

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. CASH BALANCE PLAN		1b Three-digit plan number (PN) ▶ 002
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		1c Effective date of plan 01/01/2013
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		2b Employer Identification Number (EIN) 46-4251129
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		2c Sponsor's telephone number 330-493-3400
5a Total number of participants at the beginning of the plan year		2d Business code (see instructions) 621340
b Total number of participants at the end of the plan year.....		3b Administrator's EIN
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)		3c Administrator's telephone number
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		4b EIN
d(1) Total number of active participants at the beginning of the plan year.....		4d PN
d(2) Total number of active participants at the end of the plan year.....		5a 11
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		5b 0
		5c(1)
		5c(2)
		5d(1) 10
		5d(2) 0
		5e 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.	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	1646626	0
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	1646626	0
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	0	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	0	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		0
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1646626	
e Certain deemed and/or corrective distributions (see instructions) .	8e		
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		1646626
i Net income (loss) (subtract line 8h from line 8c)	8i		-1646626
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: 1C
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			
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 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** 0

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 02/28/2023 (MM/DD/YYYY) and the Opinion Letter serial number Q705311A.

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection
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For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

▶ **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.

A Name of plan <u>HEARING CENTER MANAGEMENT COMPANY, LTD. CASH BALANCE PLAN</u>	B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>HEARING CENTER MANAGEMENT COMPANY, LTD.</u>	D Employer Identification Number (EIN) <u>46-4251129</u>	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F 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>01</u> Year <u>2023</u>		
2	Assets:		
	a Market value	2a	<u>1252068</u>
	b Actuarial value	2b	<u>1252068</u>
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target
	a For retired participants and beneficiaries receiving payment	<u>0</u>	<u>0</u>
	b For terminated vested participants	<u>0</u>	<u>0</u>
	c For active participants	<u>13</u>	<u>1252068</u>
	d Total	<u>13</u>	<u>1252068</u>
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)		
	a Funding target disregarding prescribed at-risk assumptions	4a	
	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	4b	
5	Effective interest rate	5	<u>5.00 %</u>
6	Target normal cost		
	a Present value of current plan year accruals	6a	<u>0</u>
	b Expected plan-related expenses	6b	<u>0</u>
	c Target normal cost	6c	<u>0</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.

SIGN HERE		
	Signature of actuary	<u>07/21/2024</u>
	<u>2024L BRADFORD BARLOW JR.</u>	Date
	Type or print name of actuary	<u>23-05743</u>
	<u>BARLOW CONSULTING INC.</u>	Most recent enrollment number
	Firm name	<u>412-498-6993</u>
	<u>1240 MERIDIAN DRIVE</u> <u>PRESTO, PA 15142</u>	Telephone number (including area code)
	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 II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9	Amount remaining (line 7 minus line 8)	0	0
10	Interest on line 9 using prior year's actual return of _____ %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		0
b(1)	Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.18</u> %		0
b(2)	Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c	Total available at beginning of current plan year to add to prefunding balance		0
d	Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages			
14	Funding target attainment percentage	14	100.00 %
15	Adjusted funding target attainment percentage	15	98.87 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	139.80 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls		18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees		
Totals ▶			18(b)	0	18(c)	0	

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	0

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? Yes No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? Yes No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

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

21 Discount rate:

a Segment rates:	1st segment: 4.75 %	2nd segment: 5.00 %	3rd segment: 5.74 %	<input type="checkbox"/> N/A, full yield curve used
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b Applicable month (enter code)..... **21b** 4

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	0
b Excess assets, if applicable, but not greater than line 31a	31b	0

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
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	
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34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)..... **34** 0

	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)..... **36** 0

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)..... **37** 0

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

a Total (excess, if any, of line 37 over line 36)	38a	0
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
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40 Unpaid minimum required contributions for all years

	40	0
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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

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

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

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OMB Nos. 1210-0110
1210-0089

2023

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 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 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

Short Form Annual Return/Report of Small Employee Benefit Plan
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 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. 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 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	11
b Total number of participants at the end of the plan year	0
c(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	
c(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	
d(1) Total number of active participants at the beginning of the plan year	10
d(2) Total number of active participants at the end of the plan year	0
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	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	<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

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

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.
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- 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.

