UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-Q

☒ QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the Quarterly Period Ended March 31, 2014

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the Transition Period From _____ to _____

Commission File Number **000-50009**

PACIFIC HEALTH CARE ORGANIZATION, INC.
(Exact name of registrant as specified in its charter)

Utah	**87-0285238**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer I.D. No.)
1201 Dove Street, Suite 300 **Newport Beach, California** (Address of principal executive offices)	**92660** (Zip Code)

(949) 721-8272
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for any shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days.

Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files.)

Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of "*large accelerated filer*," "*accelerated filer*" and "*smaller reporting company*" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐ Accelerated filer ☐
Non-accelerated filer (Do not check if a smaller reporting company) ☐ Smaller reporting company ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act.)

Yes ☐ No ☒

As of May 12, 2014, the registrant had 802,424 shares of common stock, par value $0.001, issued and outstanding.

PACIFIC HEALTH CARE ORGANIZATION, INC.
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PART I. FINANCIAL INFORMATION

Item 1. Financial Information

Pacific Health Care Organization, Inc.
Condensed Consolidated Balance Sheets

ASSETS

	March 31, 2014 (Unaudited)	December 31, 2013
Current Assets		
Cash	$ 1,731,388	$ 1,265,535
Accounts receivable, net of allowance of $24,113 and $15,860	1,689,231	1,518,813
Prepaid income tax	-	6,568
Deferred tax asset	41,513	41,513
Prepaid expenses	57,671	68,613
Total current assets	3,519,803	2,901,042
Property and equipment, net		
Computer equipment	146,865	130,717
Furniture & fixtures	83,708	83,708
Office equipment	26,560	26,560
Office equipment under capital lease	63,923	63,923
Total property & equipment	321,056	304,908
Less: accumulated depreciation	(188,313)	(177,158)
Net property & equipment	132,743	127,750
Other assets	13,703	8,158
Total assets	$ 3,666,249	$ 3,036,950
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities		
Accounts payable	$ 90,781	$ 108,496
Accrued expenses	214,420	142,983
Income tax payable	136,286	2,618
Current obligations under capital lease	13,421	13,173
Deferred rent expense	20,248	21,698
Total current liabilities	475,156	288,968
Long term liabilities		
Noncurrent obligations under capital lease	4,701	8,151
Total liabilities	479,857	297,119
Commitments and Contingencies	-	-
Shareholders' Equity		
Preferred stock; 5,000,000 shares authorized at $0.001 par value; zero shares issued and outstanding	-	-
Common stock; 50,000,000 shares authorized at $0.001 par value; 802,424 shares issued and outstanding	802	802
Additional paid-in capital	623,629	623,629
Retained earnings	2,561,961	2,115,400
Total stockholders' equity	3,186,392	2,739,831
Total liabilities and stockholders' equity	$ 3,666,249	$ 3,036,950

The accompanying notes are an integral part of these condensed consolidated financial statements

Pacific Health Care Organization, Inc.
Condensed Consolidated Statements of Operations
(Unaudited)

	For three months ended March 31,	
	2014	**2013**
Revenues:		
HCO fees	$ 259,484	$ 246,689
MPN fees	253,429	205,741
UR fees	725,855	332,270
MBR fees	475,220	331,581
NCM fees	254,129	215,116
Other	60,552	52,713
Total revenues	2,028,669	1,384,110
Expenses:		
Depreciation	11,155	10,808
Bad debt provision	8,253	-
Consulting fees	75,899	99,481
Salaries & wages	586,827	500,336
Professional fees	105,612	75,778
Insurance	68,648	58,180
Outsource service fees	264,568	139,257
Data maintenance	19,171	27,737
General & administrative	123,361	128,973
Total expenses	1,263,494	1,040,550
Income from operations	765,175	343,560
Other income (expense)		
Interest income	-	459
Interest (expense)	(379)	(723)
Total other income (expense)	(379)	(264)
Income before taxes	764,796	343,296
Income tax provision	318,235	139,411
Net income	$ 446,561	$ 203,885
Basic and fully diluted earnings per share:		
Earnings per share amount	$ .56	$ .25
Weighted average common shares outstanding	802,424	802,424

The accompanying notes are an integral part of these condensed consolidated financial statements

Pacific Health Care Organization, Inc.
Condensed Consolidated Statements of Cash Flows
(Unaudited)

