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

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☐ a single-employer plan
- ☒ a DFE (specify) G

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

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

D Check box if filing under:
- ☒ 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
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2001

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)
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

110 N. CARPENTER STREET
CHICAGO, IL 60607-2101

2b Employer Identification Number (EIN)
36-7112271

2c Plan Sponsor's telephone number
630-623-3000

2d Business code (see instructions)

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2026	TIMOTHY MORGAN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor

NATIONAL OPERATORS INSURANCE TEAM

110 N. CARPENTER STREET
CHICAGO, IL 60607

3b Administrator's EIN: 36-2998455

3c Administrator's telephone number: 630-623-3000

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**	23219
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)**	22954
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	20874
b	Retired or separated participants receiving benefits	**6b**	239
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	21113
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4A 4B 4D 4E 4F 4H 4L 4Q

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

- (1) [ ] **R** (Retirement Plan Information)
- (2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) [ ] **DCG** (Individual Plan Information) – Number Attached _____
- (5) [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1) [X] **H** (Financial Information)
- (2) [ ] **I** (Financial Information – Small Plan)
- (3) [X] **A** (Insurance Information) – Number Attached 8
- (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.) ..... [X] 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.) ..... [X] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 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 173076047

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
BLUECROSS BLUESHIELD OF ILLINOIS

(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	(g) To
36-1236610	70670	53200-LICENSEE	31598	01/01/2025	12/31/2025

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
192000	30000

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

WILLIS TOWERS WATSON US LLC
COMMISSION LOCKBOX 28852
PO BOX 28852
NEW YORK, NY 10087-8852

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
192000	30000	SPECIAL PROGRAMS	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		(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	

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] Health (other than dental or vision)
- **b** [X] 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** [X] Other (specify) ▶ MENTAL & PSYCH COUNSEL & CHEM DEP

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	210298551		
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	210298551
b Benefit charges (1) Claims paid	9b(1)	205050190		
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	205050190
(4) Claims charged			9b(4)	205050190
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)	192000		
(B) Administrative service or other fees	9c(1)(B)	16327431		
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)	-11271071		
(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)	5248360
(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	0
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. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
FIDELITY SECURITY LIFE INSURANCE COMPANY

(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	**(g)** To
43-0949844	71870	10410	31424	01/01/2025	12/31/2025

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

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

(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	

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

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(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] 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)**	39488870		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	39488870
b Benefit charges (1) Claims paid	**9b(1)**	56353962		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	56353962
(4) Claims charged			**9b(4)**	56353962
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)**	1076834		
(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)**	1076834
(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**	0
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 [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
SECURIAN LIFE INSURANCE COMPANY

(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	(g) To
41-1412669	93742	70144	30937	01/01/2025	12/31/2025

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
522946	112204

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

WILLIS TOWERS WATSON US LLC
COMMISSION LOCKBOX 28852
PO BOX 28852
NEW YORK, NY 10087-8852

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
522946	112204	SUPPLEMENTAL COMMISSIONS	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		(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	

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] 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** [X] Other (specify) ▶ BUSINESS TRAVEL ACCIDENT

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(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)			
(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)	0
(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	4980444
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 [X] No

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

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
DELTA DENTAL OF ILLINOIS

(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	**(g)** To
36-2612058	47589	20150	25590	01/01/2025	12/31/2025

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

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

(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	

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] 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)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(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)			
(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)	0
(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	720056
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 [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
EYEMED VISION CARE

(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	**(g)** To
43-0949844	71870	97647961001	35159	01/01/2025	12/31/2025

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

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

(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	

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] 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)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(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)**			
(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)**	0
(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**	2213286
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 [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
MAGELLAN HEALTH

(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	**(g)** To
52-2135463	54199	MCDN0-001	22338	01/01/2025	12/31/2025

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

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

(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	

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] Other (specify) ▶ EMPLOYEE ASSISTANCE PROGRAM

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid	9a(2)		
	(3) Increase (decrease) in unearned premium reserve	9a(3)		
	(4) Earned ((1) + (2) - (3))		9a(4)	0
b	Benefit charges (1) Claims paid	9b(1)		
	(2) Increase (decrease) in claim reserves	9b(2)		
	(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)		
	(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)	0
	(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	259710
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 [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
EYEMED VISION CARE

(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	(g) To
43-0949844	71870	97648041001	478	01/01/2025	12/31/2025

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

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

(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	

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] 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)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(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)			
(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)	0
(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	34116
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 [X] No

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

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance 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.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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
HARTFORD LIFE AND ACCIDENT

(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	(g) To
06-0838648	70815	715293G	8482	01/01/2025	12/31/2025

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
473934	86608

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

WILLIS TOWERS WATSON US LLC
COMMISSION LOCKBOX 28852
PO BOX 28852
NEW YORK, NY 10087-8852

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
473934	86608	BONUS	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		(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	

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
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** [X] Temporary disability (accident and sickness)
- **f** [X] 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)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(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)			
(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)	0
(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	5124341
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 [X] 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.**	**2025** **This Form is Open to Public Inspection.**

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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

U.S. BANCORP ASSET MANAGEMENT, INC.

41-2003732

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

U.S. BANCORP FUND SERVICES, LLC

39-1939072

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

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

(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

(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)

INCLUDED HEALTH, INC

45-3580052

(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?
23 50	NONE	6160500	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

LICENSEES HEALTH CONSULTING

93-3699504

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	589564	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

WILLIS TOWERS WATSON US LLC

53-0181291

(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?
11 16 22 38 50 53 70	NONE	424938	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [X]

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)

CAPFINANCIAL PARTNERS LLC

26-0058143

(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?
16 27 50 70	NONE	104659	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

OWNERS RISK MANAGEMENT ASSOCIATION

221 N LA SALLE DR
CHICAGO, IL 60654

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	95661	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GRANT THORNTON, LLP

36-6055558

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	71875	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

PRICEWATERHOUSECOOPERS, LLP

13-4008324

(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?
16 50 70	NONE	53000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

HELMSBRISCOE RESOURCEONE

20875 N 90TH PL
SUITE 210
SCOTTSDALE, AZ 85255

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	52958	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

AON RISK SERVICES

52-0220400

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	22892	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

U.S. BANK NATIONAL ASSOCIATION

31-0841368

(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?
21 25 28 50 52 62	TRUSTEE	21059	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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

CC LAW & POLICY PLLC

19670 BEACH ROAD, #552
JUPITER, FL 33469

(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?
29 50	NONE	7000	Yes [ ] No [X]	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

2025

This Form is Open to Public Inspection.

