Rule 13d-1(b)
[ ] Rule 13d-1(c)
[ ] Rule 13d-1(d)

*The remainder of this cover page shall be filled out for a reporting person's initial filing on this form with respect to the subject class of securities, and for any subsequent amendment containing information which would alter the disclosures provided in a prior cover page.

The information required in the remainder of this cover page shall not be deemed to be "filed" for the purpose of Section 18 of the Securities Exchange Act of 1934 ("Act") or otherwise subject to the liabilities of that section of the Act but shall be subject to all other provisions of the Act (however, see the Notes).

CUSIP No. 48562P103

(1)Names of reporting persons. BlackRock, Inc.

(2) Check the appropriate box if a member of a group
(a) [ ]

(b) [X]

(3) SEC use only

(4) Citizenship or place of organization

Delaware

Number of shares beneficially owned by each reporting person with:

(5) Sole voting power

9338737

(6) Shared voting power

None

(7) Sole dispositive power

9593247

(8) Shared dispositive power

None

(9) Aggregate amount beneficially owned by each reporting person

9593247

(10) Check if the aggregate amount in Row (9) excludes certain shares

(11) Percent of class represented by amount in Row 9

10.0%

(12) Type of reporting person

HC

Item 1.

Item 1(a) Name of issuer:

KAPSTONE PAPER & PACKAGING CORP.

Item 1(b) Address of issuer's principal executive offices:

1101 Skokie Blvd, Suite 300
Northbrook IL 60062

Item 2.

2(a) Name of person filing:

BlackRock, Inc.

2(b) Address or principal business office or, if none, residence:

BlackRock Inc.
40 East 52nd Street
New York, NY 10022

2(c) Citizenship:

See Item 4 of Cover Page

2(d) Title of class of securities:

Common Stock

2(e) CUSIP No.:
See Cover Page

Item 3.

If this statement is filed pursuant to Rules 13d-1(b), or 13d-2(b) or (c), check whether the person filing is a:
[ ] Broker or dealer registered under Section 15 of the Act;
[ ] Bank as defined in Section 3(a)(6) of the Act;
[ ] Insurance company as defined in Section 3(a)(19) of the Act;
[ ] Investment company registered under Section 8 of the Investment Company Act of 1940;
[ ] An investment adviser in accordance with Rule 13d-1(b)(1)(ii)(E);
[ ] An employee benefit plan or endowment fund in accordance with Rule 13d-1(b)(1)(ii)(F);
[X] A parent holding company or control person in accordance with Rule 13d-1(b)(1)(ii)(G);
[ ] A savings associations as defined in Section 3(b) of the Federal Deposit Insurance Act (12 U.S.C. 1813);
[ ] A church plan that is excluded from the definition of an investment company under section 3(c)(14) of the Investment Company Act of 1940;
[ ] A non-U.S. institution in accordance with Rule 240.13d-1(b)(1)(ii)(J);
[ ] Group, in accordance with Rule 240.13d-1(b)(1)(ii)(K). If filing as a non-U.S. institution in accordance with Rule 240.13d-1(b)(1)(ii)(J), please specify the type of institution:

Item 4. Ownership

Provide the following information regarding the aggregate number and percentage of the class of securities of the issuer identified in Item 1.

Amount beneficially owned:

9593247

Percent of class

10.0%

Number of shares as to which such person has:

Sole power to vote or to direct the vote

9338737

Shared power to vote or to direct the vote

None

Sole power to dispose or to direct the disposition of

9593247

Shared power to dispose or to direct the disposition of

None

Item 5.

Ownership of 5 Percent or Less of a Class. If this statement is being filed to report the fact that as of the date hereof the reporting person has ceased to be the beneficial owner of more than 5 percent of the class of securities, check the following [ ].

Item 6. Ownership of More than 5 Percent on Behalf of Another Person

If any other person is known to have the right to receive or the power to direct the receipt of dividends from, or the proceeds from the sale of, such securities, a statement to that effect should be included in response to this item and, if such interest relates to more than 5 percent of the class, such person should be identified. A listing of the shareholders of an investment company registered under the Investment Company Act of 1940 or the beneficiaries of employee benefit plan, pension fund or endowment fund is not required.

Various persons have the right to receive or the power to direct the receipt of dividends from, or the proceeds from the sale of the common stock of
KAPSTONE PAPER & PACKAGING CORP..
No one person's interest in the common stock of
KAPSTONE PAPER & PACKAGING CORP.
is more than five percent of the total outstanding common shares.

Item 7. Identification and Classification of the Subsidiary Which Acquired the Security Being Reported on by the Parent Holding Company or Control Person.

