MOLINA HEALTHCARE INC
Form S-1
March 02, 2004
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As filed with the Securities and Exchange Commission on March 2, 2004.

Registration No. 333-

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM S-1

REGISTRATION STATEMENT

UNDER

THE SECURITIES ACT OF 1933

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**6324**	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(Primary Standard Industrial Classification Code Number)**	**(I.R.S. Employer Identification Number)**

One Golden Shore Drive

Long Beach, CA 90802

(562) 435-3666

(Address, including zip code, and telephone number including area code, of registrant s principal executive offices)

J. Mario Molina, M.D.

President and Chief Executive Officer

One Golden Shore Drive

Long Beach, CA 90802

(562) 435-3666

(Name, address, including zip code, and telephone number including area code, of agent for service)

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Approximate date of commencement of proposed sale to the public: As soon as practicable after the effective date of this Registration Statement.

If any of the securities being registered on this form is to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933 check the following box. ¨

If this Form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ¨

If this Form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ¨

If this Form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ¨

If delivery of the prospectus is expected to be made pursuant to Rule 434 under the Securities Act, please check the following box. ¨

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Proposed Maximum Aggregate Offering Price(1)	Amount of Registration Fee
Common Stock, par value $0.001	$150,000,000	$19,005

(1) Estimated solely for the purpose of calculating the registration fee pursuant to rule 457(a) of the Securities Act of 1933.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until this Registration Statement shall become effective on such date as the Commission, acting pursuant to Section 8(a), may determine.

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The information contained in this prospectus is not complete and may be changed without notice. These securities may not be sold until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities, and it is not soliciting an offer to buy these securities, in any state where the offer or sale of these securities in not permitted.

PROSPECTUS (Not Complete)

Issued March [__], 2004

4,000,000 Shares

Common Stock

Molina Healthcare, Inc. is offering 2,000,000 shares of common stock and the selling stockholders identified in this prospectus are offering an additional 2,000,000 shares of common stock in a firmly underwritten offering. We will not receive any of the proceeds from the sale of the shares sold by the selling stockholders.

Our common stock is listed on the New York Stock Exchange under the symbol MOH. The last reported sale price of our common stock on March 1, 2004 was $32.53 per share.

Investing in the common stock involves a high degree of risk.

See Risk Factors beginning on page 7.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

	Per Share	Total
Offering Price	$ [_____]	$ [_____]
Discounts and Commissions to Underwriters	$ [_____]	$ [_____]
Offering Proceeds to Company	$ [_____]	$ [_____]
Offering Proceeds to Selling Stockholders	$ [_____]	$ [_____]

The underwriters also may purchase from Molina Healthcare, Inc. up to an additional 505,200 shares of common stock and from certain selling stockholders up to an additional 94,800 shares of common stock at the public offering price less the underwriting discounts and commissions, to cover any over-allotments. The underwriters can exercise this right at any time within 30 days after the offering. The underwriters expect to deliver the shares of common stock to investors on [_____], 2004.

Banc of America Securities LLC **CIBC World Markets**

SG Cowen

Legg Mason Wood Walker

Incorporated

The date of this prospectus is March , 2004.

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PROSPECTUS SUMMARY

Our Business

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. We were founded in 1980 by C. David Molina, M.D. as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, we received our license as a health maintenance organization, or HMO, and began operating as a health plan. Over the past several years, we have taken advantage of attractive expansion opportunities. We established a Utah health plan in 1997 and later acquired health plans in Michigan and Washington. We now operate health plans in California, Washington, Michigan and Utah. Our annual revenue has grown from $135.9 million in 1998 to $793.5 million in 2003, while our net income grew from $2.6 million to $42.5 million over the same period. As of December 31, 2003, we had approximately 564,000 members.

From our inception, we have designed our company to work with government agencies to serve low-income populations. Low-income families and individuals have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity. Our success has been driven by our expertise in working with government programs, experience with low-income members, 24 years of owning and operating primary care clinics, our cultural and linguistic expertise and our focus on operational and administrative efficiency.

Recent Developments

On February 23, 2004, we signed a definitive agreement to acquire, by merger with our newly formed subsidiary, the capital stock of Health Care Horizons, Inc., which is the parent company of New Mexico-based Cimarron Health Plan, for approximately $69.0 million, subject to adjustments. Health Care Horizons, Inc. has approximately $6.9 million in outstanding bank debt. We intend to fund the acquisition through available cash and expect to close the transaction by the third quarter of 2004, subject to regulatory approvals, the approval of Health Care Horizons, Inc. s shareholders and other closing conditions. Cimarron membership is comprised of approximately 66,000 Medicaid members and approximately 38,000 commercial members as of February 1, 2004. We expect to divest or transition the Cimarron commercial membership to focus on the Medicaid business. New Mexico represents a new market for us. We estimate the acquisition will generate annualized Medicaid revenues in the range of $255.0 million to $265.0 million in 2004. We expect the acquisition to result in approximately $0.05 to $0.07 of accretion to our earnings per share for the second half of 2004, assuming closing on July 1, 2004, and $0.14 to $0.18 of accretion to our earnings per share on an annualized basis subsequent to completion of integration which we expect to occur during 2005.

On February 27, 2004, our Washington subsidiary signed a definitive agreement to acquire the Medicaid and Basic Health contracts of Premera Blue Cross of Washington for $18.0 million, subject to regulatory approvals. As of February 1, 2004, the contracts to be transferred covered approximately 66,000 Medicaid and Basic Health members. The Basic Health program is similar to Medicaid but receives no federal funding. We expect the acquisition to close in the third quarter of 2004. We believe the addition of these members at closing will give us approximately 45% of eligible Medicaid and Basic Health members in Washington. We expect the acquisition to result in approximately $0.10 to $0.12 of accretion to our earnings per share for the second half of 2004, assuming closing on July 1, 2004, and $0.20 to $0.25 of accretion to our earnings per share on an annualized basis.

Our Industry

Medicaid provides health care coverage to low-income families and individuals and is jointly funded by state and federal governments. Each state establishes its own eligibility standards, benefit packages, payment

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rates and program administration within federal guidelines. In 2002, Medicaid covered approximately 51.0 million individuals, with 50% of those being children, according to the Kaiser Commission on Medicaid and the Uninsured. The federal Centers for Medicare and Medicaid Services estimates the total health care expenditures for Medicaid and the State Children s Health Insurance Program was $263.6 billion in 2002 and projects total outlays will reach $432.5 billion in 2008.

Under traditional Medicaid programs, health care services are made available to low-income individuals in a largely uncoordinated manner. Beneficiaries typically receive minimal preventive care and have limited access to primary care physicians. Treatment is often postponed until medical conditions become more acute, leading to higher utilization of costly emergency room services. In addition, providers are paid on a fee-for-service basis and lack incentives to monitor utilization and control costs. In response, the federal government has expanded the ability of state Medicaid agencies to explore and, in many cases, mandate the use of managed care for Medicaid beneficiaries. From 1996 to 2002, enrollment in Medicaid managed care programs increased from approximately 13.3 million to approximately 23.1 million, according to the Centers for Medicare and Medicaid Services. All states in which we operate have mandated Medicaid managed care programs.

Our Approach

We have built a successful Medicaid managed care company by integrating those capabilities that we believe have allowed us to compete in our industry. Our approach to managed care is based on the following key attributes:

Experience. We have significant expertise as a government contractor and a strong track record of obtaining and renewing contracts. We have served Medicaid beneficiaries as a provider and a health plan for 24 years. In that time we have developed and forged strong relationships with the constituents whom we serve members, providers and government agencies.

Administrative Efficiency. We maintain a disciplined focus on business processes, seeking to centralize functions where practical and standardize practices where appropriate across our health plans. As a result, we believe our administrative efficiency is among the best in our industry. In addition, we have designed our administrative and operational infrastructure to be scalable for rapid and cost-effective expansion in new and existing markets.

Proven Expansion Capability. We have successfully replicated our business model in existing and new markets through the acquisition of health plans, the development of new operations and the transition of members from other plans. The establishment of our health plan in Utah reflects our ability to replicate our business model in new states, while acquisitions in Michigan and Washington demonstrates our ability to acquire and successfully integrate existing operations in new and existing markets, respectively. We are now the market leader in Utah and Washington, and we have the third largest enrollment in Michigan and the third largest enrollment among non-governmental health plans in California.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We contract with providers that are suited, based on proximity, culture, language and experience, to provide services to our members. In addition, we operate 21 primary care clinics in California. These clinics require low capital expenditures, minimal startup time and are profitable. Our clinics provide select communities with access to primary care and provide us with insights into physician practice patterns, first hand knowledge of the needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. We have significant expertise in developing targeted health care programs for our culturally diverse members. We contract with a broad network of providers who have the

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capabilities to address the language and cultural needs of our members. We believe we are well-positioned to successfully serve this growing population.

Proven Medical Management. We believe our experience as a provider helps us to improve medical outcomes for our members. We carefully monitor day-to-day medical management in order to provide appropriate care to our members and ensure an efficient delivery network. We have also designed and implemented disease management and health education programs that address the particular health care needs of our members.

Our Strategy

Our objective is to be the leading managed care organization serving beneficiaries of Medicaid and other government-sponsored managed care programs for low-income families and individuals. To achieve this objective, we intend to:

- maintain our focus on serving low-income families and individuals,
- increase our membership through internal growth, development of new plans and acquisitions in existing and new markets,
- continue to actively manage our medical costs, and
- maximize our operational efficiencies.

Our Company

Molina Healthcare, Inc. was incorporated in California in 1999, as the parent company of our health plan subsidiaries, under the name American Family Care, Inc. We changed our name to Molina Healthcare, Inc. in March of 2000. We reincorporated in Delaware on June 26, 2003. 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 a part of this prospectus. Our company is the federally registered owner of the Molina service mark and name. All other product names, trademarks, service marks and trade names referred to are the property of their respective owners.

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THE OFFERING

Common stock offered by us	2,000,000 shares
Common stock offered by the selling stockholders	2,000,000 shares
Over-allotment option by us	505,200 shares
Over-allotment option by certain selling stockholders	94,800 shares
Common stock to be outstanding after this offering	27,472,225 shares
Use of proceeds	We intend to use the net proceeds of this offering primarily for acquisitions, expansions and general corporate purposes, including working capital.
New York Stock Exchange symbol	MOH

In the table above, the number of shares of common stock to be outstanding after this offering is based on the number of shares outstanding as of February 27, 2004. This information excludes:

- 698,760 shares of common stock issuable upon the exercise of vested stock options with a weighted average exercise price of $4.87 per share,
- 258,500 shares of common stock issuable upon the exercise of unvested stock options with a weighted average exercise price of $25.33 per share,
- 2,546,640 shares of common stock reserved for issuance under the 2002 Equity Incentive Plan, and
- 525,870 shares of common stock reserved for issuance under the 2002 Employee Stock Purchase Plan.

The information in this prospectus assumes no exercise of the underwriters over-allotment option, except where indicated in the table of principal and selling stockholders.

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SUMMARY CONSOLIDATED FINANCIAL DATA

The following tables summarize historical and pro forma, and as adjusted, consolidated financial data for our business. You should read the summary historical and pro forma consolidated financial data set forth below together with Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and the notes to those financial statements and the Unaudited Pro Forma Financial Information included elsewhere in this prospectus.

	Year Ended December 31,			
	2001	2002	2003	2003 Pro Forma(1)
	(dollars in thousands, except per share data)			
Statements of Income Data:				
Revenue:				
Premium revenue	$ 499,471	$ 639,295	$ 789,536	$ 1,133,280
Other operating revenue	1,402	2,884	2,247	4,232
Investment income	2,982	1,982	1,761	1,475
Total operating revenue	503,855	644,161	793,544	1,138,987
Expenses:				
Medical care costs	408,410	530,018	657,921	955,966
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	42,822	61,227	61,543	100,342
Depreciation and amortization	2,407	4,112	6,333	10,957
Total expenses	453,639	595,357	725,797	1,067,265
Operating income	50,216	48,804	67,747	71,722
Total other expense, net	(561)	(405)	(1,334)	(1,883)
Income before income taxes	49,655	48,399	66,413	69,839
Provision for income taxes	19,453	17,891	23,896	25,169
Income before minority interest	30,202	30,508	42,517	44,670
Minority interest	(73)			
Net income	30,129	30,508	42,517	44,670
Net income per share:				
Basic	1.51	1.53	1.91	2.01
Diluted	1.46	1.48	1.88	1.97
Weighted average number of common shares outstanding	20,000,000	20,000,000	22,224,000	22,224,000
	20,572,000	20,609,000	22,629,000	22,629,000

Weighted average number of common shares and potential dilutive common shares outstanding				
Operating Statistics:				
Medical care ratio (2)	81.5%	82.5%	83.1%	84.0%
Marketing, general and administrative expense ratio (3)	8.5%	9.5%	7.8%	8.8%
Members (4)	405,000	489,000	564,000	672,000

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	As of December 31,				
	2001	2002	2003	2003 As Adjusted(5)	2003 Pro Forma(1)
	(dollars in thousands)				
Balance Sheet Data:					
Cash, cash equivalents and investments	$ 102,750	$ 139,300	$ 240,672	$ 301,958	$ 220,515
Total assets	149,620	204,966	344,585	405,871	401,504
Long-term debt (including current maturities)	3,401	3,350			6,919
Total liabilities	84,861	109,699	123,263	123,263	180,182
Stockholders equity	64,759	95,267	221,322	282,608	221,322

(1) The pro forma data gives effect to the acquisition of Health Care Horizons, Inc. (including the commercial line of business) as if the pending acquisition had occurred at January 1, 2003, and excludes the pending Washington transaction.

(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 risk and savings sharing programs. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective healthcare 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) Marketing, general and administrative expense ratio represents such expenses as a percentage of total operating revenue.

(4) Number of members at end of year, excluding the pending Washington transaction.

(5) The as adjusted data gives effect to our receipt of approximately $61.3 million net proceeds from the sale of 2,000,000 shares of common stock offered by us at an assumed offering price of $32.53 per share after deducting estimated underwriting discounts and commissions and estimated offering expenses.

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RISK FACTORS

An investment in our common stock involves a high degree of risk. You should carefully consider the following factors and other information contained in this prospectus before you decide whether to invest in the shares. If any of the following risks actually occur, the market price of our common stock could decline and you may lose all or part of the money you paid to buy the shares. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties, including those not presently known to us or that we currently deem immaterial, also may result in decreased revenues, increased expenses or other events which could result in a decline in the price of our common stock.

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 state and federal 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 state and federal 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 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. All of the states in which we operate are presently considering legislation that would reduce reimbursement or payment levels by the state governments or reduce the number of persons eligible for Medicaid. Reductions in Medicaid payments could reduce our profitability if we are unable to reduce our expenses.

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. For example, in California, we contract with Health Net, Inc. for Los Angeles County. Health Net s contract for Los Angeles County will terminate in 2004 unless Health Net prevails in a competitive bidding process for the contract. If Health Net does not prevail in the bidding process or Health Net s contract for Los Angeles County is terminated with or without cause, or our subcontract with Health Net is terminated, we could lose all of our Los Angeles County Medi-Cal business, unless we make alternative arrangements. Absent earlier termination with or without cause, our Medi-Cal contracts for San Bernardino and Riverside Counties will also terminate in March 2005, unless they are renewed. In Washington, our Healthy Options contract will expire in December 2005, if not renewed. In Utah, our contract expires in June 2004. Our other contracts are also eligible for termination or 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 were unable to effectively manage medical costs, our profitability would 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

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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 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. While our estimates of claims incurred but not reported have been adequate in the past, they 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. If we estimate claims incurred but not reported too conservatively, we understate our profits, which could result in inaccurate disclosure to the public in our periodic reports.

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. Compliance with this law is uncertain and has and will continue to affect our profitability. Similarly, 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.

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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 the State Children s Health Insurance Program. 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.

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 theoretically 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 and expansion 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 and expansion, we believe that acquisitions and expansions 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

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terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete acquisitions and expansion initiatives, we may be unable to realize the anticipated benefits from acquisitions and expansions because of operational factors or difficulty in integrating the acquisition or expansion with the 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,
- additional members, who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing and record keeping systems, 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. In the case of an acquisition of a business located in a state in which we do not already operate, such as our pending New Mexico acquisition, we are 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 comply with these regulatory requirements for an acquisition in a timely manner, or at all.

Certain acquisitions, such as our pending New Mexico acquisition, are subject to approval of the shareholders of the company to be acquired. The shareholders of a target company could prevent a pending acquisition by failing to consent to the transaction.

For all of the above reasons, we may not be able to sustain our pattern of growth.

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

Depending on acquisition 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 2003, we had total revenue of $793.5 million. 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 and it may be difficult for us to execute our acquisition and expansion strategy.

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

We secured a $75.0 million credit facility which we plan to use for general corporate purposes and acquisitions. Our credit facility documents contain 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 my 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, all of whom have entered into employment agreements with us. These employment 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,

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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 and stock price.

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, 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 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, 2001, 2002 and 2003 without approval of the regulatory authorities were approximately $22.1 million, $28.9 million and $29.1 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.

Risks Associated With This Offering

We cannot guarantee that an active trading market for our common stock will be sustained.

We have only been a public company since July 2003. The average daily trading volume of our common stock on the New York Stock Exchange in 2003 and 2004 has been less than 120,000 shares. An active public market for our common stock may not be sustained after this offering. If an active trading market fails to be sustained, you may be unable to sell your shares of common stock at or above the price you paid.

Volatility of our stock price could adversely affect stockholders.

The market price of our common stock could fluctuate significantly as a result of:

- state and federal budget decreases,
- adverse publicity regarding health maintenance organizations and other managed care organizations,

- 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,

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- the operating and stock price performance of other comparable companies,
- the termination of our Medicaid or State Children s Health Insurance Program 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.

Investors may not be able to resell their shares of our common stock following periods of volatility because of the market s adverse reaction to such volatility. 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.

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 $22.69 the per share net tangible book value of our assets immediately following the offering (on an as adjusted basis as of December 31, 2003) and
- the investors in the offering will have contributed 23.0% of the total amount to fund us (before deducting the estimated underwriting discounts and commissions and offering expenses) but will own only 7.3% of our outstanding shares of our common stock.

As of February 27, 2004, we had outstanding options to purchase 957,260 shares of our common stock, of which 698,760 were vested. 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 to five year period. Once these options vest, you 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 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, the underwriters may release these shares from these restrictions at any time. In evaluating whether to grant such a request, the underwriters 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.

Based on shares outstanding as of February 27, 2004, approximately 17,624,255 restricted shares of common stock may be sold in the public market by existing stockholders 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.

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

Upon completion of this offering, our executive officers and directors will, in the aggregate, beneficially own approximately 23.7% of our capital stock. Members of the Molina family (some of whom are also officers or directors) will, in the aggregate, beneficially own approximately 56.9% of our capital stock, 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 themselves or together with our officers and directors, will have the ability to influence our management and affairs and the outcome of matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter and any merger, consolidation or sale of all or substantially all of our assets.

