

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2012</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information

For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012

A This return/report is for: a multiemployer plan; a multiple-employer plan; or
 a single-employer plan; a DFE (specify) _____

B This return/report is: the first return/report; the final return/report;
 an amended return/report; a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here

D Check box if filing under: Form 5558; automatic extension; the DFVC program;
 special extension (enter description) _____

Part II Basic Plan Information --- enter all requested information

1a Name of plan Community Coordinated Care for Children 401(k) Plan	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">001</td> </tr> <tr> <td colspan="2">1c Effective date of plan 01/01/1990</td> </tr> </table>	1b Three-digit plan number (PN) ▶	001	1c Effective date of plan 01/01/1990	
1b Three-digit plan number (PN) ▶	001				
1c Effective date of plan 01/01/1990					
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) Community Coordinated Care for Children, Inc. 3500 W. Colonia Drive US Orlando FL 32808	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) 59-1371754</td> </tr> <tr> <td>2c Sponsor's telephone number (407) 532-4124</td> </tr> <tr> <td>2d Business code (see instructions) 624410</td> </tr> </table>	2b Employer Identification Number (EIN) 59-1371754	2c Sponsor's telephone number (407) 532-4124	2d Business code (see instructions) 624410	
2b Employer Identification Number (EIN) 59-1371754					
2c Sponsor's telephone number (407) 532-4124					
2d Business code (see instructions) 624410					

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		10/15/13	PATRICIA E. FRANK
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10/15/13	PATRICIA E. FRANK
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional)	Preparer's telephone number (optional)
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3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor Name <input type="checkbox"/> Same as Plan Sponsor Address	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 20px; width: 100%;"></div>
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	307
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
a Active participants	6a	209
b Retired or separated participants receiving benefits	6b	0
c Other retired or separated participants entitled to future benefits	6c	71
d Subtotal. Add lines 6a, 6b, and 6c	6d	280
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	280
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	279
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
 2E 2F 2G 2J 2K 2T 3D

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
--	--

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules (1) <input checked="" type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> 1 A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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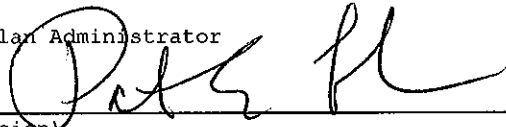
5500 Electronic Filing Authorization

Plan Name: Community Coordinated Care for Children 401(k) Plan
EIN/PN: 59-1371754/001
Plan Year: 01/01/2012 - 12/31/2012

I hereby authorize Bates and Company, Inc. to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500 for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan Administrator

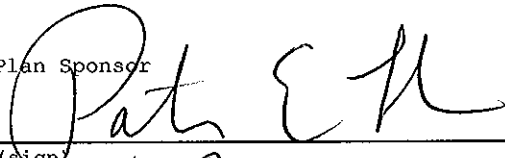


(sign)

10/15/13

(date)

Plan Sponsor



(sign)

10/15/13

(date)

**SUMMARY ANNUAL REPORT
FOR
Community Coordinated Care for Children, Inc. Welfare Benefit Plan**

This is a summary of the annual report of the Community Coordinated Care for Children, Inc. Welfare Benefit Plan, EIN 59-1371754, Plan No. 501, for period June 01, 2011 through May 31, 2012. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with The Lincoln National Life Insurance Company and Unitedhealth Care Insurance Company to pay certain health and welfare benefit claims incurred under the terms of the plan. The total premiums paid for the plan year ending May 31, 2012 were \$2,111,871.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Community Coordinated Care for Children, Inc. at 3500 W. Colonial Drive, Orlando, FL 32808, or by telephone at (407) 532-4124.

You also have the legally protected right to examine the annual report at the main office of the plan (Community Coordinated Care for Children, Inc., 3500 W. Colonial Drive, Orlando, FL 32808) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

EFAST2 Filing Authorization for the Form 5500/5500-SF

Name of Plan: Community Coordinated Care for Children, Inc. Welfare Benefit Plan

EIN/PN: 59-1371754/501

Plan Year Ending: 05/31/2012

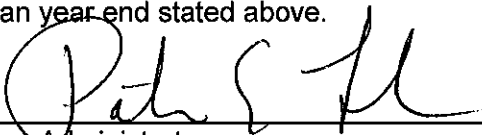
Authorization of Practitioner to Electronically Sign and File

I hereby authorize Verisight, Inc. to electronically sign and file the above-named return/report through EFAST2.

