

**Form 5500-SF**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Short Form Annual Return/Report of Small Employee Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**

OMB Nos. 1210-0110  
1210-0089

**2024**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A** This return/report is for:  a single-employer plan  a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)
- 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** Check box if filing under:  Form 5558  automatic extension  DFVC program  
 special extension (enter description)
- D** If the plan is a collectively-bargained plan, check here ..... ▶
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ..... ▶

**Part II Basic Plan Information**—enter all requested information

<b>1a</b> Name of plan VALLEY DRUG OF MALTA, INC. DBA ZIEGLER PHARMACY CASH BALANCE PLAN		<b>1b</b> Three-digit plan number (PN) ▶	002
		<b>1c</b> Effective date of plan	01/01/2018
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) VALLEY DRUG OF MALTA, INC. ZIEGLER PHARMACY  PO BOX 1240 MALTA, MT 59538		<b>2b</b> Employer Identification Number (EIN)	81-0414201
		<b>2c</b> Sponsor's telephone number	406-654-2038
		<b>2d</b> Business code (see instructions)	446110
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		<b>3b</b> Administrator's EIN	
		<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. <b>a</b> Sponsor's name <b>c</b> Plan Name		<b>4b</b> EIN	
		<b>4d</b> PN	
<b>5a</b> Total number of participants at the beginning of the plan year .....	<b>5a</b>		4
<b>b</b> Total number of participants at the end of the plan year .....	<b>5b</b>		4
<b>c(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....	<b>5c(1)</b>		
<b>c(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>5c(2)</b>		
<b>d(1)</b> Total number of active participants at the beginning of the plan year .....	<b>5d(1)</b>		4
<b>d(2)</b> Total number of active participants at the end of the plan year .....	<b>5d(2)</b>		3
<b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>5e</b>		0

**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, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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.	09/23/2025	GREG ZIEGLER
	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

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) .....  Yes  No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) .....  Yes  No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? .....  Yes  No  Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year \_\_\_\_\_ (See instructions.)

<b>Part III Financial Information</b>			
<b>7</b> Plan Assets and Liabilities		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total plan assets .....	<b>7a</b>	455578	586140
<b>b</b> Total plan liabilities .....	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	455578	586140
<b>8</b> Income, Expenses, and Transfers for this Plan Year		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>	103538	
<b>(2)</b> Participants .....	<b>8a(2)</b>		
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>		
<b>b</b> Other income (loss) .....	<b>8b</b>	27024	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		130562
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>		
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .	<b>8e</b>		
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>		
<b>g</b> Other expenses .....	<b>8g</b>		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		0
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		130562
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>		

<b>Part IV Plan Characteristics</b>	
<b>9a</b>	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 1B 1C 3D
<b>b</b>	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

<b>Part V Compliance Questions</b>				
<b>10</b> During the plan year:		<b>Yes</b>	<b>No</b>	<b>Amount</b>
<b>a</b> 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) .....	<b>10a</b>		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	<b>10b</b>		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	<b>10c</b>	X		30000
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	<b>10d</b>		X	
<b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....	<b>10e</b>		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	<b>10f</b>		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....	<b>10g</b>		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	<b>10h</b>			
<b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....	<b>10i</b>			

**Part VI Pension Funding Compliance**

**11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below.  Yes  No

**a** Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a** 0

**b PBGC missed contribution reporting requirements.** If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

Yes.

No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

No. Other. Provide explanation \_\_\_\_\_

**12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.  Yes  No

**a** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.**

**b** Enter the minimum required contribution for this plan year **12b**

**c** Enter the amount contributed by the employer to the plan for this plan year **12c**

**d** Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) **12d**

**e** Will the minimum funding amount reported on line 12d be met by the funding deadline?  Yes  No  N/A

**Part VII Plan Terminations and Transfers of Assets**

**13a** Has a resolution to terminate the plan been adopted in any plan year?  Yes  No

**a** If "Yes," enter the amount of any plan assets that reverted to the employer this year. **13a**

**b** Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?  Yes  No

**c** 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.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

**Part VIII IRS Compliance Questions**

**14a** Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules?  Yes  No

**14b** If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

- Design-based safe harbor method
- "Prior year" ADP test
- "Current year" ADP test
- N/A

**15** If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 03 / 30 / 2018 (MM/DD/YYYY) and the Opinion Letter serial number J501723A.

