Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	**Annual Return/Report of Employee Benefit Plan** This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	OMB Nos. 1210-0110 1210-0089 **2022** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 05/31/2023

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [X] the final return/report
- [ ] an amended return/report
- [X] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [ ] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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
EMPLOYEE BENEFIT PLAN OF MTLD, INC.

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 08/01/2013

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)

MTLD, INC.

PO BOX 5
KANNAPOLIS, NC 28082-0005

1912 S. RIDGE AVE.
KANNAPOLIS, NC 28083

2b Employer Identification Number (EIN) 46-2877510

2c Plan Sponsor's telephone number 704-933-2218

2d Business code (see instructions) 722513

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	09/26/2023	LINDA ROSENBALM
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/26/2023	LINDA ROSENBALM
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] 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

5 Total number of participants at the beginning of the plan year	**5**	20
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	3
a(2) Total number of active participants at the end of the plan year	**6a(2)**	0
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f Total. Add lines **6d** and **6e**.	**6f**	0
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	0
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

2F 2G 2S 2T

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ....…….….. ☐ Yes ☐ No

If “Yes” is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ……..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2022 Form M-1 annual report. If the plan was not required to file the 2022 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code______________________

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 05/31/2023

A Name of plan EMPLOYEE BENEFIT PLAN OF MTLD, INC.	**B** Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 MTLD, INC.	**D** Employer Identification Number (EIN) 46-2877510

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

1 Coverage Information:

(a) Name of insurance carrier

MUTUAL OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	Policy or contract year (g) To
13-1614399	88668	059042C	0	10/01/2022	05/31/2023

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	400

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

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

ATLANTA REGIONAL OFFICE

FIVE CONCOURSE PARKWAY SUITE 1275
ATLANTA, GA 30328

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
0	400	ADMINISTRATIVE FEE	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	0
5 Current value of plan's interest under this contract in separate accounts at year end	5	0

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ N/A

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☒ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year			7b	9753
c Additions: (1) Contributions deposited during the year	7c(1)	0		
(2) Dividends and credits	7c(2)	0		
(3) Interest credited during the year	7c(3)	0		
(4) Transferred from separate account	7c(4)	0		
(5) Other (specify below) ▶	7c(5)	0		
(6)Total additions			7c(6)	0
d Total of balance and additions (add lines **7b** and **7c(6)**).			7d	9753
e Deductions:				
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	9714		
(2) Administration charge made by carrier	7e(2)	39		
(3) Transferred to separate account	7e(3)			
(4) Other (specify below) ▶	7e(4)			
(5) Total deductions			7e(5)	9753
f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	**9a(1)**	0		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	0		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**	0		
(2) Increase (decrease) in claim reserves	**9b(2)**	0		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**	400		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	400
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2022** **This Form is Open to Public Inspection.**

For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 05/31/2023

A Name of plan
EMPLOYEE BENEFIT PLAN OF MTLD, INC.

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
MTLD, INC.