I understand that in granting this authority:

- I must manually sign and date page 1 of the Form 5500 or page 2 of the Form 5500-S/F, as applicable, and provide a scanned copy of that signature page to Verisight before the electronic filing can be initiated;
- Verisight will retain a copy of this written authorization in its records;
- Verisight will notify the individual signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOL, IRS, or PBGC regarding this annual return/report; and
- A copy of my signature, as it appears on page 1 of the Form 5500 or page 2 of the Form 5500-S/F, as applicable, will be included with the return/report posted by the Department of Labor on the Internet for public disclosure.
- Verisight shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.

This authorization is applicable only to the filing for the above-named Plan and applies only for Plan year end stated above.



Plan Administrator

3/6/13
Date

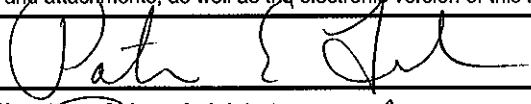
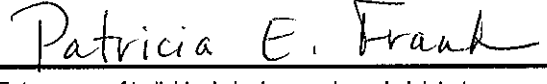
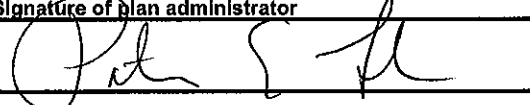
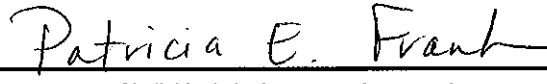
Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2011 This Form Is Open to Public Inspection
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Part I Annual Report Identification Information			
For calendar plan year 2011 or fiscal plan year beginning		06/01/2011	and ending
			05/31/2012
A This return/report is for:	<input type="checkbox"/> a multiemployer plan;	<input type="checkbox"/> a multiple-employer plan; or	
	<input checked="" type="checkbox"/> a single-employer plan;	<input type="checkbox"/> a DFE (specify) _____	
B This return/report is:	<input type="checkbox"/> the first return/report;	<input type="checkbox"/> the final return/report;	
	<input type="checkbox"/> an amended return/report;	<input type="checkbox"/> a short plan year return/report (less than 12 months).	
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>		
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558;	<input type="checkbox"/> automatic extension;	<input type="checkbox"/> the DFVC program;
	<input type="checkbox"/> special extension (enter description)		

Part II Basic Plan Information —enter all requested information			
1a Name of plan	Community Coordinated Care for Children, Inc. Welfare Benefit Plan		
1b Three-digit plan number (PN) ▶	501		
	05/01/1990		
2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan)	2b Employer Identification Number (EIN)		
Community Coordinated Care for Children, Inc.	59-1371754		
3500 W. Colonial Drive	2c Sponsor's telephone number		
Orlando	FL	32808	(407) 532-4124
	2d Business code (see instructions)		
	813000		

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		3/6/13	
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		3/6/13	
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2011)
v.012611



Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <div style="font-size: 2em; font-weight: bold; text-align: center;">2011</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information				
For calendar plan year 2011 or fiscal plan year beginning		06/01/2011	and ending	05/31/2012
A This return/report is for:	<input type="checkbox"/> a multiemployer plan;	<input checked="" type="checkbox"/> a multiple-employer plan; or		
	<input checked="" type="checkbox"/> a single-employer plan;	<input type="checkbox"/> a DFE (specify) _____		
B This return/report is:	<input type="checkbox"/> the first return/report;	<input type="checkbox"/> the final return/report;		
	<input type="checkbox"/> an amended return/report;	<input type="checkbox"/> a short plan year return/report (less than 12 months).		
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>			
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558;	<input type="checkbox"/> automatic extension;	<input type="checkbox"/> the DFVC program;	
	<input type="checkbox"/> special extension (enter description)			