	Three Months Ended March 31,	
	2014	**2013**
Cash flows from operating activities:		
Net income	$ 446,561	$ 203,885
Adjustments to reconcile net income to net cash:		
Depreciation	11,155	10,808
Changes in operating assets & liabilities		
Increase in bad debt provision	8,253	-
(Increase) in accounts receivable	(178,671)	(95,147)
Decrease in other receivables	-	7,344
(Increase) decrease in prepaid income tax	6,568	(90,422)
Decrease (increase) in prepaid expenses	10,942	(43,999)
(Increase) in other assets	(5,545)	-
(Decrease) in accounts payable	(17,715)	(35,510)
(Decrease) increase in deferred rent expense	(1,450)	(340)
Increase in accrued expenses	71,437	93,719
Increase (decrease) in income tax payable	133,668	(74,690)
(Decrease) in unearned revenue	-	(2,443)
Net cash provided by (used in) operating activities	485,203	(26,795)
Cash flows from investing activities		
Purchase of furniture and office equipment	(16,148)	(988)
Net cash used in investing activities	(16,148)	(988)
Cash flows from financing activities		
Payment of obligation under capital lease	(3,202)	(4,693)
Net cash used in financing activities	(3,202)	(4,693)
Increase (decrease) in cash	465,853	(32,476)
Cash at beginning of period	1,265,535	479,674
Cash at end of period	$ 1,731,388	$ 447,198
Supplemental cash flow information		
Cash paid for:		
Interest	$ 383	$ 1,439
Income taxes paid	$ 178,000	$ 390,422

The accompanying notes are an integral part of these condensed consolidated financial statements

Pacific Health Care Organization, Inc.
Notes to Condensed Consolidated Financial Statements
For the Three Months Ended March 31, 2014

NOTE 1 - BASIS OF FINANCIAL STATEMENT PRESENTATION

The accompanying unaudited condensed consolidated financial statements have been prepared by Pacific Health Care Organization, Inc. (the "Company") pursuant to the rules and regulations of the Securities and Exchange Commission (the "SEC"). Certain information and footnote disclosures normally included in financial statements prepared in accordance with generally accepted accounting principles have been condensed or omitted in accordance with such rules and regulations. The information furnished in the interim condensed consolidated financial statements includes normal recurring adjustments and reflects all adjustments, which, in the opinion of management, are necessary for a fair presentation of such financial statements. Although management believes the disclosures and information presented are adequate to make the information not misleading, it is suggested that these interim condensed financial statements be read in conjunction with the Company's audited financial statements and notes thereto included in its Annual Report on Form 10-K for the year ended December 31, 2013. Operating results for the three-months ended March 31, 2014 are not necessarily indicative of the results to be expected for the year ending December 31, 2014.

Revenue Recognition — In general, the Company recognizes revenue when (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the fee is fixed or determinable and (iv) collectability is reasonably assured. Revenues are generated as services are provided to the customer based on the sales price agreed and collected. The Company recognizes revenue as the time is worked or as units of production are completed, which is when the revenue is earned and realized. Labor costs are recognized as the costs are incurred. The Company derives its revenue from the sale of Managed Care Services, Review Services and Case Management Services. These services may be sold individually or combined. When a sale combines multiple elements, the Company accounts for multiple-deliverable revenue arrangements in accordance with the guidance included in ASC 605-25.

These fees include monthly administration fees, claim network fees, flat rate fees or hourly fees depending on the agreement with the client. Such revenue is recognized at the end of each month for which services are performed.

Management reviews each agreement in accordance with the provision of the revenue recognition topic ASC 605 that addresses multiple-deliverable revenue arrangements. The multiple-deliverable arrangements entered into consist of bundled managed care which included various units of accounting such as network solutions and patient management which includes managed care. Such elements are considered separate units of accounting due to each element having value to the customer on a stand-alone basis. The selling price for each unit of accounting is determined using contract price. When the Company's customers purchase several products the pricing of the products sold is generally the same as if the products were sold on an individual basis. Revenue is recognized as the work is performed in accordance with the Company's customer contracts. Based upon the nature of the Company's products, bundled managed care elements are generally delivered in the same accounting period. The Company recognizes revenue for patient management services ratably over the life of the customer contract. The Company estimates, based upon prior experience in managed care, the deferral amount from when the customers claim is received to when the customer contract expires. Advance payments from subscribers and billings made in advance are recorded on the balance sheet as deferred revenue.

Reclassifications – Certain 2013 quarterly balances have been reclassified to conform to the 2014 presentation. The reclassifications have had no effect on the financial position, operations or cash flows for the quarter ended March 31, 2014.

NOTE 2 - SUBSEQUENT EVENTS

In accordance with ASC 855-10 Company management reviewed all material events through the date of issuance and there are no material subsequent events to report.

Item 2. Management's Discussion and Analysis of Financial Statements and Results of Operations

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended and Section 21E of the Securities Exchange Act of 1934, as amended, that are based on our management's beliefs and assumptions and on information currently available to our management. For this purpose any statement contained in this report that is not a statement of historical fact may be deemed to be forward-looking, including statements about our revenue, spending, cash flow, products, actions, intentions, plans, strategies and objectives. Without limiting the foregoing, words such as "*may*," "*hope*," "*will*," "*expect*," "*believe*," "*anticipate*," "*estimate*," "*projected*" or "*continue*" or comparable terminology are intended to identify forward-looking statements. These statements by their nature involve substantial risks and uncertainty, and actual results may differ materially depending on a variety of factors, many of which are not within our control. These factors include but are not limited to economic conditions generally and in the industry in which we and our customers participate; competition within our industry, including competition from much larger competitors; legislative requirements or changes which could render our services less competitive or obsolete; our failure to successfully develop new services and/or products or to anticipate current or prospective customers' needs; price increases or employee limitations; and delays, reductions, or cancellations of contracts we have previously entered.