See Exhibit A

Item 8. Identification and Classification of Members of the Group

If a group has filed this schedule pursuant to Rule 13d-1(b)(ii)(J), so indicate under Item 3(j) and attach an exhibit stating the identity and Item 3 classification of each member of the group. If a group has filed this schedule pursuant to Rule 13d-1(c) or Rule 13d-1(d), attach an exhibit stating the identity of each member of the group.

Item 9. Notice of Dissolution of Group

Notice of dissolution of a group may be furnished as an exhibit stating the date of the dissolution and that all further filings with respect to transactions in the security reported on will be filed, if required, by members of the group, in their individual capacity.

See Item 5.

Item 10. Certifications
By signing below I certify that, to the best of my knowledge and belief, the securities referred to above were acquired and are held in the ordinary course of business and were not acquired and are not held for the purpose of or with the effect of changing or influencing the control of the issuer of the securities and were not acquired and are not held in connection with or as a participant in any transaction having that purpose or effect.

Signature.

After reasonable inquiry and to the best of my knowledge and belief, I certify that the information set forth in this statement is true, complete and correct.

Dated: February 06, 2014
BlackRock, Inc.

Signature: Matthew J. Fitzgerald

Name/Title Attorney-In-Fact

The original statement shall be signed by each person on whose behalf the statement is filed or his authorized representative. If the statement is signed on behalf of a person by his authorized

representative other than an executive officer or general partner of the filing person, evidence of the representative's authority to sign on behalf of such person shall be filed with the statement, provided, however, that a power of attorney for this purpose which is already on file with the Commission may be incorporated by reference. The name and any title of each person who signs the statement shall be typed or printed beneath his signature.

Attention: Intentional misstatements or omissions of fact constitute Federal criminal violations (see 18 U.S.C. 1001).

Exhibit A

Subsidiary

BlackRock Advisors (UK) Limited
BlackRock Advisors, LLC
BlackRock Asset Management Canada Limited
BlackRock Asset Management Ireland Limited
BlackRock Financial Management, Inc.
BlackRock Fund Advisors*
BlackRock Fund Management Ireland Limited
BlackRock Institutional Trust Company, N.A.
BlackRock International Limited
BlackRock Investment Management (Australia) Limited
BlackRock Investment Management (UK) Ltd
BlackRock Investment Management, LLC
BlackRock Japan Co Ltd
BlackRock Life Limited

*Entity beneficially owns 5% or greater of the outstanding shares of the security class being reported on this Schedule 13G.

Exhibit B

POWER OF ATTORNEY

The undersigned, BLACKROCK, INC., a corporation duly organized under the laws of the State of Delaware, United States (the "Company"), does hereby make, constitute and appoint each of Matthew Mallow, Howard Surloff, Edward Baer, Bartholomew Battista, Dan Waltcher, Karen Clark, Daniel Ronnen, John Stelley, Brian Kindelan, John Blevins, Richard Froio, Matthew Fitzgerald and Con Tzatzakis acting severally, as its true and lawful attorneys-in-fact, for the purpose of, from time to time, executing in its name and on its behalf, whether the Company is acting individually or as representative of others, any and all documents, certificates, instruments, statements, other filings and amendments to the foregoing (collectively, "documents") determined by such person to be necessary or appropriate to comply with ownership or control-person reporting requirements imposed by any United States or non-United States governmental or regulatory authority, including without limitation Forms 3, 4, 5, 13D, 13F, 13G and 13H and any amendments to any of the foregoing as may be required to be filed with the Securities and Exchange Commission, and delivering,

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furnishing or filing any such documents with the appropriate
governmental, regulatory authority or other person, and giving and
granting to each such attorney-in-fact power and authority to act in
the premises as fully and to all intents and purposes as the Company
might or could do if personally present by one of its authorized
signatories, hereby ratifying and confirming all that said
attorney-in-fact shall lawfully do or cause to be done by
virtue hereof. Any such determination by an attorney-in-fact named
herein shall be conclusively evidenced by such person's execution,
delivery, furnishing or filing of the applicable document.

This power of attorney shall expressly revoke the power of attorney
dated 30th day of November,2011 in respect of the subject matter hereof,
shall be valid from the date hereof and shall remain in full force and
effect until either revoked in writing by the Company, or, in respect of
any attorney-in-fact named herein, until such person ceases to be an
employee of the Company or one of its affiliates.

IN WITNESS WHEREOF, the undersigned has caused this power of
attorney to be executed as of this 10th day of July, 2012.

BLACKROCK, INC.


By:_ /s/ Chris Leavy
Name: Chris Leavy
Title: Chief Investment Officer
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ary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, providers are paid on a fee-for-service basis and lack incentive to monitor utilization and control costs.