<b>SCHEDULE SB</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500 or 5500-SF.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

▶ **Round off amounts to nearest dollar.**  
 ▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan <u>VALLEY DRUG OF MALTA, INC. DBA ZIEGLER PHARMACY CASH BALANCE PLAN</u>	<b>B</b> Three-digit plan number (PN) ▶	<u>002</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>VALLEY DRUG OF MALTA, INC.</u>	<b>D</b> Employer Identification Number (EIN) <u>81-0414201</u>	
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

**Part I Basic Information**

<b>1</b> Enter the valuation date:	Month <u>12</u> Day <u>31</u> Year <u>2024</u>		
<b>2</b> Assets:			
<b>a</b> Market value .....	<b>2a</b>	<u>482602</u>	
<b>b</b> Actuarial value .....	<b>2b</b>	<u>482602</u>	
<b>3</b> Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
<b>a</b> For retired participants and beneficiaries receiving payment .....	<u>0</u>	<u>0</u>	<u>0</u>
<b>b</b> For terminated vested participants .....	<u>1</u>	<u>3306</u>	<u>3306</u>
<b>c</b> For active participants .....	<u>3</u>	<u>499170</u>	<u>499170</u>
<b>d</b> Total .....	<u>4</u>	<u>502476</u>	<u>502476</u>
<b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
<b>a</b> Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>		
<b>b</b> Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor .....	<b>4b</b>		
<b>5</b> Effective interest rate .....	<b>5</b>	<u>5.59 %</u>	
<b>6</b> Target normal cost			
<b>a</b> Present value of current plan year accruals .....	<b>6a</b>	<u>84091</u>	
<b>b</b> Expected plan-related expenses .....	<b>6b</b>	<u>0</u>	
<b>c</b> Target normal cost .....	<b>6c</b>	<u>84091</u>	

**Statement by Enrolled Actuary**  
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>			
	Signature of actuary	<u>09/23/2025</u>	Date
	<u>MICHEAL SPICKARD, EA</u>	<u>23-05310</u>	Most recent enrollment number
	<u>SUMMIT RPS</u>	<u>330-730-7432</u>	Telephone number (including area code)
	<u>3137 NORTHVIEW ROAD UNIONTOWN, OH 44685</u>		
	Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions



**Part V Assumptions Used to Determine Funding Target and Target Normal Cost**

<b>21</b> Discount rate:				
<b>a</b> Segment rates:	1st segment: 5.03 %	2nd segment: 5.26 %	3rd segment: 5.59 %	<input type="checkbox"/> N/A, full yield curve used
<b>b</b> Applicable month (enter code) .....				<b>21b</b> 1
<b>22</b> Weighted average retirement age .....				<b>22</b> 65
<b>23</b> Mortality table(s) (see instructions)	<input checked="" type="checkbox"/> Prescribed - combined	<input type="checkbox"/> Prescribed - separate	<input type="checkbox"/> Substitute	

**Part VI Miscellaneous Items**

<b>24</b> Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<b>25</b> Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<b>26</b> Demographic and benefit information		
<b>a</b> Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<b>b</b> Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment ...	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<b>27</b> If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	<b>27</b>	

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

<b>28</b> Unpaid minimum required contributions for all prior years .....	<b>28</b>	0
<b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	<b>29</b>	0
<b>30</b> Remaining amount of unpaid minimum required contributions (line 28 minus line 29).....	<b>30</b>	0

**Part VIII Minimum Required Contribution For Current Year**

<b>31</b> Target normal cost and excess assets (see instructions):			
<b>a</b> Target normal cost (line 6c) .....	<b>31a</b>	84091	
<b>b</b> Excess assets, if applicable, but not greater than line 31a .....	<b>31b</b>	0	
<b>32</b> Amortization installments:	Outstanding Balance	Installment	
<b>a</b> Net shortfall amortization installment .....	19874	1917	
<b>b</b> Waiver amortization installment.....	0	0	
<b>33</b> If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount .....	<b>33</b>		
<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).....	<b>34</b>	86008	
	Carryover balance	Prefunding balance	Total balance
<b>35</b> Balances elected for use to offset funding requirement .....	0	0	0
<b>36</b> Additional cash requirement (line 34 minus line 35) .....	<b>36</b>	86008	
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....	<b>37</b>	99510	
<b>38</b> Present value of excess contributions for current year (see instructions)			
<b>a</b> Total (excess, if any, of line 37 over line 36)	<b>38a</b>	13502	
<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances.....	<b>38b</b>	0	
<b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....	<b>39</b>	0	
<b>40</b> Unpaid minimum required contributions for all years .....	<b>40</b>	0	

**Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions)**

<b>41</b> If an election was made to use the extended amortization rule for a plan year beginning on or before December 31, 2021, check the box to indicate the first plan year for which the rule applies. <input type="checkbox"/> 2019 <input type="checkbox"/> 2020 <input type="checkbox"/> 2021
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**Form 5500-SF**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Short Form Annual Return/Report of Small Employee Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500-SF.**

OMB Nos. 1210-0110  
1210-0089

**2024**

**This Form Is Open to Public Inspection**

**Part I Annual Report Identification Information**

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

- A** This return/report is for:  a single-employer plan  a multiple-employer plan (not multiemployer) (Pension Plan filers checking this box must attach Schedule MEP. Other plans must attach a list of participating employer information in accordance with the form instructions.)
- 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** Check box if filing under:  Form 5558  automatic extension  DFVC program  
 special extension (enter description)
- D** If the plan is a collectively-bargained plan, check here
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan VALLEY DRUG OF MALTA, INC. DBA ZIEGLER PHARMACY CASH BALANCE PLAN	<b>1b</b> Three-digit plan number (PN) ▶ 002
	<b>1c</b> Effective date of plan 01/01/2018
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see Instructions) VALLEY DRUG OF MALTA, INC.  ZIEGLER PHARMACY  PO BOX 1240  MALTA MT 59538	<b>2b</b> Employer Identification Number (EIN) 81-0414201
	<b>2c</b> Sponsor's telephone number (406) 654-2038
	<b>2d</b> Business code (see Instructions) 446110
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	<b>3b</b> Administrator's EIN
	<b>3c</b> Administrator's telephone number
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN <b>4d</b> PN
<b>5a</b> Total number of participants at the beginning of the plan year	<b>5a</b> 4
<b>b</b> Total number of participants at the end of the plan year	<b>5b</b> 4
<b>c(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	<b>5c(1)</b>
<b>c(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>5c(2)</b>
<b>d(1)</b> Total number of active participants at the beginning of the plan year	<b>5d(1)</b> 4
<b>d(2)</b> Total number of active participants at the end of the plan year	<b>5d(2)</b> 3
<b>e</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>5e</b> 0

**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, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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.

<b>SIGN HERE</b>		9-23-25	GREG ZIEGLER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) .....  Yes  No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) .....  Yes  No  
 If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? .....  Yes  No  Not determined  
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year \_\_\_\_\_ (See instructions.)

**Part III | Financial Information**

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
<b>a</b> Total plan assets .....	7a	455,578	586,140
<b>b</b> Total plan liabilities .....	7b		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	7c	455,578	586,140
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
(1) Employers .....	8a(1)	103,538	
(2) Participants .....	8a(2)		
(3) Others (including rollovers) .....	8a(3)		
<b>b</b> Other income (loss) .....	8b	27,024	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	8c		130,562
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	8d		
<b>e</b> Certain deemed and/or corrective distributions (see instructions) .	8e		
<b>f</b> Administrative service providers (salaries, fees, commissions) ....	8f		
<b>g</b> Other expenses .....	8g		
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	8h		0
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	8i		130,562
<b>j</b> Transfers to (from) the plan (see instructions) .....	8j		

**Part IV | Plan Characteristics**

- 9a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 1B 1C 3D
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

**Part V | Compliance Questions**

10 During the plan year:		Yes	No	Amount
<b>a</b> 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) .....	10a		X	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	10b		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	10c	X		30,000
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	10d		X	
<b>e</b> Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.) .....	10e		X	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	10f		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....	10g		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	10h			
<b>i</b> If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....	10i			

**Part VI Pension Funding Compliance**

**11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 11 blank and complete line 12 below.  Yes  No

**a** Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 ..... **11a** 0

**b** PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:  
 Yes.  
 No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.  
 No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.  
 No. Other. Provide explanation \_\_\_\_\_

**12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? .....  Yes  No  
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

**a** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. .... Month Day Year

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

**b** Enter the minimum required contribution for this plan year ..... **12b**

**c** Enter the amount contributed by the employer to the plan for this plan year ..... **12c**

**d** Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) ..... **12d**

**e** Will the minimum funding amount reported on line 12d be met by the funding deadline?.....  Yes  No  N/A

**Part VII Plan Terminations and Transfers of Assets**

**13a** Has a resolution to terminate the plan been adopted in any plan year? .....  Yes  No

**a** If "Yes," enter the amount of any plan assets that reverted to the employer this year..... **13a**

**b** Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....  Yes  No

**c** 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.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

**Part VIII IRS Compliance Questions**

**14a** Does the plan satisfy the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules?  Yes  No

**14b** If this is a Code section 401(k) plan, check all boxes that apply to indicate how the plan is intended to satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under Code sections 401(k)(3) and 401(m)(2).

- Design-based safe harbor method
- "Prior year" ADP test
- "Current year" ADP test
- N/A

**15** If the plan sponsor is an adopter of a pre-approved plan that received a favorable IRS Opinion Letter, enter the date of the Opinion Letter 03/30/2018 (MM/DD/YYYY) and the Opinion Letter serial number J501723a.

**SCHEDULE SB  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan  
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500 or 5500-SF.

OMB No. 1210-0110

**2024**

This Form Is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

▶ Round off amounts to nearest dollar.

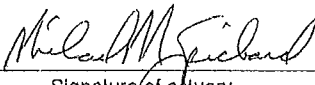
▶ Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan VALLEY DRUG OF MALTA, INC. DBA ZIEGLER PHARMACY CASH BALANCE PLAN	<b>B</b> Three-digit plan number (PN) ▶	002
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF VALLEY DRUG OF MALTA, INC.	<b>D</b> Employer Identification Number (EIN)  81-0414201	
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		
<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500		

Part I Basic Information			
1	Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2024</u>		
2	Assets:		
	a Market value .....	<b>2a</b>	482,602
	b Actuarial value .....	<b>2b</b>	482,602
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target
	a For retired participants and beneficiaries receiving payment.....	0	0
	b For terminated vested participants.....	1	3,306
	c For active participants .....	3	499,170
	d Total.....	4	502,476
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>		
	a Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	<b>4b</b>	
5	Effective interest rate .....	<b>5</b>	5.59 %
6	Target normal cost.....		
	a Present value of current plan year accruals.....	<b>6a</b>	84,091
	b Expected plan-related expenses .....	<b>6b</b>	0
	c Target normal cost .....	<b>6c</b>	84,091

**Statement by Enrolled Actuary**

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>	 Signature of actuary	09/20/2025 Date
	MICHEAL SPICKARD, EA Type or print name of actuary	23-05310 Most recent enrollment number
	SUMMIT RPS Firm name	(330) 730-7432 Telephone number (including area code)
	3137 NORTHVIEW ROAD  UNIONTOWN OH 44685 Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2024  
v. 240311



**Part V Assumptions Used to Determine Funding Target and Target Normal Cost**

21 Discount rate:

a Segment rates:	1st segment: 5.03 %	2nd segment: 5.26 %	3rd segment: 5.59 %	<input type="checkbox"/> N/A, full yield curve used
------------------	------------------------	------------------------	------------------------	---

b Applicable month (enter code) ..... 21b 1

22 Weighted average retirement age ..... 22 65

23 Mortality table(s) (see instructions)  Prescribed - combined  Prescribed - separate  Substitute

**Part VI Miscellaneous Items**

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.....  Yes  No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.....  Yes  No

26 Demographic and benefit information

a Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....  Yes  No

b Is the plan required to provide a projection of expected benefit payments? If "Yes," see instructions regarding required attachment...  Yes  No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment..... 27

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

28 Unpaid minimum required contributions for all prior years ..... 28 0

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)..... 29 0

30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29) ..... 30 0

**Part VIII Minimum Required Contribution For Current Year**

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6c) .....	31a	84,091
b Excess assets, if applicable, but not greater than line 31a .....	31b	0

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment .....	19,874	1,917
b Waiver amortization installment.....	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_) and the waived amount ..... 33

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).... 34 86,008

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement .....	0	0	0
36 Additional cash requirement (line 34 minus line 35) .....			86,008
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....			99,510

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36)	38a	13,502
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....	38b	0

39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) ..... 39 0

40 Unpaid minimum required contributions for all years ..... 40 0

**Part IX Pension Funding Relief Under the American Rescue Plan Act of 2021 (See Instructions)**

41 If an election was made to use the extended amortization rule for a plan year beginning on or before December 31, 2021, check the box to indicate the first plan year for which the rule applies.  2019  2020  2021

**SCHEDULE SB, LINE 22**  
**DESCRIPTION OF WEIGHTED AVERAGE**  
**RETIREMENT AGE**

Each Participant is assumed to retire at his/her normal retirement age. The age entered is the age specified in the Plan.