D Employer Identification Number (EIN)
46-2877510

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

DELAWARE FUNDS
100 COMMERCE SQUARE
2005 MARKET STREET
PHILADELPHIA, PA 19103

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

GOLDMAN SACHS VIT FUNDS
200 WEST STREET
NEW YORK, NY 10282

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

NEUBERGER BERMAN
1290 AVENUE OF THE AMERICAS
NEW YORK, NY 10104

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

VICTORY FUNDS
4900 TIEDEMAN ROAD 4TH FLOOR
BROOKLYN, OH 44144

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

MFS	111 HUNTINGTON AVENUE BOSTON, MA 02199

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

T ROSE PRICE	100 EAST PRATT STREET BALTIMORE, MD 21202

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

PIMCO	840 NEWPORT CENTER DRIVE NEWPORT BEACH, CA 92660

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

AMERICAN FUNDS	333 SOUTH HOPE STREET LOS ANGELES, CA 90071

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

CALVERT	4550 MONTGOMERY AVEUE SUITE 1000N BETHESDA, MD 20814

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

AMERICAN CENTURY INVESTMENTS	PO BOX 419786 KANSAS CITY, MO 64141

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

INVESCO VI MAIN STREET	PO BOX 5270 DENVER, CO 80217

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

DWS	222 SOUTH RIVERSIDE PLAZA CHICAGO, IL 60606

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

VANGUARD	PO BOX 2600 VALLEY FORGE, PA 19482

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

FIDELITY INVESTMENTS	82 DEVONSHIRE STREET BOSTON, MA 02109

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

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

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

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

MUTUAL OF AMERICA INVESTMENT CORP

320 PARK AVENUE
NEW YORK, NY 10022

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 15 65	INSURANCE CARRIER	400	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III	Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	**DFE/Participating Plan Information** This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	OMB No. 1210-0110 **2022** **This Form is Open to Public Inspection.**

For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 05/31/2023

A Name of plan EMPLOYEE BENEFIT PLAN OF MTLD, INC.	**B** Three-digit plan number (PN) ▶ 001
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 MTLD, INC.	**D** Employer Identification Number (EIN) 46-2877510

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT NUMBER SA1

b Name of sponsor of entity listed in (a): MUTUAL OF AMERICA COMPOSITE

c EIN-PN 13-1614399-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 0

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name	SAFE HARBOR 401K PROFIT SHARING PLAN FOR EMPLOYEES OF MTLD, INC.	
b Name of plan sponsor	MTLD, INC.	**c** EIN-PN 46-2877510-001
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN
a Plan name		
b Name of plan sponsor		**c** EIN-PN

SCHEDULE I (Form 5500)	Financial Information—Small Plan	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**2022** **This Form is Open to Public Inspection**

For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 05/31/2023

A Name of plan EMPLOYEE BENEFIT PLAN OF MTLD, INC.	**B** Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 MTLD, INC.	**D** Employer Identification Number (EIN) 46-2877510

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

1 **Plan Assets and Liabilities:**		**(a)** Beginning of Year	**(b)** End of Year
a Total plan assets	**1a**	570116	0
b Total plan liabilities	**1b**	0	0
c Net plan assets (subtract line 1b from line 1a)	**1c**	570116	0
2 **Income, Expenses, and Transfers for this Plan Year:**		**(a)** Amount	**(b)** Total
a Contributions received or receivable:			
(1) Employers	**2a(1)**	0	
(2) Participants	**2a(2)**	0	
(3) Others (including rollovers)	**2a(3)**	0	
b Noncash contributions	**2b**	0	
c Other income	**2c**	31441	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	**2d**		31441
e Benefits paid (including direct rollovers)	**2e**	601517	
f Corrective distributions (see instructions)	**2f**	0	
g Certain deemed distributions of participant loans (see instructions)	**2g**	0	
h Administrative service providers (salaries, fees, and commissions)	**2h**	40	
i Other expenses	**2i**	0	
j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	**2j**		601557
k Net income (loss) (subtract line 2j from line 2d)	**2k**		-570116
l Transfers to (from) the plan (see instructions)	**2l**		0

3 **Specific Assets:** If the plan held assets at any time during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

		Yes	No	Amount
a Partnership/joint venture interests	**3a**		X	
b Employer real property	**3b**		X	
c Real estate (other than employer real property)	**3c**		X	
d Employer securities	**3d**		X	
e Participant loans	**3e**		X	
f Loans (other than to participants)	**3f**		X	
g Tangible personal property	**3g**		X	

Part II Compliance Questions

4 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		175000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j	X		
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☒ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year ______.

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☐ Yes ☐ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year ______.

SCHEDULE R (Form 5500)	Retirement Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**2022** **This Form is Open to Public Inspection.**

For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 05/31/2023

A Name of plan EMPLOYEE BENEFIT PLAN OF MTLD, INC.	**B** Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 MTLD, INC.	**D** Employer Identification Number (EIN) 46-2877510

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions........ **1** 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 13-3590259 ______________

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year........ **3** 0

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?........ ☐ Yes ☐ No ☐ N/A

If the plan is a defined benefit plan, go to line 8.