Forward-looking statements are predictions and not guarantees of future performance or events. The forward-looking statements are based on current industry, financial and economic information, which we have assessed but which by its nature, is dynamic and subject to rapid and possibly abrupt changes. Our actual results could differ materially from those stated or implied by such forward-looking statements due to risks and uncertainties associated with our business. We hereby qualify all our forward-looking statements by these cautionary statements. We undertake no obligation to amend this report or revise publicly these forward-looking statements (other than pursuant to reporting obligations imposed on registrants pursuant to the Securities Exchange Act of 1934) to reflect subsequent events or circumstances.

The following discussion should be read in conjunction with our financial statements and the related notes contained elsewhere in this report and in our other filings with the Securities and Exchange Commission.

Throughout this quarterly report on Form 10-Q, unless the context indicates otherwise, the terms, "we," "us," "our" or "the Company" refer to Pacific Health Care Organization, Inc., ("PHCO") and our wholly-owned subsidiaries Medex Healthcare, Inc. ("Medex"), Industrial Resolutions Coalition, Inc. ("IRC"), Medex Managed Care, Inc. ("MMC"), Medex Medical Management, Inc. ("MMM") and Medex Legal Support, Inc., ("MLS").

Overview

We are a specialty workers' compensation managed care company providing a range of services for California employers and claims administrators. Workers' compensation costs continue to increase due to rising medical costs, inflation, fraud and other factors. Medical and indemnity costs associated with workers' compensation in the state of California are billions of dollars annually. Our focus goes beyond the medical cost of claims. Our goal is to reduce the entire cost of the claim, including medical, legal and administrative costs. Through our wholly-owned subsidiaries we provide a range of effective workers' compensation cost containment services, including but not limited to:

- Health Care Organizations ("HCOs")
- Medical Provider Networks ("MPNs")
- HCO + MPN
- Workers' Compensation Carve-Outs
- Utilization Review ("UR")
- Medical Bill Review ("MBR")
- Nurse Case Management ("NCM")

Health Care Organizations

HCOs are networks of health care professionals specializing in the treatment of workplace injuries and in back-to-work rehabilitation and training. HCOs were created to appeal to employees, while providing substantial savings to the employer clients. In most cases, the HCO program gives the employer client 180 days of medical control in a provider network within which the employer client has the ability to direct the claim. The injured worker may change physicians once, but may not leave the network. The increased length of time during which the employer has control over the claim is designed to decrease the incidence of fraudulent claims and disability awards and is also based upon the notion that if there is more control over medical treatment there will be more control over getting injured workers back on the job and therefore, more control over the cost of claims and workers' compensation premiums.

Our subsidiary Medex holds two HCO licenses. Through these licenses we cover the entire state of California. We offer injured workers a choice of enrolling in an HCO with a network managed by primary care providers requiring referrals to specialists or a second HCO where injured workers do not need any prior authorization to be seen and treated by specialists.

Our two HCO networks have contracted with over 3,900 individual providers and clinics, as well as hospitals, pharmacies, rehabilitation centers and other ancillary services enabling our HCOs to provide comprehensive medical services throughout California. We are continually developing these networks based upon the nominations of new clients and the approvals of their claims administrators. Provider credentialing is performed by Medex.

HCO guidelines impose certain reporting, information delivery and fee collection obligations upon HCOs. These requirements increase the administrative costs and obligations on HCOs as compared to MPNs, although the obligations and cost differentials are not as substantial as they were in the past.

Medical Provider Networks

Like an HCO, an MPN is a network of health care professionals, but MPN networks do not require the same level of medical expertise in treating work place injuries. Under an MPN program the employer client dictates which physician the injured employee will see for the initial visit. Thereafter, the employee can choose to treat with any physician within the MPN network. Under the MPN program, however, for as long as the employee seeks treatment for his injury, he can only seek treatment from physicians within the MPN network.

The MPN program seems to allow medical control by the employer client for the life of the claim because the employee must stay within the MPN network for treatment. However, the employer client has control of only the initial treatment before the employee can treat with anyone in the network. In addition, the MPN statute and regulations allow the injured worker to dispute treatment decisions, leading to second and third opinions, and then a review by an Independent Medical Reviewer, whose decision can result in the employer client losing medical control.

Unlike HCOs, MPNs are not assessed annual fees and have no annual enrollment notice delivery requirements. As a result, there are fewer administrative costs associated with an MPN program, which allows MPNs to market their services at a lower cost than HCOs. For this reason, many clients opt to use the less complicated MPN even though the employer client has less control over employee claims.