Plan Name:	Valley Drug of Malta, Inc. dba Ziegler Pharmacy Cash Balance Plan
Plan Sponsor's Name:	Valley Drug of Malta Inc. dba Ziegler Pharmacy
Plan Number:	002
EIN:	81-0414201

## Schedule SB, Part V - Statement of Actuarial Assumptions

Target Assumptions:

Male Nonannuitant: 2024 Nonannuitant Male  
 Female Nonannuitant: 2024 Nonannuitant Female  
 Male Annuitant: 2024 Annuitant Male  
 Female Annuitant: 2024 Annuitant Female  
 Applicable months from valuation month: 1  
 Probability of lump sum: 100.00%  
 Use pre-retirement mortality: No

Options:

Use optional combined mortality table for small plans: Yes  
 Use discount rate transition: No  
 Lump sums use proposed regulations: Yes

Actuarial Equivalent Floor

Stability period: plan year  
 Lookback months: 1  
 Nonannuitant: N/A  
 Annuitant: 2024 Applicable

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Segment rates:	5.03	5.28	5.36
High Quality Bond rates:	N/A	N/A	N/A
Final rates:	5.03	5.28	5.59
Override:	0.00	0.00	0.00

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
Current:	5.01	5.13	5.15
Override:	0.00	0.00	0.00

Salary Scale

Male: 0.00%  
 Female: 0.00%

Late Retirement Rates

Male: N/A  
 Female: N/A

Withdrawal

Male: N/A  
 Female: N/A

Marriage Probability

Male: 0.00%  
 Female: 0.00%  
 Expense loading: 0.00%

Setback

0

Withdrawal-Select

Male: N/A  
 Female: N/A

Disability Rates

Male: N/A  
 Female: N/A

Early Retirement Rates

Male: N/A  
 Female: N/A

Mortality

Male: N/A  
 Female: N/A

Setback

0  
 0

Subsidized Early Retirement Rates

Male: N/A  
 Female: N/A

Name of Plan: VALLEY DRUG OF MALTA, INC  
 Plan Sponsor's EIN: 06-1520181  
 Plan Number: 002



Schedule SB, Part V - Summary of Plan Provisions

	<u>Annuity</u>	<u>Percent</u>	<u>Years</u>
Normal:	Life only	0.00%	0
QJSA:	Joint and contingent	50.00%	0

Significant Changes in Plan Provisions Since Last Valuation

Name of Plan: VALLEY DRUG OF MALTA, INC DBA ZIEGLER PHARMACY CASH BALANCE  
Plan Sponsor's EIN: 06-1520181  
Plan Number: 002

## Schedule SB, Part V - Summary of Plan Provisions

### Benefit Formula

Benefits are based on the actuarial equivalent of the hypothetical account balance. The hypothetical contributions are \$100,000 for the owner/ pharmacist plus 3% of compensation for other participants.

Name of Plan: VALLEY DRUG OF MALTA, INC DBA ZIEGLER PHARMACY CASH BALANCE  
Plan Sponsor's EIN: 06-1520181  
Plan Number: 002

**Schedule SB, line 32 - Schedule of Amortization Bases**

Charges/Credits

<u>Type of Base</u>	<u>Effective Date</u>	<u>Interest Rate</u>	<u>Initial Amount</u>	<u>Initial Amort</u>	<u>Current Balance</u>	<u>Rem Amort</u>	<u>Payment</u>
Shortfall	12/31/2023	5.03 / 5.28	16,294	15.00	15,304	14.00	1,492
Shortfall	12/31/2024	5.03 / 5.28	4,570	15.00	4,570	15.00	425
<b>Totals</b>	Shortfall				19,874		1,917

Name of Plan: VALLEY DRUG OF MALTA, INC DBA ZIEGLER PHARMACY CASH BALANCE  
 Plan Sponsor's EIN: 06-1520181  
 Plan Number: 002