5 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 ruling letter granting the waiver. **Date:** Month ________ Day ________ Year ________

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 **a** Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)........ **6a**

b Enter the amount contributed by the employer to the plan for this plan year........ **6b**

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)........ **6c**

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline?........ ☐ Yes ☐ No ☐ N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?........ ☐ Yes ☐ No ☐ N/A

Part III Amendments

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box........ ☐ Increase ☐ Decrease ☐ Both ☐ No

Part IV ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?........ ☐ Yes ☐ No

11 **a** Does the ESOP hold any preferred stock?........ ☐ Yes ☐ No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)........ ☐ Yes ☐ No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market?........ ☐ Yes ☐ No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that (1) contributed more than 5% of total contributions to the plan during the plan year or (2) was one of the top-ten highest contributors (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ________________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ________________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ________________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ________________________________

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

d Date collective bargaining agreement expires *(If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.)* Month _______ Day _______ Year _______

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____________
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): ________________________________

14 Enter the number of deferred vested and retired participants (inactive participants), as of the beginning of the plan year, whose contributing employer is no longer making contributions to the plan for:

a The current plan year. Check the box to indicate the counting method used to determine the number of inactive participants: ☐ last contributing employer ☐ alternative ☐ reasonable approximation (see instructions for required attachment)	**14a**	
b The plan year immediately preceding the current plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14b**	
c The second preceding plan year. ☐ Check the box if the number reported is a change from what was previously reported (see instructions for required attachment)	**14c**	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	**15a**	
b The corresponding number for the second preceding plan year	**15b**	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	**16a**	
b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	**16b**	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

19 If the total number of participants is 1,000 or more, complete lines (a) through (c)

a Enter the percentage of plan assets held as:
Stock: _______% Investment-Grade Debt: _______% High-Yield Debt: _______% Real Estate: _______% Other: _______%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

20 **PBGC missed contribution reporting requirements.** If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

a Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? ☐ Yes ☐ No

b If line 20a is "Yes," 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____