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 anti-takeover laws prevent Delaware corporations from engaging in business combinations with any stockholder, including all affiliates and associates of the stockholder, who owns 15.0% or more of the corporation s outstanding voting stock, for three years following the date that the stockholder acquired 15.0% or more of the corporation s voting stock unless specified conditions are met, as further described in Description of Capital Stock.

Our certificate of incorporation and bylaws 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 you and other 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.

You should rely only on the information contained in this prospectus. We have not authorized anyone to provide you with different information. We are not making an offer to sell these securities in any jurisdiction where the offer or sale is not permitted. You should assume that the information appearing in this prospectus is accurate as of the date on the front cover of this prospectus only. Our business, financial condition, results of operations and prospects may have changed since that date.

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FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements that involve risks and uncertainties. These forward-looking statements are often accompanied by words such as believe, anticipate, plan, expect, estimate, intend, seek, goal, may, will, and similar expressions include, without limitation, statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions and investments and the adequacy of our available cash resources. These statements may be found in the sections of this prospectus entitled Prospectus Summary, Risk Factors, Use of Proceeds, Management s Discussion and Analysis of Financial Condition and Results of Operations and Business. Investors are cautioned that matters subject to forward-looking statements involve risks and uncertainties, including economic, regulatory, competitive and other factors that may affect our business. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

Actual results may differ from projections or estimates due to a variety of important factors. Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other operating expenses. A variety of factors, including competition, changes in health care practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payors, major epidemics, disasters and numerous other factors affecting the delivery and cost of health care, such as major health care providers inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs and other operating expenses. Once set, premiums are generally fixed for one year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. The expiration, cancellation or suspension of our HMO contracts by the federal and state governments would also negatively impact us.

Due to these factors and risks, no assurance can be given with respect to our future premium levels or our ability to control our future medical costs.

From time to time, legislative and regulatory proposals have been made at the federal and state government levels related to the health care system, including but not limited to limitations on managed care organizations (including benefit mandates) and reform of the Medicaid program. Such legislative and regulatory action could have the effect of reducing the premiums paid to us by governmental programs or increasing our medical costs. We are unable to predict the specific content of any future legislation, action or regulation that may be enacted or when any such future legislation or regulation will be adopted. Therefore, we cannot predict accurately the effect of such future legislation, action or regulation on our business.

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USE OF PROCEEDS

We estimate that we will receive net proceeds from the sale of the shares of common stock in this offering of $61.3 million, based on an assumed public offering price of $32.53 per share and after deducting estimated underwriting discounts and commissions and estimated offering expenses. If the underwriters exercise their over-allotment option in full, we estimate that our net proceeds will be $76.9 million. We will not receive any of the proceeds from the sale of common stock by the selling stockholders.

The principal purposes of this offering are to obtain additional capital and to facilitate future access to public debt and equity markets. As of the date of this prospectus, we have no specific plans to use the net proceeds from this offering (including the over-allotment option, if exercised) other than as set forth below:

- pursue acquisitions and expansions of health plans and contracts for government sponsored health programs in existing and new markets, and
- general corporate purposes, including working capital.

We have not determined the amount of net proceeds to be used specifically for the foregoing purposes. As a result, management will have broad discretion over the use of the proceeds from this offering. Pending any such uses, we intend to invest the net proceeds in interest bearing securities.

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PRICE RANGE OF COMMON STOCK

Our common stock has been listed for trading on the New York Stock Exchange under the symbol MOH since our initial public offering on July 2, 2003. Prior to that time, there was no public market for the common stock. The following table sets forth, for the periods indicated, the high and low sales prices per share of our common stock as reported by the New York Stock Exchange.

Date Range	High Sales Price	Low Sales Price
July 2, 2003 to September 30, 2003	$ 27.75	$ 20.00
October 1, 2003 to December 31, 2003	$ 29.00	$ 21.75
January 1, 2004 to March 1, 2004	$ 32.81	$ 23.25

On March 1, 2004, the last reported sale price of our common stock on the New York Stock Exchange was $32.53 per share. As of February 27, 2004, there were approximately 1,318 holders of our common stock, including record holders and individual participants in a security position listing.

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DIVIDEND POLICY

We have in the past declared and paid cash dividends on our common stock. There were no dividends declared in 2003, 2002, 2001 or 1999. Dividends in the amount at $1,000,000 were declared in 2000. 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 following table shows our cash, cash equivalents and capitalization, as of December 31, 2003:

- on an actual basis, unadjusted for any exercise of outstanding options to purchase common stock that were vested at December 31, 2003, and
- on an as adjusted basis to reflect the issuance and sale of 2,000,000 shares of common stock by us in this offering at an assumed public offering price of $32.53 per share less estimated underwriting discounts and commissions and estimated offering expenses payable by us.

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 appearing elsewhere in this prospectus.

	December 31, 2003	
	Actual	As Adjusted
	(dollars in thousands, except per share data)	
Cash, cash equivalents and investments	$ 240,672	$ 301,958
Stockholders equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 25,373,785 shares actual; 27,373,785 shares as adjusted	25	27
Preferred stock, $0.001 par value; 20,000,000 shares authorized; no shares issued and outstanding, actual or as adjusted		
Additional paid-in capital	103,854	165,138
Accumulated other comprehensive income	54	54
Retained earnings	137,779	137,779
Treasury stock	(20,390)	(20,390)
Total stockholders equity	221,322	282,608

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SELECTED CONSOLIDATED FINANCIAL DATA

We derived the following selected consolidated financial data for the five years ended December 31, 2003 from our audited consolidated financial statements. The pro forma information is unaudited and has been derived from the unaudited Pro Forma Financial Information included herein. You should read the data in conjunction with our consolidated financial statements, related notes, and other financial information included herein.

	Year Ended December 31,					
	1999	2000(1)	2001(1)	2002(1)	2003(1)	2003 Pro Forma(2)
	(dollars in thousands, except per share data)					
Statements of Income Data:						
Revenue:						
Premium revenue	$ 181,929	$ 324,300	$ 499,471	$ 639,295	$ 789,536	$ 1,133,280
Other operating revenue	2,358	1,971	1,402	2,884	2,247	4,232
Investment income	1,473	3,161	2,982	1,982	1,761	1,475
Total operating revenue	185,760	329,432	503,855	644,161	793,544	1,138,987
Expenses:						
Medical care costs	148,138	264,408	408,410	530,018	657,921	955,966
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	18,511	38,701	42,822	61,227	61,543	100,342
Depreciation and amortization	1,625	2,085	2,407	4,112	6,333	10,957
Total expenses	168,274	305,194	453,639	595,357	725,797	1,067,265
Operating income	17,486	24,238	50,216	48,804	67,747	71,722
Total other expense, net	(1,190)	(197)	(561)	(405)	(1,334)	(1,883)
Income before income taxes	16,296	24,041	49,655	48,399	66,413	69,839
Provision for income taxes	6,576	9,156	19,453	17,891	23,896	25,169
Income before minority interest	9,720	14,885	30,202	30,508	42,517	44,670
Minority interest	(267)	79	(73)			
Net income	9,453	14,964	30,129	30,508	42,517	44,670
Net income per share:						
Basic	0.47	0.75	1.51	1.53	1.91	2.01
Diluted	0.47	0.73	1.46	1.48	1.88	1.97

Cash dividends declared per Share		0.05				
Weighted average number of common shares outstanding (3)	20,000,000	20,000,000	20,000,000	20,000,000	22,224,000	22,224,000
Weighted average number of common shares and potential dilutive common shares outstanding (3)	20,173,000	20,376,000	20,572,000	20,609,000	22,629,000	22,629,000
Operating Statistics:						
Medical care ratio (4)	80.4%	81.0%	81.5%	82.5%	83.1%	84.0%
Marketing, general and administrative expense ratio (5)	10.0%	11.7%	8.5%	9.5%	7.8%	8.8%
Members (6)	199,000	298,000	405,000	489,000	564,000	672,000

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	As of December 31,						
	1999(1)	2000(1)	2001(1)	2002(1)	2003(1)	2003 As Adjusted(7)	2003 Pro Forma(2)
	(dollars in thousands, except per share data)						
Balance Sheet Data:							
Cash, cash equivalents and investments	$ 26,120	$ 45,785	$ 102,750	$ 139,300	$ 240,672	$ 301,958	$ 220,515
Total assets	101,636	102,012	149,620	204,966	344,585	405,871	401,504
Long-term debt (including current maturities)	17,296	3,448	3,401	3,350			6,919
Total liabilities	80,991	67,405	84,861	109,699	123,263	123,263	180,182
Stockholders equity	20,645	34,607	64,759	95,267	221,322	282,608	221,322

(1) The balance sheet and operating results of the Washington health plan have been included in the consolidated balance sheet as of December 31, 1999, the date of acquisition, and in each of the consolidated statements of income for periods thereafter.

(2) The pro forma data gives effect to the acquisition of Health Care Horizons, Inc. (including the commercial line of business) as if the pending acquisition had occurred at January 1, 2003, and excludes the pending Washington transaction.

(3) The weighted average number of common shares and potential dilutive common shares outstanding for 1999 has been adjusted to reflect a share exchange in 1999 in which each share of Molina Healthcare of California (formerly Molina Medical Centers) was exchanged for 5,000 shares of Molina Healthcare, Inc. (formerly American Family Care, Inc.), and Molina Healthcare, Inc. became the parent company.

(4) 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 risk and savings sharing programs. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective healthcare 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.

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

(6) Number of members at end of year, excluding the pending Washington transaction.

(7) The as adjusted data gives effect to our receipt of approximately $61.3 million in net proceeds from the sale of 2,000,000 shares of common stock offered by us at an assumed offering price of $32.53 per share after deducting estimated underwriting discounts and commissions and estimated offering expenses.

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UNAUDITED PRO FORMA FINANCIAL INFORMATION

The following Unaudited Pro Forma Condensed Consolidated Financial Statements give effect to the pending purchase of Health Care Horizons, Inc., or the HCH Purchase. The Unaudited Pro Forma Condensed Consolidated Statement of Income for the year ended December 31, 2003 gives effect to the HCH Purchase as if it had occurred on January 1, 2003. The Unaudited Pro Forma Condensed Consolidated Balance Sheet presents our financial position at December 31, 2003 giving effect to the HCH Purchase as if it had occurred on that date.

The HCH Purchase will be accounted for under the purchase method of accounting. Accordingly, the amount of the consideration to be paid will be allocated to assets acquired and liabilities assumed based on their estimated fair values. The excess of such consideration over the estimated fair value of such assets and liabilities has been preliminarily allocated to certain identifiable intangible assets and goodwill. The purchase price allocation may be adjusted upon completion of the final valuation of the assets and liabilities of Health Care Horizons, Inc. The effect of any such adjustment is not expected to be significant. The Unaudited Pro Forma Condensed Consolidated Financial Statements do not give effect to any synergies that may be realized as a result of the HCH Purchase, management s intent to divest or transition the Health Care Horizons, Inc. commercial line of business, management s plan to terminate employees, abandon leases and incur other costs involving the exit of one or more activities shortly after closing the HCH Purchase and nonrecurring/unusual restructuring charges that may be incurred as a result of the integration of Health Care Horizons, Inc. The amount of such charges cannot be reasonably determined at this time.

The Unaudited Pro Forma Condensed Consolidated Financial Statements are provided for informational purposes only and do not purport to present the combined financial position or results of operations of Molina Healthcare, Inc. and Health Care Horizons, Inc. had the acquisition assumed therein occurred on the dates specified, nor are they necessarily indicative of the results of operations that may be expected in the future.

The Unaudited Pro Forma Condensed Consolidated Financial Statements should be read in conjunction with: (i) our historical financial statements, and the notes thereto, which are included in this Prospectus, and (ii) the selected historical financial data appearing elsewhere in this Prospectus.

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MOLINA HEALTHCARE, INC.

UNAUDITED PRO FORMA CONDENSED CONSOLIDATED STATEMENT OF INCOME

For the Year Ended December 31, 2003

(dollars in thousands, except per share data)

	Molina Healthcare, Inc.	Health Care Horizons, Inc.	Pro Forma Adjustments(a)	Pro Forma Consolidated
Revenue:				
Premium revenue	$ 789,536	$ 343,744		$ 1,133,280
Other operating revenue	2,247	1,985		4,232
Investment income	1,761	452	$ (738)(b)	1,475
Total operating revenue	793,544	346,181	(738)	1,138,987
Expenses:				
Medical care costs	657,921	298,045		955,966
Marketing, general and administrative expenses	61,543	38,799		100,342
Depreciation and amortization	6,333	624	4,000(c)	10,957
Total expenses	725,797	337,468	4,000	1,067,265
Operating income	67,747	8,713	(4,738)	71,722
Total other expense, net	(1,334)	(549)		(1,883)
Income (loss) before income taxes	66,413	8,164	(4,738)	69,839
Provision for income taxes	23,896	3,073	(1,800)(e)	25,169
Net income (loss)	42,517	5,091	(2,938)	44,670
Basic income per share	1.91			2.01
Diluted income per share	1.88			1.97
Weighted average number of common shares outstanding	22,224,000			22,224,000
Weighted average number of common shares and potential dilutive common shares outstanding	22,629,000			22,629,000

See accompanying notes.

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MOLINA HEALTHCARE, INC.

UNAUDITED PRO FORMA CONDENSED CONSOLIDATED BALANCE SHEET

December 31, 2003

(dollars in thousands)

	Molina Healthcare, Inc.	Health Care Horizons, Inc.	Pro Forma Adjustments(a)	Pro Forma Consolidated
Assets				
Current assets:				
Cash, cash equivalents and investments	$ 240,672	$ 48,843	$ (69,000)(d)	$ 220,515
Receivables	53,689	5,163		58,852
Deferred income taxes	2,442			2,442
Prepaid and other current assets	5,254	3,673		8,927
Total current assets	302,057	57,679	(69,000)	290,736
Property and equipment, net	18,380	1,541		19,921
Goodwill and intangible assets, net	12,284	7,321	58,814(d)	78,419
Restricted investments	2,000			2,000
Deferred income taxes	1,996	482		2,478
Advances to related parties and other assets	7,868	82		7,950
Total assets	344,585	67,105	(10,186)	401,504
Liabilities and stockholders equity				
Current liabilities:				
Medical claims and benefits payable	105,540	30,151		135,691
Deferred revenue		773		773
Accounts payable and accrued liabilities	11,419	7,701	300(d)	19,420
Income taxes payable	2,882	2,738		5,620
Current maturities of long-term debt		2,400		2,400
Total current liabilities	119,841	43,763	300	163,904
Long-term debt, less current maturities		4,519		4,519
Other long-term liabilities	3,422	737		4,159
Deferred income taxes			7,600(d)	7,600
Total liabilities	123,263	49,019	7,900	180,182
Commitments and contingencies				
Stockholders equity:				
Common stock	25	4	(4)(d)	25
Preferred stock				
Paid-in capital	103,854	4,734	(4,734)(d)	103,854
Accumulated other comprehensive income	54			54
Retained earnings	137,779	13,348	(13,348)(d)	137,779
Treasury stock	(20,390)			(20,390)

Total stockholders equity	221,322	18,086	(18,086)	221,322
Total liabilities and stockholders equity	344,585	67,105	(10,186)	401,504

See accompanying notes.

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MOLINA HEALTHCARE, INC.

NOTES TO UNAUDITED PRO FORMA CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(dollars in thousands)

December 31, 2003

a. **Integration synergies.** Molina Healthcare, Inc. believes that it will achieve synergies from the integration of the acquisition by eliminating redundant administrative costs and using its increased purchasing power to achieve lower health care and general and administrative expenses. The anticipated impact of such synergies, estimated at $3,000 to $4,000 per year on a pre-tax basis, as well as the anticipated divestiture or transition of the commercial line of business of Health Care Horizons, Inc. (which recorded approximately $113,900 in premium revenue in 2003) have not been reflected in the Unaudited Pro Forma Condensed Consolidated Statement of Income. The Unaudited Pro Forma Condensed Consolidated Financial Statements do not reflect management s plan to terminate employees, abandon leases, and incur other costs involving the exit of one or more activities shortly after closing the HCH Purchase, and any nonrecurring/unusual restructuring charges (which are estimated at $2,500) that may be incurred as a result of the integration of Health Care Horizons, Inc.

b. **Investment income.** This pro forma adjustment reflects a reduction to investment income of $738 assuming a payment of $69,300 for Health Care Horizons, Inc. on January 1, 2003. The pro forma decrease in investment income assumes the payment of the acquisition cost on January 1, 2003 and a return on investment of 1.07%.

c. **Amortization of intangibles.** This pro forma adjustment reflects the amortization of a Medicaid service contract with the state of New Mexico valued at approximately $20,000 arising from the acquisition that is classified as an identifiable intangible asset. This identifiable intangible asset is being amortized on a straight-line basis over 60 months. We ceased amortization of goodwill effective January 1, 2002 in accordance with Statement of Financial Accounting Standards No. 142, Goodwill and Other Intangible Assets .

d. **Goodwill and intangible assets.** The following is an analysis of estimated goodwill and intangible assets in connection with the acquisition:

Purchase price consideration	$ 69,000
Direct transaction costs	300
Total purchase price	69,300
Less net assets acquired	(18,086)
Add back goodwill included in net assets acquired	7,321
Acquisition cost in excess of net assets acquired	58,535

Allocation of acquisition cost in excess of net assets acquired:

Allocation to identifiable intangible assets	
Medicaid contract	$ 20,000

Allocation to other than identifiable intangible assets	
Goodwill before deferred tax adjustment	38,535
Less Health Care Horizons, Inc. goodwill	(7,321)
	31,214
Pro forma increase in deferred tax liability due to step up in identifiable intangible assets	7,600
Pro forma increase in goodwill	38,814
Net pro forma adjustment to goodwill and intangible assets	58,814

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e. **Provision for income taxes.** Pro forma adjustment to reflect the tax effect of the acquisition at statutory rates in effect during the fiscal year ended December 31, 2003.

Pro forma adjustments to income before income taxes	$ 4,738
Statutory tax rate	38%
Pro forma adjustment	1,800

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion of our financial condition and results of operations should be read in conjunction with the Selected Consolidated Financial Data and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this prospectus. The following discussion contains forward-looking statements based upon current expectations and related to future events and our future financial performance that involve risks and uncertainties. Our actual results and timing of events could differ materially from those anticipated in these forward-looking statements as a result of many factors, including those set forth under Risk Factors, Forward-Looking Statements and Business and elsewhere in this prospectus.

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. Our objective is to become the leading managed care organization in the United States focused primarily on serving people who receive health care benefits through state-sponsored programs for low income populations.