Part II Basic Plan Information —enter all requested information			
1a Name of plan	Community Coordinated Care for Children, Inc. Welfare Benefit Plan		
	1b Three-digit plan number (PN) ▶	501	
		05/01/1990	
2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan)	2b Employer Identification Number (EIN)		
Community Coordinated Care for Children, Inc.	59-1371754		
3500 W. Colonial Drive	2c Sponsor's telephone number		
Orlando	(407) 532-4124		
FL 32808	2d Business code (see instructions)		
	813000		

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		3/6/13	Patricia E. Frank
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		3/6/13	Patricia E. Frank
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") SAME	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN
	4c PN
5 Total number of participants at the beginning of the plan year	5 250
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d). a Active participants b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a, 6b, and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits..... f Total. Add lines 6d and 6e..... g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a 248
	6b 1
	6c 10
	6d 259
	6e
	6f
	6g
	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

4A 4B 4D 4E 4F 4H 4L

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1) **R** (Retirement Plan Information)
- (2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- (1) **H** (Financial Information)
- (2) **I** (Financial Information - Small Plan)
- (3) **3** **A** (Insurance Information)
- (4) **C** (Service Provider Information)
- (5) **D** (DFE/Participating Plan Information)
- (6) **G** (Financial Transaction Schedules)

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2011</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2011 or fiscal plan year beginning 06/01/2011 and ending 05/31/2012

A Name of plan	B Three-digit plan number (PN) ▶	501
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Community Coordinated Care for Children, Inc. Welfare Benefit Plan

C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
Community Coordinated Care for Children, Inc.	59-1371754

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
The Lincoln National Life Insurance Company

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0472300	65676	000010142492	290	06/01/2011	05/31/2012

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
9,626	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

Cash & Associates PA
801 N Orange Ave Ste 810
Orlando FL 32801

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
9,626			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year		7b	
c Additions: (1) Contributions deposited during the year	7c(1)		
	7c(2)		
	7c(3)		
	7c(4)		
	7c(5)		
(6) Total additions		7c(6)	
d Total of balance and additions (add b and c(6))		7d	
e Deductions:			
	7e(1)		
	7e(2)		
	7e(3)		
(4) Other (specify below).....	7e(4)		
(5) Total deductions		7e(5)	
f Balance at the end of the current year (subtract e(5) from d)		7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a Health (other than dental or vision)
- b Dental
- c Vision
- d Life insurance
- e Temporary disability (accident and sickness)
- f Long-term disability
- g Supplemental unemployment
- h Prescription drug
- i Stop loss (large deductible)
- j HMO contract
- k PPO contract
- l Indemnity contract
- m Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)	
	(4) Earned ((1) + (2) - (3)).....		9a(4)
b	Benefit charges (1) Claims paid.....	9b(1)	
	(2) Increase (decrease) in claim reserves.....	9b(2)	
	(3) Incurred claims (add (1) and (2)).....		9b(3)
	(4) Claims charged.....		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions.....	9c(1)(A)	
	(B) Administrative service or other fees.....	9c(1)(B)	
	(C) Other specific acquisition costs.....	9c(1)(C)	
	(D) Other expenses.....	9c(1)(D)	
	(E) Taxes.....	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges.....	9c(1)(G)	
	(H) Total retention.....		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)
	(2) Claim reserves.....		9d(2)
	(3) Other reserves.....		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).).....		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	96,261
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2011 This Form is Open to Public Inspection
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For calendar plan year 2011 or fiscal plan year beginning **06/01/2011** and ending **05/31/2012**

A Name of plan	B Three-digit plan number (PN)	▶ 501
Community Coordinated Care for Children, Inc. Welfare Benefit Plan		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
Community Coordinated Care for Children, Inc.	59-1371754	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
UnitedHealth Care Insurance Company

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2739571	79413	302876	290	06/01/2011	05/31/2012

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
4,325	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
 Ins & Payroll Resource Group
 of Florida
 4301 Vineland Rd #E5
 Orlando FL 32811

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4,325			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits	7c(2)	
(3) Interest credited during the year	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)..... ▶	7c(5)	

(6) Total additions **7c(6)**

d Total of balance and additions (add b and c(6)). **7d**

e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract e(5) from d)..... **7f**

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) **▶** Accidental Death and Dismemberment