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

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 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

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 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	

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>	<u>7-23-24</u>	Mia Mounts
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Mia M. Mounts</i>	<u>7-23-24</u>	
	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		1b Three-digit plan number (PN) ▶	002
Hearing Center Management Company, Ltd. Cash Balance Plan		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)		2b Employer Identification Number (EIN)	46-4251129
Hearing Center Management Company, Ltd.		2c Sponsor's telephone number (330) 493-3400	
4072 Munson St. NW		2d Business code (see instructions)	621340
US Canton OH 44718			
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.		4b EIN	
a Sponsor's name		4d PN	
c Plan Name			
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	

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>		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>		Mia M. Mounts Mg Mbr
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

Schedule SB, line 22 -
Description of Weighted Average Retirement Age
Hearing Center Management Company, Ltd. Cash Balance Plan
/ 002
For the plan year 01/01/2023 through 12/31/2023

The age reported is the weighted average of the assumed retirement ages for all active participants as of the valuation date based on their funding target or target normal cost should the funding target of the plan be zero rounded to the nearest whole age. For an active late retiree, the assumed retirement age may be later than the Plan's normal retirement age. Each participant's rate of retirement is assumed to be 100% of his/her assumed retirement age.

**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

2023

This Form is Open to Public Inspection

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

▶ **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.

A Name of plan <u>Hearing Center Management Company, Ltd. Cash Balance Plan</u>		B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>Hearing Center Management Company, Ltd.</u>		D Employer Identification Number (EIN) <u>46-4251129</u>	

E Type of plan: Single Multiple-A Multiple-B **F** Prior year plan size: 100 or fewer 101-500 More than 500

Part I Basic Information

1 Enter the valuation date: Month 12 Day 01 Year 2023

2 Assets:	
a Market value	2a <u>1,252,068</u>
b Actuarial value	2b <u>1,252,068</u>

3 Funding target/participant count breakdown:	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	<u>0</u>	<u>0</u>	<u>0</u>
b For terminated vested participants	<u>0</u>	<u>0</u>	<u>0</u>
c For active participants	<u>13</u>	<u>1,252,068</u>	<u>1,252,068</u>
d Total	<u>13</u>	<u>1,252,068</u>	<u>1,252,068</u>

4 If the plan is in at-risk status, check the box and complete lines (a) and (b)

a Funding target disregarding prescribed at-risk assumptions	4a
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	4b

5 Effective interest rate **5** 5.00 %

6 Target normal cost	
a Present value of current plan year accruals	6a <u>0</u>
b Expected plan-related expenses	6b <u>0</u>
c Target normal cost	6c <u>0</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.

SIGN HERE	<u>Jewel Bradford Barlow, Jr.</u>	<u>07/21/2024</u>
	Signature of actuary	Date
	<u>20241 Bradford Barlow Jr.</u>	<u>23-05743</u>
	Type or print name of actuary	Most recent enrollment number
	<u>Barlow Consulting Inc.</u>	<u>(412) 498-6993</u>
	Firm name	Telephone number (including area code)
	<u>1240 Meridian Drive</u>	
	Firm address	
	<u>US Presto PA 15142</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 II Beginning of Year Carryover and Prefunding Balances	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>0.00</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		0
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.18</u> % ...		0
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance		0
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d - line 12)	0	0

Part III Funding Percentages		
14 Funding target attainment percentage	14	100.00 %
15 Adjusted funding target attainment percentage	15	98.87 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	139.80 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls							
18 Contributions made to the plan for the plan year by employer(s) and employees:							
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees		
Totals ▶			18(b)	0	18(c)	0	

19 Discounted employer contributions -- see instructions for small plan with a valuation date after the beginning of the year:			
a Contributions allocated toward unpaid minimum required contributions from prior years	19a	0	
b Contributions made to avoid restrictions adjusted to valuation date	19b	0	
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	0	
20 Quarterly contributions and liquidity shortfalls:			
a Did the plan have a "funding shortfall" for the prior year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
c If line 20a is "Yes," see instructions and complete the following table as applicable:			

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used To Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:

1st segment: 4.75 %	2nd segment: 5.00 %	3rd segment: 5.74 %
------------------------	------------------------	------------------------