We generate revenues primarily from premiums we receive from the states in which we operate. In 2003 we received approximately 84% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies and other managed care organizations with which we operate as a subcontractor. These are recognized as premium revenue in the month members are entitled to receive health care services. We also received approximately 5% of our premium revenue from the Medicaid programs in Washington and Michigan for newborn deliveries, or birth income, on a per case basis which are recorded in the month the deliveries occur. Premium revenue is fixed in advance of the periods covered and is not subject to significant accounting estimates. Approximately 11% of our premium revenue in 2003 was realized under a cost plus reimbursement agreement that our Utah subsidiary has with that state. Premium rates are periodically adjusted by the state Medicaid programs.

Membership growth has been the primary reason for our increasing revenues. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members in each of our service areas in the periods presented. The 2003 Pro Forma information gives effect to our acquisition of Health Care Horizons, Inc. as if such acquisition had occurred as of December 31, 2003. The enrollment information for Health Care Horizons, Inc. excludes commercial membership. The 2003 Pro Forma information does not give effect to our pending Washington acquisition.

	As of December 31,			
Market	2001	2002	2003	2003 Pro Forma
California	229,000	253,000	254,000	254,000
Washington	134,000	161,000	183,000	183,000
Michigan	26,000	33,000	82,000	82,000
Utah	16,000	42,000	45,000	45,000
New Mexico (pending)				66,000

Total	405,000	489,000	564,000	630,000

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The following table sets forth the approximate percentages of our total enrollment in each of our service areas in the periods presented. The 2003 Pro Forma information gives effect to our acquisition of Health Care Horizons, Inc. as if such acquisition had occurred as of December 31, 2003. The enrollment information for Health Care Horizons, Inc. excludes commercial membership. The 2003 Pro Forma information does not give effect to our pending Washington acquisition.

	As of December 31,			
				2003
Market	2001	2002	2003	Pro Forma
California	56.5%	51.7%	45.0%	40.3%
Washington	33.1%	32.9%	32.5%	29.1%
Michigan	6.4%	6.8%	14.5%	13.0%
Utah	4.0%	8.6%	8.0%	7.1%
New Mexico (pending)				10.5%
Total	100.0%	100.0%	100.0%	100.0%

Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California and savings sharing revenues in California and Michigan where we receive additional incentive payments from the states if inpatient medical costs are less than prescribed amounts.

Our operating expenses include expenses related to medical care services and marketing, general and administrative, or MG&A, costs. Our results of operations depend on our ability to effectively manage expenses related to health benefits and accurately predict costs incurred.

Expenses related to medical care services include two components: direct medical expenses and medically related administrative costs. Direct medical expenses include payments to physicians, hospitals and providers of ancillary medical services, such as pharmacy, laboratory and radiology services. Medically related administrative costs include expenses relating to health education, quality assurance, case management, disease management, 24 hour on-call nurses, member services and compliance. In general primary care physicians are paid on a capitation basis (a fixed amount per member per month regardless of actual utilization of medical services), while specialists and hospitals are paid on a fee-for-service basis. For the year ended December 31, 2003, approximately 75% of our direct medical expenses were related to fees paid to providers on a fee-for-service basis with the balance paid on a capitation basis. Physician providers not paid on a capitated basis are paid on a fee schedule set by the state or our contracts with our providers. We pay hospitals in a variety of ways, including fee-for-service, per diems, diagnostic related groups and case rates.

Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. Fee-for-service payments are expensed in the period services are provided to our members. Medical care costs include actual historical claims experience and estimates of medical expenses incurred but not reported, or IBNR. Monthly, we estimate our IBNR based on a number of factors, including prior claims experience, inpatient hospital utilization data and prior authorization of medical services. As part of this review, we also consider estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership and medical cost trends. These estimates are adjusted monthly as more information becomes available. We use the service of independent actuaries to review our estimates monthly and certify them quarterly. We believe our process for estimating IBNR is adequate, but there can be no assurance that medical care costs will not exceed such estimates.

MG&A costs are largely comprised of wage and benefit costs related to our employee base and other administrative expenses. Some of these services are provided locally, while others are delivered to our health plans from a centralized location. The major centralized functions are claims processing, information systems, finance and accounting and legal and regulatory. Locally provided functions include marketing, plan administration and provider relations. Included in MG&A expenses are premium taxes for the Washington and (beginning in the second quarter of 2003) Michigan health plans, as those states assess taxes based on premium revenue.

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Subsequent Events

On February 23, 2004, we signed a definitive agreement to acquire, by merger with our newly formed subsidiary, the capital stock of Health Care Horizons, Inc., which is the parent company of New Mexico-based Cimarron Health Plan, for approximately $69.0 million, subject to adjustments. Health Care Horizons, Inc. has approximately $6.9 million in outstanding bank debt. We intend to fund the acquisition through available cash and expect to close the transaction by the third quarter of 2004, subject to regulatory approvals, the approval of Health Care Horizons, Inc. s shareholders and other closing conditions. Cimarron membership is comprised of approximately 66,000 Medicaid members and approximately 38,000 commercial members as of February 1, 2004. We expect to divest or transition the Cimarron commercial membership to focus on the Medicaid business. New Mexico is a new market for us. We estimate the acquisition will generate annualized Medicaid revenues in the range of $255.0 million to $265.0 million in 2004. We expect the acquisition to result in approximately $0.05 to $0.07 of accretion to our earnings per share for the second half of 2004, assuming closing on July 1, 2004, and $0.14 to $0.18 of accretion to earnings per share on an annualized basis subsequent to completion of integration which we expect to occur during 2005.

On February 27, 2004, our Washington subsidiary signed a definitive agreement to acquire the Medicaid and Basic Health contracts of Premera Blue Cross of Washington for $18.0 million, subject to regulatory approvals. As of February 1, 2004, the contracts to be transferred covered approximately 66,000 Medicaid and Basic Health members. The Basic Health program is similar to Medicaid but receives no federal funding. We expect acquisition to close in the third quarter of 2004. We believe the addition of these members at closing will give us approximately 45% of eligible Medicaid and Basic Health members in Washington. We expect the acquisition to result in approximately $0.10 to $0.12 of accretion to our earnings per share for the second half of 2004, assuming closing on July 1, 2004, and $0.20 to $0.25 of accretion to our earnings per share on an annualized basis.

Results of Operations

The following table sets forth selected operating ratios. All ratios with the exception of the medical care ratio are shown as a percentage of total operating revenue. The medical care ratio is shown as a percentage of premium and other operating revenue because there is a direct relationship between the premiums and other operating revenue earned and the cost of health care.

	Year Ended December 31,		
	2001	2002	2003
Premium revenue	99.1%	99.2%	99.5%
Other operating revenue	0.3%	0.5%	0.3%
Investment income	0.6%	0.3%	0.2%
Total operating revenue	100.0%	100.0%	100.0%
Medical care ratio	81.5%	82.5%	83.1%
Marketing, general and administrative expenses	8.5%	9.5%	7.8%
Operating income	10.0%	7.6%	8.5%
Net income	6.0%	4.7%	5.4%

Year Ended December 31, 2003 Compared to Year Ended December 31, 2002

Premium Revenue

Premium revenue for the year ended December 31, 2003 was $789.5 million, up $150.2 million (23.5%) from $639.3 million for the year ended December 31, 2002. Membership growth contributed $109.5 million to the increase in revenue. Year-over-year enrollment increased 15.3% to 564,000 members at December 31, 2003, from 489,000 members at the same date of the prior year. Membership growth was most pronounced at our

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Michigan HMO, which saw year-over-year enrollment increase to 82,000 from 33,000. The Michigan HMO added 9,400 and 32,000 members in the third and fourth quarters of 2003, respectively, as a result of the acquisition of Medicaid contracts from other health plans. The remainder of the additional revenue, or $40.7 million, was attributable to increases in premium rates and proportionally greater increases in membership in those states with higher premium rates.

Other Operating Revenue

Other operating revenue decreased to $2.2 million for the year ended December 31, 2003 from $2.9 million for the year ended December 31, 2002. The decrease was the result of reduced savings sharing revenue at our California and Michigan HMOs.

Investment Income

Investment income for the year ended December 31, 2003 decreased to $1.8 million from $2.0 million for the year ended December 31, 2002 due to lower investment yields, which were partially offset by greater invested balances.

Medical Care Costs

Medical care costs for the year ended December 31, 2003 were $657.9 million, representing 83.1% of premium and other operating revenue for all of 2003, as compared with $530.0 million, representing 82.5% of premium and other operating revenue, for 2002. The increase in the medical care ratio was due to increases in specialty, hospital and pharmacy expenses, partially offset by reduced capitation costs. Additionally, medical margins in 2003 were reduced by changes in the state of Washington s method of compensating Molina for certain healthcare costs reimbursed by the Supplemental Security Income program.

Marketing, General and Administrative Expenses

MG&A expenses for the year ended December 31, 2003, were $61.5 million as compared with $53.4 million (after deducting $7.8 million in stock option settlement expenses) for the year ended December 31, 2002. The increase was primarily due to an increase in premium tax expense of $4.2 million in 2003. MG&A expenses as a percentage of operating revenue were 7.8% for the year ended December 31, 2003 as compared with 8.3% (adjusted for the stock option settlement expense) for the year ended December 31, 2002.

Depreciation and Amortization

Depreciation and amortization expense for the year ended December 31, 2003 increased to $6.3 million from $4.1 million for the year ended December 31, 2002. The increase was primarily due to increased capital spending for computer equipment and leasehold improvements.

Interest Expense

Interest expense increased to $1.5 million for the year ended December 31, 2003 from $0.4 million for the year ended December 31, 2002. Interest expense increased due to the amortization of loan fee expenses associated with our credit facility, as well as the payment of interest on amounts borrowed under that facility. Interest expense was reduced by our repayment of a mortgage note in the second quarter of 2003.

Provision for Income Taxes

Income taxes totaled $23.9 million in 2003, resulting in an effective tax rate of 36.0%, as compared to $17.9 million in 2002, or an effective tax rate of 37.0%. The lower 2003 tax rate was due to: (i) our Washington health plan, which does not pay state income taxes, generated a greater percentage of our total earnings; and (ii) $1.6 million of California Economic Development Tax Credits (Credits) generated in 2003 as compared to

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$.4 million generated in 2002. Approximately $1.0 million of the 2003 Credits relate to prior years that are being recovered through amended state tax filings. The table below includes a breakdown of the total 2003 Credits, net of recovery fees paid to consultants (included in marketing, general and administrative expenses).

	Reduced Income Taxes	Recovery Fees	Net Income	Diluted Earnings Per Share
2003	$ 585	$ 107	$ 478	$ .02
Prior years	1,034	189	845	.04
Total 2003 Credits	$ 1,619	$ 296	$ 1,323	$ .06

The prior year credit recognized in 2003, net of recovery fees, of $845 ($.04 per diluted share) was accounted for as a change in estimate. We are continuing to validate prior year credits and expect to recognize additional credits in 2004 as claims are filed with the state of California.

Year Ended December 31, 2002 Compared to Year Ended December 31, 2001

Premium Revenue

Premium revenue increased 28.0% or $139.8 million to $639.3 million in 2002 from $499.5 million in 2001, due to internal and acquisition-related membership growth, premium rate increases and changes in our Utah Medicaid contract. Approximately $115.7 million of the increase was due to membership growth, which increased 20.7% from 405,000 at December 31, 2001 to 489,000 at December 31, 2002. Of this increase, approximately 14,000 members were added through an acquisition by our Washington health plan effective July 1, 2002. Our health plans also received average annual rate increases of 3.2% which increased premium revenue by approximately $15.8 million in 2002. A revision in the Utah health plan contract effective July 1, 2002 resulted in approximately $8.3 million in additional revenues during the six month period ended December 31, 2002 as compared to 2001.

Other Operating Revenue

Other operating revenue increased 105.7% or $1.5 million to $2.9 million in 2002 from $1.4 million in 2001, primarily due to favorable settlements under savings sharing programs. During 2002, the Michigan and California HMOs received $1.2 million in savings sharing incentives for prior contract periods, which were in excess of amounts previously estimated.

Investment Income

Investment income primarily includes interest and dividend income. Investment income decreased 33.5% or $1.0 million to $2.0 million in 2002 from $3.0 million in 2001 due to lower investment yields, which was partially offset by an increase in the amount of funds invested.

Medical Care Costs

Medical care costs increased 29.8% or $121.6 million to $530.0 million in 2002 from $408.4 million in 2001. The medical care ratio for 2002 increased to 82.5% from 81.5% in 2001. The increase was attributed to higher inpatient costs in Michigan and specialty costs in California. Increased specialty costs primarily relate to emergency room visits and outpatient surgeries. The increased costs were partially offset by premium rate increases and additional revenues under the revised Utah Medicaid contract effective July 1, 2002.

Marketing, General and Administrative Expenses

MG&A expenses increased 43.0% or $18.4 million to $61.2 million in 2002 from $42.8 million in 2001. $9.5 million of the increase was due to increased personnel costs required to support our membership growth.

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Our employees, measured as full-time equivalents, increased from approximately 713 at December 31, 2001 to approximately 830 at December 31, 2002. Additionally during 2002, we agreed to acquire fully vested options to purchase 735,200 shares of our common stock from two executives for total cash payments of $8.7 million. The cash settlements resulted in a fourth quarter 2002 compensation charge of $7.8 million ($4.9 million net of tax effect). See Note 9 to the Consolidated Financial Statements. Premium taxes and regulatory fees also increased by $1.6 million in 2002 as compared to 2001 due to membership growth in the Washington health plan which pays premium taxes on revenue in lieu of state income taxes. Excluding the charge for stock option settlements, our MG&A expense ratio decreased to 8.3% for 2002, from 8.5% in 2001, due to higher total operating revenue in 2002.

Depreciation and Amortization

Depreciation and amortization expense increased 70.8% or $1.7 million to $4.1 million in 2002 from $2.4 million in 2001. During 2002, the Washington and California health plans recorded amortization expense related to intangible assets that were acquired through the assignment of Medicaid contracts in July 2002 and December 2001, respectively. These assets are amortized over the related contract terms (including renewal periods), not exceeding 18 months. Total amortization expense was $2.0 million in 2002 as compared to $0.4 million in 2001. Increased capital expenditures in computers and equipment accounted for the remaining increase.

Provision for Income Taxes

Income taxes totaled $17.9 million in 2002, resulting in an effective tax rate of 37.0%, as compared to $19.5 million in 2001, or an effective tax rate of 39.2%. The lower rate in 2002 was due to increased earnings generated from our Washington health plan which does not pay state income taxes and $0.4 million in additional California tax credits.

Acquisitions

Effective August 1, 2003 approximately 9,400 members were transferred to our Michigan HMO under the terms of an agreement with another health plan. Effective October 1, 2003 approximately 32,000 members were transferred to our Michigan HMO under the terms of an agreement with another health plan. Total costs associated with these two transactions were $8.9 million. In both instances the entire cost of the transaction was recorded as an identifiable intangible asset and is being amortized over 60 months.

Liquidity and Capital Resources

We generate cash from premium revenue, services provided on a fee-for-service basis at our clinics and investment income. Our primary uses of cash include the payment of expenses related to medical care services, MG&A expenses and acquisitions. From time to time, we may need to raise capital and draw on the credit facility in order to fund geographic and product expansions and acquisitions of health care businesses. We generally receive premium revenue in advance of payment of claims for related health care services, with the exception of our Utah HMO.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets. As of December 31, 2003, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. As of December 31, 2003, our investments consisted solely of investment grade debt securities (all of which are classified as current assets) with a maximum maturity of five years and an average duration of two years. Three professional portfolio managers operating under documented investment guidelines manage our investments. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds.

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The average annualized portfolio yield for the years ended December 31, 2001, 2002 and 2003 was approximately 4.5%, 1.7% and 1.1%, respectively.

In July 2003 we completed an initial public offering of our common stock. We sold 7,590,000 shares, generating net proceeds of approximately $119.6 million after deducting approximately $3.9 million in fees, costs and expenses and $9.3 million in underwriters discount.

Net cash provided by operating activities was $61.4 million in 2001, $45.7 million in 2002 and $45.6 million in 2003. Because we generally receive premium revenue in advance of payment for the related medical care costs (with the exception of our Utah health plan), our cash available has increased during periods when we experienced enrollment growth. Our ability to support the increase in membership with existing infrastructure also allows us to retain a larger portion of the additional premium revenue as profit.

We had working capital of $74.6 million at December 31, 2002 and $182.2 million at December 31, 2003. At December 31, 2002 and 2003, we had cash, cash equivalents and investments of $139.3 million and $240.7 million, respectively. Increased working capital and cash, cash equivalent, and investment balances at December 31, 2003 were principally the result of our initial public offering of common stock and cash flow provided by operating activities.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various jurisdictions in which we operate. Our restricted investments are invested principally in certificates of deposit and treasury securities with maturities of up to twelve months. As of December 31, 2003, all of our subsidiaries were in compliance with the minimum capital requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements at least through 2004. We also believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements and capital expenditures at least through 2004.

Credit Facility

We entered into a credit agreement dated as of March 19, 2003, under which a syndication of lenders provided a $75.0 million senior secured revolving credit facility. We plan to use this credit facility for general corporate purposes and acquisitions. During the first six months of 2003 we borrowed a total of $8.5 million under this credit facility and repaid the entire amount in July 2003 with proceeds from our initial public offering of common stock.

Banc of America Securities LLC and CIBC World Markets Corp. are co-lead arrangers of the credit facility. Bank of America, N.A. is the administrative agent of the credit facility and CIBC World Markets Corp. is the syndication agent. Bank of America, NA, an affiliate of Banc of America Securities LLC, CIBC Inc., an affiliate of CIBC World Markets Corp., Societe Generale, an affiliate of SG Cowen Securities Corporation, U.S. Bank National Association and East West Bank, are lenders under the credit facility. The interest rate per annum under the credit facility is (a) LIBOR plus a margin ranging from 200 to 250 basis points or (b) the higher of (i) Bank of America prime or (ii) the federal funds rate plus 0.50%, plus a margin ranging from 100 to 150 basis points. The credit facility includes a sublimit for the issuance of standby and commercial letters of credit to be issued by Bank of America, NA All amounts that may be borrowed under the credit facility are due and payable in full by March 20, 2006. The credit facility is secured by substantially all of our parent company s real and personal property and the real and personal property of our non-HMO subsidiary and, subject to certain limitations, all shares of our Washington HMO subsidiary, our Michigan HMO subsidiary and both of our Utah subsidiaries. The credit facility requires us to perform within covenants and requires approval of certain acquisitions above certain prescribed thresholds. The credit facility contains customary terms and conditions, and we have incurred and will incur customary fees in connection with the credit facility.