In an effort to improve quality and provide more uniform and more cost-effective care, most states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives a predetermined payment per enrollee for the covered health care services. The health plan, in turn, arranges for the provision of such services by contracting with a network of providers who are responsible for providing a comprehensive range of medical and hospital services. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Our Approach

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. We believe we are well positioned to capitalize on the growth opportunities in our markets. Our approach to managed care is based on the following key attributes:

Experience. For 25 years, we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. In that time we have developed and forged strong relationships with the constituents whom we serve members, providers, and government agencies.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency.

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations and the transition of members from other health plans.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions.

Cultural and Linguistic Expertise. We have a 25-year history of developing targeted health care programs for our culturally diverse membership and believe we are well-positioned to successfully serve these growing populations.

Proven Medical Management. We believe that our experience as a health care provider has helped us to improve medical outcomes for our members while at the same time enhancing the cost effectiveness of care.

Our Strategy

Our objective is to be the leading managed care organization serving Medicaid, SCHIP, and other low-income members. To achieve this objective, we intend to:

Focus on Serving Low-Income Families and Individuals. We will continue to focus on serving the beneficiaries of Medicaid and other government-sponsored programs, as our experience, infrastructure, and health care programs position us to optimally serve this population.

Increase our Membership. We will seek to grow our membership by expanding within existing markets and entering new markets.

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Manage Medical Costs. We will continue to use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members.

Leverage Operational Efficiencies. We will continue to leverage our centralized administrative infrastructure, flexible information systems and dedication to controlling administrative costs to provide economies of scale, allowing us to integrate new members and expand quickly in new and existing markets.

Our Health Plans

As of December 31, 2004, our operating health plans are located in California, Michigan, New Mexico, Utah and Washington. We have also recently established a start-up operation in Indiana, where our HMO-licensed subsidiary will begin serving members in April 2005. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members by state in the periods presented.

	As of December 31,		
State	**2004**	**2003**	**2002**
California	253,000	254,000	253,000
Michigan	158,000	82,000	33,000
New Mexico	65,000		
Utah	49,000	45,000	42,000
Washington	263,000	183,000	161,000
Total	788,000	564,000	489,000

Provider Networks

We arrange health care services for our members through contracts with providers that include our own clinics, independent physicians and groups, hospitals, and ancillary providers. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

The following table shows the total approximate number of primary care physicians, specialists, and hospitals participating in our network as of December 31, 2004:

	California	**Michigan**	**New Mexico**	**Utah**	**Washington**	**Total**
Primary care physicians	2,201	1,249	1,488	1,250	2,714	8,902
Specialists	6,366	1,899	6,275	2,097	5,325	21,962

Hospitals	85	41	69	38	81	314

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. Our medical management programs include specialized disease management programs that address the particular health care needs of our members, educational programs designed to increase awareness of various diseases, conditions, and methods of prevention and pharmacy management programs that focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications.

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Best Practices

We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Health Plan Employer Data and Information Set (HEDIS) and accreditation by the National Committee on Quality Assurance, or NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Our California, Michigan, New Mexico, Utah, and Washington HMOs have each been accredited by the NCQA and we intend to seek accreditation for our Indiana HMO.

Our Company

Our principal executive offices are located at One Golden Shore Drive, Long Beach, CA 90802, and our telephone number is (562) 435-3666. Our website is located at www.molinahealthcare.com. Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this prospectus.

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The Offering

Common stock offered by us	1,000,000 shares
Common stock offered by the selling stockholders	2,000,000 shares (of which 983,191 shares are being offered by the Molina Siblings Trust, 671,809 shares are being offered by the MRM GRAT 903/2 and 345,000 shares are being offered by the MRM GRAT 904/2, see Principal and Selling Stockholders)
Over-allotment option by the Molina Siblings Trust	450,000 shares
Common stock to be outstanding after this offering	28,668,108 shares
Use of proceeds	We estimate that the net proceeds to us from the offering will be approximately $45.5 million (based on an assumed offering price of $46.09 per share, the last reported sale price of our common stock on the New York Stock Exchange on March 31, 2005). We intend to use approximately $3.1 million of the net proceeds to repay amounts outstanding under our credit facility. We intend to use the balance of the net proceeds for working capital and other general corporate purposes, which may include acquisitions. We will not receive any proceeds from the sale of shares by the selling stockholders.
New York Stock Exchange symbol	MOH
Risk Factors	This offering involves risks. See Risk Factors on page 9.

The number of shares of our common stock to be outstanding immediately after this offering is based on the number of shares outstanding as of March 31, 2005. It excludes, as of March 31, 2005, 618,787 shares of common stock subject to options outstanding under our stock incentive plans with a weighted average exercise price of $15.39 per share, of which options to purchase 436,497 shares were exercisable.

Unless otherwise indicated, all information contained in this prospectus assumes no exercise of the underwriters option to purchase up to 450,000 additional shares.

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Summary Consolidated Financial Data

The summary consolidated financial data presented below has been derived from our audited financial statements. See Management s Discussion and Analysis of Financial Condition and Results of Operations, as well as our audited financial statements and related notes included or incorporated by reference in this prospectus.

	Year Ended December 31,				
	2004(1)	2003	2002	2001	2000
	(Dollars in thousands, except per share data)				
Statements of Income Data:					
Revenue:					
Premium revenue	$ 1,166,870	$ 789,536	$ 639,295	$ 499,471	$ 324,300
Other operating revenue	4,168	2,247	2,884	1,402	1,971
Total premium and other operating revenue	1,171,038	791,783	642,179	500,873	326,271
Investment income	4,230	1,761	1,982	2,982	3,161
Total revenue	1,175,268	793,544	644,161	503,855	329,432
Expenses:					
Medical care costs	984,686	657,921	530,018	408,410	264,408
Salary, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	94,150	61,543	61,227	42,822	38,701
Depreciation and amortization	8,869	6,333	4,112	2,407	2,085
Total expenses	1,087,705	725,797	595,357	453,639	305,194
Operating income	87,563	67,747	48,804	50,216	24,238
Total other income (expense), net	122	(1,334)	(405)	(561)	(197)
Income before income taxes	87,685	66,413	48,399	49,655	24,041
Provision for income taxes	31,912	23,896	17,891	19,453	9,156
Income before minority interest	55,773	42,517	30,508	30,202	14,885
Minority interest				(73)	79
Net income	$ 55,773	$ 42,517	$ 30,508	$ 30,129	$ 14,964
Net income per share:					
Basic	$ 2.07	$ 1.91	$ 1.53	$ 1.51	$ 0.75
Diluted	$ 2.04	$ 1.88	$ 1.48	$ 1.46	$ 0.73
Cash dividends declared per share					$ 0.05
	26,965,000	22,224,000	20,000,000	20,000,000	20,000,000

Weighted average number of common shares outstanding					
Weighted average number of common shares and potential dilutive common shares outstanding	27,342,000	22,629,000	20,609,000	20,572,000	20,376,000

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	Year Ended December 31,				
	2004(1)	2003	2002	2001	2000
Operating Statistics:					
Medical care ratio(2)	84.1%	83.1%	82.5%	81.5%	81.0%
Salary, general and administrative expense ratio(3)	8.0%	7.8%	9.5%	8.5%	11.7%
Members (by category)(4)					
TANF	691,000	510,000	447,000	376,000	277,000
SCHIP	30,000	24,000	20,000	14,000	9,000
Basic Health	21,000	5,000	5,000	2,000	2,000
ABD	46,000	25,000	17,000	13,000	10,000
Total Members	788,000	564,000	489,000	405,000	298,000

	As of December 31,				
	2004(1)	2003	2002	2001	2000
	(Dollars in thousands)				
Balance Sheet Data:					
Cash and cash equivalents	$ 228,071	$ 141,850	$ 139,300	$ 102,750	$ 45,785
Total assets	533,859	344,585	204,966	149,620	102,012
Long-term debt (including current maturities)	1,894		3,350	3,401	3,448
Total liabilities	203,237	123,263	109,699	84,861	67,405
Stockholders equity	330,622	221,322	95,267	64,759	34,607

(1) The balance sheet and operating results of the New Mexico HMO have been included since July 1, 2004, the date of acquisition. For additional information regarding this acquisition, including pro forma financial information, see our Current Report on Form 8-K/A, filed with the Securities and Exchange Commission, or SEC, on September 13, 2004, and our Current Report on Form 8-K, filed with the SEC on April 4, 2005. See also, Incorporation of Documents by Reference.

(2) Medical care ratio represents medical care costs as a percentage of premium and other operating revenue. Other operating revenue includes revenues related to our California clinics and reimbursements under various risks and savings sharing programs. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See Management s Discussion and Analysis of Financial Condition and Results of Operations for further discussion.

(3) Salary, general and administrative expense ratio represents such expenses as a percentage of total operating revenue.

(4) Number of members at end of period.

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RISK FACTORS

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully consider the risk factors set forth herein, as well as other information we include or incorporate by reference in this prospectus and the additional information in the other reports we file with the SEC.

Risks Related To Our Business

Reductions in Medicaid funding could substantially reduce our profitability.