PLAN 0-59042 Safe-Harbor 401(k) Profit Sharin g Plan for Employees of MTLD, In

ANNUAL RETURN/REPORT OF EMPLOYEE BENEFITS PLANS

5500 PLAN PLAN YEAR 20230101 20231231

PARTICIPANT COUNTS - MAIN FORM, PART II

5 TOTAL NUMBER OF PARTICIPANTS AT BEGINNING OF PLAN YEAR 5 20

6 A(1) ACTIVE PARTICIPANTS AT BEGINNING OF PLAN YEAR. . . . . 6 A(1) 3

A(2) ACTIVE PARTICIPANTS AT END OF PLAN YEAR. . . . . 6 A(2) 3

B RETIRED OR SEPARATED PARTICIPANTS RECEIVING BENEFITS. . . . . 6 B 0

C RETIRED OR SEPARATED PARTICIPANTS ENTITLED TO FUTURE BENEFITS . . . . 6 C 0

D SUBTOTAL {6A(2), 6B AND 6C} . . . . 6 D 3

E DECEASED PARTICIPANTS WHOSE BENEFICIARIES ARE RECEIVING OR ARE ENTITLED TO RECEIVE BENEFITS . . . . . 6 E 0

F TOTAL {6D AND 6E} . . . . 6 F 3

G NUMBER OF PARTICIPANTS WITH ACCOUNT BALANCES AT END OF PLAN YEAR . . . . 6 G 0

H NUMBER OF PARTICIPANTS THAT TERMINATED EMPLOYMENT DURING THE PLAN YEAR WITH ACCRUED BENEFITS THAT WERE

LESS THAN 100% VESTED . . . . 6 H 0

PLAN 0-59042 Safe-Harbor 401(k) Profit Sharin g Plan for Employees of MTLD, In

ANNUAL RETURN/REPORT OF EMPLOYEE BENEFITS PLANS

5500 PLAN PLAN YEAR 20230101 20231231

PLAN ASSET INFORMATION - SCHEDULE H, PART I BEGINNING OF YEAR END OF YEAR

1B (1) RECEIVABLES: EMPLOYER CONTRIBUTIONS. . . . . 1 B(1) 0 0

1B (2) RECEIVABLES: PARTICIPANT CONTRIBUTIONS . . . . 1 B(2) 0 0

1C (1) INTEREST BEARING CASH (INCLUDING MONEY MARKET FUNDS AND CDS) 1C (1) 0 0

1C (2) US GOVERNMENT SECURITIES 1C (2) 0 0

1C (3A) CORPORATE DEBT INSTRUMENTS: PREFERRED. 1C (3A) 0 0

1C (3B) CORPORATE DEBT INSTRUMENTS: ALL OTHER. 1C (3B) 0 0

1C (4A) CORPORATE STOCKS: PREFERRED. 1C (4A) 0 0

1C (4B) CORPORATE STOCKS: COMMON 1C (4B) 0 0

1C (5) PARTNERSHIP/JOINT VENTURE INTERESTS. 1C (5) 0 0

1C (6) REAL ESTATE (OTHER THAN EMPLOYER REAL PROPERTY 1C (6) 0 0

1C (7) LOANS (OTHER THAN TO PARTICIPANTS) 1C (7) 0 0

1C (8) PARTICIPANT LOANS. 1C (8) 0 0

1C (9) VALUE OF INTEREST IN COMMON / COLLECTIVE TRUSTS. 1C (9) 0 0

1C (10) VALUE OF INTEREST IN POOLED SEPARATE ACCOUNTS. 1C (10) 68,172 0

1C (11) VALUE OF INTEREST IN MASTER TRUSTS 1C (11) 0 0

1C (12) VALUE OF INTEREST 103-12 INVESTMENT ENTITIES 1C (12) 0 0

1C (13) VALUE OF INTEREST IN REGISTERED INVESTMENT COMPANIES 1C (13) 0 0

1C (14) VALUE OF FUNDS HELD IN INSURANCE COMPANY GENERAL ACCOUNT (UNALLOCATED CONTRACTS) . 1C (14) 32 0

1C (15) OTHER. 1C (15) 0 0

TOTAL EXCLUDED FROM 5500 REPORT 0 0

PLAN 0-59042 Safe-Harbor 401(k) Profit Sharin g Plan for Employees of MTLD, In

ANNUAL RETURN/REPORT OF EMPLOYEE BENEFITS PLANS

5500 PLAN PLAN YEAR 20230101 20231231

SELECTED INCOME AND EXPENSES - SCHEDULE H, PART II

2A CONTRIBUTIONS
2A (1A) RECEIVED OR RECEIVABLE FROM EMPLOYERS. 2A (1A) 0
2A (1B) RECEIVED OR RECEIVABLE FROM EMPLOYEES. 2A (1B) 0
2A (1C) RECEIVED OR RECEIVABLE FROM OTHERS 2A (1C) 0

2B EARNING ON INVESTMENTS

2B (1A) INTEREST: INTEREST BEARING CASH (INCLUDING MONEY MARKET FUNDS AND CD). 2B (1A) 0
2B (1B) INTEREST: U. S. GOVERNMENT SECURITIES. 2B (1B) 0
2B (1C) INTEREST: CORPORATE DEBT INSTRUMENTS 2B (1C) 0
2B (1D) INTEREST: LOANS (OTHER THAN TO PARTICIPANTS) 2B (1D) 0
2B (1E) INTEREST: PARTICIPANT LOANS. 2B (1E) 0
2B (1F) INTEREST: OTHER. 2B (1F) 0
2B (1G) TOTAL INTEREST. ADD LINES 2B(1)(A) THROUGH (F). 2B (1G) 0