HCO + MPN

As a licensed HCO and MPN, in addition to offering HCO and MPN programs, we are also able to offer our clients a combination of the HCO and MPN programs. Under this plan model an employer can enroll its employees in the HCO program, and then prior to the expiration of the 90-day or 180-day treatment period under the HCO program, the employer can enroll the employee into the MPN program. This allows employers to take advantage of both programs. We believe that we are currently the only entity that offers both programs together in a combination program.

Workers' Compensation Carve-outs

Through IRC we seek to create legal agreements for the implementation of Workers' Compensation Carve-Outs for California employers with collective bargaining units and the administration of such programs within the statutory and regulatory requirements. The California legislature permits employers and employees to engage in collective bargaining over alternative systems to resolve disputes in the workers' compensation context. These systems are called carve-outs because the employers and employees covered by such collective bargaining agreements are carved out from the state workers' compensation system.

Utilization Review

Utilization review includes utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with the provision of such medical treatment services pursuant to California Workers' Compensation law, or other jurisdictional statutes.

We provide UR to self-insured clients, insurance companies and public entities. UR helps to reduce costs for the payer and determine if the recommended treatment is appropriate. MMC offers automated review services that can cut the overhead costs of our clients and increase payer savings. Our UR staff is experienced in the workers' compensation industry and dedicated to providing a high standard of customer service.

Medical Bill Review

Medical bill review refers to professional analysis of medical provider, services, or equipment billing to ascertain the proper reimbursement. Such services include, but are not limited to, coding review and rebundling, customary and reasonableness review, fee schedule analysis, out-of-network bill review, pharmacy review, PPO management, and repricing.

In connection with our MBR services, we provide bill review (cost containment) services to self-insured employers, insurance companies and the public sector to help reduce medical expenses paid by our customers. In providing these services we provide network savings on top of State Fee Schedule savings allowing top provider networks to achieve savings.

We offer our clients quick turnaround, state of the art software and the expertise of our bill review staff. We are committed to service and believe the reputation of our staff sets us apart from our competition.

Nurse Case Management

Nurse case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an injured worker's health needs. Our nurse case managers use communication and available resources to promote quality, cost-effective outcomes with the goal of returning the injured worker to gainful employment and maximum medical improvement as soon as medically appropriate.

Our credentialed registered nurses have expertise in various clinical areas and extensive backgrounds in workers' compensation. This combination allows our nurses the opportunity to facilitate medical treatment while understanding the nuances of workers' compensation up to and including litigation. By providing these services, we contribute to effective delivery of medical treatment assuring the injured worker receives quality treatment in a timely and appropriate manner to return the worker to gainful employment.

Lien Representation Services

Through MLS we began offering our customers all aspects of lien defense from negotiation to lien litigation, including filing petitions for reconsideration in February 2012. MLS significantly scaled down its operations in January 2013 as a result of the potential negative impact of Senate Bill 863. Signed into law on August 31, 2012, Senate Bill 863 reactivated significant lien filing fees. Any lien filed after January 1, 2013, must be accompanied by an electronic filing fee to the DWC of $150. Liens filed prior to January 1, 2013 must pay a $100 activation fee prior to any conference or trial. In addition, SB 863 created statutes of limitation for liens – three years for services performed prior to July 1, 2013 and 18 months for services subsequent to that date.

The DWC previously instituted a lien filing fee of $100 in 2002 (this program only lasted 2 years). The immediate result of such fees reduced the number of liens filed in California by approximately 40%. This coupled with the restriction of the new statutes of limitation, has led us to believe that this is an unprofitable market to pursue at the present time. MLS is currently exploring other legal support services to offer to its new and existing clients. MLS did not generate any revenues during the three months ended March 31, 2014. During the three months ended March 31, 2013 MLS recorded revenues totaling $7,999.

We offer our HCO and MPN services through our wholly-owned subsidiary Medex. IRC participate in our Carve-Outs business. MMC oversees and manages our UR and MBR business and MMM oversees our NCM services.

Results of Operations

Comparison of the three months ended March 31, 2014 and 2013

Revenue

Total revenues during the three month period ended March 31, 2014 increased 47% to $2,028,669 compared to the three month period ended March 31, 2013. Although total revenues increased by 47%, the total number of employee enrollees only increased by 11% during the three month period ended March 31, 2014 when compared to the same period in 2013. As of March 31, 2014 we had approximately 597,000 total enrollees. Enrollment consisted of approximately 78,000 HCO enrollees and 519,000 MPN enrollees. By comparison as of March 31, 2013 we had approximately 537,000 total enrollees, including approximately 72,000 HCO enrollees and 465,000 MPN enrollees. Although the net increase in HCO enrollment during the three month period ended March 31, 2014 when compared to the same period in 2013 was 9%, HCO revenues increased by only 5%. This slower growth rate in HCO revenues was primarily attributable to recording a price adjustment to a major customer, partially offset by the addition of new customers.