Substantially all of our revenues come from state Medicaid premiums. The premium rates paid by each state to health plans like ours differ depending on a combination of factors, such as upper payment limits established by the federal and state governments, a member s health status, age, gender, county or region, benefit mix, and member eligibility categories. Future Medicaid premium rate levels may be affected by continued government efforts to contain medical costs, or federal and state budgetary constraints. Changes in Medicaid funding could, for example, reduce the number of persons enrolled in or eligible for Medicaid, reduce the amount of reimbursement or payment levels by the federal or state governments or increase our administrative or health benefit costs. Additionally, changes could eliminate coverage for certain benefits such as our pharmacy, behavioral health, vision, or other benefits. In some cases, changes in funding could be made retroactive. The federal government and all of the states in which we operate are presently considering proposals and legislation that would implement certain Medicaid reforms or redesigns, reduce reimbursement or payment levels, or reduce the number of persons eligible for Medicaid. Reductions in Medicaid payments at either the federal or state level could reduce our profitability if we are unable to reduce our expenses.

As part of President Bush s 2006 Budget submission to Congress, there are a number of proposals related to federal funding of Medicaid. The Administration proposes to reduce federal funding to states for Medicaid by $60 billion over a ten-year period. This $60 billion reduction would be partially offset by $15 billion in proposed new Medicaid-related initiatives. The President s 2006 Budget contains little detail on these Medicaid proposals, and it is expected that more discussion of these proposals will occur throughout the year. It is uncertain whether any of these proposals, or a variation thereof, will be enacted. If the President s proposals are ultimately adopted and states are required to reduce or change funding mechanisms, our operations and financial performance could be adversely affected.

If our government contracts or our subcontracts with government contractors are not renewed or are terminated, our business will suffer.

All of our contracts are terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are subject to cancellation by the state in the event of unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. In addition, most contracts are terminable without cause. Most contracts are for a specified period and are subject to non-renewal. Our other contracts are also eligible for termination or non-renewal through annual competitive bids. We may face increased competition as other plans attempt to enter our markets through the contracting process. If we are unable to renew, successfully rebid, or compete for any of our government contracts, or if any of our contracts are terminated, our business will suffer.

If we are unable to effectively manage medical costs, our profitability could be reduced.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage medical costs. Historically, our medical care costs as a percentage of premium and other operating revenue have fluctuated. Relatively small changes in these medical care ratios can create significant changes in our financial results. Changes in health care laws, regulations and practices, level of use of health care services, hospital costs, pharmaceutical costs, major epidemics, terrorism or bioterrorism, new medical technologies, and other external factors, including general economic conditions such as inflation levels, could reduce our ability to predict and effectively control the costs of providing health care services. Although we have been able to manage medical care costs through a variety of techniques, including various payment methods to primary care physicians and

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other providers, advance approval for hospital services and referral requirements, medical management and quality management programs, our information systems, and reinsurance arrangements, we may not be able to continue to effectively manage medical care costs in the future. If our medical care costs increase, our profits could be reduced or we may not remain profitable.

A failure to accurately estimate incurred but not reported medical care costs may hamper our operations.

Our medical care costs include estimates of claims incurred but not reported. We, together with our independent actuaries, estimate our medical claims liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services and other relevant factors. The estimation methods and the resulting reserves are continually reviewed and updated, and adjustments, if necessary, are reflected in the period known. Our estimates of claims incurred but not reported may be inadequate in the future, which would negatively affect our results of operations. Further, our inability to accurately estimate claims incurred but not reported may also affect our ability to take timely corrective actions, further exacerbating the extent of the negative impact on our results.

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than stockholders. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations along with the terms of our government contracts regulate how we do business, what services we offer, and how we interact with members and the public. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations could reduce our profitability by:

imposing additional capital requirements,

increasing our liability,

increasing our administrative and other costs,

increasing or decreasing mandated benefits,

forcing us to restructure our relationships with providers, or

requiring us to implement additional or different programs and systems.

For example, Congress enacted the Health Insurance Portability and Accountability Act of 1996 which mandates that health plans enhance privacy protections for member protected health information. This requires health plans to add, at significant cost, new administrative, information, and security systems to prevent inappropriate release of protected member health information. The requirements for compliance with this law are uncertain and will continue to affect our profitability. The regulations enacting this law also establish significant criminal

penalties and civil sanctions for non-compliance, including fines for violations of the regulations by our business associates. Individual states periodically consider adding operational requirements applicable to health plans, often without identifying funding for these requirements. California recently required all health plans to make available to members independent medical review of their claims. This requirement is costly to implement and could affect our profitability.