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Redemptions

In January and February 2003, we redeemed 1,201,174 shares of our common stock at $16.98 per share from Janet M. Watt, Josephine M. Battiste, the Mary R. Molina Living Trust, the Mary Martha Molina Trust (1995), the Janet M. Watt Trust (1995) and the Josephine M. Molina Trust (1995). These stockholders held a combined interest of 40.0% prior to the redemption, which was reduced to 36.2% at the completion of the redemption. The total cash payment of $20,390,000 was made from available cash reserves. The remainder beneficiaries of the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste. We agreed to the redemptions in response to requests for prompt liquidity by certain stockholders.

In July 2003 we completed a previously contemplated repurchase of an aggregate of 1,120,571 shares of our common stock from two stockholders for $17.50 per share or an aggregate purchase price of $19.61 million. Of such shares, we purchased 912,806 shares owned by the MRM GRAT 301/2 and 207,765 shares owned by the Mary R. Molina Living Trust. These shares were subsequently retired. These stockholders held a combined interest of 27.8% prior to the repurchase, which was reduced to 23.2% after the completion of the repurchase. The remainder beneficiaries of the MRM GRAT 301/2 and the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through the four HMOs operating in California, Washington, Michigan and Utah. The HMOs are subject to state laws that, among other things, may require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to their stockholders.

The National Association of Insurance Commissioners has adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital rules. These new HMO rules, which may vary from state to state, have been adopted in Washington, Michigan and Utah. California has not adopted risk based capital requirements for HMOs and has not formally given notice of its intention to do so. The National Association of Insurance Commissioners HMO rules, if adopted by California, may increase the minimum capital required for that state.

As of December 31, 2003, our HMOs had aggregate statutory capital and surplus of approximately $88.8 million, compared with the required minimum aggregate statutory capital and surplus of approximately $41.5 million. All our HMOs were in compliance with the minimum capital requirements.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. The determination of our liability for claims and medical benefits payable is particularly important to the portrayal of our financial position and results of operations and requires the application of significant judgment by our management and, as a result, is subject to an inherent degree of uncertainty.

Our medical care costs include actual historical claims experience and estimates for medical care costs incurred but not reported to us, or IBNR. We, together with our independent actuaries, estimate medical claims liabilities using actuarial methods based upon 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. We also record reserves for estimated referral claims related to medical groups under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of

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medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses are not expected to be significant.

In applying this policy, our management uses judgment to determine the appropriate assumptions to be used in the determination of the required estimates. While we believe our estimates are adequate, it is possible that future events could require us to make significant adjustments or revisions to these estimates. In assessing the adequacy of the medical claims liabilities, we consider our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our customers and information available from other outside sources as appropriate.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2003, our lease obligations for the next five years and thereafter are as follows: $5.5 million in 2004, $5.0 million in 2005, $4.8 million in 2006, $4.2 million in 2007, $3.4 million in 2008 and an aggregate of $12.1 million thereafter.

On February 23, 2004, we signed a definitive agreement to acquire, by merger with our newly formed subsidiary, the capital stock of Health Care Horizons, Inc., which is the parent company of New Mexico-based Cimarron Health Plan, for approximately $69.0 million, subject to adjustments. Health Care Horizons, Inc. has approximately $6.9 million in outstanding bank debt. We intend to fund the acquisition through available cash and expect to close the transaction by the third quarter of 2004, subject to regulatory approvals, the approval of Health Care Horizons, Inc. s shareholders and other closing conditions.

On February 27, 2004, our Washington subsidiary signed a definitive agreement to acquire the Medicaid and Basic Health contracts of Premera Blue Cross of Washington for $18.0 million, subject to regulatory approvals.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off balance sheet financing arrangements except for operating leases which are disclosed in the Commitments and Contingencies section of our consolidated financial statements appearing elsewhere in this prospectus and the notes thereto. We have made certain advances and loans to related parties which are discussed in the Related Party Transactions section of this prospectus and in the consolidated financial statements appearing elsewhere in this prospectus and the notes thereto.

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments which potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables and restricted investments.

We invest a substantial portion of our cash in the CADRE Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. The CADRE Funds are a series of funds managed by the CADRE Institutional Investors Trust (Trust), a

Delaware business trust registered as an open-end management investment fund. Our investments are managed by three professional portfolio managers operating under documented investment guidelines. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

As of December 31, 2003 we had cash and cash equivalents of $141.9 million, investments of $98.8 million and restricted investments of $2.0 million. The cash equivalents consist of highly liquid securities with original maturities of up to three months that are readily convertible into known amounts of cash. Our investments (all of which are classified as current assets) consist solely of investment grade debt securities with a maximum

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maturity of five years and an average duration of two years. The restricted investments consist of interest-bearing deposits required by the respective states in which we operate. These investments are subject to interest rate risk and will decrease in value if market rates increase. All non-restricted investments are maintained at fair market value on the balance sheet. We have the ability to hold these investments until maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Inflation

According to U.S. Bureau of Labor Statistics Data, the national health care cost inflation rate has exceeded the general inflation rate for the last four years. We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services.

While we currently believe our strategies to mitigate health care cost inflation will continue to be successful, competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations or other factors may affect our ability to control health care costs.

Compliance Costs

The Health Insurance Portability and Accounting Act of 1996, the federal law designed to protect health information, contemplates establishment of physical and electronic security requirements for safeguarding health information. The U.S. Department of Health and Human Services recently finalized regulations establishing security requirements for health information. Such requirements may lead to additional costs related to the implementation of additional systems and programs that we have not yet identified.

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BUSINESS

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. C. David Molina, M.D. founded our company in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. We recognized the growing need for more effective management and delivery of health care services to underserved Medicaid beneficiaries and became licensed as an HMO. We have grown over the past several years by taking advantage of attractive expansion opportunities. We established a Utah health plan in 1997, and later acquired health plans in Michigan and Washington. In July 2003, we completed our initial public offering of our common stock. As of December 31, 2003, we had approximately 564,000 members.

Our members have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity. From our inception, we have designed our company to work with government agencies to serve low-income populations. Our success has resulted from our expertise in working with government agencies, our extensive experience with meeting the needs of our members, our 24 years of owning and operating primary care clinics, our cultural and linguistic expertise and our focus on operational and administrative efficiency.

Our annual revenue has increased from $135.9 million in 1998 to $793.5 million in 2003. Over the same period, our net income grew from $2.6 million to $42.5 million due to our effective medical management programs and our ability to leverage fixed and administrative costs. In California, our largest market in terms of membership, we have been successful in an environment characterized by significant competition, heavy regulation and among the lowest state Medicaid expenditure rates per beneficiary in the U.S. In Washington, we have become the market leader while increasing profitability as a result of our strong provider network and efficient operations. In Michigan, we more than doubled our membership in 2003. We believe that our experience, administrative efficiency, proven ability to replicate a disciplined business model in new markets and ability to customize local provider contracts position us well for continued growth and success.

Recent Developments

On February 23, 2004, we signed a definitive agreement to acquire, by merger with our newly formed subsidiary, the capital stock of Health Care Horizons, Inc., which is the parent company of New Mexico-based Cimarron Health Plan, for approximately $69.0 million, subject to adjustments. Health Care Horizons, Inc. has approximately $6.9 million in outstanding bank debt. We intend to fund the acquisition through available cash and expect to close the transaction by the third quarter of 2004, subject to regulatory approvals, the approval of Health Care Horizons, Inc. s shareholders and other closing conditions. Cimarron membership is comprised of approximately 66,000 Medicaid members and approximately 38,000 commercial members as of February 1, 2004. We expect to divest or transition the Cimarron commercial membership to focus on the Medicaid business. New Mexico is a new market for us. We estimate the acquisition will generate annualized Medicaid revenues in the range of $255.0 million to $265.0 million in 2004. We expect the acquisition to result in approximately $0.05 to $0.07 of accretion to our earnings per share for the second half of 2004, assuming closing on July 1, 2004, and $0.14 to $0.18 of accretion to our earnings per share on an annualized basis subsequent to completion of integration which we expect to occur during 2005.

On February 27, 2004, our Washington subsidiary signed a definitive agreement to acquire the Medicaid and Basic Health contracts of Premera Blue Cross of Washington for $18.0 million, subject to regulatory approvals. As of February 1, 2004, the contracts to be transferred covered approximately 66,000 Medicaid and Basic Health members. The Basic Health program is similar to Medicaid but receives no federal funding. We expect the acquisition to close in the third quarter of 2004. We believe the addition of these members at closing will give us approximately

45% of eligible Medicaid and Basic Health members in Washington. We expect the acquisition to result in approximately $0.10 to $0.12 of accretion to our earnings per share for the second half of 2004, assuming closing on July 1, 2004, and $0.20 to $0.25 of accretion to our earnings per share on an annualized basis.

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Our Industry

Medicaid and SCHIP. Medicaid provides health care coverage to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal guidelines. The State Children s Health Insurance Program is a matching program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. States have the option of administering the State Children s Health Insurance Program through their Medicaid programs.

The state and federal governments jointly finance Medicaid and the State Children s Health Insurance Program through a matching program in which the federal government pays a percentage based on the average per capita income in each state. Typically, this percentage match is at least 50%. Federal payments for Medicaid have no set dollar ceiling and are only limited by the amount states are willing to spend. State and local governments pay the share of Medicaid costs not paid by the federal government.

Medicaid Managed Care. The Medicaid members we serve generally come from diverse cultures and ethnicities. Many have had limited education and do not speak English. Lack of adequate transportation is common.

Under traditional Medicaid programs, health care services are made available to low-income individuals in an uncoordinated manner. These individuals typically have minimal access to preventive care such as immunizations and access to primary 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 incentives to monitor utilization and control costs.

In an effort to provide improved, 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 is paid 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.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore, and, in many cases, mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have mandated Medicaid managed care programs in place.

Our Approach

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

Experience. For 24 years we have focused on serving Medicaid beneficiaries as both a health plan and a provider through our clinics. In that time we have developed strong relationships with the constituents whom we serve members, providers and government agencies. Our ability to deliver quality care, establish and maintain provider networks, and our administrative efficiency have allowed us to compete successfully for government contracts. We have a very strong track record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

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Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency. These include centralized claims processing and information services which operate on a single platform. We have standardized medical management programs, pharmacy benefits management contracts and health education. As a result, we believe our administrative efficiency is among the best in our industry. In addition, we have designed our administrative and operational infrastructure to be scalable for rapid and cost-effective expansion in new and existing markets.

Proven Expansion Capability. We have successfully developed and then replicated our business model. This has included the acquisition of health plans, the development of new operations and the transition of members from other plans. The establishment of our health plan in Utah reflected our ability to replicate our business model in new states, while the acquisitions in Michigan and Washington demonstrated our ability to acquire and successfully integrate existing health plan operations. For example, since our acquisition in Washington on December 31, 1999, membership increased from approximately 60,000 members to approximately 183,000 members as of December 31, 2003 while profitability also improved. Our plan is now the largest Medicaid managed care plan in the state. In Utah, our health plan is the largest Medicaid managed care plan in the state with 45,000 members as of December 31, 2003. Our Michigan HMO added 49,000 members in 2003 primarily due to the successful integration of members acquired from competing multi-product health plans which exited the Medicaid market.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We arrange health care services through contracts with providers that include our own clinics, independent physicians and medical groups, hospitals and ancillary providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates and diagnostics related groups. Our provider network strategy is to contract with providers that are best suited, based on proximity, culture and experience, to provide services to a low-income population.

We operate 21 company-owned primary care clinics in California. Our clinics are profitable, requiring low capital expenditures and minimal start-up time. Our clinics serve an important role in providing certain communities with access to primary care and provide us with insights into physician practice patterns, first hand knowledge of the unique needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. National census data shows that the population is becoming increasingly diverse. We have a 24-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. We contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. We have established cultural advisory committees in all of our major markets. Our full-time cultural anthropologist advises these cultural advisory committees. We educate employees and providers about the differing needs among our members. We develop member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience. In addition, our website is accessible in six languages.

Proven Medical Management. We believe our experience as a health care provider has helped us to improve medical outcomes for our members. We carefully monitor day-to-day medical management in order to provide appropriate care to our members and ensure an efficient delivery network. We have developed disease management and health education programs that address the particular health care needs of our members. We have established pharmacy management programs and policies that have allowed us to manage our pharmaceutical costs effectively. For example, our staff pharmacists educate our providers on the use of generic drugs rather than branded drugs. As a result, we believe our generic utilization rate is among the highest in our industry.

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Our Strategy

Our objective is to be the leading managed care organization serving Medicaid and State Children s Health Insurance Program members. To achieve this objective, we intend to:

Focus on serving low income families and individuals. We believe the Medicaid population, characterized by low income and significant ethnic diversity, requires unique services to meet its health care needs. Our 24 years of experience in serving this community has provided us significant expertise in meeting the unique needs of our members. 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 have grown our membership through a combination of acquisitions and internal growth. Increasing our membership provides the opportunity to grow and diversify our revenues, increase profits, enhance economies of scale and strengthen our relationships with providers and government agencies. We will seek to grow our membership by expanding within existing markets and entering new markets.

- *Expand within existing markets.* We expect to grow in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, maintaining positive provider relationships and integrating members from other health plans.

- *Enter new markets.* We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion on markets with strong provider dynamics, an attractive competitive landscape, significant size and mandated Medicaid managed care enrollment.

Manage medical costs. We will continue to use our information systems, positive provider relationships and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the efficacy of treatment, these programs facilitate the identification of our members with special or particularly high cost needs and help limit the cost of their treatment.

Leverage operational efficiencies. Our centralized administrative infrastructure, flexible information systems and dedication to controlling administrative costs provide economies of scale. Our existing systems have significant expansion capacity, allowing us to integrate new members and expand quickly in new and existing markets.

Our Health Plans

Our health plans are located in California, Washington, Michigan and Utah. An overview of our health plans is outlined in the table below:

Summary of Health Plans as of December 31, 2003

State	Total Members	Percent of Total Members	LTM Operating Revenue (1)	Percent of LTM Revenue	Number of Contracts	Expiration Date
			(in thousands)			
California	254,000	45.0%	$ 277,222	35.0%	5	Varies between June 30, 2004 and March 31, 2005
Washington	183,000	32.5%	$ 334,462	42.2%	2	December 31, 2004 and December 31, 2005
Michigan	82,000	14.5%	$ 90,674	11.5%	1	September 30, 2004
Utah	45,000	8.0%	$ 89,425	11.3%	2	June 30, 2004 and June 30, 2006

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(1) Includes premium and other operating revenue for the twelve months ended December 31, 2003.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services and limited pharmacy benefits. We are usually paid a negotiated amount per member per month, with the amount varying from contract to contract. We are also paid an additional amount for each newborn delivery in Washington and Michigan. Since July 1, 2002 our Utah health plan has been reimbursed by the state for all medical costs incurred by Medicaid members plus a 9% administrative fee. Our contracts in Washington and Michigan have higher monthly payments than in California, but require us to cover more services. In California, the state retains responsibility for certain high cost services, such as specified organ transplants and pediatric oncology cases. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. Molina Healthcare of California has the third largest enrollment of Medicaid beneficiaries among non-governmental health plans in the state. We arrange health care services for our members either as a direct contractor to the state or through subcontracts with other health plans. Our plan serves counties with three of the largest Medicaid populations in California Riverside, San Bernardino and Los Angeles Counties as well as Sacramento and Yolo Counties.

Washington. Molina Healthcare of Washington, Inc. is now the largest Medicaid managed health plan in the state, with 183,000 members at December 31, 2003. We serve members in 30 of the state s 39 counties.

Michigan. Membership of Molina Healthcare of Michigan grew to 82,000 members at December 31, 2003 from 33,000 members at December 31, 2002. Effective August 1, 2003 approximately 9,400 members were transferred to our Michigan HMO under the terms of an agreement with another health plan. Effective October 1, 2003 approximately 32,000 members were transferred to our Michigan HMO under the terms of an agreement with another health plan. Our Michigan HMO serves the metropolitan Detroit area, as well as over 30 other counties throughout Michigan.

Utah. Molina Healthcare of Utah, Inc. is the largest Medicaid managed care health plan in Utah. We serve Salt Lake County as well as fourteen other counties that collectively contain over 80% of the population in the state. Effective July 1, 2003, our contract was amended to provide us a stop loss guarantee for all Medicaid members. Of the Utah HMO s 45,000 members at December 31, 2003, approximately 38,000 are Medicaid members, with State Children s Health Insurance Program members comprising the remainder. Under the terms of the amendment, the state of Utah agreed to pay us 100% of medical costs plus 9% of medical costs as an administrative fee for providing medical and utilization management services to Medicaid members. In addition, if the actual medical costs and administrative fee are less than a predetermined amount, we will receive all or a portion of the difference as additional revenue. The additional revenue we could receive is equal to the savings up to 5% of the predetermined amount plus 50% of the savings above 5% of that amount. For any members above 40,000, we have an executed memorandum of understanding with the state providing that the state will reimburse us for all medical costs associated with those members plus an administrative fee per member per month. Relative to the memorandum of understanding, there is no assurance we will enter into such a contract amendment or that its terms will be the same as the memorandum of understanding. Our Utah health plan is compensated for coverage offered to State Children s Health Insurance Program members on a per member per month basis.

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

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providers in geographic areas, in specialties and with appropriate cultural and linguistic experience to meet the needs of our low-income 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, 2003, 2002 and 2001:

		California	Washington	Michigan	Utah	Total
Primary care physicians	2003	2,099	1,917	657	956	5,629
	2002	1,890	1,759	495	794	4,938
	2001	1,838	1,613	413	730	4,594
Specialists	2003	6,879	4,788	1,375	1,273	14,315
	2002	6,130	4,028	1,055	1,986	13,199
	2001	5,785	2,879	965	1,741	11,370
Hospitals	2003	112	80	37	19	248
	2002	97	73	38	15	223
	2001	101	72	37	15	225

Physicians. We contract with primary care physicians, medical groups, specialists and independent practice associations. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. Our most frequently utilized specialists are obstetricians/gynecologists, ear, nose and throat specialists, and orthopedic surgeons. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Primary Care Clinics. We operate 21 company-owned primary care clinics in California staffed by physicians, physician assistants, and nurse practitioners. In 2003, the clinics had over 153,000 patient visits. These clinics are located in neighborhoods where our members reside, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs and administrative procedures of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic related groups and case rates.

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.

Disease Management. We develop specialized disease management programs that address the particular health care needs of our members. *Motherhood Matters* is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *Breathe with Ease* is a multidisciplinary disease management program that provides intensive health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15. We anticipate that both of our programs will be fully implemented in all states in which we operate.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions and methods of

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prevention in a manner that supports our providers, while meeting the unique needs of our members. For example, we provide our members with a copy of *What To Do When Your Child Is Sick*. This book, available in Spanish, Vietnamese and English, is designed to educate parents on the use of primary care physicians, emergency rooms and nurse call centers.

Pharmacy Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications when available. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices and the importance of cost-effective care. This has resulted in a 99% generic utilization rate when a generic alternative is available in our drug formulary, while at the same time enhancing our quality of care.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity and enables medical directors to compare costs, identify trends and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is highly scalable. The software is flexible, easy to use and readily allows us to accommodate enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating rapid and efficient integration of new plans and acquisitions.