2B (2A) DIVIDENDS: PREFERRED STOCK 2B (2A) 0
2B (2B) DIVIDENDS: COMMON STOCK. 2B (2B) 0
2B (2C) DIVIDENDS: REGISTERED INVESTMENT COMPANY SHARES (E.G. MUTUAL FUNDS). 2B (2C) 0
2B (2D) TOTAL DIVIDENDS. ADD LINES 2B(2)(A) THROUGH (C) 2B (2D) 0

2B (4) NET GAIN (LOSS) ON SALE OF ASSETS
2B (4A) AGGREGATE PROCEEDS 2B (4A) 0
2B (4B) AGGREGATE CARRYING AMOUNT. 2B (4B) 0
2B (4C) NET GAIN (LOSS). 2B (4C) 0

2B (5B) UNREALIZED APPRECIATION OTHER. 2B (5B) 0

2B (6) NET INVESTMENT GAIN (LOSS) FROM COMMON / COLLECTIVE TRUSTS 2B (6) 0

2B (7) NET INVESTMENT GAIN (LOSS) FROM POOLED SEPARATE ACCOUNTS 2B (7) 2,884

2B (8) NET INVESTMENT GAIN (LOSS) FROM MASTER TRUSTS. 2B (8) 0

2B (9) NET INVESTMENT GAIN (LOSS) FROM 103-12 INVESTMENT ENTITIES 2B (9) 0

2B (10) NET INVESTMENT GAIN (LOSS) FROM REGISTERED INVESTMENT COMPANIES. 2B (10) 0

2C OTHER INCOME 2C 0

2E (1) BENEFIT PAYMENTS: DIRECTLY TO PARTICIPANTS OR BENEFICIARIES. 2E (1) 71,088
2E (2) BENEFIT PAYMENTS: TO INSURANCE CARRIERS FOR THE PROVISION OF BENEFITS. 2E (2) 0

2F CORRECTIVE DISTRIBUTIONS 2F 0

2G CERTAIN DEEMED DISTRIBUTIONS OF PARTICIPANT LOANS. 2G 0

2I (4) OTHER FEES 2I (4) 0

2L (1) TRANSFER OF ASSETS TO THIS PLAN. 2L (1) 0
2L (2) TRANSFER OF ASSETS FROM THIS PLAN. 2L (2) 0

SMALL PLAN FINANCIAL INFORMATION - SCHEDULE I, PART I	BEGINNING OF YEAR	END OF YEAR
1 A TOTAL PLAN ASSETS . . . . .1 A 68,204 0		