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

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:

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):

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)

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name MCDONALD'S LICENSEES HEALTH & WELFARE PLAN

b Name of plan sponsor NATIONAL FRANCHISEE LEADERSHIP ALLIANCE | **c** EIN-PN 36-2998455-510

a Plan name RMHC HEALTH & WELFARE PLAN

b Name of plan sponsor GLOBAL ADVISORY COUNCIL | **c** EIN-PN 56-2344840-501

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 H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MCDONALDS LICENSEES HEALTH AND WELFARE TRUST

D Employer Identification Number (EIN)
36-7112271

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	553346	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	3696148	3443738
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	82450776	77738177
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
1e Buildings and other property used in plan operation	1e		
1f Total assets (add all amounts in lines 1a through 1e)	1f	86700270	81181915
Liabilities			
1g Benefit claims payable	1g	57265560	71536975
1h Operating payables	1h	2950849	1282030
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through1j)	1k	60216409	72819005
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	26483861	8362910

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	271289518	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		271289518
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	893887	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		893887
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	1617429	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		1617429
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		8925389
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		282726223
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	251938402	
(2) To insurance carriers for the provision of benefits	2e(2)	28835536	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		280773938
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	17014665	
(3) Recordkeeping fees	2i(3)	0	
(4) IQPA audit fees	2i(4)	71875	
(5) Investment advisory and investment management fees	2i(5)	104660	
(6) Bank or trust company trustee/custodial fees	2i(6)	21059	
(7) Actuarial fees	2i(7)	447830	
(8) Legal fees	2i(8)	7000	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	2406147	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		20073236
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		300847174
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-18120951
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

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

(1) Name: GRANT THORNTON LLP **(2)** EIN: 36-6055558

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

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

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

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**			
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e Was this plan covered by a fidelity bond?	**4e**			
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**			
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**			
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**			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**			
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [ ] No

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

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 _____.

Combined Financial Statements and Report of Independent Certified Public Accountants

McDonald's Licensees and Ronald McDonald House Charities Health and Welfare Group Insurance Arrangement

December 31, 2025 and 2024

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REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

National Operators Insurance Team
McDonald's Licensees and Ronald McDonald House Charities Health and Welfare Group Insurance Arrangement

Opinion

We have audited the combined financial statements of McDonald's Licensees and Ronald McDonald House Charities Health and Welfare Group Insurance Arrangement (the "GIA" or "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the combined statements of benefit obligations and net assets available for benefits as of December 31, 2025 and 2024, and the related combined statement of changes in benefit obligations and net assets available for benefits for the year ended December 31, 2025, and the related notes to the combined financial statements.

In our opinion, the accompanying combined financial statements present fairly, in all material respects, the benefit obligations and net assets available for benefits of the GIA as of December 31, 2025 and 2024, and the changes in its benefit obligations and net assets available for benefits for the year ended December 31, 2025, in accordance with accounting principles generally accepted in the United States of America.

Basis for opinion

We conducted our audits of the combined financial statements in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the GIA and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of management for the financial statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the GIA's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the plan, and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the GIA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the GIA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental schedules required by ERISA
Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The combined supplemental schedules of assets (held at end of year) as of December 31, 2025 and reportable transactions for the year ended December 31, 2025 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such supplementary information is the responsibility of management

and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures. These additional procedures included comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with US GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying supplemental schedules are fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Grant Thornton LLP

Chicago, Illinois
October 13, 2026

McDonald's Licensees and Ronald McDonald House Charities
Health and Welfare Group Insurance Arrangement

COMBINED STATEMENTS OF BENEFIT OBLIGATIONS AND NET ASSETS AVAILABLE FOR BENEFITS

December 31,

	2025	2024
Benefit obligations (Note C)		
Claims payable, claims incurred but not reported and premiums due to insurers	$ 71,536,975	$ 57,265,560
Assets		
Investments, at fair value (Note F)	81,181,915	86,146,924
Other current assets	-	553,346
Total assets	81,181,915	86,700,270
Liabilities		
Administrative expenses payable	1,282,030	2,950,849
Total liabilities	1,282,030	2,950,849
Net assets available for benefits	79,899,885	83,749,421
SURPLUS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	$ 8,362,910	$ 26,483,861

The accompanying notes are an integral part of these combined financial statements.

McDonald's Licensees and Ronald McDonald House Charities
Health and Welfare Group Insurance Arrangement

COMBINED STATEMENT OF CHANGES IN BENEFIT OBLIGATIONS AND NET ASSETS AVAILABLE FOR BENEFITS

Year ended December 31, 2025

Increase in benefit obligations	
Increase (decrease) during the year attributable to	
Claims and premiums incurred	$ 280,773,938
Claims and premiums paid	(266,502,523)
Net increase in benefit obligations	14,271,415
Increase in net assets available for benefits	
Additions to net assets	
Contributions (Note A)	271,289,518
Investment income	
Net appreciation in fair value of investments	8,925,389
Interest and dividends	2,511,316
Total investment income	11,436,705
Less: investment expenses	104,660
Net investment income	11,332,045
Total additions	282,621,563
Deductions from net assets	
Health claims paid	237,666,986
Insurance premiums paid	28,835,537
Administrative and professional expenses	18,353,611
Income tax expense	1,614,965
Total deductions	286,471,099
Net decrease in net assets available for benefits	(3,849,536)
DECREASE IN NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS	(18,120,951)
Surplus of net assets available benefits over benefit obligations	
Beginning of year	26,483,861
End of year	$ 8,362,910

The accompanying notes are an integral part of this combined financial statement.

NOTE A - DESCRIPTION OF THE GROUP INSURANCE ARRANGEMENT

The following description of the McDonald's Licensees and Ronald McDonald House Charities Health and Welfare Group Insurance Arrangement (the GIA) is provided for general information purposes only. Participants should refer to the Plan document for more complete information.

General

The GIA provides health and other benefits to participating employees of the McDonald's Licensees Health and Welfare Plan and to the employees of the Ronald McDonald House Charities Health and Welfare Plan (together referred to as the Plans). Any Licensee or Chapter that adopts the prototype plan document is considered an employer. The Plans and the GIA are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The GIA constitutes a multiple-employer welfare arrangement under ERISA and is reported as a group insurance arrangement under Regulation Section 2520.104-43 of ERISA. Both Plans are administered by the National Operators Insurance Team (the "Plans' Administrator"). The National Franchise Leadership Alliance is the sponsor of the McDonald's Licensees Health & Welfare Plan and the Global Advisory Council is the sponsor of the Ronald McDonald House Charities Health & Welfare Plan (collectively, the "Plans' Sponsors").

Eligibility

Each adopting employer establishes their own eligibility requirements, including job classification and service requirements. If an employee meets the employer's description of eligibility, has applied and been approved for coverage and is actively at work, then that employee is entitled to benefits under these Plans.