We are subject to various routine and non-routine governmental reviews, audits, and investigation. Violation of the laws governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, and exclusion from participation in government sponsored health programs, including Medicaid and SCHIP. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue.

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States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are typically approved for multi-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state s application for renewal, our business would suffer as a result of a likely decrease in membership.

Our business depends on our information systems, and our inability to effectively integrate, manage, and keep secure our information systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, monitoring utilization and other cost factors, supporting our health care management techniques, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to produce timely and accurate reports could be adversely affected. In addition, our information system software is leased from a third party. If the owner of the software were to become insolvent and fail to support the software, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and client data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if they are not prevented.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of Medicaid contract rights and other health plans have accounted for a significant amount of our growth. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that acquisitions similar in nature to those we have historically executed will be important to our future growth strategy. Many of the other potential purchasers of these assets have greater financial resources than we have. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include the integration of:

additional employees who are not familiar with our operations,

new provider networks, which may operate on terms different from our existing networks,

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additional members, who may decide to transfer to other health care providers or health plans,

disparate information, claims processing, and record keeping systems, and

internal controls and accounting policies, including those which require judgmental and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. For example, the previously announced agreements to transfer to the company the Medi-Cal (Medicaid) and Healthy Families Program (California s SCHIP) contracts of both Sharp Health Plan and Universal Care in San Diego County require four separate governmental agency approvals. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we will be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of the state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or to comply with these regulatory requirements for an acquisition in a timely manner, or at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced or to sustain our pattern of growth.

Ineffective management of our growth may negatively affect our results of operations, financial condition, and business.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In 1998, we had total revenue of $135.9 million. In 2004, we had total revenue of $1.175 billion. Continued rapid growth could place a significant strain on our management and on other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is currently subject to significant changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by financial resources available to a health plan. Many other organizations with which we compete have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership.

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions and declare dividends.

We have a credit facility that imposes various restrictions and covenants, including prescribed debt coverage ratios, net worth requirements, and acquisition limitations, that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified

values and declare dividends without lender approval. Our growth strategy may be negatively impacted by our inability to act with complete flexibility.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our President and Chief Executive Officer and our Executive Vice Presidents, some of whom have entered into employment agreements with us. These employment

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agreements may not provide sufficient incentives for those employees to continue their employment with us. While we believe that we could find replacements, the loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel which could negatively impact our operations.

Claims relating to medical malpractice and other litigation could cause us to incur significant expenses.

Our providers involved in medical care decisions may be exposed to the risk of medical malpractice claims. Providers at the primary care clinics we operate in California are employees of our California subsidiary. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our subsidiary may experience increased exposure to liability for acts or omissions by our employees and for acts or injuries occurring on our premises. We maintain errors and omissions insurance in the amount of $5 million per occurrence and in aggregate for each policy year, medical malpractice insurance for our clinics in the amount of $1 million per occurrence, and an annual aggregate limit of $3 million, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management s attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

In addition, claimants often sue managed care organizations for improper denials or delay of care. Also, Congress, as well as several states, are considering legislation that would permit managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. If this or similar legislation were enacted, claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

The results of our operations could be negatively impacted by both upturns and downturns in general economic conditions.

The number of persons eligible to receive Medicaid benefits has historically increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. However, during such economic downturns, state and federal budgets could decrease, causing states to attempt to cut health care programs, benefits, and rates. If federal or state funding were decreased while our membership was increasing, our results of operations would be negatively affected. Conversely, the number of persons eligible to receive Medicaid benefits may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels and profitability to decrease, which could lead to decreases in our operating income.

If state regulators do not approve payments of dividends and distributions by our affiliates to us, it may negatively affect our business strategy.

We principally operate through our health plan subsidiaries. These subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. In Michigan, New Mexico, Utah and Washington, our health plans must give thirty days

advance notice and the opportunity to disapprove extraordinary dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year

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end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2004, 2003, and 2002 without approval of the regulatory authorities were approximately $27.9 million, $29.0 million, and $28.9 million, respectively, assuming no dividends had been paid during the respective calendar years. If the regulators were to deny or significantly restrict our subsidiaries requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments on amounts drawn from our credit facility.

Unforeseen changes in regulations or pharmaceutical market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our HMOs to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our financial condition and results of operations.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. As permitted by SEC guidance, our internal control evaluation and testing, and the attestation of our independent registered public accounting firm, included in our Annual Report on Form 10-K for the year ended December 31, 2004 did not cover the internal controls of Health Care Horizons, Inc., which we acquired on July 1, 2004.