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, or 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.

Claims Processing. We pay at least 90% of properly billed claims within 30 days. Claims received electronically can be imported directly into the claims system, and many can be adjudicated automatically, thus eliminating the need for manual intervention. Most physician claims that are received in hard copy are scanned into electronic format and are processed by the claims system automatically. Our California headquarters is a central processing center for all of our health plan claims.

Compliance. Our health plans have established high standards of ethical conduct for operations. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for the health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

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Competition

The Medicaid managed care industry is fragmented. We compete with a large number of national, regional and local Medicaid service providers. Below is a general description of our principal competitors for state contracts, members and providers:

- Multi-Product Managed Care Organizations National and regional managed care organizations that have Medicaid members in addition to members in Medicare and private commercial plans.
- Medicaid HMOs Managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- Prepaid Health Plans Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- Primary Care Case Management Programs Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states present barriers to entry into our industry.

We compete for contracts, renewals of contracts, members and providers. Governments consider many factors in awarding contracts to health plans. Among such factors are the plan s provider network, medical management, degree of member satisfaction, timeliness of claims payment and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services offered, accessibility of services and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment and administrative service capabilities.

Regulation

Our health care operations are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently.

In order to operate a health plan, we must apply for and obtain a certificate of authority or license from the state. Our health plans are licensed to operate as HMOs in California, Washington, Michigan and Utah. In those jurisdictions, we are regulated by the agency with responsibility for the oversight of HMOs. In most cases that agency is the state department of insurance. In California that agency is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we

can meet the requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Each of our health plans is required to report quarterly on its performance to the appropriate state regulatory agencies. They also undergo periodic examinations and reviews by the states. The health plans generally must

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obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its a net worth at an amount determined by statute or regulation. Any acquisition of another plan s members must also be approved by the state, and our ability to invest in certain financial securities may be proscribed by statute.

In addition, we are also regulated by each state s department of health services, or equivalent agency charged with oversight of the Medicaid and the State Children s Health Insurance Programs. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the state and federal governments fund it, Medicaid is a state-operated and implemented program. Our contracts with the state Medicaid programs place additional requirements on us. Within broad guidelines established by the federal government, each state:

- establishes its own eligibility standards,
- determines the type, amount, duration and scope of services,
- sets the rate of payment for services, and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states, such as Washington, award contracts to any applicant that can demonstrate it meets the state s requirements. Others, such as California, engage in a competitive bidding process. In either case, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state s operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- we must measure provider access and availability in terms of the time needed to reach the doctor s office using public transportation,
- our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services,
- we must have linkages with schools, city or county health departments, and other community-based providers of health care, in order to demonstrate our ability to coordinate all of the sources from which our members may receive care,
- we must have the capability to meet the needs of the disabled and others with special needs,
- our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf, and
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our member handbook, newsletters and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers and our members against any risk of our insolvency.

Once awarded, our contracts generally have terms of one to six years, with renewal options at the discretion of the states. Our health plans are subject to periodic reporting and comprehensive quality assurance evaluations. We submit periodic utilization reports and other information to the state or county Medicaid program of our operations. We are not permitted to enroll members directly, and are permitted to market only in accordance with strict guidelines.

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HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- afford privacy to patient health information, and
- protect the privacy of patient health information through physical and electronic security measures.

The Federal Centers for Medicare and Medicaid Services are still working to adopt final regulations to fully implement HIPPA. We expect to achieve compliance with HIPAA by the applicable deadlines. However, given the complexity of HIPPA, the recent adoption of some final regulations, the need to adopt additional final regulations, the possibility that the regulations may change and may be subject to changing, and perhaps conflicting, interpretation, our ability to comply with all of the HIPAA requirements is uncertain and the cost of compliance not yet determined.

Fraud and Abuse Laws. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing and violation of patient privacy rights. Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we believe that our compliance efforts are adequate, ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Properties

We lease a total of 34 facilities, including 21 medical clinics in California. We own a 32,000 square foot office building in Long Beach, California, which serves as our corporate headquarters.

Employees

As of December 31, 2003, we had approximately 893 full-time employees, including physicians, nurses, and administrators. Our employee base is multicultural and reflects the diverse member base we serve. We believe we have good relations with our employees. None of our employees are represented by a union.

Legal Proceedings

We are involved in legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our financial position, results of operations or cash flows.

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MANAGEMENT

Our executive officers, key employees and directors, and their ages and positions are as follows:

Name	Age	Position
J. Mario Molina, M.D.	45	President & Chief Executive Officer; Chairman of the Board
John C. Molina, J.D.	39	Executive Vice President, Financial Affairs, Chief Financial Officer & Treasurer; Director
George S. Goldstein, Ph.D.	62	Executive Vice President, Health Plan Operations; Chief Operating Officer; Director
Mark L. Andrews, Esq.	46	Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary
M. Martha Bernadett, M.D.	40	Executive Vice President, Development
Harvey A. Fein	57	Vice President, Financial Affairs
Joseph W. White, CPA	45	Vice President, Accounting
Richard A. Helmer, M.D.	54	Vice President & Chief Medical Officer
David W. Erickson	49	Vice President, Information Services & Chief Information Officer
Ronna Romney (2)(3)	60	Director
Ronald Lossett, CPA, D.B.A. (1)(3)	62	Director
Charles Z. Fedak, CPA (1)(2)(3)	52	Director
Sally K. Richardson (1)(2)	71	Director

(1) Member of the Compensation Committee.
(2) Member of the Corporate Governance and Nominating Committee.
(3) Member of the Audit Committee.

J. Mario Molina, M.D. has served as our President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as our Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was our Vice President responsible for provider contracting and relation member services, market and quality assurance from 1994 to 1996. Dr. Molina presently serves as a member of the Financial Solvency Standards Board (which is an advisory committee to the California State Department of Managed Health Care), and is a member of the board of the California Association of Health Plans. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina and M. Martha Bernadett, M.D.

John C. Molina, J.D. has served as our Executive Vice President, Financial Affairs since 1995, our Treasurer since 2002 and our Chief Financial Officer since 2003. He also has served as a director since 1994. Mr. Molina has been employed by us for 24 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He earned a J.D. from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D. and M. Martha Bernadett, M.D.

George S. Goldstein, Ph.D. has served as our Executive Vice President, Health Plan Operations and Chief Operating Officer since 1999 and has served as a director since 1998. Dr. Goldstein served as the Chief

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Executive Officer of Molina Healthcare of California from 1999 to 2003. Before joining us, Dr. Goldstein served as Chief Executive Officer of United Health Care Corporation of Southern California and Nevada from 1996 to 1998. Dr. Goldstein also served as Senior Vice President of State Programs for Foundation Health Services, Inc. from 1993 to 1996. In Colorado and New Mexico, he held cabinet positions under three governors from 1975 to 1985, and was responsible for the Medicaid, public health, mental health and environmental programs. He earned a Ph.D. in Experimental Psychology from Colorado State University.

Mark L. Andrews, Esq. has served as our Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary since 1998. He also has served as a member of the Executive Committee of our executive officers since 1998. Before joining us, Mr. Andrews was a partner at Wilke, Fleury, Hoffelt, Gould & Birney of Sacramento, California from 1984 through 1997, where he chaired that firm s health care and employment law groups and represented us as outside counsel from 1994 through 1997. He earned a J.D. from Hastings College of the Law.

M. Martha Bernadett, M.D. has served as Executive Vice President, Development since 2002. From 1992-1994 she worked as a staff physician in family practice, from 1994-1996 she served as Associate Medical Director, from 1996-1999 she served as Vice President responsible for provider contracting and relations, network development, provider information, process improvement, credentialing and facility site review. Since 1999 she has served as Vice President and General Manager of the staff model operations of Molina Healthcare of California. Dr. Bernadett currently serves on the California Health Manpower Policy Commission and is the Principal Investigator on a grant from The Robert Wood Johnson Foundation to improve healthcare access for Latinos. She earned an M.D. from the University of California, Irvine and an M.B.A. from Pepperdine University. Dr. Bernadett is the sister of J. Mario Molina, M.D. and John C. Molina.

Harvey A. Fein has served as our Vice President, Financial Affairs, since 1995. Mr. Fein was Director of Corporate Finance at Blue Cross of California WellPoint Health Networks, Inc. from 1990 to 1994. He earned an M.B.A. from the University of Wisconsin.

Joseph W. White, CPA has served as our Vice President, Accounting since June 2003. Prior to joining us, Mr. White served as the Chief Financial Officer and Controller of Maxicare Health Plans, Inc. since 2001. He was Maxicare s Director of Financial Accounting and Reporting from 1995 to 2000 and held various financial positions with Maxicare since 1987. Mr. White earned an M.B.A. from the University of Virginia. Mr. White is a certified public accountant.

Richard A. Helmer, M.D. has served as our Vice President and Chief Medical Director since 2000. Dr. Helmer was an independent consultant from 1998 to 2000. He served as a medical director with FHP, Inc. from 1994 to 1998, and as a medical director for TakeCare, Inc. (the predecessor to FHP, Inc.) from 1992 to 1994.

David W. Erickson has served as our Vice President, Information Services and our Chief Information Officer since 1999. Prior to joining us, Mr. Erickson served as the Vice President and Chief Information Officer for United Health Care from 1997 to 1999, where he was responsible for information services for eight western states that cared for 3.5 million members.

Ronna Romney has served as a director since 1999 and also served as a director of our Michigan health plan since from 1999 to 2003. She has served as a director for Park-Ohio Holding Corporation, a publicly-traded logistics company, from 1999 to the present. Ms. Romney was a candidate for the United States Senate in 1996. She has published two books. From 1989 to 1993 she served as Chairperson of the President s Commission on White House Fellowships. From 1984 to 1992, Ms. Romney served as the Republican National Committeewoman for the state of Michigan, and from 1982 to 1985, she served as Commissioner of the Presidents National Advisory Council on Adult Education.

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Ronald Lossett, CPA, D.B.A. has served as a director since 2002. Mr. Lossett has served as a director of our California health plan since 1997. He was Chairman of the Board of Pacific Physician Services, Inc. and Chief Executive Officer prior to its merger with MedPartners, Inc. in 1996. Mr. Lossett is a certified public accountant.

Charles Z. Fedak, CPA has served as a director since 2002. Mr. Fedak founded Charles Z. Fedak & Co., Certified Public Accountants, in 1981. He was previously employed by KPMG Peat Marwick (formerly KPMG Main Hurdman) from 1975 to 1980. Mr. Fedak is a certified public accountant.

Sally K. Richardson has served as our director since 2003. Since 1999, Ms. Richardson has served as the Executive Director of the Institute for Health Policy Research and as Associate Vice President for the Health Services Center of West Virginia University. From 1997 to 1999, she served as the Director of the Center for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human Services. Ms. Richardson served as a member of the White House Health Care Reform Task Force in 1993. She currently serves on the National Advisory Committee on Rural Health, U.S. Department of Health and Human Resources, and the Policy Council, National Office of March of Dimes.

Board of Directors

We have a seven member board of directors, four of whom are independent directors. Ronna Romney is the lead independent director.

Board Committees

We have established an audit committee, a compensation committee and a corporate governance and nominating committee, each composed entirely of independent directors. The audit committee reviews our internal accounting procedures and reports to the board of directors with respect to other auditing and accounting matters, including the selection of our independent auditors, the scope of annual audits, fees and the performance of our independent auditors. The audit committee consists of Charles Z. Fedak, Ronna Romney and Ronald Lossett, the chair of the committee. Our board of directors has determined that Mr. Lossett, one of our independent directors, is the audit committee financial expert. The compensation committee reviews and recommends to the board of directors the salaries, benefits and stock option grants for our executive officers. The compensation committee also administers our stock option and other employee benefit plans. The compensation committee consists of Ms. Richardson, Mr. Lossett and Mr. Fedak, the chair of the committee. The corporate governance and nominating committee develops and oversees corporate governance processes and nominates candidates for election to the board of directors. The corporate governance and nominating committee consists of Ms. Richardson, Mr. Fedak and Ms. Romney, the chair of the committee.

Classes of Directors

Our board of directors is divided into three classes. Mr. Molina, Mr. Fedak and Ms. Richardson serve as Class II directors, whose terms expire at the 2004 annual meeting of stockholders. Dr. Molina and Ms. Romney serve as Class III directors, whose terms expire at the 2005 annual meeting of stockholders. Mr. Lossett and Dr. Goldstein serve as Class I directors, whose terms expire at the 2006 annual meeting of stockholders. At each of our annual stockholders meetings, the successors to the directors whose terms will then expire will be elected to serve until the third annual stockholders meeting after their election. Any additional directorships resulting from an increase in the number of directors will be distributed among the three classes so that, as nearly as possible, each class will consist of one-third of the directors. These provisions,

when taken in conjunction with other provisions of our certificate of incorporation authorizing the board of directors to fill vacant directorships, may delay a stockholder from removing incumbent directors and simultaneously gaining control of the board of directors by filling the vacancies with its own nominees.

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Agreements with Employees

We have entered into employment agreements with our Chief Executive Officer, J. Mario Molina, M.D., our Executive Vice President, Financial Affairs, Chief Financial Officer and Treasurer, John C. Molina, J.D., our Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary, Mark L. Andrews, our Executive Vice President, Health Plan Operations and Chief Operating Officer, George S. Goldstein, Ph.D., and our Executive Vice President, Development, M. Martha Bernadett, M.D.

The agreements each have an initial term with automatic one year extensions. The agreement with Dr. Molina has an initial term of three years which began on January 1, 2002, a base annual salary of $500,000 and a discretionary annual bonus of up to the lesser of $500,000 or 1% of our earnings before interest, taxes, depreciation and amortization for such year. The agreement with John C. Molina has an initial term of two years which began on January 1, 2002, a base annual salary of $400,000 and a discretionary annual bonus of up to 50% of his base annual salary. The agreement with Mark L. Andrews has an initial term of three years which began on December 1, 2001, a base annual salary of $323,400 and a discretionary annual bonus of up to 40% of his base annual salary. The agreement with Dr. Goldstein has an initial term of three years which began on December 1, 2001, a base annual salary of $358,400 and a discretionary bonus of up to 45% of his base annual salary. The agreement with Dr. Bernadett has an initial term of one year which began on January 1, 2002, a base annual salary of $300,000 and a discretionary bonus of up to 33% of her base annual salary.

These agreements provide for their continued employment for a period of two years following the occurrence of a change of control (as defined below) of our ownership. Under these agreements, each executive s terms and conditions of employment, including his rate of base salary, bonus opportunity, benefits and his title, position, duties and responsibilities, are not to be modified in a manner adverse to the executive following the change of control. If an eligible executive s employment is terminated by us without cause (as defined below) or is terminated by the executive for good reason (as defined below) within two years of a change of control, we will provide the executive with two times the executive s annual base salary and target bonus for the year of termination, full vesting of Section 401(k) employer contributions and stock options, and continued retirement, deferred compensation, health and welfare benefits for the earlier of three years or the date the executive receives substantially similar benefits from another employer. Additionally, if the executive s employment is terminated by us without cause or the executive resigns for good reason before a change of control, the executive will be entitled to receive one year s base salary, the target bonus for the year of the employment termination, full vesting of Section 401(k) employer contributions and stock options and continued retirement, deferred compensation, health and welfare benefits for the earlier of eighteen months or the date the executive receives substantially similar benefits from another employer. Payment of severance benefits is contingent upon the executive signing a release agreement waiving claims against us.

The agreements also ensure that an executive who receives severance benefits whether or not in connection with a change in control will also receive various benefits and payments otherwise earned by or owing to the executive for his prior service. Such an executive will receive a pro-rata target bonus for the year of his employment termination and payment of all accrued benefit obligations. We will also make additional payments to any eligible executive who incurs any excise taxes pursuant to the golden parachute provisions of the Internal Revenue Code in respect of the benefits and other payments provided under the agreement or otherwise on account of the change of control. The additional payments will be in an amount such that, after taking into account all applicable federal, state and local taxes applicable to such additional payments, the executive is able to retain from such additional payments an amount equal to the excise taxes that are imposed without regard to these additional payments.

A change of control generally means a merger or other change in corporate structure after which the majority of our stockholders are no longer stockholders, a sale of substantially all of our assets or our approved dissolution or liquidation. Cause is generally defined as the occurrence of one or more acts of unlawful actions involving moral turpitude or gross negligence or willful failure to perform duties or intentional breach of obligations under the employment. Good reason generally means the occurrence of one or more events that have

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an adverse effect on the executive s terms and conditions of employment, including any reduction in the executive s base salary, a material reduction of the executive s benefits or substantial diminution of the executive s incentive awards or fringe benefits, a material adverse change in the executive s position, duties, reporting relationship, responsibilities or status with us, the relocation of the executive s principal place of employment to a location more than 50 miles away from his prior place of employment or an uncured breach of the employment agreement. However, no reduction of salary or benefits will be good reason if the reduction applies to all executives proportionately.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 640,000 shares and a related put option held by Dr. Goldstein. The put option permitted Dr. Goldstein to require us to purchase the 640,000 shares of stock underlying his options at their fair market value based on a methodology set forth in a previous employment agreement. These options were settled through a cash payment of $7,660,000 determined based on the negotiated fair value per share in excess of the exercise price of the 640,000 shares as if the options were exercised and the shares repurchased. The cash settlement resulted in a 2002 fourth quarter compensation charge of $6,880,000.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 95,200 shares held by Mr. Andrews through a cash payment of $1,023,400. The cash payment was determined based on the negotiated fair value per share in excess of the exercise price of the 95,200 shares as if the options were exercised and the shares repurchased. The cash settlement resulted in a 2002 fourth quarter compensation charge of $915,500.

Except as discussed above, there are no other equity instruments issued by us whereby holders have a put right to require us to repurchase their shares at their election. In addition, we do not anticipate additional purchases of vested options or shares from other holders.

Compensation of Directors

We pay each non-employee director an annual retainer of $35,000. We also pay an additional annual retainer of $7,500 to the chair of the audit committee, $5,000 to each audit committee member and $2,500 to each of the chairs of the other committees. We pay each non-employee director $1,200 for each board and committee meeting attended in person; provided, however, audit committee members receive $2,400 for each audit committee meeting. Non-employee directors receive $600 for participation in telephonic meetings. Each non-employee director shall receive annually an option to purchase 4,000 shares of common stock, vested immediately, with an exercise price equal to fair market value at the time of grant. In addition, each non-employee director received an option to purchase 10,000 shares of common stock, that fully vested upon the closing of our initial public offering, with an exercise price equal to fair market value at the time of grant, or $16.98 per share. Additionally, each non-employee director purchased shares in our initial public offering under our directed share program. We also pay certain expenses incurred by the directors.

