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

Part I Annual Report Identification Information

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] 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:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
MILITARY DELI & BAKERY SERVICE, INC. HEALTH AND WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/1998

2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan)

MILITARY DELI & BAKERY SERVICE, INC

10600 N TRADEMARK PKWY SUITE 412
RANCHO CUCAMONGA, CA 91730

2b Employer Identification Number (EIN)
95-4598949

2c Sponsor's telephone number
909-373-1344

2d Business code (see instructions)
722210

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	Filed with authorized/valid electronic signature.	10/01/2012	GARY SCHINDLER DIR OF BUS MGMT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	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")
MILITARY DELI & BAKERY SERVICE, INC

10600 N TRADEMARK PKWY SUITE 412
RANCHO CUCAMONGA, CA 91730

3b Administrator's EIN
95-4598949

3c Administrator's telephone number
909-373-1344

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**	853
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**	861
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	861
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	861
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
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 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:
4L 4F 4E 4D 4A

9a Plan funding arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		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)	X	**H** (Financial Information)
(2)		**I** (Financial Information – Small Plan)
(3)		**A** (Insurance Information)
(4)	X	**C** (Service Provider Information)
(5)		**D** (DFE/Participating Plan Information)
(6)		**G** (Financial Transaction Schedules)

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2011** **This Form is Open to Public Inspection.**

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan
MILITARY DELI & BAKERY SERVICE, INC. HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MILITARY DELI & BAKERY SERVICE, INC

D Employer Identification Number (EIN)
95-4598949

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

HEALTH & WELFARE BENEFIT SYSTEMS
PO BOX 21109
ROANOKE, VA 24018

54-1583286

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	PLAN SUPERVISOR	400777	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

KING, SHORES & PRESTON CPAS
2707 BRAMBLETON AVENUE
ROANOKE, VA 24015

54-1643141

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	AUDITOR	7500	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(a) Enter name and EIN or address (see instructions)

FIRST HEALTH GROUP CORP.
8320 WARD PARKWAY
KANSAS CITY, MO 64114

33-0837721

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	46253	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

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Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

a	Name:	**b** EIN:
c	Position:	
d	Address:	**e** Telephone:

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2011

This Form is Open to Public Inspection

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan
MILITARY DELI & BAKERY SERVICE, INC. HEALTH AND WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MILITARY DELI & BAKERY SERVICE, INC

D Employer Identification Number (EIN)
95-4598949

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	1476216	1682031
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	147161	151121
(2) Participant contributions	1b(2)	7880	8185
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	1631257	1841337
Liabilities			
g Benefit claims payable	1g	159657	150815
h Operating payables	1h	37122	40604
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	196779	191419
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	1434478	1649918

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	1647560	
(B) Participants	2a(1)(B)	92171	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		1739731
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		1739731
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1059365	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		1059365
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	7500	
(2) Contract administrator fees	2i(2)	368342	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	89084	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		464926
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		1524291
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		215440
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [X] Unqualified (2) [ ] Qualified (3) [ ] Disclaimer (4) [ ] Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [ ] Yes [X] No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: KING, SHORES & PRESTON CPAS (2) EIN: 54-1643141

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, or MTIA. (2) [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.

During the plan year:

		Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		287000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i		X	
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ **Yes** ☒ **No**

If "Yes," enter the amount of any plan assets that reverted to the employer this year **Amount:**

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

KING, SHORES & PRESTON
CPAS

Independent Auditors' Report

Plan Administrator
Military Deli & Bakery Service, Inc. Health and Welfare Plan

We have audited the accompanying statements of benefit obligations and net assets available for benefits of Military Deli & Bakery Service, Inc. Health and Welfare Plan (the Plan) as of December 31, 2011 and 2010, and the related statements of changes in benefit obligations and net assets available for benefits for the years then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the benefit obligations and net assets available for benefits of Military Deli & Bakery Service, Inc. Health and Welfare Plan as of December 31, 2011 and 2010, and the changes in its benefit obligations and net assets available for benefits for the years then ended in conformity with accounting principles generally accepted in the United States of America.

King, Shores & Preston CPAs
Certified Public Accountants
Roanoke, Virginia
August 23, 201

MILITARY DELI & BAKERY SERVICE, INC.
HEALTH AND WELFARE PLAN
Financial Statements
December 31, 2011 and 2010

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KING, SHORES & PRESTON
CPAS

Independent Auditors' Report

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King, Shores & Preston CPAs
Certified Public Accountants
Roanoke, Virginia
August 23, 201

MILITARY DELI & BAKERY SERVICE, INC.
HEALTH AND WELFARE PLAN
Statements of Benefit Obligations and Net Assets Available for Benefits
December 31, 2011 and 2010

	2011	2010
BENEFIT OBLIGATIONS		
Claims payable and claims incurred but not reported	$ 150,815	$ 159,657
TOTAL BENEFIT OBLIGATIONS	150,815	159,657
ASSETS		
Cash and cash equivalents	1,682,031	1,476,216
Sponsor contributions receivable	151,121	147,161
Participant contributions receivable	8,185	7,880
Total assets	1,841,337	1,631,257
LIABILITIES		
Accounts payable	40,604	37,122
Total liabilities	40,604	37,122
NET ASSETS AVAILABLE FOR BENEFITS	1,800,733	1,594,135
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	$ 1,649,918	$ 1,434,478

See accompanying notes to financial statements.