2 A(1) EMPLOYERS. . . . . .2 A(1) 0

2 A(2) PARTICIPANTS . . . . .2 A(2) 0

2 A(3) OTHERS (INCLUDING ROLLOVERS) . . . . .2 A(3) 0

2 C OTHER INCOME. . . . . .2 C 2,885

2 E BENEFITS PAID (INCLUDING DIRECT ROLLOVERS) .2 E 71,088

2 F CORRECTIVE DISTRIBUTIONS . . . . .2 F 0

2 G CERTAIN DEEMED DISTRIBUTIONS OF PARTICIPANT LOANS . . . . .2 G 0

2 H OTHER EXPENSES. . . . . .2 H 0

2 K NET TRANSFERS . . . . .2 K 0

3 E PARTICIPANT LOANS . . . . .3 E 0

3 F LOANS (OTHER THAN TO PARTICIPANT) . . . . .3 F 0

PLAN 0-59042 Safe-Harbor 401(k) Profit Sharin g Plan for Employees of MTLD, In

ANNUAL RETURN/REPORT OF EMPLOYEE BENEFITS PLANS

5500 PLAN PLAN YEAR 20230101 20231231

SCHEDULE D: SELECTED DFE/PARTICIPATING PARTICIPATING PLAN INFORMATION

(A) NAME OF MTIA, CCT, PSA OR 103-12IE	(B) NAME OF SPONSOR OF ENTITY	(C) EIN-PN	(D) ENTITY CODE	(E) DOLLAR VALUE OF INTEREST
American Century Investments VP Capital Appreciation Fund		- -	P	0
American Funds Insurance Series New World Fund		- -	P	0
Calvert VP SRI Balanced Portfolio		- -	P	0
DWS Capital Growth VIP		- -	P	0
Delaware VIP Small Cap Value Series		- -	P	0
Fidelity VIP Asset Manager Portfolio		- -	P	0
Fidelity VIP Contrafund Portfolio		- -	P	0
Fidelity VIP Equity-Income Portfolio		- -	P	0
Fidelity VIP Mid Cap Portfolio		- -	P	0
Goldman Sachs VIT US Equity Insights Fund		- -	P	0
Goldman Sachs VIT Small Cap Equity Insights Fund		- -	P	0
Invesco V.I. Main Street Fund		- -	P	0
MFS VIT III Mid Cap Value Portfolio		- -	P	0
Mutual of America All America Fund		- -	P	0
Mutual of America Equity Index Fund		- -	P	0
Mutual of America Mid-Cap Equity Index Fund		- -	P	0
Mutual of America Mid Cap Value Fund		- -	P	0
Mutual of America Small Cap Growth Fund		- -	P	0
Mutual of America Small Cap Equity Index Fund		- -	P	0
Mutual of America Small Cap Value Fund		- -	P	0
Mutual of America Bond Fund		- -	P	0
Mutual of America Mid-Term Bond Fund		- -	P	0
Mutual of America Money Market Fund		- -	P	0

Mutual of America - - P 0
International Fund
Mutual of America Aggressive - - P 0

SCHEDULE D: SELECTED DFE/PARTICIPATING PARTICIPATING PLAN INFORMATION

(A) NAME OF MTIA, CCT, PSA OR 103-12IE	(B) NAME OF SPONSOR OF ENTITY	(C) EIN-PN	(D) ENTITY CODE	(E) DOLLAR VALUE OF INTEREST
Allocation Fund				
Mutual of America Composite Fund	-	-	P	0
Mutual of America Conservative Allocation Fund	-	-	P	0
Mutual of America Moderate Allocation Fund	-	-	P	0
Mutual of America Retirement Income Fund	-	-	P	0
Mutual of America 2010 Retirement Fund	-	-	P	0
Mutual of America 2015 Retirement Fund	-	-	P	0
Mutual of America 2020 Retirement Fund	-	-	P	0
Mutual of America 2025 Retirement Fund	-	-	P	0
Mutual of America 2030 Retirement Fund	-	-	P	0
Mutual of America 2035 Retirement Fund	-	-	P	0
Mutual of America 2040 Retirement Fund	-	-	P	0
Mutual of America 2045 Retirement Fund	-	-	P	0
Mutual of America 2050 Retirement Fund	-	-	P	0
Mutual of America 2055 Retirement Fund	-	-	P	0
Mutual of America 2060 Retirement Fund	-	-	P	0
Mutual of America 2065 Retirement Fund	-	-	P	0
Neuberger Berman AMT Sustainable Equity Portfolio	-	-	P	0
PIMCO VIT Real Return Portfolio	-	-	P	0
T. Rowe Price Blue Chip Growth Portfolio	-	-	P	0
Vanguard VIF Diversified Value Portfolio	-	-	P	0
Vanguard VIF International Portfolio	-	-	P	0

Vanguard VIF Real Estate Index Portfolio	- -		P	0

SCHEDULE D: SELECTED DFE/PARTICIPATING PARTICIPATING PLAN INFORMATION

(A) NAME OF MTIA, CCT, PSA OR 103-12IE	(B) NAME OF SPONSOR OF ENTITY	(C) EIN-PN	(D) ENTITY CODE	(E) DOLLAR VALUE OF INTEREST
Vanguard VIF Total Bond Market Index Portfolio		- -	P	0
Victory RS Small Cap Growth Equity VIP Series		- -	P	0