Contributions

Contributions are made monthly by the adopting Licensee and Chapter based on participant elections and the related cost established for the selected coverage options. The Plans also provide health benefits to certain eligible retired employees; however, those participants cover 100% of that cost.

Benefits

The Plans offer employee health and welfare programs that may be utilized by participating employers. The Plans permit Licensees and Chapters to select from a variety of features to offer a custom-tailored plan to employee groups. The Plans provide medical, dental and prescription drugs benefits to members. In addition, other benefits, such as vision, life, short-term disability, long-term disability, accidental death and dismemberment, identify theft, legal, and critical illness benefits, are provided.

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The accompanying combined financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

Principles of Combination

The accompanying combined financial statements represent the combined financial statements of the Plans participating in the GIA.

Use of Estimates

The preparation of combined financial statements in conformity with U.S. GAAP requires GIA's management to use estimates and assumptions that affect the reported amounts of assets, liabilities and benefit obligations, and changes therein, disclosure of contingent assets and liabilities as of the date of the combined financial statements, and the reported amounts of additions and deductions from net assets during the reporting period. Actual results could differ from those estimates.

Investment Valuation and Income Recognition

Investments are held in a bank-administered trust fund (the Trust). The Trust's investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note F for discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Interest is recorded when earned. Dividends are recorded on the ex-dividend date.

Net Appreciation (Depreciation) in Fair Value of Investments

Net realized and unrealized appreciation (depreciation) is recorded in the accompanying combined financial statements as net appreciation in fair value of investments.

Rebates

Fidelity Security Life Insurance Company (FSL) periodically receives rebates from Express Scripts, Inc. based on the actual utilization of specific drugs. If the GIA is under the claims cap with FSL for the year, FSL will remit the rebates to the GIA. Otherwise, FSL will retain the rebates and apply them against the claims cap overage. Rebates are recorded when remitted to the GIA and netted against health claims paid in the accompanying combined statement of changes in benefit obligations and net assets available for benefits. For the year ended December 31, 2025, there were no rebates remitted.

Claims Incurred but Not Reported

The GIA's obligations as of December 31 for health claims incurred by participants but not reported (IBNR) at that date were estimated by the Plans' management based on historical claims data.

Administrative and Professional Expenses

Expenses incurred in administering the Plans are paid by the Plans.

Payment of Benefits

Premiums paid to insurers are recorded as insurance premiums paid in the accompanying combined statement of changes in benefit obligations and net assets available for benefits.

Claim payments are recorded when paid by the third-party claims processors as health claims paid in the accompanying combined statement of changes in benefit obligations and net assets available for benefits. Amounts due to claims processors that have not been reimbursed by the Plans are recorded as claims payable in the accompanying combined statements of benefit obligations and net assets available for benefits.

NOTE C - BENEFIT OBLIGATIONS

The GIA provide health benefits (e.g., medical, both inpatient and outpatient hospital care, surgical, major medical, dental, and prescription drugs) to participants and covered dependents under contracts with Blue Cross Blue Shield of Illinois (BCBS), Delta Dental of Illinois (Delta Dental) and FSL. BCBS has primary responsibility for medical claims administration, medical case management services, and mental health and chemical dependency. Delta Dental has the primary responsibility for dental claims administration and dental case management services. FSL is responsible for prescription drug claims, with administration performed by Express Scripts. The contracts with BCBS, Delta Dental and FSL are minimum premium plan arrangements. Under these arrangements, a claims cap or maximum is established based on the number of participants. All claims paid by the insurance company below the claims cap are reimbursed by the GIA to the insurance company and are recorded as health claims in the accompanying combined financial statements.

Benefits incurred which exceed the claims cap are payable by the GIA in the subsequent year, subject to the terms and conditions of the arrangement with the service provider. For the years ended December 31, 2025 and 2024, medical claims exceeded the claims cap for BCBS by approximately $13,410,000 and $630,000, respectively, under the BCBS claims cap. A corresponding liability of approximately $29,945,000 and $16,535,000 is recorded within the benefit obligations at December 31, 2025 and 2024, respectively, for the unpaid portion of this claims cap.

For the years ended December 31, 2025 and 2024, prescription drug claims exceeded the claims cap for FSL by approximately $28,210,000 and $23,800,000, respectively. Based on the contract with FSL, the GIA is not liable for this overage and accordingly no liability has been recorded in the financial statements.

Claims for Delta Dental did not exceed the claims cap in either period.

The GIA also provides for fully insured benefits under contracts with insurance companies for life insurance, accidental death and dismemberment, vision, identify theft, legal, critical illness, short-term disability and long-term disability.

When they occur, net asset deficits are funded through future increased insurance premiums charged to the participating licensees and charities and investment income.

NOTE D - CONTINGENT LIABILITY

Under the provisions of the insurance contract with BCBS, the Plans have a terminal liability payment due to BCBS one month after the cancellation of the contract. The terminal liability obligation is based on an average of active participants and a factor that is determined by BCBS. Upon termination, this liability will be compared to the final settlement, which includes the following:

- Net claims plus access fee;
- All prior claims not previously included; and
- Total unreimbursed deficit.

If the final settlement is less than the terminal liability, the Plans in the GIA will receive a refund for the difference. If the final settlement is more than the terminal liability, the Plans have no additional obligation. The terminal liability obligation at December 31, 2025 and 2024 was approximately $20,800,000 and $20,000,000, respectively. The Plans have no current intention to terminate the contract.

NOTE E - PLAN TERMINATION

Although it has not expressed any intention to do so, the Plans' Sponsors have the right to modify the benefits provided to, and contributions required of, participants, to discontinue its contributions at any time and to terminate the Plans subject to the provisions of ERISA. In the event of termination of the Plans, remaining assets will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants. No assets of the Plans may revert to the Plans' Sponsors or be used for purposes other than for the exclusive benefit of the Plans' participants.

NOTE F - FAIR VALUE MEASUREMENTS

The Financial Accounting Standards Board (FASB) has issued guidance that establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The fair value hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under the FASB guidance are described below:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plans have the ability to access.

Level 2 - Inputs to the valuation methodology, including the following:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability; and
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2025 and 2024.

Money Market Fund: Valued at cost, which approximates fair value.