MILITARY DELI & BAKERY SERVICE, INC.
HEALTH AND WELFARE PLAN
Statements of Changes in Benefit Obligations and Net Assets Available for Benefits
For the Years Ended December 31, 2011 and 2010

	2011	2010
INCREASE (DECREASE) IN BENEFIT OBLIGATIONS		
Increase (decrease) during the period attributable to claims payable and claims incurred but not reported	$ (8,842)	$ 73,375
INCREASE (DECREASE) IN BENEFIT OBLIGATIONS	(8,842)	73,375
NET INCREASE IN NET ASSETS AVAILABLE FOR BENEFITS		
ADDITIONS		
Sponsor contributions	1,647,560	1,561,945
Participant contributions	92,171	93,765
TOTAL ADDITIONS	1,739,731	1,655,710
DEDUCTIONS		
Claims payments	1,068,207	889,726
Claims administration fees	368,342	371,716
Accounting and auditing fees	7,500	5,000
Network and repricing fees	78,688	70,408
Reinsurance premiums	-	43,232
Miscellaneous administrative costs	10,396	9,182
TOTAL DEDUCTIONS	1,533,133	1,389,264
NET INCREASE IN NET ASSETS AVAILABLE FOR BENEFITS	206,598	266,446
CHANGE IN EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	215,440	193,071
EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS		
Beginning of year	1,434,478	1,241,407
End of year	$ 1,649,918	$ 1,434,478

See accompanying notes to financial statements.

NOTE 1: DESCRIPTION OF PLAN

The following description of Military Deli & Bakery Service, Inc. Health and Welfare Plan (the Plan) provides only general information. Participants should refer to the plan agreement for a complete description of the Plan's provisions.

General: The Plan was established January 1, 1998 to provide health and other benefits to eligible participants. Substantially all employees of Military Deli & Bakery Service, Inc. (the Plan Sponsor) employed under a federal service contract are eligible to participate in the Plan. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Benefits: The Plan provides medical, hospital, dental, vision, death, short-term disability, prescription drug, and supplemental accident benefits for eligible participants and their dependants. The Plan provides substantially all these benefits on a self-funded basis. There was a stop-loss insurance policy in place at the beginning of 2010. However, the stop-loss insurance policy was terminated for the Plan effective June 30, 2010. No loss to the Plan is believed to have occurred as a result of the cancellation.

Medical care claims are processed by a third-party administrator.

NOTE 2: SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting: The financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

Use of Estimates: The preparation of financial statements in conformity with generally accepted accounting principles requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Cash and Cash Equivalents: The Plan considers all financial instruments purchased with an original maturity of three months or less to be cash equivalents.

Benefit Obligations: Benefit obligations include those claims for which services have been performed but which have not been paid as of December 31. Plan liabilities for claims incurred but not reported are estimated based on actual experience subsequent to the Plan's year-end. Based on the inherent uncertainties involved, it is reasonably possible that the estimate will change in the near term.

Administrative Expenses: The Plan's administrative fees, including medical care claims processing, are paid by the Plan.

Accounts Payable: This amount represents certain administrative fees pertaining to the current year, but not yet paid at year end.

Subsequent Events: Plan management has evaluated subsequent events through August 23, 2012, which is the date of the independent auditors' report, and determined that there were no subsequent events requiring disclosure.

NOTE 3: CONTRIBUTIONS

The Plan is funded by contributions from the Plan Sponsor and Plan participants. The Plan provides coverage for participants and their dependents, but if desired, spousal coverage must be purchased by the participants. Benefit payments are made from these contributions. Contributions are allocated to Plan benefits and expenses in accordance with an administrative services agreement between the Plan Sponsor and the third party administrator. The Plan Sponsor is ultimately responsible for the allocation and administration of funds and benefits provided.

NOTE 4: INCOME TAX STATUS

The Plan has not applied for exemption from state or federal income taxes. Plan management believes that the Plan qualifies for exemption from income tax under the Internal Revenue Code, and therefore, no provision for income taxes is reflected in the accompanying financial statements.

NOTE 5: CONCENTRATION

The Plan maintains its cash accounts in a commercial bank. Accounts are normally insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 per account holder. Beginning December 31, 2010, through December 31, 2012, all non-interest bearing accounts are fully insured regardless of balance. Because of this, there were no uninsured cash balances at December 31, 2011 and 2010.

NOTE 6: PLAN TERMINATION

Although is has not expressed any intent to do so, the Sponsor has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA.

NOTE 7: PARTY IN INTEREST TRANSACTIONS

Administrative fees paid to the Plan's third-party administrator during the years ended December 31, 2011 and 2010 were $393,722 and $396,260, respectively. At December 31, 2011 and 2010, amounts payable to the Plan's third-party administrator were $40,604 and $33,549, respectively.

NOTE 8: PLAN AMENDMENTS

Effective April 1, 2010, the Plan was amended to comply with the requirements of the Children's Health Insurance Program Reauthorization Act of 2010 (CHIPRA), which requires group health plans to provide a special enrollment period for those eligible employees and their dependents that lose Medicaid or CHIP coverage, or become eligible for premium assistance in the employer's group health plan under a Medicaid or CHIP program.