We will, however, have to assess the internal controls of that business no later than June 30, 2005, and are in the process of transitioning its internal controls over to our systems. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Risks Associated With This Offering

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the closing sales price of our common stock has ranged from a low of $20.15 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

state and federal budget decreases,

adverse publicity regarding health maintenance organizations and other managed care organizations,

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- government action regarding eligibility,
- changes in government payment levels,
- changes in state mandatory programs,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies,
- the termination of our Medicaid or SCHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change, and
- general economic conditions, including inflation and unemployment rates.

In addition, the stock market in general has been highly volatile recently. During this period of market volatility, the stocks of health care companies also have been highly volatile and have recorded lows well below their historical highs. Our stock may not trade at the same levels as the stock of other health care companies and the market in general may not sustain its current prices. Also, if the trading market for our stock does not continue to develop, securities analysts may not initiate or maintain research coverage of our company and our shares, and this could further depress the market for our shares.

You will experience immediate and significant dilution in the book value per share and will experience further dilution with the future exercise of stock options.

If you purchase common stock in this offering, you will incur immediate dilution, which means that you will pay a price per share that exceeds by $36.39 the per share net tangible book value of our assets immediately following the offering (on an as adjusted basis as of December 31, 2004 based on an assumed offering price of $46.09 per share, the last reported sale price of our common stock on the New York Stock Exchange on March 31, 2005).

As of March 31, 2005, we had outstanding options to purchase 618,787 shares of our common stock, of which options to purchase 436,497 shares were exercisable. From time to time, we may issue additional options to employees and non-employee directors pursuant to our equity incentive plans. These options generally vest commencing one year from the date of grant and continue vesting over a three year period. Once these options vest, our stockholders will experience further dilution as these stock options are exercised by their holders.

Future sales, or the availability for sale, of our common stock may cause our stock price to decline.

In connection with this offering, we, along with our executive officers, directors and certain stockholders who beneficially own 5% or more of our common stock, will have agreed prior to the commencement of this offering, subject to limited exceptions, not to sell or transfer any shares of common stock for 90 days after the date of this prospectus without the underwriters consent. However, Citigroup Global Markets Inc. and UBS Securities LLC, as representatives of the underwriters, may release these shares from these restrictions at any time. In evaluating whether to grant such a request, Citigroup Global Markets Inc. and UBS Securities LLC may consider a number of factors with a view toward maintaining an orderly market for, and minimizing volatility in the market price of, our common stock. These factors include, among others, the number of shares involved, recent trading volume and prices of the stock, the length of time before the lock-up expires and the reasons for, and the timing of, the request. We cannot predict what effect, if any, market sales of shares held by any stockholder or the availability of these shares for future sale will have on the market price of our common stock.

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Approximately 14,686,904 restricted shares of common stock held by our officers, directors and certain stockholders who beneficially own more than 5% of our common stock may be sold in the public market 91 days after the date of this prospectus, subject to applicable volume and other limitations imposed under federal securities laws. Sales of substantial amounts of our common stock in the public market after the completion of this offering, or the perception that such sales could occur, could adversely affect the market price of our common stock and could materially impair our future ability to raise capital through offerings of our common stock. See Shares Eligible for Future Sale below for a more detailed description of the restrictions on selling shares of our common stock after this offering.

Our directors and officers and members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Following this offering, our executive officers and directors, in the aggregate, will beneficially own approximately 17.7% of our capital stock, or 16.1% if the underwriters over-allotment option is exercised in full. Following this offering, members of the Molina family (some of whom are also officers or directors), in the aggregate, will beneficially own approximately 50.1% of our capital stock, or 48.6% if the underwriters over-allotment option is exercised in full, either directly or in trusts of which members of the Molina family are beneficiaries. In some cases, members of the Molina family are trustees of the trusts. As a result, Molina family members, acting by themselves or together with our officers and directors, will have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of substantially all of our assets. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of ownership in our company could delay, defer, or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of our controlling stockholders may be different from those of our company or our other stockholders, and our controlling stockholders may vote their common stock in a manner that may adversely affect our other stockholders.

It may be difficult for a third party to acquire our company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Our forecasts and other forward-looking statements are based on a variety of assumptions that are subject to significant uncertainties. Our performance may not be consistent with these forecasts and forward-looking statements.

From time to time in press releases and otherwise, we may publish forecasts or other forward-looking statements regarding our future results, including estimated revenues, net earnings, and other operating and

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financial metrics. Any forecast of our future performance reflects various assumptions. These assumptions are subject to significant uncertainties, and as a matter of course, any number of them may prove to be incorrect. Further, the achievement of any forecast depends on numerous risks and other factors, including those described in this prospectus, many of which are beyond our control. As a result, we cannot assure that our performance will be consistent with any management forecasts or that the variation from such forecasts will not be material and adverse. You are cautioned not to base your entire analysis of our business and prospects upon isolated predictions, but instead are encouraged to utilize the entire publicly available mix of historical and forward-looking information, as well as other available information affecting us and our services, when evaluating our prospective results of operations.