MPN, UR, MBR, NCM and Other revenues increased by 23%, 118%, 43%, 18% and 15%, respectively compared to the same period in 2013. The increase in MPN revenues of 23% was the result of enrollment increases from existing customers and the addition of new MPN customers. The primary reasons for the growth in our UR, MBR and NCM revenues were mainly attributable to increased marketing efforts to our existing customers and increased customer employee enrollment. The increase of 15% in other revenues resulted from increased network access fees from one major customer partially offset by scaling down our lien representation services in January 2013. Although we realized growth in our total revenues during the three month period ended March 31, 2014 there is no assurance that we will continue our growth rate during the remainder of 2014 at the same rate realized during our first quarter 2014.

Our business generally has a long sales cycle, typically in excess of one year. Once we have established a customer relationship, our revenue adjusts with the growth or retraction of our customers' managed headcount volume. New customers are added throughout the year and other customers terminate from the program for a variety of reasons.

In the current economic environment, we anticipate businesses will continue to seek ways to further reduce their workers' compensation program costs. Even though the HCO and MPN programs have been shown to create a favorable return on investment for employers, (as our services are a significant component of the employers' loss prevention programs), it is always a challenge to justify our fees to our customers, especially in this economy. In order to convince employers that HCO and/or MPN fees are well-spent, we must continue to provide a framework for expeditiously returning employees back to work at the lowest cost. As a result, we may experience some client turnover in the form of existing employer clients seeking to terminate or renegotiate the scope and terms of existing services.

HCO Fees

During the three month periods ended March 31, 2014 and 2013, HCO fee revenues were $259,484 and $246,689, respectively. While HCO enrollment increased 9% during the three month period ended March 31, 2014, we realized only a 5% increase in revenue from HCO fees. As noted above, the slower growth rate in HCO revenues was primarily attributable to recording a price adjustment to a major customer partially offset by the addition of new customers.

MPN Fees

MPN fee revenues for the three month periods ended March 31, 2014 and 2013 were $253,429 and $205,741, respectively, an increase of 23%. During the same period MPN enrollment increased 12%. Revenue growth outpaced enrollment growth principally as a result of an increase in the volume of claims network fees generated from a number of existing clients and higher network administration fees charged to new customers.

UR Fees

During the three month period ended March 31, 2014 UR revenues increased by $393,585 to $725,855 when compared to the same period a year earlier. UR service revenues grew largely as a result of our increased marketing efforts in this area of our business to our existing customers.

MBR fees

During the three month period ended March 31, 2014, MBR revenues increased by $143,639 to $475,220 when compared to the same period a year earlier. MBR service revenues grew largely from the increase in the number of hospital bills reviewed during the three month period ended March 31, 2014 as well as, increased marketing efforts in this area of our business to our existing customers and new customers.

NCM Fees

During the three month periods ended March 31, 2014 and 2013 NCM revenue was $254,129 and $215,116, respectively. This increase of $39,013 was the result of increased customer employee enrollment primarily by existing customers.

Other Fees

Other fees consist of revenues derived from lien service and network access and claims repricing services provided by Medex and MLS. Other fee revenues for the three month periods ended March 31, 2014 and 2013 were $60,552 and $52,713, respectively.

Network Access and Repricing Fees

Our network access and claims repricing fees are generated from certain customers who have access to our network and split with Medex the cost savings generated from their PPO. During the three month periods ended March 31, 2014 and 2013 network access fee revenues generated were $60,522, and $44,714, respectively. This increase of $15,808 was primarily the result of one customer having higher savings realized from using our network.

Lien Representation Fees

MLS commenced offering lien representation services in February 2012. MLS significantly scaled down its operations in January 2013 resulting from the potential negative impact of Senate Bill 863. Signed into law on August 31, 2012, Senate Bill 863 reactivated significant lien filing fees. Any lien filed after January 1, 2013, must be accompanied by an electronic filing fee to the Division of Workers' Compensation of $150. Liens filed prior to January 1, 2013 must pay a $100 activation fee prior to any conference or trial. In addition, SB 863 created statutes of limitation for liens: three years for services performed prior to July 1, 2013, and 18 months for services subsequent to that date.

From 2002 to 2004, the DWC instituted a $100 lien filing fee. The immediate result of such fees reduced the number of liens filed in California by approximately 40%. This coupled with the restriction of the new statutes of limitation, has led us to believe that this is an unprofitable market for us to pursue at the present time. During the three month period ended March 31, 2014 MLS had no revenues and during the same period a year earlier MLS recorded $7,999 in lien service revenues. MLS is currently exploring other legal support services it can offer to new and existing clients.

Expenses

Total expenses for the three months ended March 31, 2014 and 2013 were $1,263,494 and $1,040,550 respectively. The increase of $222,944 was the result of increases in depreciation, bad debt provision, salaries and wages, professional fees, insurance, and outsource service fees, partially offset by decreases in consulting fees, data maintenance and general and administrative expense.