SCHEDULE R: DISTRIBUTIONS INFORMATION

EIN(S) OF PAYOR(S) WHO PAID BENEFITS ON BEHALF OF THE PLAN

EIN - PAYOR 1:
EIN - PAYOR 2:

NUMBER OF PARTICIPANTS WHOSE BENEFITS WERE DISTRIBUTED IN A SINGLE SUM: 000017

ACTIVE PARTICIPANTS INCLUDED IN COUNTS FOR LINE 6A(1)

PARTICIPANT ID	NAME	STATUS	TERM DATE	BEN CD	PLAN ENTRY
-**-5	James, Avis	04			04/01/2021
-**-1	Hopper, Tarah	00			04/01/2022
-**-8	Flowers, Ashley	04			04/01/2021

NUMBER OF PARTICIPANTS INCLUDED IN THIS GROUP ... 3

PLAN 0-59042 Safe-Harbor 401(k) Profit Sharin g Plan for Employees of MTLD, In

ANNUAL RETURN/REPORT OF EMPLOYEE BENEFITS PLANS

5500 PLAN PLAN YEAR 20230101 20231231

ACTIVE PARTICIPANTS INCLUDED IN COUNTS FOR LINE 6A(2)

PARTICIPANT ID	NAME	STATUS	TERM DATE	BEN CD	PLAN ENTRY
-**-5	James, Avis	04			04/01/2021
-**-1	Hopper, Tarah	00			01/01/2022
-**-8	Flowers, Ashley	04			04/01/2021

NUMBER OF PARTICIPANTS INCLUDED IN THIS GROUP ... 3

PAGE 12 RPT-955 FORM 5500 AS OF 2023/12/31 233 22:33

PLAN 0-59042 Safe-Harbor 401(k) Profit Sharin g Plan for Employees of MTLD, In

ANNUAL RETURN/REPORT OF EMPLOYEE BENEFITS PLANS

5500 PLAN PLAN YEAR 20230101 20231231

PARTICIPANTS INCLUDED IN COUNT FOR BEGINNING OF YEAR TOTAL (LINE 5)

PARTICIPANT ID	NAME	STATUS	TERM DATE	BEN CD	PLAN ENTRY
-**-5	James, Avis	04			04/01/2021
-**-7	Edwards, Cameron	31	01/09/2021		10/01/2019
-**-7	Brown, Paul	31	06/25/2018		09/01/2016
-**-0	Brown-Waddell, Jazlon	31	01/13/2020		04/01/2019
-**-0	Payne, Allen	31	08/11/2018		05/01/2016
-**-5	Olvera, Jose O	31	05/09/2022		09/01/2007
-**-8	Dotson, Donnie L	31	05/09/2022		09/01/1995
-**-1	Hopper, Tarah	00			01/01/2022
-**-6	Herbert, Jerald K	31	05/09/2022		02/01/2016
-**-9	Phillips, Tashawn	31	04/25/2021		10/01/2019
-**-3	Pearson, Shannon C	31	10/12/2020		03/01/2011
-**-2	Hale, Joseph E	31	02/12/2020		04/01/2019
-**-8	Shrewsbury, Derin	31	10/28/2018		07/01/2016
-**-1	Barbare, Tasha	31	07/09/2019		10/01/2018
-**-6	Privett, Cathy	31	03/08/2022		10/01/2018
-**-6	Patterson, Jerome	31	05/09/2022		04/01/2021
-**-8	Flowers, Ashley	04			04/01/2021
-**-7	Berry, Ashley	31	05/09/2022		10/30/2019
-**-6	Miller, Katelyn	31	08/22/2019		10/01/2018
-**-0	Morgan, Shayla	31	03/16/2020		04/01/2019