SPECIAL NOTE REGARDING FORWARD-LOOKING INFORMATION

This prospectus and the documents we incorporate by reference in this prospectus contain forward-looking statements within the meaning of Section 27A of the Securities Act, and Section 21E of the Securities Exchange Act. All statements, other than statements of historical facts, that we include in this prospectus and in the documents we incorporate by reference in this prospectus, may be deemed forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words anticipate, believe, estimate, expect, intend, may, project, will, would and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we actually will achieve the plans, intentions or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make, including the factors included in the documents we incorporate by reference in this prospectus. You should read these factors and the other cautionary statements made in the documents we incorporate by reference as being applicable to all related forward-looking statements wherever they appear in this prospectus and any document incorporated by reference. We caution you that we do not undertake any obligation to update forward-looking statements made by us.

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USE OF PROCEEDS

We estimate that the net proceeds to us from the sale of the 1,000,000 shares of common stock that we are offering will be approximately $45.5 million, after deducting an underwriting discount and estimated offering expenses (based on an assumed offering price of $46.09 per share, the last reported sale price of our common stock on the New York Stock Exchange on March 31, 2005). We will not receive any proceeds from the sale of shares by the selling stockholders or upon any exercise of the underwriters over-allotment option. We intend to use approximately $3.1 million of the net proceeds to repay amounts outstanding under our credit facility, which has a maturity date of March 8, 2010 and bears interest at a floating rate which was 6.0% as of March 31, 2005. The borrowings under this credit facility were used to pay fees and expenses associated with the amendment and restatement of the credit facility in March 2005. We intend to use the balance of the net proceeds for working capital and other general corporate purposes. We may apply proceeds to fund working capital to, among other things:

increase market penetration within our current service areas;

pursue opportunities for the development of new markets;

expand services and products available to our members;

strengthen our capital base by increasing the statutory capital of our health plan subsidiaries; and

acquire businesses, assets and technologies that are complementary to our business.

In particular, we may use proceeds to acquire Medicaid and SCHIP businesses, specialty services businesses, and contract rights in order to increase our membership and to expand our business into new service areas.

Except for the repayment of amounts outstanding under our credit facitlity, we have not determined the amount of net proceeds to be used specifically for the foregoing purposes. As a result, our management will have broad discretion to allocate our net proceeds. Pending application of our net proceeds, we intend to invest the net proceeds in investment-grade, interest-bearing instruments.

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PRICE RANGE OF COMMON STOCK AND DIVIDEND POLICY

Our common stock became listed on the New York Stock Exchange, Inc. on July 2, 2003 under the symbol MOH. Prior to that time, there was no established public trading market for any class of our common equity. As of March 31, 2005, there were approximately 53 holders of record of our common stock. The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2003		
Third Quarter (beginning July 2, 2003)	$ 27.75	$ 20.15
Fourth Quarter	29.00	21.75
2004		
First Quarter	$ 33.45	$ 23.25
Second Quarter	39.74	29.21
Third Quarter	38.18	29.79
Fourth Quarter	49.45	34.90
2005		
First Quarter	$ 53.23	$ 42.15

We currently anticipate that we will retain any future earnings for the development and operation of our business. Accordingly, we do not anticipate declaring or paying any cash dividends in the foreseeable future. Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Laws of the states in which we operate or may operate, as well as requirements of the government sponsored health programs in which we participate, limit the ability of our subsidiaries to pay dividends to us. In addition, the terms of our credit facility limit our ability to pay dividends.

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CAPITALIZATION

The table below sets forth the following as of December 31, 2004:

- our historical cash, cash equivalents and investments and capitalization; and
- our cash and capitalization as adjusted to give effect to the sale by us of 1,000,000 shares of common stock, after deducting the underwriting discount and estimated offering expenses (based on an assumed public offering price of $46.09 per share, the last reported sale price of our common stock on the New York Stock Exchange on March 31, 2005).

Actual common stock data are as of December 31, 2004 and excludes 694,452 shares issuable upon the exercise of options to purchase shares of common stock issued under our equity incentive plans at a weighted average price of $14.64 per share, of which options to purchase 417,352 shares were exercisable.

You should read the following table in conjunction with Management s Discussion and Analysis of Financial Condition and Results of Operations, and our consolidated financial statements and related notes included or incorporated by reference in this prospectus.

	December 31, 2004