We may, in our discretion, grant additional stock options and other equity awards to our non-employee directors from time to time under the 2002 Equity Incentive Plan, which is summarized below. The board may also decide to have automatic annual option grants under the 2002 Equity Incentive Plan.

Compensation Committee Interlocks and Insider Participation

No member of our compensation committee serves as a member of the board of directors or compensation committee of any entity that has one or more executive officers serving as a member of our board of directors or compensation committee.

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Executive Compensation

The following summary compensation table sets forth information concerning compensation earned in fiscal years 2003, 2002 and 2001 by individuals who served as our Chief Executive Officer and the remaining four most highly compensated executive officers as of December 31, 2003 and 2002. We refer to these executives collectively as our named executive officers.

		Annual Compensation			Long-Term Compensation Awards		
Name And Principal Position		Salary ($)	Bonus ($)	Other Annual Compensation ($) (1)	Securities Underlying Options (#) (2)	Securities Underlying Options ($) (3)	All Other Compensation ($) (4)
J. Mario Molina, M.D.	2003	$ 567,308					$ 9,566(5)
Chief Executive Officer, President, and Chairman	2002	567,308	$ 500,000	$ 4,200			7,430(5)
	2001	400,000	250,000	7,200			7,100(5)
John C. Molina, J.D.	2003	453,846					8,378(6)
Executive Vice President, Financial Affairs, Chief Financial Officer, Treasurer and Director	2002	453,846	278,592	4,200			7,013(6)
	2001	250,272	175,000	7,200			7,013(6)
George S. Goldstein, Ph.D.	2003	453,846					10,447(7)
Executive Vice President, Health Plan Operations, Chief Operating Officer and Director	2002	406,646	160,973	8,450			9,176(7)
	2001	327,691	116,969	7,300	160,000	1,206,240	8,647(7)
Mark L. Andrews, Esq.	2003	366,935					8,954(8)
Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary	2002	362,169	129,336	4,550			7,277(8)
	2001	287,290	80,400	7,250	72,000	542,808	7,037(8)
M. Martha Bernadett, M.D.	2003	340,385					8,510(9)
Executive Vice President, Development	2002	318,802	99,000	6,900			6,960(9)
	2001	232,863	128,723	6,900			6,960(9)

(1) Auto allowances.
(2) Options granted to each named executive officer during 2003, 2002 and 2001 to purchase the Company s common shares.
(3) Estimated fair value of the options on the date of grant.
(4) All other compensation includes employer matching contributions under the Company s 401(k) plan and the portion of premiums on life insurance benefits in excess of $50,000.
(5) 401(k) contributions of $8,000, $6,800 and $6,800 in 2003, 2002 and 2001, respectively, and insurance premiums of $1,566, $630 and $300 in 2003, 2002 and 2001, respectively.
(6) 401(k) contributions of $8,000, $6,800 and $6,800 in 2003, 2002 and 2001, respectively, and insurance premiums of $378, $213 and $213 in 2003, 2002 and 2001, respectively.
(7) 401(k) contributions of $8,000, $6,800 and $6,800 in 2003, 2002 and 2001, respectively, and insurance premiums of $2,447, $2,376 and $1,847 in 2003, 2002 and 2001, respectively.
(8) 401(k) contributions of $8,000, $6,800 and $6,800 in 2003, 2002 and 2001, respectively, and insurance premiums of $954, $477 and $237 in 2003, 2002 and 2001, respectively.
(9) 401(k) contributions of $8,000, $6,800 and $6,800 in 2003, 2002 and 2001, respectively, and insurance premiums of $510, $160 and $160 in 2003, 2002 and 2001, respectively.

Option Grants In Last Fiscal Year. We did not grant any stock options during the fiscal year ended December 31, 2003 to our named executive officers.

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Year-End Option Exercise and Option Value Table. The following table sets forth information concerning the number and value of unexercised options to purchase common stock held by the named executive officers. The values of the unexercised in-the-money options have been calculated on the basis of the closing price of our common stock on the New York Stock Exchange on December 31, 2003.

Aggregated Option Exercises in Fiscal Year Ended December 31, 2003

And Fiscal Year-End Option Values

Name	Number of Shares Acquired in Exercise	Value Realized	Number of Securities Underlying Unexercised Options at Fiscal Year-End		Value of Unexercised In-The-Money Options at Fiscal Year-End	
			Exercisable	Unexercisable	Exercisable	Unexercisable
J. Mario Molina, M.D.		$			$	$
John C. Molina, J.D.						
George S. Goldstein, Ph.D.			160,000		3,316,800	
Mark L. Andrews, Esq.	12,000	277,200	164,800		3,648,304	
M. Martha Bernadett, M.D.						

STOCK PLANS

2002 Equity Incentive Plan

The 2002 Equity Incentive Plan permits us to grant incentive stock options (within the meaning of Section 422 of the Internal Revenue Code), non-qualified stock options, restricted stock, performance shares and stock bonus awards to our officers, employees, directors, consultants, advisors and other service providers effective as of the offering date. The Equity Incentive Plan currently allows for the issuance of 2,546,640 shares of common stock, with a maximum of 600,000 of those shares eligible for issuance as restricted stock, performance shares and stock bonus awards. Upon each January 1st, the number of shares issuable under the Equity Incentive Plan will automatically increase by the lesser of 400,000 shares or 2% of our issued and outstanding capital stock on a fully-diluted basis, unless our board of directors otherwise determines to provide a smaller increase. 546,640 shares reserved for issuance under the Omnibus Stock and Incentive Plan for Molina Healthcare, Inc. (as described below) that were not needed for outstanding options granted under that plan are included in the shares reserved for the 2002 Equity Incentive Plan.

Our compensation committee administers the Equity Incentive Plan. Subject to the provisions of the Equity Incentive Plan, the compensation committee may select the individuals eligible to receive awards, determine the terms and conditions of the awards granted (including the number of shares or options to be awarded and the purchase price or exercise price, as the case may be), accelerate the vesting schedule of any award and generally administer and interpret the plan.

We intend to comply with the deductibility restrictions under Section 162(m) of the Internal Revenue Code of 1986, as amended. Stock option grants to our named executive officers after the end of the so-called reliance period for transition to public company status under United States Treasury regulations will have an exercise price at least equal to our common stock s then fair market value, and the number of shares that may be subject to equity awards made during any one calendar year to a named executive officer shall not exceed 600,000.

Options are typically subject to vesting schedules, terminate ten years from the date of grant (five years in the case of incentive stock options granted to employees holding 10% or more of the voting power of Molina Healthcare, Inc., including any subsidiary corporations) and may be exercised for specified periods after the grantee terminates employment or other service relationship with us. The vesting date and service requirements of each award are determined by the compensation committee. The compensation committee may place additional conditions on equity awards such as the achievement of performance goals or objectives in a grant document.

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Upon the exercise of options, the option exercise price must be paid in full either (i) in cash or by certified or bank check or other instrument acceptable to the compensation committee, or (ii) so long as it would not result in a financial charge against our earnings, by delivery of shares of common stock owned by the optionee for at least six months with a fair market value equal to the option exercise price or by a broker-assisted cashless exercise.

Restricted stock and performance shares may not be sold, assigned, transferred or pledged except as specifically provided in the grant document. If a restricted stock or performance share award recipient terminates employment or other services relationship with us or other events specified in the grant document occur, we have the right to repurchase some or all of the shares of stock subject to the award at the exercise price of such stock.

In the event of a change in control, the stock option agreements may provide for immediate accelerated vesting of any unvested shares as if the employee continued employment for another twelve months with additional accelerated vesting of any remaining unvested shares upon termination of the optionholder s employment without cause or resignation by the optionholder for good reason within a year of the change in control. Notwithstanding the foregoing, we may require all outstanding awards to be exercised before the change in control, terminate each outstanding award in exchange for a payment of cash and/or securities to the extent that such awards are vested, or terminate each outstanding award for no consideration to the extent that awards are unvested.

2000 Omnibus Stock and Incentive Plan

We have frozen any further grants of stock based compensation under the 2000 Omnibus Stock and Incentive Plan. As of December 31, 2003, stock options to purchase a total of 797,200 shares at a weighted average exercise price of $4.77 per share were outstanding under the Plan. All such options were fully vested at December 31, 2003.

2002 Employee Stock Purchase Plan

Our 2002 Employee Stock Purchase Plan was adopted by our board of directors and approved by our stockholders in July 2002. The 2002 Employee Stock Purchase Plan is intended to qualify under Section 423 of the Internal Revenue Code and is administered by our compensation committee.

Up to 600,000 shares of common stock may be issued under the Employee Stock Purchase Plan, 80,130 of which have been issued as of the effective date of this offering. Upon each January 1st, the number of shares issuable under the Employee Stock Purchase Plan will automatically increase by the lesser of 1% or 6,000 shares of our issued and outstanding capital stock on a fully-diluted basis.

Offerings under the Employee Stock Purchase Plan will begin on each January 1 and July 1 and will have a duration of six months. Generally, all employees who are customarily employed for more than 20 hours per week as of the first day of the applicable offering period will be eligible to participate in the Employee Stock Purchase Plan. Any employee who first becomes eligible during an offering or is hired during an offering and otherwise meets the eligibility requirements will be eligible to participate in the offering on the first day of the offering period after the employee satisfies the eligibility requirements. An employee who owns or is deemed to own shares of stock representing in excess of 5% of the combined voting power of all classes of our stock (including the stock of any parent or subsidiary corporation) will not be eligible to participate in the Employee Stock Purchase Plan.

During each offering, an employee may purchase shares under the Employee Stock Purchase Plan by authorizing payroll deductions of up to 15% of his or her compensation during the offering period. Unless the employee has previously withdrawn from the offering, his or her accumulated payroll deductions will be used to purchase common stock on the last business day of each offering period at a price equal to 85% of the fair market

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value of the common stock on the first day of the offering period or, if later, the date on which the participant first begins participating in the offering or, or the last day of the offering period, whichever is lower. Under applicable tax rules, an employee may purchase no more than $25,000 worth of common stock (as measured by the fair market value of the shares acquired) in any calendar year.

In the event of a change in control, we will accelerate the purchase date of the then current purchase period to a date immediately prior to the change in control, unless the acquiring or successor corporation assumes or replaces the purchase rights outstanding under the Employee Stock Purchase Plan. In the event of a proposed dissolution or liquidation of the Company, the current offering period will terminate immediately prior to the consummation of such event and we may either accelerate the purchase date of such purchase period to a date immediately prior to such event or return all accumulated payroll deductions to each participant, without interest.

401(k) Plan

We have established a 401(k) plan for our employees that is intended to be qualified under Section 401(k) of the Internal Revenue Code. Eligible employees are permitted to contribute to the 401(k) plan through payroll deduction within statutory and plan limits. The Company matches up to the first 4% of compensation contributed by employees.

Limitation of Liability of Directors and Indemnification of Directors and Officers

As permitted by the Delaware General Corporation Law, or DGCL, our certificate of incorporation provides that our directors shall not be liable to us or our stockholders for monetary damages for breach of fiduciary duty as a director to the fullest extent permitted by the DGCL as it now exists or as it may be amended. As of the date of this prospectus, the DGCL permits limitations of liability for a director s breach of fiduciary duty other than liability (i) for any breach of the director s duty of loyalty to us or our stockholders, (ii) for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, (iii) under Section 174 of the DGCL, or (iv) for any transaction from which the director derived an improper personal benefit. Our bylaws provide that directors and officers shall be, and in the discretion of our board of directors, non-officer employees may be, indemnified by us to the fullest extent authorized by Delaware law, as it now exists or may in the future be amended, against all expenses and liabilities reasonably incurred in connection with service for or on our behalf. The bylaws also provide that the right of directors and officers to indemnification shall be a contract right and shall not be exclusive of any other right now possessed or hereafter acquired under any bylaw, agreement, vote of stockholders or otherwise. We also have directors and officers insurance against certain liabilities. This provision does not alter a director s liability under the federal securities laws or to parties other than the Company or our stockholders and does not affect the availability of equitable remedies, such as an injunction or rescission, for breach of fiduciary duty.

Insofar as indemnification for liabilities arising under the Securities Act may be permitted to our directors, officers or controlling persons as described above, we have been advised that in the opinion of the Securities and Exchange Commission, or SEC, such indemnification is against public policy as expressed in the Securities Act and is therefore unenforceable.

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RELATED PARTY TRANSACTIONS

Indemnification Agreements

We have entered into an indemnification agreement with each of our directors, executive officers and certain key officers. The indemnification agreement provides that the director or officer will be indemnified to the fullest extent not prohibited by law for claims arising in such person s capacity as a director or officer. We believe that these agreements are necessary to attract and retain skilled management with experience relevant to our industry. In addition, our obligations under the indemnification agreements with our independent directors are guaranteed up to a maximum of $22.5 million by the Mary R. Molina Living Trust, the holder of approximately 18.1% of our common stock.

Option Settlements

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 640,000 shares and a related put option held by Dr. Goldstein through a cash payment of $7,660,000. The cash payment was determined based on the negotiated fair value per share in excess of the exercise price of the 640,000 shares as if the options were exercised and the shares repurchased. The cash settlement resulted in a 2002 fourth quarter compensation charge of $6,880,000.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 95,200 shares held by Mr. Andrews through a cash payment of $1,023,400. The cash payment was determined based on the negotiated fair value per share in excess of the exercise price of the 95,200 shares as if the options were exercised and the shares repurchased. The cash settlement resulted in a 2002 fourth quarter compensation charge of $915,500.

Loans

In 1996, we received a note receivable from the Molina Family Trust (of which Mary R. Molina, mother of J. Mario Molina, M.D. and John C. Molina, J.D., is the trustee and beneficiary) for the purchase of two medical buildings, which were subsequently leased to us (see Facility Leases below for discussion). The note receivable is secured by the two medical buildings and bears interest at 7% with monthly payments of $2,295 due through September 30, 2026. The balance outstanding at December 31, 2001 and 2002 was $321,000 and $316,000, respectively. The Molina Family Trust is not a beneficial owner of our common stock. The remaining balance outstanding was repaid on May 30, 2003.

In 2001, we received a note receivable from the Molina Siblings Trust (of which John C. Molina, J.D. is the trustee and J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the beneficiaries) for the purchase of a medical building, which was subsequently leased to us (see Facility Leases below for discussion). The note receivable was repaid in December 2002. The Molina Siblings Trust beneficially owns approximately 13.2% of our common stock prior to this offering.

In 2000, we extended a $500,000 credit line to the Molina Siblings Trust. The balance outstanding, which bears interest at 7%, is due in 2010 and is secured by 86,189 shares of our common stock. The balance outstanding at December 31, 2001 and 2002 was $392,000 and $388,000,

respectively. The remaining balance outstanding was repaid on May 30, 2003.

Facility Leases

The agreement to lease the two medical buildings from the Molina Family Trust was entered into in April 1995. These leases have five 5-year renewal options and the rates may change every five years based on the Consumer Price Index. Effective May 2001, we entered into a similar agreement with the Molina Siblings Trust for the lease of another medical clinic. The lease is for seven years with two 10-year renewal options and provides for fixed annual rate increases of 3% during the base term. Rental expense for these leases totaled $295,000, $390,000 and $383,000 for the years ended December 31, 2001, 2002 and 2003, respectively. Rental

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rates under these leases are equal to the average of the rates of our leases with third parties as a means of approximating fair value. Future minimum lease payments are as follows: $392,000 in 2004; $332,000 in 2005; $318,000 in 2006; $327,000 in 2007; and $82,000 in 2008.

Services Contracts

We received architecture services from a firm in which Janet M. Watt, sister of J. Mario Molina, M.D. and John C. Molina, J.D., was formerly a partner through 2001. Ms. Watt beneficially owns less than 1.0% of our common stock prior to this offering. We also received technology services from Laurence B. Watt, husband of Janet M. Watt. Aggregate payments for these services during the years ended December 31, 2001 and 2002 were $130,000 and $86,000, respectively. There were no services provided during 2003. The contracts under which these services were provided have been terminated.

Split-Dollar Life Insurance

Since 1997, we were a party to Collateral Assignment Split-Dollar Insurance Agreements with the Molina Siblings Trust, the Trust. We agreed to make premium payments towards the life insurance policies held by the Trust on the life of Mary R. Molina, a former employee and director and a current stockholder, in exchange for services from Mrs. Molina when she served on our board of directors and was the director of our Child Health and Disability Prevention Department. The aggregate cash surrender value of the policies as of December 31, 2003 was $1,802,000. We were not an insured under the policies, but were entitled to receive repayment of all premium advances from the Trust upon the earlier of Mrs. Molina s death or cancellation of the policies. Advances during 2001, 2002 and 2003 were $786,000, $653,000 and $973,000, respectively. Receivables at December 31, 2002 and 2003 were discounted based on Mrs. Molina s remaining actuarial life using discount rates commensurate with instruments of similar terms and risk characteristics (4% in both 2002 and 2003). Such receivables totaled $1,496,000 and $2,188,000 at December 31, 2002 and 2003, respectively, and were secured by the cash surrender values of the policies. On March 2, 2004, the Collateral Assignment Split-Dollar Insurance Agreements were terminated by the early repayment of the advances to the Trust.

Redemption of Stock

In January and February 2003, we redeemed 1,201,174 shares of our common stock at $16.98 per share from Janet M. Watt, Josephine M. Battiste, the Mary R. Molina Living Trust, the Mary Martha Molina Trust (1995), the Janet M. Watt Trust (1995) and the Josephine M. Molina Trust (1995). These stockholders held a combined interest of approximately 40.0% prior to the redemption, which was reduced to approximately 36.2% after completion of the redemption. The total cash payment of $20,390,000 was made from available cash reserves. The remainder beneficiaries of the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste. We agreed to the redemptions in response to requests for prompt liquidity by certain stockholders. The remainder beneficiaries of the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste.

In July 2003 we completed a previously contemplated repurchase of an aggregate of 1,120,571 shares of our common stock from two stockholders for $17.50 per share or an aggregate purchase price of $19,610,000. Of such shares, we purchased 912,806 shares owned by the MRM GRAT 301/2 and 207,765 shares owned by the Mary R. Molina Living Trust. These shares were subsequently retired. These stockholders held a combined interest of approximately 27.8% prior to the repurchase, which was reduced to approximately 23.2% after completion of the repurchase. The remainder beneficiaries of the MRM GRAT 301/2 and the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste.

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PRINCIPAL AND SELLING STOCKHOLDERS

The following table sets forth information regarding the beneficial ownership of our common stock as of February 27, 2004 by:

- each person, entity or group known by us to own beneficially more than 5% of our outstanding common stock,
- each of our named executive officers and directors,
- all of our executive officers and directors as a group, and
- each selling stockholder.