NUMBER OF PARTICIPANTS INCLUDED IN THIS GROUP ... 20

PAGE 13 RPT-955 FORM 8955-SSA AS OF 2023/12/31 233 22:33

PLAN 0-59042 Safe-Harbor 401(k) Profit Sharin g Plan for Employees of MTLD, In

ANNUAL RETURN/REPORT OF EMPLOYEE BENEFITS PLANS

PLAN YEAR 20230101 20231231

ANNUAL REGISTRATION OF SEPARATED PARTICIPANTS
FORM 8955-SSA WITH DEFERRED VESTED BENEFITS ADDITIONAL PAGES

PART II

(1A) PLAN NAME : Safe-Harbor 401(k) Profit Sharin
g Plan for Employees of MTLD, In (1B) PLAN NUMBER: 001
(2A) PLAN SPONSOR: MTLD, Inc. (2B) EIN: 46-2877510

(6A) SEPARATED PARTICIPANTS REQUIRED TO BE REPORTED ON FORM 8955-SSA 0
(6B) SEPARATED PARTICIPANTS VOLUNTARILY REPORTED ON FORM 8955-SSA 6
(7) TOTAL NUMBER OF PARTICIPANTS REPORTED ON LINES 6A AND 6B 6

PART III

(9) SEPARATED PARTICIPANTS WITH DEFERRED VESTED BENEFITS:

ENTRY CODE	SSN	NAME		ANNUITY PAYMENT TYPE	FREQ	D. C. PLAN TOTAL VALUE
(A)	(B)	(C)	(D)	(E)		(G)
D	***-**-***5	Olvera, Jose O		M	A	
D	***-**-***8	Dotson, Donnie L		M	A	
D	***-**-***6	Herbert, Jerald K		M	A	
D	***-**-***6	Privett, Cathy		M	A	
D	***-**-***6	Patterson, Jerome		M	A	
D	***-**-***7	Berry, Ashley		M	A	

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OOOOOO  MM    MM NN    NN IIIIIII
 OOOOOOOO MMM  MMM NNN   NN IIIIIII
 OO    OO MMMMMMMMM NNNN  NN   II
 OO    OO MMMMMMMMM NN NN NN   II
 OO    OO MM MM MM NN  NNNN   II
 OO    OO MM    MM NN   NNN   II
 OOOOOOOO MM    MM NN    NN IIIIIII
  OOOOOO  MM    MM NN     N IIIIIII
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RELEASE V7.20.00

EMPLOYEE BENEFIT RECORD KEEPING SYSTEM - SUNGARD OMNI

THESE REPORTS ARE FOR:

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THIS PLAN IS ADMINISTERED BY:

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              OO    OO MMMMMMMM NN NN NN   II
              OO    OO MM MM MM NN  NNNN   II
              OO    OO MM    MM NN   NNN   II
              OOOOOOOO MM    MM NN    NN IIIIII
               OOOOOO  MM    MM NN     N IIIIII          RELEASE V7.20.00

      EMPLOYEE BENEFIT RECORD KEEPING SYSTEM -  SUNGARD OMNI

THESE REPORTS ARE FOR:

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                           OO    OO MMMMMMMMM NN NN NN   II
                           OO    OO MM MM MM NN  NNNN   II
                           OO    OO MM    MM NN   NNN   II
                           OOOOOOOO MM    MM NN    NN IIIIII
                            OOOOOO  MM    MM NN     N IIIIII                   RELEASE V7.20.00
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EMPLOYEE BENEFIT RECORD KEEPING SYSTEM - SUNGARD OMNI

THESE REPORTS ARE FOR:

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OOOOOO  MM    MM NN    NN IIIIII
 OOOOOOOO MMM  MMM NNN   NN IIIIII
 OO    OO MMMMMMMMM NNNN  NN   II
 OO    OO MMMMMMMMM NN NN NN   II
 OO    OO MM MM MM NN  NNNN   II
 OO    OO MM    MM NN   NNN   II
 OOOOOOOO MM    MM NN    NN IIIIII
  OOOOOO  MM    MM NN     N IIIIII
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RELEASE V7.20.00

EMPLOYEE BENEFIT RECORD KEEPING SYSTEM - SUNGARD OMNI

THESE REPORTS ARE FOR:

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