Mutual Funds: Shares held by the GIA at year end are valued based on quoted prices of the fund in active markets.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the GIA believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following tables set forth by level, within the fair value hierarchy, the Plans' assets at fair value as of December 31:

	2025			
	Level 1	Level 2	Level 3	Total
Money market fund	$ 3,443,738	$ -	$ -	$ 3,443,738
Mutual funds	77,738,177	-	-	77,738,177
Total investments, at fair value	$ 81,181,915	$ -	$ -	$ 81,181,915

	2024			
	Level 1	Level 2	Level 3	Total
Money market fund	$ 3,696,148	$ -	$ -	$ 3,696,148
Mutual funds	82,450,776	-	-	82,450,776
Total investments, at fair value	$ 86,146,924	$ -	$ -	$ 86,146,924

NOTE G - RISKS AND UNCERTAINTIES

The Plans invest in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in these financial statements.

The IBNR is reported based on estimates over historical claims data. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

NOTE H - TAX STATUS OF THE TRUST

The Trust is a non-qualified trust that subjects its earnings from investments to federal and state income taxes at the applicable trust tax rates. U.S. GAAP requires GIA management to evaluate tax positions taken by the Plans and recognize a tax liability if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service or other applicable taxing authorities. The Plans' Administrator has analyzed the tax positions taken by the Plans and has concluded that, as of December 31, 2025 and 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the combined financial statements. The Plans are subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE I - RELATED-PARTY TRANSACTIONS AND PARTY IN INTEREST TRANSACTIONS

U.S. Bank, N.A. serves as trustee to the GIA. U.S. Bank, N.A. and their affiliates serve as investment advisors, provide custody services, and employ managers of funds sponsored by First American Funds.

Investment transactions and trustee fees associated with the trustee qualify as party-in-interest transactions. Fees incurred by the Plans for trustee services were approximately $41,300 for the year ended December 31, 2025 and is recorded in administrative and professional expenses.

NOTE J - RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31:

	2025	2024
Net assets available for benefits per financial statements	$ 79,899,885	$ 83,749,421
Less: benefit obligations	(71,536,975)	(57,265,560)
Net assets available for benefit per Form 5500	$ 8,362,910	$ 26,483,861

The following is a reconciliation of net decrease in net assets available for benefits per the financial statements to Form 5500 for the year ended December 31, 2025:

Net decrease in assets available for benefits per financial statements	$ (3,849,536)
Add: benefit obligations at beginning of year	57,265,560
Less: benefit obligations at end of year	(71,536,975)
Net loss per Form 5500	$ (18,120,951)

NOTE K - SUBSEQUENT EVENTS

GIA management evaluated the GIA's December 31, 2025 combined financial statements for subsequent events through October 13, 2026, the date the combined financial statements were available to be issued. GIA management is not aware of any subsequent events that would require recognition or disclosure in the combined financial statements.

COMBINED SUPPLEMENTAL SCHEDULES

McDonald's Licensees and Ronald McDonald House Charities
Health and Welfare Group Insurance Arrangement

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

December 31, 2025

Employer ID No: 36-7112271, Plan #: 501

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
*	First American Funds	Money Market Fund	$ 3,443,738	$ 3,443,738
		Mutual Funds		
	Vanguard	Mega Cap Index Fund	3,555,834	4,267,881
	GQG Partners	Emerging Markets Equity	1,135,583	1,125,340
	Vanguard	Intermediate-Term Tax-Exempt Fund	22,768,198	20,995,334
	iShares	Core S&P Mid-Cap ETF	3,902,454	5,779,884
	Vanguard	500 Index Fund	16,679,799	28,074,555
	FPA	Crescent Portfolio	5,144,519	5,836,882
	MFS	International Growth R6	2,826,999	3,060,315
	John Hancock	Disciplined Value	2,930,468	3,158,512
	Vanguard	Total International Stock Index Fund	5,400,521	5,439,474
		Total investments	$ 67,788,113	$ 81,181,915

* Represents a party-in-interest.

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS

*Indicates a single transaction that exceeds 5% of value

CATEGORY 1 - SINGLE TRANSACTION EXCEEDS 5% OF VALUE

Issue: 31846V203 - First Am Govt Ob Fd Cl Y

01/02/2025 10121830	B	22,447,542.120	1.0000		- 22,447,542 *	22,447,542
01/16/2025 10121830	S	- 6,185,464.930	1.0000		6,185,465 *	6,185,465
01/31/2025 10121830	S	- 16,467,102.970	1.0000		16,467,103 *	16,467,103
02/03/2025 10121830	B	22,785,998.150	1.0000		- 22,785,998 *	22,785,998
02/28/2025 10121830	S	- 18,175,780.260	1.0000		18,175,780 *	18,175,780
03/03/2025 10121830	B	22,728,079.720	1.0000		- 22,728,080 *	22,728,080
03/17/2025 10121830	S	- 6,404,935.520	1.0000		6,404,936 *	6,404,936
03/31/2025 10121830	S	- 18,078,347.690	1.0000		18,078,348 *	18,078,348
04/01/2025 10121830	B	22,337,446.780	1.0000		- 22,337,447 *	22,337,447
04/30/2025 10121830	S	- 17,913,087.540	1.0000		17,913,088 *	17,913,088
05/01/2025 10121830	B	22,441,365.710	1.0000		- 22,441,366 *	22,441,366

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
05/19/2025 10121830	S	- 6,164,401.390	1.0000		6,164,401 *	6,164,401	
05/27/2025 10121831	B	9,076,564.520	1.0000		- 9,076,565 *	9,076,565	
05/30/2025 10121830	S	- 15,800,001.170	1.0000		15,800,001 *	15,800,001	
06/02/2025 10121830	B	21,969,508.980	1.0000		- 21,969,509 *	21,969,509	
06/17/2025 10121830	S	- 5,328,627.390	1.0000		5,328,627 *	5,328,627	
06/30/2025 10121830	S	- 17,593,015.700	1.0000		17,593,016 *	17,593,016	
07/02/2025 10121830	B	22,358,447.500	1.0000		- 22,358,448 *	22,358,448	
07/15/2025 10121830	S	- 5,663,780.040	1.0000		5,663,780 *	5,663,780	
07/31/2025 10121830	S	- 17,416,716.040	1.0000		17,416,716 *	17,416,716	
08/01/2025 10121830	B	21,873,985.780	1.0000		- 21,873,986 *	21,873,986	
08/20/2025 10121830	S	- 6,670,515.720	1.0000		6,670,516 *	6,670,516	
09/02/2025 10121830	B	4,641,881.770	1.0000		- 4,641,882 *	4,641,882	
09/15/2025 10121830	S	- 5,672,402.500	1.0000		5,672,403 *	5,672,403	
09/30/2025 10121830	S	- 17,089,683.150	1.0000		17,089,683 *	17,089,683	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
10/01/2025 10121830	B	21,743,894.220	1.0000		- 21,743,894 *	21,743,894	
10/31/2025 10121830	S	- 18,192,931.590	1.0000		18,192,932 *	18,192,932	
11/03/2025 10121830	B	21,522,631.020	1.0000		- 21,522,631 *	21,522,631	
11/19/2025 10121830	S	- 5,249,058.070	1.0000		5,249,058 *	5,249,058	
11/28/2025 10121830	B	4,584,269.220	1.0000		- 4,584,269 *	4,584,269	
12/22/2025 10121830	S	- 5,990,210.400	1.0000		5,990,210 *	5,990,210	
12/31/2025 10121830	S	- 17,380,404.460	1.0000		17,380,404 *	17,380,404	
Issue: 922908710 - Vanguard 500 Index Admiral							
05/27/2025 10121831	S	- 9,601.402	536.3800		5,150,000 *	3,251,703	1,898,297
GRAND TOTAL				**0**	**473,098,084**	**471,199,787**	**1,898,297**