Beneficial ownership is determined in accordance with the rules of the SEC. These rules generally attribute beneficial ownership of securities to persons who possess sole or shared voting power or investment power with respect to those securities and include shares of common stock issuable upon the exercise of stock options or warrants that are immediately exercisable or exercisable within 60 days. Shares of common stock subject to options currently exercisable or exercisable within 60 days are deemed outstanding for computing the percentage of the person holding these options but are not deemed outstanding for computing the percentage of any other person. Unless otherwise indicated, the persons or entities identified in this table have sole voting and investment power with respect to all shares shown as beneficially owned by them, subject to applicable community property laws. Unless otherwise indicated, the address of each of the named individuals is c/o Molina Healthcare, Inc., One Golden Shore Drive, Long Beach, California 90802.

Percentage ownership calculations prior to the offering are based on 25,472,225 shares outstanding as of February 27, 2004.

To the extent that any shares are issued on exercise of options, warrants or other rights to acquire shares of our capital stock that are presently outstanding or granted in the future, there will be further dilution to new public investors. The following table assumes the exercise by the underwriters of the entire over-allotment option.

	Prior to the Offering			After the Offering	
Name	Number of Shares Beneficially Owned(1)	Percentage of Outstanding Shares	Number of Shares Offered	Number of Shares Beneficially Owned	Percentage of Outstanding Shares(2)
J. Mario Molina, M.D. (3)	649,121	2.5%		649,121	2.3%
John C. Molina, J.D. (4)	5,718,056	22.4%	1,379,736	4,338,320	15.5%
William Dentino (5)	10,494,181	41.2%	620,264	9,873,917	35.2%
Curtis Pedersen (6)	9,514,605	37.4%	620,264	8,894,341	31.7%
Mary R. Molina Living Trust (7)	4,796,889	18.7%	620,264	4,149,625	14.8%
Molina Marital Trust (8)	3,464,716	13.6%		3,464,716	12.3%
Molina Siblings Trust (9)	3,356,000	13.2%		3,356,000	12.0%

MRM GRAT 301/3 (10)	1,056,678	4.1%	1,056,678		
MRM GRAT 502/2(11)	323,058	*	323,058		
MRM GRAT 903/2 (12)	1,250,000	4.9%		1,250,000	4.5%
George S. Goldstein, Ph.D. (13)	160,000	*	80,000	80,000	*
Mark L. Andrews, Esq. (14)	164,800	*	14,800	150,000	*
M. Martha Bernadett, M.D. (15)	622,640	2.4%		622,640	2.2%
Ronna Romney (16)	24,000	*		24,000	*
Ronald Lossett, CPA, D.B.A. (17)	38,000	*		38,000	*
Charles Z. Fedak, CPA (18)	24,000	*		24,000	*
Sally K. Richardson (19)	22,000	*		22,000	*
FMR Corp. (20)	1,452,686	5.7%		1,452,686	5.2%
Fidelity Management & Research Company (21)	1,268,986	5.0%		1,268,986	4.5%
All executive officers and directors as a group (9 persons) (22)	7,422,617	29.1%	2,094,800	5,948,081	21.2%

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Represents shares offered by three trusts. Such shares are also shown under the respective trustees of the trusts.

* Denotes less than 1%.

(1) As required by SEC regulation, the number of shares shown as beneficially owned includes shares which could be purchased within 60 days after February 27, 2004.

(2) Percentage ownership calculations after the offering are based on 28,072,225 shares outstanding after the offering and assumes the exercise by the underwriters of the entire over-allotment option.

(3) Includes 474,440 shares owned by J. Mario Molina, M.D.; 160,000 shares owned by the Molina Family Partnership, L.P., of which Dr. Molina is the general partner with sole voting and investment power; and 14,681 shares owned by Dr. Molina and Therese A. Molina as community property as to which Dr. Molina has shared voting and investment power. Dr. Molina is a Director and our President and Chief Executive Officer and the brother of John C. Molina, J.D. and M. Martha Bernadett, M.D.

(4) Includes 1,056,678 shares (all of which will be sold in this offering) owned by the MRM GRAT 301/3, of which Mr. Molina is the trustee with sole voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries. As a result of the expiration of the MRM GRAT 301/3 on March 28, 2004, most of the trust s assets will be distributed to the remainder beneficiaries. Also includes 323,058 shares (all of which will be sold in this offering) owned by the MRM GRAT 502/2, of which Mr. Molina is the trustee with sole voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries. As a result of the expiration of the MRM GRAT 502/2 on May 29, 2004, most of the trust s assets will be distributed to the remainder beneficiaries. Also includes 426,676 shares owned by John C. Molina; 11,881 shares owned by Mr. Molina and Michelle A. Molina as community property as to which Mr. Molina has shared voting and investment power; 192,303 shares owned by the John C. Molina Trust (1995), of which Mr. Molina and Mr. Dentino are co-trustees with shared investment power and Mr. Molina is the beneficiary, and as to which Mr. Molina has sole voting power pursuant to a proxy; 62,933 shares owned by the Molina Children s Trust for John C. Molina (1997), of which Mr. Molina and Mr. Dentino are co-trustees with shared voting and investment power and Mr. Molina is the beneficiary; 3,356,000 shares owned by the Molina Siblings Trust, of which Mr. Molina is the trustee with sole voting and investment power and J. Mario Molina, M.D., M. Martha Bernadett, M.D., Josephine M. Battiste, Janet M. Watt and Mr. Molina are the beneficiaries; and 50,394 shares owned by the M/T Molina Children s Education Trust, of which Mr. Molina is the trustee with sole voting and investment power and J. Mario Molina, M.D. s children are the beneficiaries; 238,133 shares owned by the MRM GRAT 303/2, of which Mr. Molina is the trustee with sole voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries. As a result of the expiration of the MRM GRAT 303/2 on March 27, 2005, most of the trust s assets will be distributed to the remainder beneficiaries. Mr. Molina is a Director and our Executive Vice President, Financial Affairs, Chief Financial Officer and Treasurer and the brother of J. Mario Molina, M.D. and M. Martha Bernadett, M.D.

(5) Includes 1,000 shares held by Mr. Dentino; 4,796,889 shares (620,264 of which will be sold in this offering) owned by the Mary R. Molina Living Trust, of which Mr. Dentino and Curtis Pedersen are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; and 3,464,716 shares owned by the Molina Marital Trust, of which Mr. Dentino and Mr. Pedersen are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries. Also includes 1,250,000 shares owned by the MRM GRAT 903/2, of which Mr. Dentino and Mr. Pedersen are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries. As a result of the expiration of the MRM GRAT 903/2 on September 17, 2005, most of the trust s assets will be

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distributed to the remainder beneficiaries. Also, includes 192,303 shares owned by the John C. Molina Trust (1995), of which Mr. Molina and Mr. Dentino are co-trustees with shared investment power and Mr. Molina is the beneficiary, and as to which Mr. Molina has sole voting power pursuant to a proxy; 237,303 shares owned by the Janet M. Watt Trust (1995), of which Ms. Watt and Mr. Dentino are co-trustees with shared investment power and Ms. Watt is the beneficiary, as to which Ms. Watt has sole voting power pursuant to a proxy; 237,303 shares owned by the Josephine M. Molina Trust (1995), of which Ms. Battiste and Mr. Dentino are co-trustees with shared investment power and Ms. Battiste is the beneficiary, as to which Ms. Battiste has sole voting power pursuant to a proxy; 62,933 shares owned by the Molina Children s Trust for John C. Molina (1997), of which Mr. Molina and Mr. Dentino are co-trustees with shared voting and investment power and Mr. Molina is the beneficiary; 125,867 shares owned by the Molina Children s Trust for Janet M. Watt (1997), of which Mr. Dentino and Janet M. Watt are co-trustees with shared voting and investment power and Ms. Watt is the beneficiary; and 125,867 shares owned by the Molina Children s Trust for Josephine M. Molina (1997), of which Mr. Dentino and Josephine M. Battiste are co-trustees with shared voting and investment power and Ms. Battiste is the beneficiary. Mr. Dentino is counsel to Mrs. Molina and has provided legal services to various Molina family members and entities in which they have interests. His address is 555 Capitol Mall, Suite 1500, Sacramento, California 95814.

(6) Includes 3,000 shares owned by Mr. Pedersen and Rosi A. Pedersen as community property, as to which Mr. Pedersen has shared voting and investment power; 4,796,881 shares (620,264 of which will be sold in this offering) owned by the Mary R. Molina Living Trust, of which Mr. Pedersen and Mr. Dentino are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; 3,464,716 shares owned by the Molina Marital Trust, of which Mr. Pedersen and Mr. Dentino are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; and 1,250,000 shares owned by the MRM GRAT 903/2, of which Mr. Dentino and Mr. Pedersen are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries. As a result of the expiration of the MRM GRAT 903/2 on September 17, 2005, most of the trust s assets will be distributed to the remainder beneficiaries. Mr. Pedersen is the uncle of J. Mario Molina, M.D., John C. Molina, J.D. and M. Martha Bernadett, M.D.

(7) Beneficial ownership is described in footnotes 5 and 6.

(8) Beneficial ownership is described in footnotes 5 and 6.

(9) Beneficial ownership is described in footnote 4.

(10) Beneficial ownership is described in footnote 4.

(11) Beneficial ownership is described in footnote 4.

(12) Beneficial ownership is described in footnotes 5 and 6.

(13) Includes 160,000 shares which may be purchased pursuant to options. Dr. Goldstein is our Director, Executive Vice President, Health Plan Operations and Chief Operating Officer. The number of shares offered assumes the exercise by the underwriters of the entire over-allotment option. Dr. Goldstein will sell up to 80,000 shares only if the underwriters exercise the entire over-allotment option.

(14) Includes 164,800 shares which may be purchased pursuant to options. Mr. Andrews is our Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary. The number of shares offered assumes the exercise by the underwriters of the entire over-allotment option. Mr. Andrews will sell up to 14,800 shares only if the underwriters exercise the entire over-allotment option.

(15) Includes 507,459 shares owned by M. Martha Bernadett, M.D.; 14,681 shares owned by Dr. Bernadett and Faustino Bernadett as community property, as to which Dr. Bernadett has shared voting and investment power; 86,505 shares owned by 11 trusts, of which Dr. Bernadett is the trustee with sole voting and investment power and 11 of Mary R. Molina s grandchildren and step-grandchildren are the beneficiaries; and 13,995 shares owned by nine trusts, of which Dr. Bernadett is the trustee with sole voting and investment power and nine of Mary R. Molina s grandchildren are the beneficiaries. Dr. Bernadett is our Executive Vice President, Development, and the sister of J. Mario Molina, M.D. and John C. Molina, J.D.

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(16) Includes 4,000 shares owned by Ms. Romney; 2,000 shares owned by Ms. Romney s spouse; 18,000 shares which may be purchased pursuant to options. Ms. Romney is our director.

(17) Includes 20,000 shares owned by the Lossett Family Trust, of which Mr. Lossett is a co-trustee with shared voting and investment power and Mr. Lossett is a beneficiary; and 18,000 shares which may be purchased pursuant to options. Mr. Lossett is our director.

(18) Includes 6,000 shares owned by Mr. Fedak and Mari L. Fedak as community property as to which Mr. Fedak has shared voting and investment power; 18,000 shares which may be purchased pursuant to options. Mr. Fedak is our director.

(19) Includes 4,000 shares owned by Mr. Richardson and Don R. Richardson as joint tenants as to which Ms. Richardson has shared voting and investment power; and 18,000 shares which may be purchased pursuant to options. Ms. Richardson is our director.

(20) Based on the Schedule 13G filed by such stockholder. Such stockholder s address is 82 Devonshire Street, Boston, Massachusetts 02109.

(21) Based on the Schedule 13G filed by such stockholder. Such stockholder s address is 82 Devonshire Street, Boston, Massachusetts 02109.

(22) Includes all shares beneficially owned or which may be purchased by J. Mario Molina, M.D., John C. Molina, J.D., George S. Goldstein, Ph.D., Mark L. Andrews, Esq., M. Martha Bernadett, M.D., Ronna Romney, Ronald Lossett, CPA, D.B.A., Charles Z. Fedak, CPA, and Sally K. Richardson.

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DESCRIPTION OF CAPITAL STOCK

We are authorized to issue 80,000,000 shares of common stock and 20,000,000 shares of preferred stock. Shares of each class have a par value of $0.001 per share. The following description summarizes information about our capital stock. You can obtain more comprehensive information about our capital stock by consulting our bylaws and certificate of incorporation, as well as the Delaware General Corporation Law.

Common Stock

Each share of our common stock entitles the holder to one vote on all matters submitted to a vote of stockholders, including the election of directors. Subject to any preference rights of holders of preferred stock, the holders of common stock are entitled to receive dividends, if any, declared from time to time by the directors out of legally available funds. In the event of our liquidation, dissolution or winding up, the holders of common stock are entitled to share ratably in all assets remaining after the payment of liabilities, subject to any rights of holders of preferred stock to prior distribution.

The common stock has no preemptive or conversion rights or other subscription rights. There are no redemption or sinking fund provisions applicable to the common stock. All outstanding shares of common stock are fully paid and nonassessable and the shares of common stock to be issued on completion of this offering will be fully paid and nonassessable.

Preferred Stock

The board of directors has the authority, without action by the stockholders, to designate and issue preferred stock and to designate the rights, preferences and privileges of each series of preferred stock, which may be greater than the rights attached to the common stock. It is not possible to state the actual effect of the issuance of any shares of preferred stock on the rights of holders of common stock until the board of directors determines the specific rights attached to that preferred stock. The effects of issuing preferred stock could include one or more of the following:

- restricting dividends on the common stock,
- diluting the voting power of the common stock,
- impairing the liquidation rights of the common stock, or
- delaying or preventing a change of control of our company.

There are currently no shares of preferred stock outstanding.

There are currently no warrants outstanding.

Anti-Takeover Effects of Certain Provisions of Delaware Law and Molina s Certificate of Incorporation and Bylaws

We are governed by the provisions of Section 203 of the Delaware General Corporation Law. In general, Section 203 prohibits a public Delaware corporation from engaging in a business combination with an interested stockholder for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner. A business combination includes mergers, asset sales or other transactions resulting in a financial benefit to the interested stockholder. An interested stockholder is a person who, together with affiliates and associates, owns (or within three years, did own) 15.0% or more of the corporation s outstanding voting stock. The statute could delay, defer or prevent a change of control of our company.

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Some provisions of our certificate of incorporation and bylaws, may be deemed to have an anti-takeover effect and may delay or prevent a tender offer or takeover attempt that a stockholder might consider in one s best interest, including those attempts that might result in a premium over the market price for the shares held by stockholders.

The issuance of additional shares of common stock could have the effect of delaying, deferring or preventing a change of control, even if such change in control would be beneficial to our stockholders.

The terms of certain provisions of our certificate of incorporation and bylaws may have the effect of discouraging a change in control. Such provisions include the requirement that all stockholder action must be effected at a duly-called annual meeting or special meeting of the stockholders and the requirement that stockholders follow an advance notification procedure for stockholder business to be considered at any annual meeting of the stockholders.

Classified Board of Directors

Our board of directors is divided into three classes of directors serving staggered three-year terms. As a result, approximately one-third of the board of directors is elected each year. These provisions, when coupled with the provision of our certificate of incorporation authorizing the board of directors to fill vacant directorships or increase the size of the board of directors, may deter a stockholder from removing incumbent directors and simultaneously gaining control of the board of directors by filling the vacancies created by such removal with its own nominees.

Cumulative Voting

Under cumulative voting, a minority stockholder holding a sufficient percentage of a class of shares may be able to ensure the election of one or more directors. Our certificate of incorporation expressly denies stockholders the right to cumulative voting in the election of directors.

Advance Notice Requirements for Stockholder Proposals and Director Nominations

Our bylaws provide that stockholders seeking to bring business before an annual meeting of stockholders, or to nominate candidates for election as directors at an annual meeting of stockholders, must provide timely notice in writing. To be timely, a stockholder s notice must be delivered to or mailed and received at our principal executive offices not less than 90 days prior to the anniversary date of the immediately preceding annual meeting of stockholders. However, in the event that the annual meeting is called for a date that is not within 30 days before or after such anniversary date, notice by the stockholder in order to be timely must be received not later than the close of business on the 10th day following the date on which notice of the date of the annual meeting was mailed to stockholders or made public, whichever first occurs. Our bylaws also specify requirements as to the form and content of a stockholder s notice. These provisions may preclude, delay or discourage stockholders from bringing matters before an annual meeting of stockholders or from making nominations for directors at an annual meeting of stockholders.

Stockholder Action; Special Meeting of Stockholders

Our certificate of incorporation eliminates the ability of stockholders to act by written consent. It further provides that special meetings of our stockholders may be called only by our Chairman of the Board, Chief Executive Officer, President, a majority of our directors or committee of the board of directors specifically designated to call special meetings of stockholders. These provisions may limit the ability of stockholders to remove current management or approve transactions that stockholders may deem to be in their best interests and, therefore, could adversely affect the price of our common stock.

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Authorized but Unissued Shares

Our authorized but unissued shares of common stock and preferred stock will be available for future issuance without stockholder approval. These additional shares may be utilized for a variety of corporate purposes, including future public offerings to raise additional capital, corporate acquisitions and employee benefit plans. The existence of authorized but unissued shares of common stock and preferred stock could render more difficult or discourage an attempt to effect a change in our control or change in our management by means of a proxy contest, tender offer, merger or otherwise.

Charter Amendments

Delaware law provides generally that the affirmative vote of a majority of the shares entitled to vote on any matter is required to amend a corporation s certificate of incorporation or bylaws, unless either a corporation s certificate of incorporation or bylaws require a greater percentage.

Transfer Agent Registrar

The transfer agent and registrar for our common stock is Continental Stock Transfer & Trust Company.

Listing

Our common stock is listed on the New York Stock Exchange under the symbol MOH.

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SHARES ELIGIBLE FOR FUTURE SALE

We cannot predict the effect, if any, that market sales of shares or the availability of any shares for sale will have on the market price of the common stock prevailing from time to time. Sales of substantial amounts of common stock (including shares issued on the exercise of outstanding options and warrants), or the perception that such sales could occur, could adversely affect the market price of our common stock and our ability to raise capital through a future sale of our securities.

After this offering, 27,472,225 shares of common stock will be outstanding. The number of shares outstanding after this offering is based on the number of shares outstanding as of February 27, 2004 and assumes no exercise of outstanding options or the over-allotment option. The 4,000,000 shares sold in this offering will be freely tradable without restriction under the Securities Act.

Approximately 7,696,890 shares of common stock held by existing stockholders are restricted shares. Restricted shares may be sold in the public market only if registered or if they qualify for an exception from registration under Rules 144 or 701 promulgated under the Securities Act, which are summarized below. All restricted shares will be available for resale in the public market in reliance on Rule 144 immediately following this offering.

(114,848

)

(378,557

)

(778,714

)

(54,880

)

(1,326,999

)

Assets

5,477

148,087

300,498

18,704

472,766

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Evolve One, Inc.