Bad Debt

During the three month period ending March 31, 2014 we recorded a bad debt provision totaling $8,253 to cover potential uncollectible account receivables. During three month period ending March 31, 2013 no bad debt provision was recorded. At March 31, 2014 and December 31, 2013 our allowances for bad debt balances were $24,113 and $15,860, respectively.

Consulting Fees

During the three months ended March 31, 2014 consulting fees decreased to $75,899 from $99,481 during the three months ended March 31, 2013. This decrease of $23,582 was primarily the result of decreased IT consultant fees, the termination of the lien consultant as of January 31, 2013 and termination of an administrative consultant as of March 31, 2013.

Salaries and Wages

Salaries and wages increased $86,491or 17% to $586,827 during the three months ended March 31, 2014 compared to $500,336 during the three months ended March 31, 2013. The increase in salaries and wages was primarily due to hiring new employees as follows:

Medex added, as new positions, a senior account executive in July 2013 and a client liaison administrator in January 2014. PHCO added an accounting clerk in May 2013 and a controller in February 2014 who replaced the accounting manager. MMC hired a director of workers' compensation and managed care in August of 2013 and an account manager in November 2013.

Professional Fees

For the three months ended March 31, 2014 we incurred professional fees of $105,612, compared to $75,778 during the three months ended March 31, 2013. This 39% increase in fees was primarily the result of increased professional fees paid for field case management services, accounting fees and legal expenses.

Insurance

During the three months ended March 31, 2014 we incurred insurance expenses of $68,648, a $10,468 increase over the prior year three-month period. The increase in 2014 was primarily due to premium increases for our employee group health medical coverage resulting from the increase in our total number of employees. We are currently reviewing our entire company insurance policies and do not expect a material increase during the remainder of this fiscal year.

Outsource Service Fees

Outsource service fees consist of costs incurred in outsourcing MBR services and certain NCM and UR services. We do not, at this time, have enough volume to justify creating our own MBR and UR in-house staff. Instead, we utilize outside vendors to provide specific services for our clients, charging additional fees over and above those paid to said vendors for administration and coordination of MBR, NCM and UR services directly to the clients. We incurred $264,568 and $139,257 in outsource service fees during the three-month periods ended March 31, 2014 and 2013, respectively. This $125,311 increase was primarily the result of the increased demand for our MBR, NCM and UR services.

Data Maintenance

During the three months ended March 31, 2014 and 2013 data maintenance fees were $19,171 and $27,737, respectively. The decrease of $8,566 in data maintenance fees was primarily attributable to lower data maintenance costs resulting from fewer numbers of existing customers sending out renewal notifications associated with HCO enrollees for the period ended March 31, 2014.

General and Administrative

General and administrative expenses decreased 4% to $123,361 during the three-month period ended March 31, 2014. This decrease of $5,612 was primarily attributable to decreases in advertising, employment agency fees, equipment and repairs, license and permits, office supplies and travel and entertainment, partially offset by increases in dues and subscriptions, rent equipment, telephone, office rent, vacation expense and miscellaneous general administrative expenses. We expect current levels of general and administrative expenses to increase by approximately 15% to 20% over the remaining months of 2014.

Income from Operations

As a result of the 47% increase in total revenue during the three month period ending March 31, 2014, which was partially offset by the 21% increase in total expenses during the three month period ended March 31, 2014, our income from operations increased by 123% during the three month period ended March 31, 2014.

Income Tax Provision

Because we realized income before taxes of $764,796 during the three month period ended March 31, 2014, compared to $343,296 during the three month period March 31, 2013 we realized a $178,824 or 128%, increase in our income tax provision.

Net Income

During the three months ended March 31, 2014, total revenues of $2,028,669 were higher by $644,559 when compared to the same period in 2013. This increase in total revenues was partially offset by increases in total expenses of $222,944 resulting in income from operations of $765,175 compared to income from operations of $343,560 during three months ended March 31, 2013. Correspondingly, we realized net income of $446,561 for the three months ended March 31, 2014, compared to net income of $203,885, during the three months ended March 31, 2013. We expect increases in revenues to continue in the second quarter of 2014, when compared to the second quarter of 2013. We expect most of this increase to be generated from services offered by the Company to existing and new customers.

Liquidity and Capital Resources

As of March 31, 2014, we had cash on hand of $1,731,388 compared to $1,265,535 at December 31, 2013. The $465,853 increase in cash on hand is primarily the result of increases in revenue from operations, accrued expenses, income tax payable, bad debt provision and depreciation, with decreases in prepaid expenses and prepaid income tax. These changes were partially offset by increases in accounts receivable, other assets, and decreases in accounts payable and deferred rent. Barring a significant downturn in the economy, we believe that cash on hand and anticipated revenues from operations will be sufficient to cover our operating costs over the next twelve months.