CATEGORY 2 - SERIES OF TRANSACTIONS WITH SAME BROKER EXCEEDS 5% OF VALUE

Broker: BofA Secs/Bofas Prime Broker

Issue: 464287507 - Ishares Core S P Mid Cap Etf							
05/27/2025 10121831	S	- 60,897.000	59.3009	1,218	3,610,029	2,922,519	687,510
Issue: 464287507 - Ishares Core S P Mid Cap Etf							
05/27/2025 10121832	S	- 23,141.000	59.3009	463	1,371,819	885,999	485,820

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
Total For BofA Secs/Bofas Prime Broker				**1,681**	**4,981,848**	**3,808,518**	**1,173,330**
GRAND TOTAL				**1,681**	**4,981,848**	**3,808,518**	**1,173,330**

CATEGORY 3 - SERIES OF TRANSACTIONS IN SAME SECURITY EXCEEDS 5% OF VALUE

Issue: 31846V203 - First Am Govt Ob Fd Cl Y

01/02/2025 10121830	B	22,447,542.120	1.0000		- 22,447,542 *	22,447,542
01/03/2025 10121830	B	63,629.700	1.0000		- 63,630	63,630
01/03/2025 10121831	B	9,550.020	1.0000		- 9,550	9,550
01/03/2025 10121832	B	1,069.190	1.0000		- 1,069	1,069
01/10/2025 10121830	B	2,267.510	1.0000		- 2,268	2,268
01/13/2025 10121830	B	15,566.640	1.0000		- 15,567	15,567
01/15/2025 10121830	B	47,709.650	1.0000		- 47,710	47,710
01/17/2025 10121830	B	42.460	1.0000		- 42	42
01/21/2025 10121830	B	453,865.410	1.0000		- 453,865	453,865
01/22/2025 10121830	B	30,088.520	1.0000		- 30,089	30,089

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
01/23/2025 10121830	B	476.490	1.0000		- 476	476	
02/03/2025 10121830	B	22,785,998.150	1.0000		- 22,785,998 *	22,785,998	
02/04/2025 10121830	B	64,333.520	1.0000		- 64,334	64,334	
02/04/2025 10121831	B	8,659.250	1.0000		- 8,659	8,659	
02/04/2025 10121832	B	1,060.920	1.0000		- 1,061	1,061	
02/06/2025 10121830	B	10,579.740	1.0000		- 10,580	10,580	
02/07/2025 10121830	B	588.680	1.0000		- 589	589	
02/14/2025 10121830	B	459,531.220	1.0000		- 459,531	459,531	
03/03/2025 10121830	B	22,728,079.720	1.0000		- 22,728,080 *	22,728,080	
03/04/2025 10121830	B	61,651.480	1.0000		- 61,651	61,651	
03/04/2025 10121831	B	4,460.030	1.0000		- 4,460	4,460	
03/04/2025 10121832	B	581.920	1.0000		- 582	582	
03/06/2025 10121830	B	16,579.340	1.0000		- 16,579	16,579	
03/07/2025 10121830	B	16,592.780	1.0000		- 16,593	16,593	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
03/13/2025 10121830	B	50,447.390	1.0000		- 50,447	50,447	
03/14/2025 10121830	B	462,899.320	1.0000		- 462,899	462,899	
03/21/2025 10121831	B	19,151.430	1.0000		- 19,151	19,151	
03/21/2025 10121832	B	9,091.480	1.0000		- 9,091	9,091	
03/24/2025 10121830	B	354.230	1.0000		- 354	354	
03/24/2025 10121832	B	1,999,607.780	1.0000		- 1,999,608	1,999,608	
04/01/2025 10121830	B	22,337,446.780	1.0000		- 22,337,447 *	22,337,447	
04/02/2025 10121830	B	66,776.620	1.0000		- 66,777	66,777	
04/02/2025 10121830	B	4,826.930	1.0000		- 4,827	4,827	
04/02/2025 10121831	B	36.780	1.0000		- 37	37	
04/02/2025 10121832	B	1,754.930	1.0000		- 1,755	1,755	
04/04/2025 10121830	B	3,488.040	1.0000		- 3,488	3,488	
04/09/2025 10121830	B	2,300.000	1.0000		- 2,300	2,300	
04/15/2025 10121830	B	454,878.250	1.0000		- 454,878	454,878	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
04/23/2025 10121830	B	16,069.260	1.0000		- 16,069	16,069	
04/23/2025 10121831	B	112,061.000	1.0000		- 112,061	112,061	
05/01/2025 10121830	B	22,441,365.710	1.0000		- 22,441,366 *	22,441,366	
05/02/2025 10121830	B	66,813.200	1.0000		- 66,813	66,813	
05/02/2025 10121831	B	34.290	1.0000		- 34	34	
05/02/2025 10121832	B	3,292.790	1.0000		- 3,293	3,293	
05/06/2025 10121830	B	7,137.360	1.0000		- 7,137	7,137	
05/07/2025 10121830	B	2,235.170	1.0000		- 2,235	2,235	
05/08/2025 10121830	B	2,300.000	1.0000		- 2,300	2,300	
05/15/2025 10121830	B	1,206,570.050	1.0000		- 1,206,570	1,206,570	
05/22/2025 10121830	B	22,797.820	1.0000		- 22,798	22,798	
05/27/2025 10121830	B	49,158.540	1.0000		- 49,159	49,159	
05/27/2025 10121831	B	9,076,564.520	1.0000		- 9,076,565 *	9,076,565	
05/27/2025 10121832	B	54,235.660	1.0000		- 54,236	54,236	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
05/29/2025 10121830	B	42.460	1.0000		- 42	42	
06/02/2025 10121830	B	21,969,508.980	1.0000		- 21,969,509 *	21,969,509	
06/03/2025 10121830	B	66,601.380	1.0000		- 66,601	66,601	
06/03/2025 10121831	B	4,457.790	1.0000		- 4,458	4,458	
06/03/2025 10121832	B	78.500	1.0000		- 79	79	
06/05/2025 10121830	B	6,381.060	1.0000		- 6,381	6,381	
06/06/2025 10121830	B	37,462.000	1.0000		- 37,462	37,462	
06/09/2025 10121830	B	6,104.860	1.0000		- 6,105	6,105	
06/11/2025 10121830	B	11,613.890	1.0000		- 11,614	11,614	
06/12/2025 10121830	B	35,074.400	1.0000		- 35,074	35,074	
06/20/2025 10121831	B	10,744.560	1.0000		- 10,745	10,745	
06/20/2025 10121832	B	5,872.260	1.0000		- 5,872	5,872	
06/25/2025 10121830	B	42.460	1.0000		- 42	42	
07/02/2025 10121830	B	63,385.390	1.0000		- 63,385	63,385	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
07/02/2025 10121830	B	22,358,447.500	1.0000		- 22,358,448 *	22,358,448	
07/02/2025 10121831	B	29,175.740	1.0000		- 29,176	29,176	
07/02/2025 10121832	B	3,701.530	1.0000		- 3,702	3,702	
07/09/2025 10121830	B	1,913.990	1.0000		- 1,914	1,914	
07/11/2025 10121830	B	80,167.290	1.0000		- 80,167	80,167	
07/14/2025 10121830	B	3,843.080	1.0000		- 3,843	3,843	
07/22/2025 10121830	B	2,000,000.000	1.0000		- 2,000,000	2,000,000	
07/24/2025 10121830	B	32,785.760	1.0000		- 32,786	32,786	
08/01/2025 10121830	B	21,873,985.780	1.0000		- 21,873,986 *	21,873,986	
08/04/2025 10121830	B	64,183.540	1.0000		- 64,184	64,184	
08/04/2025 10121831	B	21,516.960	1.0000		- 21,517	21,517	
08/04/2025 10121832	B	259.520	1.0000		- 260	260	
08/07/2025 10121830	B	2,300.000	1.0000		- 2,300	2,300	
08/08/2025 10121830	B	35,106.120	1.0000		- 35,106	35,106	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
08/15/2025 10121830	B	440,832.210	1.0000		- 440,832	440,832	
08/21/2025 10121830	B	425.290	1.0000		- 425	425	
08/25/2025 10121830	B	1,500.000	1.0000		- 1,500	1,500	
09/02/2025 10121830	B	4,641,881.770	1.0000		- 4,641,882 *	4,641,882	
09/03/2025 10121830	B	71,631.160	1.0000		- 71,631	71,631	
09/03/2025 10121831	B	17,072.170	1.0000		- 17,072	17,072	
09/03/2025 10121832	B	258.980	1.0000		- 259	259	
09/17/2025 10121830	B	435,152.270	1.0000		- 435,152	435,152	
09/19/2025 10121831	B	12,007.370	1.0000		- 12,007	12,007	
09/19/2025 10121832	B	6,562.430	1.0000		- 6,562	6,562	
09/24/2025 10121830	B	1,410,436.110	1.0000		- 1,410,436	1,410,436	
10/01/2025 10121830	B	21,743,894.220	1.0000		- 21,743,894 *	21,743,894	
10/01/2025 10121831	B	6,742.500	1.0000		- 6,743	6,743	
10/01/2025 10121832	B	3,651.150	1.0000		- 3,651	3,651	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
10/02/2025 10121830	B	60,277.190	1.0000		- 60,277	60,277	
10/02/2025 10121831	B	13,811.010	1.0000		- 13,811	13,811	
10/02/2025 10121832	B	253.690	1.0000		- 254	254	
10/09/2025 10121830	B	2,034.320	1.0000		- 2,034	2,034	
10/15/2025 10121830	B	66,567.740	1.0000		- 66,568	66,568	
10/17/2025 10121830	B	440,701.760	1.0000		- 440,702	440,702	
11/03/2025 10121830	B	21,522,631.020	1.0000		- 21,522,631 *	21,522,631	
11/04/2025 10121830	B	67,451.410	1.0000		- 67,451	67,451	
11/04/2025 10121830	B	76,991.300	1.0000		- 76,991	76,991	
11/04/2025 10121831	B	5,838.130	1.0000		- 5,838	5,838	
11/04/2025 10121832	B	278.660	1.0000		- 279	279	
11/12/2025 10121830	B	1,857.900	1.0000		- 1,858	1,858	
11/13/2025 10121830	B	1,200.000	1.0000		- 1,200	1,200	
11/20/2025 10121831	B	4,000,634.420	1.0000		- 4,000,634	4,000,634	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
11/28/2025 10121830	B	4,584,269.220	1.0000		- 4,584,269 *	4,584,269	
12/02/2025 10121830	B	58,379.460	1.0000		- 58,379	58,379	
12/02/2025 10121831	B	5,364.730	1.0000		- 5,365	5,365	
12/02/2025 10121832	B	257.650	1.0000		- 258	258	
12/05/2025 10121830	B	235,541.400	1.0000		- 235,541	235,541	
12/09/2025 10121830	B	28,398.580	1.0000		- 28,399	28,399	
12/16/2025 10121830	B	425,703.200	1.0000		- 425,703	425,703	
12/19/2025 10121831	B	18,684.320	1.0000		- 18,684	18,684	
12/19/2025 10121832	B	10,211.600	1.0000		- 10,212	10,212	
12/24/2025 10121830	B	1,000,000.000	1.0000		- 1,000,000	1,000,000	
12/24/2025 10121831	B	6,384.570	1.0000		- 6,385	6,385	
12/24/2025 10121832	B	3,756.260	1.0000		- 3,756	3,756	
Total For Buys				**0**	**257,858,483**	**257,858,483**	**0**
01/06/2025 10121830	S	- 71,566.320	1.0000		71,566	71,566	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
01/07/2025 10121830	S	- 15,542.320	1.0000		15,542	15,542	
01/08/2025 10121830	S	- 22,187.610	1.0000		22,188	22,188	
01/15/2025 10121831	S	- 328,892.000	1.0000		328,892	328,892	
01/16/2025 10121830	S	- 6,185,464.930	1.0000		6,185,465 *	6,185,465	
01/27/2025 10121831	S	- 1,197.100	1.0000		1,197	1,197	
01/27/2025 10121832	S	- 519.480	1.0000		519	519	
01/29/2025 10121830	S	- 10,043.880	1.0000		10,044	10,044	
01/31/2025 10121830	S	- 16,467,102.970	1.0000		16,467,103 *	16,467,103	
02/05/2025 10121830	S	- 14,361.350	1.0000		14,361	14,361	
02/10/2025 10121830	S	- 7,139.670	1.0000		7,140	7,140	
02/18/2025 10121830	S	- 4,171,650.610	1.0000		4,171,651	4,171,651	
02/18/2025 10121831	S	- 2,400,000.000	1.0000		2,400,000	2,400,000	
02/18/2025 10121832	S	- 310,000.000	1.0000		310,000	310,000	
02/26/2025 10121831	S	- 1,226.340	1.0000		1,226	1,226	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
02/26/2025 10121832	S	- 533.050	1.0000		533	533	
02/28/2025 10121830	S	- 18,175,780.260	1.0000		18,175,780 *	18,175,780	
03/04/2025 10121830	S	- 14,371.780	1.0000		14,372	14,372	
03/05/2025 10121830	S	- 12,011.370	1.0000		12,011	12,011	
03/10/2025 10121830	S	- 14,279.340	1.0000		14,279	14,279	
03/12/2025 10121830	S	- 934.770	1.0000		935	935	
03/17/2025 10121830	S	- 6,404,935.520	1.0000		6,404,936 *	6,404,936	
03/19/2025 10121830	S	- 20,976.760	1.0000		20,977	20,977	
03/26/2025 10121830	S	- 4,513.170	1.0000		4,513	4,513	
03/26/2025 10121831	S	- 1,220.200	1.0000		1,220	1,220	
03/26/2025 10121832	S	- 529.760	1.0000		530	530	
03/31/2025 10121830	S	- 18,078,347.690	1.0000		18,078,348 *	18,078,348	
04/10/2025 10121830	S	- 7,738.960	1.0000		7,739	7,739	
04/10/2025 10121831	S	- 22,786.520	1.0000		22,787	22,787	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
04/11/2025 10121830	S	- 87,206.830	1.0000		87,207	87,207	
04/14/2025 10121830	S	- 149,211.000	1.0000		149,211	149,211	
04/16/2025 10121830	S	- 4,163,161.170	1.0000		4,163,161	4,163,161	
04/16/2025 10121832	S	- 2,000,000.000	1.0000		2,000,000	2,000,000	
04/24/2025 10121831	S	- 112,061.000	1.0000		112,061	112,061	
04/25/2025 10121832	S	- 489.430	1.0000		489	489	
04/29/2025 10121830	S	- 1,178.030	1.0000		1,178	1,178	
04/30/2025 10121830	S	- 17,913,087.540	1.0000		17,913,088 *	17,913,088	
05/02/2025 10121830	S	- 604,447.080	1.0000		604,447	604,447	
05/05/2025 10121830	S	- 156,712.500	1.0000		156,713	156,713	
05/16/2025 10121830	S	- 36,496.050	1.0000		36,496	36,496	
05/19/2025 10121830	S	- 6,164,401.390	1.0000		6,164,401 *	6,164,401	
05/27/2025 10121830	S	- 833,500.000	1.0000		833,500	833,500	
05/30/2025 10121830	S	- 15,800,001.170	1.0000		15,800,001 *	15,800,001	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
05/30/2025 10121831	S	- 2,000,000.000	1.0000		2,000,000	2,000,000	
06/03/2025 10121830	S	- 41,362.200	1.0000		41,362	41,362	
06/04/2025 10121830	S	- 28,725.670	1.0000		28,726	28,726	
06/17/2025 10121830	S	- 5,328,627.390	1.0000		5,328,627 *	5,328,627	
06/18/2025 10121830	S	- 48.000	1.0000		48	48	
06/26/2025 10121831	S	- 1,066.160	1.0000		1,066	1,066	
06/26/2025 10121832	S	- 497.510	1.0000		498	498	
06/30/2025 10121830	S	- 17,593,015.700	1.0000		17,593,016 *	17,593,016	
07/01/2025 10121830	S	-.020	1.0000				
07/03/2025 10121830	S	- 59,781.250	1.0000		59,781	59,781	
07/07/2025 10121830	S	- 26,583.150	1.0000		26,583	26,583	
07/15/2025 10121830	S	- 5,663,780.040	1.0000		5,663,780 *	5,663,780	
07/16/2025 10121830	S	- 1,658.930	1.0000		1,659	1,659	
07/22/2025 10121831	S	- 2,000,000.000	1.0000		2,000,000	2,000,000	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
07/25/2025 10121831	S	- 1,064.520	1.0000		1,065	1,065	
07/25/2025 10121832	S	- 504.790	1.0000		505	505	
07/31/2025 10121830	S	- 17,416,716.040	1.0000		17,416,716 *	17,416,716	
08/04/2025 10121830	S	- 17,181.760	1.0000		17,182	17,182	
08/05/2025 10121830	S	- 58,253.660	1.0000		58,254	58,254	
08/12/2025 10121830	S	- 20,483.070	1.0000		20,483	20,483	
08/13/2025 10121830	S	- 15,780.000	1.0000		15,780	15,780	
08/14/2025 10121830	S	- 664.460	1.0000		664	664	
08/20/2025 10121830	S	- 6,670,515.720	1.0000		6,670,516 *	6,670,516	
08/26/2025 10121831	S	- 1,079.910	1.0000		1,080	1,080	
08/26/2025 10121832	S	- 515.180	1.0000		515	515	
08/28/2025 10121830	S	- 4,676.090	1.0000		4,676	4,676	
08/29/2025 10121830	S	- 12,036.960	1.0000		12,037	12,037	
09/03/2025 10121830	S	- 39,445.150	1.0000		39,445	39,445	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
09/04/2025 10121830	S	- 55,723.880	1.0000		55,724	55,724	
09/05/2025 10121830	S	- 9,521.600	1.0000		9,522	9,522	
09/08/2025 10121830	S	- 1,671.940	1.0000		1,672	1,672	
09/09/2025 10121830	S	- 1,113.140	1.0000		1,113	1,113	
09/10/2025 10121830	S	- 983.040	1.0000		983	983	
09/15/2025 10121830	S	- 5,672,402.500	1.0000		5,672,403 *	5,672,403	
09/15/2025 10121831	S	- 639,663.000	1.0000		639,663	639,663	
09/16/2025 10121830	S	- 2,015.170	1.0000		2,015	2,015	
09/18/2025 10121830	S	- 26,052.690	1.0000		26,053	26,053	
09/22/2025 10121830	S	- 15,780.000	1.0000		15,780	15,780	
09/23/2025 10121830	S	- 3,594.980	1.0000		3,595	3,595	
09/24/2025 10121831	S	- 2,000,000.000	1.0000		2,000,000	2,000,000	
09/26/2025 10121831	S	- 1,096.760	1.0000		1,097	1,097	
09/26/2025 10121832	S	- 521.410	1.0000		521	521	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
09/30/2025 10121830	S	- 17,089,683.150	1.0000		17,089,683 *	17,089,683	
10/02/2025 10121830	S	- 66,567.740	1.0000		66,568	66,568	
10/03/2025 10121830	S	- 42,023.040	1.0000		42,023	42,023	
10/06/2025 10121830	S	- 8,578.580	1.0000		8,579	8,579	
10/10/2025 10121830	S	- 503.020	1.0000		503	503	
10/16/2025 10121830	S	- 1,718.670	1.0000		1,719	1,719	
10/21/2025 10121830	S	- 4,029,050.240	1.0000		4,029,050	4,029,050	
10/21/2025 10121831	S	- 2,000,000.000	1.0000		2,000,000	2,000,000	
10/27/2025 10121831	S	- 1,126.420	1.0000		1,126	1,126	
10/27/2025 10121832	S	- 536.090	1.0000		536	536	
10/29/2025 10121830	S	- 2,230.930	1.0000		2,231	2,231	
10/31/2025 10121830	S	- 18,192,931.590	1.0000		18,192,932 *	18,192,932	
11/05/2025 10121830	S	- 7,377.570	1.0000		7,378	7,378	
11/18/2025 10121830	S	- 1,216.630	1.0000		1,217	1,217	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
11/19/2025 10121830	S	- 5,249,058.070	1.0000		5,249,058 *	5,249,058	
11/19/2025 10121831	S	- 500,000.000	1.0000		500,000	500,000	
11/26/2025 10121831	S	- 1,143.780	1.0000		1,144	1,144	
11/26/2025 10121832	S	- 544.610	1.0000		545	545	
12/01/2025 10121830	S	- 256,907.390	1.0000		256,907	256,907	
12/02/2025 10121830	S	- 19,994.060	1.0000		19,994	19,994	
12/15/2025 10121830	S	- 1,287.300	1.0000		1,287	1,287	
12/22/2025 10121830	S	- 5,990,210.400	1.0000		5,990,210 *	5,990,210	
12/24/2025 10121831	S	- 1,000,000.000	1.0000		1,000,000	1,000,000	
12/30/2025 10121831	S	- 1,093.400	1.0000		1,093	1,093	
12/30/2025 10121832	S	- 547.030	1.0000		547	547	
12/31/2025 10121830	S	- 17,380,404.460	1.0000		17,380,404 *	17,380,404	
Total For Sells				**0**	**258,066,746**	**258,066,746**	**0**
Total First Am Govt Ob Fd Cl Y				**0**	**515,925,229**	**515,925,229**	**0**

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
Issue: 464287507 - Ishares Core S P Mid Cap Etf							
03/24/2025 10121832	S	- 1,701.000	58.5800	37	99,608	65,126	34,482
05/27/2025 10121831	S	- 60,897.000	59.3009	1,218	3,610,029	2,922,519	687,510
05/27/2025 10121832	S	- 23,141.000	59.3009	463	1,371,819	885,999	485,820
Total For Sells				**1,718**	**5,081,456**	**3,873,644**	**1,207,812**
Total Ishares Core S P Mid Cap Etf				**1,718**	**5,081,456**	**3,873,644**	**1,207,812**
Issue: 922908710 - Vanguard 500 Index Admiral							
03/27/2025 10121831	R	139.845	525.1700		- 73,442	73,442	
03/28/2025 10121832	R	56.005	525.1700		- 29,412	29,412	
06/30/2025 10121831	R	94.683	572.5800		- 54,213	54,213	
07/01/2025 10121832	R	49.633	572.5800		- 28,419	28,419	
09/29/2025 10121831	R	88.143	614.7100		- 54,182	54,182	
09/30/2025 10121832	R	46.205	614.7100		- 28,403	28,403	
12/22/2025 10121831	R	77.842	634.7600		- 49,411	49,411	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
12/24/2025 10121832	R	45.685	634.7600		- 28,999	28,999	
	Total For Reinvestments			**0**	**346,481**	**346,481**	**0**
03/24/2025 10121832	S	- 2,859.430	524.5800		1,500,000	138,162	1,361,838
05/27/2025 10121831	S	- 9,601.402	536.3800		5,150,000 *	3,251,703	1,898,297
11/20/2025 10121831	S	- 3,339.306	613.9000		2,050,000	1,135,886	914,114
	Total For Sells			**0**	**8,700,000**	**4,525,751**	**4,174,249**
	Total Vanguard 500 Index Admiral			**0**	**9,046,481**	**4,872,232**	**4,174,249**
	GRAND TOTAL			**1,718**	**530,053,166**	**524,671,105**	**5,382,061**

CATEGORY 4 - SINGLE TRANSACTION WITH ONE BROKER EXCEEDS 5% OF VALUE

NO TRANSACTIONS QUALIFIED FOR THIS SECTION

Plan Name	**MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA**
Plan Sponsor EIN	**36-7112271**
ERISA Plan #	**501**
Plan Year Ending	**12/31/2025**

The required attachment marked with an "X" in the Attachment column is included within the Accountant's Opinion attachment to Sch. H, Part III, Line 3, which consists of the entire audit report issued by the plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line #	Description	Attachment
5500 Sch. H	Line 3	Financial statements used in formulating the IQPA's opinion	X
5500 Sch. H	Line 4a	Schedule of Delinquent Participant Contributions	
5500 Sch. H	Line 4i	Schedule of Assets (Held at End of Year)	X
5500 Sch. H	Line 4i	Schedule of Assets (Acquired and Disposed of Within Year)	
5500 Sch. H	Line 4j	Schedule of Reportable Transactions	X

Plan Name	**MCDONALD'S LICENSEES/RMHC HEALTH & WELFARE GIA**
Plan Sponsor EIN	**36-7112271**
ERISA Plan #	**501**
Plan Year Ending	**12/31/2025**

The required attachment marked with an "X" in the Attachment column is included within the Accountant's Opinion attachment to Sch. H, Part III, Line 3, which consists of the entire audit report issued by the plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line #	Description	Attachment
5500 Sch. H	Line 3	Financial statements used in formulating the IQPA's opinion	X
5500 Sch. H	Line 4a	Schedule of Delinquent Participant Contributions	
5500 Sch. H	Line 4i	Schedule of Assets (Held at End of Year)	X
5500 Sch. H	Line 4i	Schedule of Assets (Acquired and Disposed of Within Year)	
5500 Sch. H	Line 4j	Schedule of Reportable Transactions	X