Notes to Consolidated Financial Statements

For the twelve months ended December 31, 2003, the Company operated in the following segments, none of which have inter-segment revenues:

	Ventures	Stogies	Corporate	Consolidated
Revenue	$	$ 1,322,803	$	$ 1,322,803
Operating (Loss)	(19,384)	(213,725)	(634,661)	(867,770)
Other Income (expense)	(9,916)	(59)	19,599	9,624
(Loss) from continuing operations	(29,300)	(213,784)	(615,062)	(858,146)
(Loss) from discontinued operations			(20,274)	(20,274)
Net (Loss)	(29,300)	(213,784)	(635,336)	(878,420)
Assets	176,453	624,493	778,692	1,579,638

The Ventures segment owns an equity interest in certain companies, mainly with Internet operations, and derives its revenue from the net gains and losses recognized when the investments are sold. In addition, the Ventures segment recognizes income or loss from the unrealized gains or losses associated with its trading securities.

The Stogies segment is an online distributor and retailer of brand name premium cigars within the United States. Stogies revenue includes wholesale sales to cigar stores, as well as, retail sales to internet customers.

AuctionStore.com segment is an eBay® Trading Assistant and Internet- based seller of consigned merchandise whose primary medium of sales is through eBay®. The relationship between AuctionStore.com, Inc. and the Seller is that of bailor (Seller) and bailee (AuctionStore.com, Inc.), in which the bailor deposits his personal property (Goods) with the bailee for the purpose of listing and selling the Goods to third parties through eBay®. The premise of AuctionStore.com is simple. A customer drops off Goods they would like to sell at our location and we arrange for those Goods to be sold online via an eBay® auction. Goods with an estimated value of less than $50 require a minimum upfront charge of $19.95 as a listing commission to be listed by AuctionStore.com for sale. Our ordinary Service Commission for Goods sold range from approximately 20% to 39%, dependent on the sales price of the Goods.

Evolve One, Inc.

Notes to Consolidated Financial Statements

Corporate assets consist primarily of cash. Interest expense is allocated to the other segments to the extent it exceeds interest income.

NOTE 14. SUBSEQUENT EVENTS

On January 26, 2005, Irwin Horowitz, a director of the Company was elected as President and Chief Executive Officer of Evolve One. Mr. Horowitz has entered into an employment agreement with the Company pursuant to which he will receive an annual salary of $12,000 per year, reimbursement of his expenses, including travel and lodging costs until such as time as he relocates his principal residence to the location of the Company s offices, and an automobile allowance of up to $1,500 on a monthly basis. In addition, the Company granted to Mr. Horowitz an option to purchase up to 50,000,000 shares of common stock exercisable at $0.30 per share and expiring January 26, 2013.

The Company also announced the resignations of Gary Schultheis, Herbert Tabin and Martin Scott as directors of the Company, and Gary Schultheis as President of the Company. The resignations were issued in connection with the selection of Mr. Horowitz as the President and Chief Executive Officer of the Company. Messrs. Schultheis and Tabin entered into separate Separation and Severance Agreements with the Company pursuant to which they provided their resignations and also agreed to the termination of their prior employment agreements with the Company. Both of them received options to purchase up to 10,000,000 shares of common stock at an exercise price of $0.30 per share expiring January 26, 2013, and both were paid the sum of $6,144 to defray health insurance premiums for the ensuing six months.

In connection with the grant of the options described above, the Company amended its Stock Option Plan to increase the number of shares covered by the plan from 8,000,000 from 100,000,000 shares of common stock.

On March 15, 2005, Evolve One entered into a Management Agreement with Diversifax Inc. Irwin Horowitz, a principal shareholder and Chief Executive officer of Evolve One, is also a principal shareholder and Chief Executive Officer of Diversifax. Under the terms of the agreement, Diversifax will make available to Evolve One its facilities at 39 Stringham Avenue, Valley Stream, New York; the services on a part-time basis of 7 persons presently employed by Diversifax for approximately 100 hours per week; equipment, hardware and software of Diversifax; and related utilities and overhead functions at that facility. The term of the agreement is for six months and may be terminated prior to the conclusion of its term on ten days prior written notice by either party, or the agreement may be renewed for a successive six-month term.

Evolve One, Inc.

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In consideration for the management services and facilities provided by Diversifax during the initial six-month term, Evolve One will issue to Diversifax 2,900,000 shares of its common stock. In addition, in the event the market price of the common stock of Evolve One on the six-month anniversary date is below $0.15 per share, Evolve One will issue to Diversifax additional shares of its common stock so that the common shares provided to Diversifax plus such additional shares of common stock will be equal in value to $435,000. In addition, Diversifax will receive 10% of the total amount of the monies received as a result of their efforts with regard to auctions being completed for accounts they have introduced to AuctionStore.com, Evolve One s wholly-owned subsidiary. Payment of the percentage fee will be made in cash or stock as determined by Diversifax.

On March 22, 2005 the Company entered into a subscription agreement with one of its directors, Robert Sands for the sale of 20 units of Evolve One, Inc, for an aggregrate price of $100,000. Each unit has a cost of $5,000 and consists of 100,000 shares of Common Stock at $.05, and one option consisting of 100,000 shares of common stock exercisable at $.25 cents per share, which will expire in 3 years.

ITEM 8. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 8A. CONTROLS AND PROCEDURES

Our management, including our chief executive officer and president and our chief financial officer, have conducted an evaluation of the effectiveness of our disclosure controls and procedures (as defined in Rule 13a-15(e) under the Securities and Exchange Act of 1934) as of December 31, 2004. Based upon that evaluation, our chief executive officer and president and our chief financial officer have concluded that our disclosure controls and procedures are effective for timely gathering, analyzing and disclosing the information we are required to disclose in our reports filed under the Exchange Act. Management plans, however, to improve the segregation of duties within our financial and administrative functions.

There have been no significant changes made in our internal controls or in other factors that could significantly affect our internal controls subsequent to that evaluation date. We are continuing to evaluate the employees involved and the control procedures in place as well as the costs and benefits of making changes in the number and duties of employees. We are also working to document controls this year and to identify other items that might require remediation in connection with our compliance with Section 404 of the Sarbanes-Oxley Act of 2002.

ITEM 9. DIRECTORS, EXECUTIVE OFFICERS, PROMOTERS AND CONTROL PERSONS, COMPLIANCE WITH SECTION 16(a) OF THE EXCHANGE ACT

DIRECTORS, EXECUTIVE OFFICERS AND SIGNIFICANT EMPLOYEES

The following table sets forth the names, ages and current positions with the Company held by the Directors, Executive Officers and Significant Employees, together with the year such positions were assumed. There is no immediate family relationship between or among any of the Directors, Executive Officers or Significant Employees. The Company is not aware of any arrangement or understanding between any Director or Executive officer and any other person pursuant to which he was elected to his current position.

Name	Age	Position or Office With the Company	Date First Elected
Irwin Horowitz	67	President, Director	2004
Robert Sands	50	Director	2005
Marissa Dermer	37	Controller	2000

Dr. Irwin Horowitz is currently President, Director of the Company. Dr. Horowitz previously served as a director of the Company from 1997 until late 2000. Dr. Horowitz received his podiatry degree from the M.J. Lewi College of Podiatric Medicine in 1959. Dr. Horowitz has been Chairman of the Board, Chief Executive Officer and President of DiversiFax Inc., Sarasota, Florida since approximately 1992. DiversiFax conducts business as IMSG Systems and certain companies in the coin operated copier business. Dr. Horowitz served as Chairman of the Board and President of IMSG Systems, Inc. in Valley Stream, New York and certain affiliated companies since 1969. Dr. Horowitz also previously served as a director for one year in 1997 of Langer Biomechanics Group, Inc., Long Island, New York, a publicly traded company primarily engaged in the business of manufacturing and selling orthotic products.

Robert Sands is currently a director for the Company. Mr. Sands has been President and CEO of DirectPro, LLC since he founded the company in 1985. DirectPro, LLC is a company that serves and impacts the marketing needs of a blue chip roster of today s largest corporations. He has held prior senior positions with American Express, McGraw Hill and J. Walter Thompson. He also currently serves on the Board of two charitable organizations.

Marissa Dermer is currently the controller for the Company. Ms. Dermer is also currently a Director of publicly traded, Onspan Networking Inc., symbol ONSP and is their Chief Financial Officer. From September 1997 to April 2000, Ms. Dermer was an assistant controller with Mitchell Hutchins Asset Management, Inc., the mutual fund advisory group of Paine Webber Inc. Prior to her employment with Paine Webber, Ms. Dermer was a manager of David Berdon and Company LLP, a prominent public accounting firm headquartered in New York City from 1990 to 1997. Ms. Dermer graduated in 1990 from the State University of New York at Albany with a degree in Business/Accounting.

Audit Committee

The Board of Directors does not have an audit committee. The Board acts as the Audit Committee.

The company has not hired a qualified financial expert. The company does not intend to hire someone in that capacity until operations are significant enough to warrant the hiring of such person.

COMPLIANCE WITH SECTION 16(a) OF THE EXCHANGE ACT

None.

ITEM 10. EXECUTIVE COMPENSATION

The following table shows the cash compensation of the Company s former chief executive officer and each officer whose total cash compensation exceeded $100,000, for the three fiscal years ended December 31, 2004. The Company has no long-term compensation plans.

Name and Principal Position	Fiscal Year Ended	Salary ($)	Bonus ($)	Other Annual Compensation	All Other Compensation
Gary Schultheis	12/31/04	$	$	N/A	N/A
	12/31/03	$ 100,000	$ 5,572	N/A	N/A
	12/31/02	$ 100,000	$ 5,572	N/A	N/A
Herbert Tabin	12/31/04	$	$	N/A	N/A
	12/31/03	$ 100,000	$ 5,572	N/A	N/A
	12/31/02	$ 100,000	$ 5,052	N/A	N/A

In 2004 and 2003 the Company accrued $248,074 and $130,000 in salaries in accordance with the employment agreement signed January 3, 2002 with its President and Director of Marketing, (see Employment Contracts below). On December 20, 2004 members of former management forgave approximately $478,000 of debt accrued under the employment contracts.

Option/SAR Grants in Last Fiscal Year

Name	Number of Securities Underlying options/SARs granted (number)	Percent of total options/SARs granted to employees in fiscal year	Exercise or base price ($/share)	Expiration date
Gary Schultheis	32,000	50%	.0016375	1/3/09
Herbert Tabin	32,000	50%	.0016375	1/3/09

Aggregated Option/SAR Exercises in Last Fiscal Year and FY-End Option/SAR Values

Name	Shares Acquired On Exercise (number)	Value realized ($)	Number of Securities underlying unexercised options/SARs at FY-end (number) Exercisable/ Unexercisable	Value of unexercised in-the-money options/SARs at FY-end ($) Exercisable/ Unexercisable

Gary Schultheis	0	None	None
Herbert Tabin	0	None	None

EMPLOYMENT CONTRACTS

In January 2002, the Company s President and Director of Marketing entered into employment agreements with the Company. The contracts expire in January 2009 and provide for the granting of 32,000 stock options (as restated for the stock splits) each to the President and Director of Marketing at an exercise price of the average of closing price for the five (5) trading days preceding the anniversary date less fifteen (15%) percent each year. The annual salary under each of the agreements is $150,000, which is to be increased by 10% each year. On January 26, 2005 Mr. Schultheis and Tabin entered into separate Separation and Severance Agreements with the Company pursuant to which they provided their resignations and also agreed to the termination of their employment agreements with the Company. Each of them received options to purchase up to 10,000,000 shares of common stock at an exercise price of $0.30 per share expiring January 26, 2013, and both were paid the sum of $6,144 to defray health insurance premiums for the ensuing six months.

On January 22, 2005 the Company s new President, Dr. Irwin Horowitz, entered into an employment agreement with the Company pursuant to which he is to receive an annual salary of $12,000 per year, reimbursement of his expenses, including travel and lodging costs until such as time as he relocates his principal residence to the location of the Company s offices, and an automobile allowance of up to $1,500 on a monthly basis. In addition, the Company granted to Mr. Horowitz an option to purchase up to 50,000,000 shares of common stock exercisable at $0.30 per share and expiring January 26, 2013.

ITEM 11. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT.

The following table indicates all persons who, as of December 31, 2004, the most recent practicable date, are known by the Company to own beneficially more than 5% of any class of the Company s voting securities and all Directors of the Company and all Officers who are not Directors of the Company, as a group. As of December 31, 2004, there were 29,178,432 (1) shares of the Company s common stock outstanding.

Title Of Class	**Name and Address of Beneficial Owner**	**Amount and Nature of Beneficial Owner**	**% of Class**
Common	Gary Schultheis (2) 1000 Clint Moore Rd, Suite 101 Boca Raton, FL 33487	9,441,096	32.35%
Common	Herbert Tabin (3) 1000 Clint Moore Rd, Suite 101 Boca Raton, FL 33487	9,443,976	32.37%
Common	Irwin Horowitz (4) 1000 Clint Moore Rd, Suite 101 Boca Raton, FL 33487	389,600	0.013%
Common	All directors and executive officers as a group (two persons)	19,274,672	66.05%

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(1) This amount includes options to acquire an aggregate of 2,624,000 common shares of stock, 64,000 common shares at an exercise price of $.000875 per share, and 64,000 shares at an exercise price of $.000125 per share, and 64,000 shares at an exercise price of $.016375, 2,400,000 at an exercise price of $.0225 and 32,000 common shares of stock at an exercise price of $.5625 per share
(2) This amount includes options to acquire 1,296,000 common shares of stock, 32,000 at an exercise price of $.000875 per share and 32,000 at an exercise price of $.000125 per share, and 32,000 shares at an exercise price of $.016375, and 1,200,000 at an exercise price of $.0225.
(3) This amount includes options to acquire 1,296,000 common shares of stock, 32,000 at an exercise price of $.000875 per share and 32,000 at an exercise price of $.000125 per share, and 32,000 shares at an exercise price of $.016375, and 1,200,000 at an exercise price of $.0225.
(4) This amount includes options to acquire 32,000 common shares of stock at an exercise price of $.5625 per share

ITEM 12. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

The Company issued a demand line of credit with Onspan Networking, Inc. a related party, totaling $1,000,000, under which Onspan Networking, Inc. could borrow on an unsecured basis with interest at 5% annually. On June 19, 2003 Onspan Networking, Inc. borrowed $675,000 under this line of credit. The Company accrued $17,940 in interest on the note. Onspan Networking, Inc. repaid the original balance outstanding under the line of credit, including accrued interest. This line of credit expired upon repayment on May 27, 2004.

The terms of the demand line of credit stated that Onspan Networking, Inc. must issue options to the Company to purchase common stock equal to 10% of the dollar amount of the loan advance at an exercise price of $0.10 per share, and options to purchase common stock equal to 90% of the dollar amount of the loan advance at the ten trading day average at the time of the draw ($0.30 at June 19, 2003). On June 19, 2003, Onspan Networking, Inc. granted 67,500 stock options to Evolve One, Inc. under the revolving note agreement. The options have an exercise price of $.10 per share. Onspan Networking, Inc. also granted on June 19, 2003, 607,500 stock options to Evolve One, Inc. in the same note agreement. These options have an exercise price of $.30 per share. The Company currently has excluded these options on common stock from assets of the Company as the underlying stock, due to market conditions, are not readily convertible to cash. If conditions are satisfied and the underlying stock becomes marketable, the options would be reclassified as a derivative and recorded at fair value as an adjustment through current period results of operations.

On December 20, 2004 the Company eliminated virtually all of its debt when certain shareholders contributed $478,074 of debt to capital.

ITEM 13. EXHIBITS AND REPORTS ON FORM 8-K

The following documents are filed as a part of this report or are incorporated by reference to previous filings, if so indicated:

(a) Exhibits

Exhibit Number	Description
14	Code of Business Ethics (Filed as Exhibit 14 to registrant December 2002, Form 10-KSB)
21	Subsidiaries of Evolve One, Inc. (Filed as Exhibit 21 to registrant December 2002, Form 10-KSB)
31.1	Certification of President and Principal Financial and Accounting Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of President and Principal Financial and Accounting Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

(b) Reports on Form 8-K

Form 8-K Current Report filed on March 15, 2005

Form 8-K Current Report filed on February 4, 2005

Form 8-K Current Report filed on February 1, 2005

Form 8-K Current Report filed on December 22, 2004

Form 8-K Current Report filed on November 19, 2004

Form 8-K Current Report filed on November 15, 2004

Form 8-K Current Report filed on August 25, 2004

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

AUDIT FEES

The aggregate audit fees billed by Goldstein Lewin & Co. for professional services rendered for the audit of our annual financial statements included in our Annual Report on Form 10-KSB for the fiscal year ended December 31, and for the review of quarterly financial statements included in our Quarterly Reports on Form 10-QSB for the quarters ending March 31, June 30, and September 30, were $28,045 and $27,500 for 2004 and 2003, respectively.

AUDIT RELATED FEES

For the fiscal years ended December 31, 2004 and 2003, no fees were billed for assurance and related services by Goldstein, Lewin & Co. relating to the performance of the audit of our financial statements which are not reported under the caption Audit Fees above.

TAX FEES

For the fiscal years ended December 31, 2004 and 2003 the aggregate fees billed for tax compliance, tax advice and tax planning, including the preparation of federal and state corporate income tax returns billed to Evolve One by Goldstein Lewin & Co. for the fiscal years ended December 31, 2004 and 2003 were approximately $5,400.

ALL OTHER FEES

Other than fees relating to the services described above under Audit Fees, Audit-Related Fees and Tax Fees, there were no additional fees billed by Goldstein Lewin & Co. for services rendered to Evolve One for the fiscal years ended December 31, 2004 and 2003.

AUDIT COMMITTEE POLICIES

Effective May 6, 2003, the Securities and Exchange Commission adopted rules that require that before our independent auditor is engaged by us to render any auditing or permitted non-audit related service, the engagement be:

* approved by our audit committee; or

* entered into pursuant to pre-approval policies and procedures established by the audit committee, provided the policies and procedures are detailed as to the particular service, the audit committee is informed of each service, and such policies and procedures do not include delegation of the audit committee s responsibilities to management.

The audit committee pre-approves all services provided by our independent auditors, including those set forth above. The audit committee has considered the nature and amount of fees billed by Goldstein Lewin & Co. and believes that the provision of services for activities unrelated to the audit is compatible with maintaining Goldstein Lewin & Co. s independence.

SIGNATURES

In accordance with the requirements of the Exchange Act, the registrant caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

EVOLVE ONE, INC.

Date: August 30, 2005 By: /s/ Irwin Horowitz
Irwin Horowitz,
President
(President and Principal Financial and Accounting Officer)

In accordance with the Exchange Act, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Date: August 30, 2005 By: /s/ Irwin Horowitz
Irwin Horowitz,
Director

Date: August 30, 2005 By: /s/ Robert Sands
Robert Sands,
Director