 N/A, full yield curve used

b Applicable month (enter code) **21b** 4

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** 0

b Excess assets, if applicable, but not greater than line 31a **31b** 0

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
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** 0

	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) **36** 0

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37** 0

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

a Total (excess, if any, of line 37 over line 36) **38a** 0

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, Part V
Statement of Actuarial Assumptions/Methods
Hearing Center Management Company, Ltd. Cash Balance Plan
/ 002
For the plan year 01/01/2023 through 12/31/2023

Valuation Date: 12/01/2023

Funding Method: As prescribed in IRC Section 430
 Age - Eligibility age at last birthday and other ages at nearest birthday

Retrospective Compensation - Current compensation

Form of Payment - Assumed form of payment for funding is lump sum which is the Hypothetical Account Balance. Funding Target for lump sum is the current Hypothetical Account Balance projected to the assumed retirement date using the Interest Credit Rate discounted using appropriate segment rate. Lump sum on plan actuarial equivalence rates will not exceed 415 maximum allowable distribution, which is the lesser amount computed using a) 5.5% interest and the Applicable Mortality Table or b) plan actuarial equivalence interest and mortality

Interest Rates -	Segment rates for the Fourth Month Prior to Val Date as permitted under IRC 430(h)(2)(C)	Segment rates as of September 30, 2022 As permitted under IRC 430(h)(2)(C)(iv)(II) - ARP																								
	<table border="1"> <thead> <tr> <th>Segment #</th> <th>Year</th> <th>Rate %</th> </tr> </thead> <tbody> <tr> <td>Segment 1</td> <td>0 - 5</td> <td>3.42</td> </tr> <tr> <td>Segment 2</td> <td>6 - 20</td> <td>4.33</td> </tr> <tr> <td>Segment 3</td> <td>> 20</td> <td>4.43</td> </tr> </tbody> </table>	Segment #	Year	Rate %	Segment 1	0 - 5	3.42	Segment 2	6 - 20	4.33	Segment 3	> 20	4.43	<table border="1"> <thead> <tr> <th>Segment #</th> <th>Year</th> <th>Rate %</th> </tr> </thead> <tbody> <tr> <td>Segment 1</td> <td>0 - 5</td> <td>4.75</td> </tr> <tr> <td>Segment 2</td> <td>6 - 20</td> <td>5.00</td> </tr> <tr> <td>Segment 3</td> <td>> 20</td> <td>5.74</td> </tr> </tbody> </table>	Segment #	Year	Rate %	Segment 1	0 - 5	4.75	Segment 2	6 - 20	5.00	Segment 3	> 20	5.74
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Segment #	Year	Rate %																								
Segment 1	0 - 5	4.75																								
Segment 2	6 - 20	5.00																								
Segment 3	> 20	5.74																								

Pre-Retirement - Mortality Table - None
 Early Retirement Table - None
 Turnover Table - None
 Disability Table - None
 Salary Scale - None
 Interest Credit Rate - Current Yr - 3% Projected Yrs - 3%
 Expense Load - None
 Ancillary Ben Load - None

Post-Retirement - Mortality Table - 23C - 2023 Combined
 Cost of Living - None

Asset Valuation Method: Fair market value of assets adjusted for contributions under IRC 430(g)(4)

Discrimination Test Assumptions:

HCE Determination - Based on all employees

Otherwise Excludable - Otherwise Excludable HCEs are included with the Not Otherwise Excludable employees

410(b)/401(a)(4) Testing:

Pre-Retirement - Interest - 8.5% CB Projection Rate - 3%

Post-Retirement - Interest - 8.5%
 Mortality Table - I83F - 1983 Individual Annuity (female)

Permissively Aggregated Plans - Tested as a Single Plan

Compensation - Use current compensation to calculate the benefit accrual rate (annual method)

Testing Age - Normal retirement age or attained age, if older

Normal Form for MVAR - Joint with 50% Survivor Benefits

Schedule SB, Part V
Statement of Actuarial Assumptions/Methods
Hearing Center Management Company, Ltd. Cash Balance Plan
/ 002
For the plan year 01/01/2023 through 12/31/2023

401(a)(26) Testing:

Compensation - Use current compensation to calculate the benefit accrual rate for 401(a)(26)

Testing Age - Normal retirement age or attained age, if older

