

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

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

- 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

1a Name of plan HEARING CENTER MANAGEMENT COMPANY, LTD. PROFIT SHARING PLAN	1b Three-digit plan number (PN) ▶	003
	1c Effective date of plan	01/01/2013
2a 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) HEARING CENTER MANAGEMENT COMPANY, LTD. 4072 MUNSON ST. NW CANTON, OH 44718	2b Employer Identification Number (EIN)	46-4251129
	2c Sponsor's telephone number	330-493-3400
	2d Business code (see instructions)	621340
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b Administrator's EIN	
	3c Administrator's telephone number	
4 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. a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5a Total number of participants at the beginning of the plan year	5a	14
b Total number of participants at the end of the plan year.....	5b	0
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	5c(1)	12
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	5c(2)	0
d(1) Total number of active participants at the beginning of the plan year.....	5d(1)	14
d(2) Total number of active participants at the end of the plan year.....	5d(2)	0
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	5e	

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.	07/23/2024	MIA M. MOUNTS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/23/2024	MIA M. MOUNTS
	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
a Total plan assets	7a	100904	0
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	100904	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)		
(2) Participants.....	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss).....	8b		
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b).....	8c		
d Benefits paid (including direct rollovers and insurance premiums to provide benefits).....	8d	100904	
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f		
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		100904
i Net income (loss) (subtract line 8h from line 8c).....	8i		-100904
j 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: 2A 2E 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
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)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.).....	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		400000
d 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	
e 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	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X	
i 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 [X] No

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

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 [X] 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? [X] Yes [] No

a If "Yes," enter the amount of any plan assets that reverted to the employer this year..... 13a 0

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? [X] 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.)

Table with 3 columns: 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 [X] 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 06/30/2020 (MM/DD/YYYY) and the Opinion Letter serial number Q703007A.

E-SIGNATURE AUTHORIZATION

for

Hearing Center Management Company, Ltd. Profit Sharing Plan

46-4251129/003

For Plan Year 01/01/2023 through 12/31/2023

I/We, the undersigned, understand that a 5500 Series filing for the plan listed above must be prepared, electronically signed and electronically transmitted to the EBSA Electronic Filing Acceptance System (EFAST).

I/We authorize Barlow Consulting, Inc. to electronically sign the 5500 Series filing on my/our behalf and to transmit that signed form to EFAST on or before the filing due date.

I/We understand that by granting this authority:

- A manually signed and dated Form 5500-SF that has been provided must be returned to Barlow Consulting, Inc. before they can begin the electronic filing process. I/We will retain a copy of this manually signed form and any schedules and attachments in the plan records.
- Barlow Consulting, Inc. will not be responsible for any late filing penalty assessed under ERISA should I/we not return the manually signed and dated Form 5500-SF prior to the filing due date.
- An electronic copy of the manually signed and dated Form 5500-SF showing my/our signatures will be included in the electronic filing and will be posted by the EBSA to the Internet for public disclosure.
- Barlow Consulting, Inc. will maintain a copy of this written authorization in its records.
- Barlow Consulting, Inc. will notify all signers about any inquiries and correspondence it receives about this filing from EFAST, EBSA, IRS or PBGC.
- Barlow Consulting, Inc. shall not be deemed to be a plan fiduciary with respect to this plan solely on account of providing the electronic signature and filing of the 5500-SF for the plan year listed above.

HCMC, Ltd. by:
Mua M. Mousset, Mg. Mbr.
Plan Administrator

7-23-24
Date

HCMC Ltd. by:
Mua M. Mousset, Mg. Mbr.
Plan Sponsor

7-23-24
Date

E-SIGNATURE AUTHORIZATION

for

Hearing Center Management Company, Ltd. Cash Balance Plan

46-4251129/002

For Plan Year 01/01/2023 through 12/31/2023

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HCMCLtd, by
Mia M. Morantz, Mg. Mbr.
Plan Administrator

7-23-24
Date

HCMC, Ltd by:
Mia M. Morantz, Mg. Mbr.
Plan Sponsor

7-23-24
Date

Form 5500-SF

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Internal Revenue Service

Department of Labor
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2023

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- 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