We currently have planned certain capital expenditures during the next twelve months to accommodate our growth. We do not anticipate this will require us to seek outside sources of funding. We do, however, from time to time, investigate potential opportunities to expand our business either through the creation of new business lines or the acquisition of existing businesses. We have not identified any suitable opportunity at the current time. An expansion or acquisition of this sort may require greater capital resources than we possess. Should we need additional capital resources, we most likely would seek to obtain such through debt and/or equity financing. We do not currently possess an institutional source of financing. Given current credit market conditions, there is no assurance that we could be successful in obtaining additional debt financing on favorable terms, or at all. Similarly, given current market and economic conditions there is no guarantee that we could negotiate appropriate equity financing.

Cash Flow

During the three months ended March 31, 2014 cash was primarily used to fund operations. We had a net increase in cash of $465,853 during the three months ended March 31, 2014. See below for additional discussion and analysis of cash flow.

	For the three months ended March 31, 2014 (unaudited)	2013 (unaudited)
Net cash provided by (used in) operating activities	$ 485,203	$ (26,795)
Net cash used in investing activities	(16,148)	(988)
Net cash used in financing activities	(3,202)	(4,693)
Net increase (decrease) in cash	$ 465,853	$ (32,476)

During the three months ended March 31, 2014, net cash provided by operating activities was $485,203 compared to net cash used in operating activities of $26,795 during the three months ended March 31, 2013. As discussed herein we realized net income of $446,561 during the three months ended March 31, 2014, compared to net income of $203,885 during the three months ended March 31, 2013.

Summary of Material Contractual Commitments

The following is a summary of our material contractual commitments as of March 31, 2014:

	Payments Due By Period				
	Total	Less than 1 year	1-3 years	3-5 years	More than 5 years
Operating Leases:					
Operating Leases – Equipment (1)	$ 49,745	$ 18,415	$ 31,330	$ -	$ -
Office Leases (2)	281,603	145,479	136,124	-	-
Total Operating Leases	$ 331,348	$ 163,894	$ 167,454	$ -	$ -
Capitalized Leases:					
Capitalized Equipment Leases (3)	$ 19,098	$ 14,323	$ 4,775	-	-
Total Capitalized Equipment Leases	19,098	14,323	4,775	-	-
Less amounts representing interest	(976)	(902)	(74)	-	-
Total Principal	$ 18,122	$ 13,421	$ 4,701	$ -	$ -

(1) In October 2013 we entered into a 36 month operating lease for an office copy machine with monthly payments at $160.93. In December 2013 we leased two document scanners with monthly operating lease payments of $206.93 each for 36 months. In February 2014 we entered into a 36 month operating lease for an office copy machine with monthly payments at $960.

(2) Following is our annual base rent for our office space throughout the remaining term of the lease:

Rent Period	Annual Rent Payments
Apr. 1 to Dec. 31, 2014	$ 108,904
Jan. 1 to Dec. 31, 2015	147,949
Jan. 1 to Feb. 29, 2016	24,750
Total	**$ 281,603**

(3) In January 2010 we entered into a capital lease arrangement whereby we leased an office copy machine for $25,543. The asset was recorded on our balance sheet under office equipment under capital lease and our liability incurred under the lease was recorded as current and noncurrent obligations under capital lease. The lease arrangement is for a term of 48 months at level rents with capital interest rate at 7%. In August 2012, we entered into a capital lease arrangement whereby we leased an office server equipment for $38,380. The asset was recorded on our balance sheet under office equipment under capital lease and our liability incurred under the lease was recorded as current and noncurrent obligations under capital lease. The lease arrangement is for a term of 36 months at level rents with capital interest rate at 7.5%.

Off-Balance Sheet Financing Arrangements

As of March 31, 2014 we had no off-balance sheet financing arrangements.

Critical Accounting Policies and Estimates

The preparation of financial statements in accordance with accounting standards generally accepted in the United States requires management to make estimates and assumptions that affect both the recorded values of assets and liabilities at the date of the financial statements and the revenues recognized and expenses incurred during the reporting period. Our estimates and assumptions affect our recognition of deferred expenses, bad debts, income taxes, the carrying value of its long-lived assets and its provision for certain contingencies. We evaluate the reasonableness of these estimates and assumptions continually based on a combination of historical information and other information that comes to its attention that may vary its outlook for the future. Actual results may differ from these estimates under different assumptions.

We believe the critical accounting policies that most impact our consolidated financial statements are described below.

Basis of Accounting — We use the accrual method of accounting.

Revenue Recognition — In general, the Company recognizes revenue when (i) persuasive evidence of an arrangement exists, (ii) delivery has occurred or services have been rendered, (iii) the fee is fixed or determinable and (iv) collectability is reasonably assured. Revenues are generated as services are provided to the customer based on the sales price agreed and collected. The Company recognizes revenue as the time is worked or as units of production are completed, which is when the revenue is earned and realized. Labor costs are recognized as the costs are incurred. The Company derives its revenue from the sale of Managed Care Services, Review Services and Case Management Services. These services may be sold individually or combined. When a sale combines multiple elements, the Company accounts for multiple-deliverable revenue arrangements in accordance with the guidance included in ASC 605-25.

These fees include monthly administration fees, claim network fees, flat rate fees or hourly fees depending on the agreement with the client. Such revenue is recognized at the end of each month for which services are performed.

Management reviews each agreement in accordance with the provision of the revenue recognition topic ASC 605 that addresses multiple-deliverable revenue arrangements. The multiple-deliverable arrangements entered into consist of bundled managed care which included various units of accounting such as network solutions and patient management which includes managed care. Such elements are considered separate units of accounting due to each element having value to the customer on a stand-alone basis. The selling price for each unit of accounting is determined using contract price. When the Company's customers purchase several products the pricing of the products sold is generally the same as if the products were sold on an individual basis. Revenue is recognized as the work is performed in accordance with the Company's customer contracts. Based upon the nature of the Company's products, bundled managed care elements are generally delivered in the same accounting period. The Company recognizes revenue for patient management services ratably over the life of the customer contract. The Company estimates, based upon prior experience in managed care, the deferral amount from when the customers claim is received to when the customer contract expires. Advance payments from subscribers and billings made in advance are recorded on the balance sheet as deferred revenue.

Principles of Consolidation — The accompanying consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries. Intercompany transactions and balances have been eliminated in consolidation.

Item 3. Quantitative and Qualitative Disclosure about Market Risk

As a smaller reporting company as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and in Item 10(f)(1) of Regulation S-K, we are electing scaled disclosure reporting obligations and therefore are not required to provide the information requested by this Item.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

Our management, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rules 13a-15(e) or 15d-15(e) under the Exchange Act), as of the end of the period covered by this quarterly report on Form 10-Q. Based on this evaluation, our Chief Executive Officer and Chief Financial Officer concluded that as of the end of the period covered by this quarterly report on Form 10-Q, our disclosure controls and procedures were effective in (1) recording, processing, summarizing and reporting, information required to be disclosed by us in the reports that we file or submit under the Exchange Act within the time periods specified in the SEC's rules and forms and (2) ensuring that information disclosed by us in such reports is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting during the quarter ended March 31, 2014 that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1A. Risk Factors

As a smaller reporting company as defined in Rule 12b-2 of the Exchange Act, and in Item 10(f)(1) of Regulation S-K, we are electing scaled disclosure reporting obligations and therefore are not required to provide the information requested by this It

Item 6. Exhibits

Exhibits. The following exhibits are filed or furnished, as applicable, as part of this report:

Exhibit Number	Title of Document
Exhibit 31.1	Certification of Principal Executive Officer pursuant to Rule 13a-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
Exhibit 31.2	Certification of Principal Financial Officer pursuant to Rule 13a-14(a) as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
Exhibit 32.1	Certification pursuant to 18 U.S.C. Section 1350 as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
Exhibit 101.INS	XBRL Instance Document
Exhibit 101.SCH	XBRL Taxonomy Extension Schema Document
Exhibit 101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
Exhibit 101.DEF	XBRL Taxonomy Definition Linkbase Document
Exhibit 101.LAB	XBRL Taxonomy Extension Linkbase Document
Exhibit 101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

PACIFIC HEALTH CARE ORGANIZATION, INC.

Date: May 13, 2014

/s/ Tom Kubota
Tom Kubota
Chief Executive Officer

Date: May 13, 2014

/s/ Fred Odaka
Fred Odaka
Chief Financial Officer

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EXHIBIT 31.1

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER
Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, Tom Kubota, certify that:

1) I have reviewed this quarterly report on Form 10-Q of Pacific Health Care Organization, Inc.

2) Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3) Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of registrant as of, and for, the periods presented in this report;

4) The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

(a) designed such disclosure controls and procedures or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles.

(c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures as of the end of the period covered by this report based on such evaluation; and

(d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal controls over financial reporting; and

5) The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 13, 2014

By: /s/ Tom Kubota
Tom Kubota
Chief Executive Officer

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EXHIBIT 31.2

CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER
Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, Fred Odaka, certify that:

1) I have reviewed this quarterly report on Form 10-Q of Pacific Health Care Organization, Inc.

2) Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3) Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of registrant as of, and for, the periods presented in this report;

4) The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

(a) designed such disclosure controls and procedures or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles.

(c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures as of the end of the period covered by this report based on such evaluation; and

(d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal controls over financial reporting; and

5) The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 13, 2014

By: /s/ Fred Odaka
Fred Odaka
Chief Financial Officer

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EXHIBIT 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT BY
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of Pacific Health Care Organization, Inc. (the "Company") for the period ended March 31, 2014 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), Tom Kubota, Chief Executive Officer of the Company, and Fred Odaka, Chief Financial Officer of the Company, each certifies, pursuant to 18 U.S.C. Section1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

Date: May 13, 2014

/s/ Tom Kubota
Tom Kubota
Chief Executive Officer

Date: May 13, 2014

/s/ Fred Odaka
Fred Odaka
Chief Financial Officer