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)	
	(4) Earned ((1) + (2) - (3)).....		9a(4)
b	Benefit charges (1) Claims paid.....	9b(1)	
	(2) Increase (decrease) in claim reserves.....	9b(2)	
	(3) Incurred claims (add (1) and (2)).....		9b(3)
	(4) Claims charged.....		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions.....	9c(1)(A)	
	(B) Administrative service or other fees.....	9c(1)(B)	
	(C) Other specific acquisition costs.....	9c(1)(C)	
	(D) Other expenses.....	9c(1)(D)	
	(E) Taxes.....	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges.....	9c(1)(G)	
	(H) Total retention.....		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)
	(2) Claim reserves.....		9d(2)
	(3) Other reserves.....		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).).....		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	43,246
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....	10b	

Specify nature of costs **▶**

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. **▶**

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2011 This Form is Open to Public Inspection
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For calendar plan year 2011 or fiscal plan year beginning 06/01/2011 and ending 05/31/2012

A Name of plan	B Three-digit plan number (PN) ▶	501
Community Coordinated Care for Children, Inc. Welfare Benefit Plan		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
Community Coordinated Care for Children, Inc.	59-1371754	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
 UnitedHealthcare Insurance Company

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2739571	79413	716786	420	06/01/2011	05/31/2012

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
67,178	2,550

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
 Cash & Associates PA
 4301 Vineland Rd Ste E5
 Orlando FL 32811-7371

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
55,740	2,550	Bonus	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
 The Ins & Payroll Resource
 Group of FL
 4301 Vineland Rd Ste E5
 Orlando FL 32811-7371

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
11,438			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
	▶			
(6) Total additions			7c(6)	
d Total of balance and additions (add b and c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
▶				
(5) Total deductions			7e(5)	
f Balance at the end of the current year (subtract e(5) from d)			7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)	
	(4) Earned ((1) + (2) - (3)).....		9a(4)
b	Benefit charges (1) Claims paid.....	9b(1)	
	(2) Increase (decrease) in claim reserves.....	9b(2)	
	(3) Incurred claims (add (1) and (2)).....		9b(3)
	(4) Claims charged.....		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions.....	9c(1)(A)	
	(B) Administrative service or other fees.....	9c(1)(B)	
	(C) Other specific acquisition costs.....	9c(1)(C)	
	(D) Other expenses.....	9c(1)(D)	
	(E) Taxes.....	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges.....	9c(1)(G)	
	(H) Total retention.....		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)
	(2) Claim reserves.....		9d(2)
	(3) Other reserves.....		9d(3)
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).).....		9e

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	1,972,364
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

**Application for Extension of Time
To File Certain Employee Plan Returns**

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.
► Information about Form 5558 and its instructions is at www.irs.gov/form5558

File With IRS Only

Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions) Community Coordinated Care for Children, Inc. Number, street, and room or suite no. (If a P.O. box, see instructions) 3500 W. Colonial Drive City or town, state, and ZIP code Orlando FL 32808	B Filer's identifying number (see instructions) Employer identification number (EIN) (9 digits XX-XXXXXXX) 59-1371754 Social security number (SSN) (9 digits XXX-XX-XXXX)											
C Plan name Community Coordinated Care for Children, Inc. Welfare Benefit Plan	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <th rowspan="2">Plan number</th> <th colspan="3">Plan year ending—</th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YYYY</th> </tr> <tr> <td style="text-align: center;">5 0 1</td> <td style="text-align: center;">5</td> <td style="text-align: center;">31</td> <td style="text-align: center;">2012</td> </tr> </table>	Plan number	Plan year ending—			MM	DD	YYYY	5 0 1	5	31	2012
Plan number	Plan year ending—											
	MM	DD	YYYY									
5 0 1	5	31	2012									

Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA

- 1 Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above.
- 2 I request an extension of time until 3 / 15 / 2013 to file Form 5500 series (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series.
- 3 I request an extension of time until / / to file Form 8955-SSA (see instructions).
Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.

The application is automatically approved to the date shown on line 2 and/or line 3 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and **(b)** the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

Part III Extension of Time To File Form 5330 (see instructions)

- 4 I request an extension of time until / / to file Form 5330.
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.

- a Enter the Code section(s) imposing the tax ►

a	
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- b Enter the payment amount attached ►

b	
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- c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date ►

c	
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5 State in detail why you need the extension:

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Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ► _____ Date ► _____