1a Name of plan Hearing Center Management Company, Ltd. Profit Sharing Plan		1b Three-digit plan number (PN) ▶	003
		1c Effective date of plan	01/01/2013
2a 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) Hearing Center Management Company, Ltd. 4072 Munson St. NW US Canton OH 44718		2b Employer Identification Number (EIN)	46-4251129
		2c Sponsor's telephone number (330)	493-3400
		2d Business code (see instructions)	621340
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor		3b Administrator's EIN	
		3c Administrator's telephone number	
4 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. a Sponsor's name c Plan Name		4b EIN	
		4d PN	
5a Total number of participants at the beginning of the plan year		5a	14
b Total number of participants at the end of the plan year		5b	0
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)		5c(1)	12
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		5c(2)	0
d(1) Total number of active participants at the beginning of the plan year		5d(1)	14
d(2) Total number of active participants at the end of the plan year		5d(2)	0
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		5e	

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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	<i>Mia M. Mounts</i>	7-23-24	Mia Mounts
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Mia M. Mounts</i>	7-23-24	
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

Form 5500-SF (2023)
v. 230728

Form 5500-SF <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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 section 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 2023 This Form is Open to Public Inspection
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Part I Annual Report Identification Information				
For calendar plan year 2023 or fiscal plan year beginning		01/01/2023	and ending	12/31/2023
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C	Check box if filing under:	<input type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input type="checkbox"/> DFVC program
		<input type="checkbox"/> special extension (enter description)		
D	If the plan is a collectively-bargained plan, check here	_____ ▶ <input type="checkbox"/>		
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here	_____ ▶ <input type="checkbox"/>		

Part II Basic Plan Information — enter all requested information			
1a	Name of plan Hearing Center Management Company, Ltd. Cash Balance Plan	1b	Three-digit plan number (PN) ▶ 002
		1c	Effective date of plan 01/01/2013
2a	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) Hearing Center Management Company, Ltd. 4072 Munson St. NW US Canton OH 44718	2b	Employer Identification Number (EIN) 46-4251129
		2c	Sponsor's telephone number (330) 493-3400
		2d	Business code (see instructions) 621340
3a	Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b	Administrator's EIN
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		4d	PN
5a	Total number of participants at the beginning of the plan year _____	5a	11
b	Total number of participants at the end of the plan year _____	5b	0
c(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) _____	5c(1)	
c(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) _____	5c(2)	
d(1)	Total number of active participants at the beginning of the plan year _____	5d(1)	10
d(2)	Total number of active participants at the end of the plan year _____	5d(2)	0
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested _____	5e	0

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SIGN HERE	<i>Mia M. Mounts</i>		Mia M. Mounts, Mg. Member
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Mia M. Mounts</i>		<i>Mia M. Mounts Mg Mbr</i>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

E-SIGNATURE AUTHORIZATION

for

Hearing Center Management Company, Ltd. Profit Sharing Plan

46-4251129/003

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e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e

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	<i>Mia M. Mounts</i>	7-23-24	Mia Mounts
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Mia M. Mounts</i>	7-23-24	
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

Form 5500-SF (2023)
v. 230728

Form 5500-SF <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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 section 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 2023 This Form is Open to Public Inspection
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Part I Annual Report Identification Information				
For calendar plan year 2023 or fiscal plan year beginning		01/01/2023	and ending	12/31/2023
A	This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> 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:	<input type="checkbox"/> the first return/report	<input checked="" 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	Check box if filing under:	<input type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input type="checkbox"/> DFVC program
		<input type="checkbox"/> special extension (enter description)		
D	If the plan is a collectively-bargained plan, check here	_____ ▶ <input type="checkbox"/>		
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here	_____ ▶ <input type="checkbox"/>		

Part II Basic Plan Information — enter all requested information			
1a	Name of plan Hearing Center Management Company, Ltd. Cash Balance Plan	1b	Three-digit plan number (PN) ▶ 002
		1c	Effective date of plan 01/01/2013
2a	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) Hearing Center Management Company, Ltd. 4072 Munson St. NW US Canton OH 44718	2b	Employer Identification Number (EIN) 46-4251129
		2c	Sponsor's telephone number (330) 493-3400
		2d	Business code (see instructions) 621340
3a	Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b	Administrator's EIN
		3c	Administrator's telephone number
4	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. a Sponsor's name c Plan Name	4b	EIN
		4d	PN
5a	Total number of participants at the beginning of the plan year _____	5a	11
b	Total number of participants at the end of the plan year _____	5b	0
c(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) _____	5c(1)	
c(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) _____	5c(2)	
d(1)	Total number of active participants at the beginning of the plan year _____	5d(1)	10
d(2)	Total number of active participants at the end of the plan year _____	5d(2)	0
e	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested _____	5e	0

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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	<i>Mia M. Mounts</i>		Mia M. Mounts, Mg. Member
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Mia M. Mounts</i>		<i>Mia M. Mounts Mg Mbr</i>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor