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 6047(e), 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

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

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:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
TOYOTA OF ESCONDIDO EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2007

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
TOYOTA OF ESCONDIDO

231 LINCOLN PARKWAY
ESCONDIDO, CA 92026

2b Employer Identification Number (EIN)
95-3263258

2c Sponsor's telephone number
760-746-0601

2d Business code (see instructions)
441110

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.	08/26/2010	LISA THOMPSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with incorrect/unrecognized electronic signature.	09/01/2010	RICK BILLUNI
	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 (if same as plan sponsor, enter "Same")
COMMUNITY ADMINISTRATORS

740 BAY BOULEVARD
CHULA VISTA, CA 91910

3b Administrator's EIN
95-3766170

3c Administrator's telephone number
619-498-6541

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:
a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	244
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	198
b	Retired or separated participants receiving benefits	**6b**	3
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	201
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	201
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants that 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:
4G 4F 4E 4D 4B 4A

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

b General Schedules

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

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

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
TOYOTA OF ESCONDIDO EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
TOYOTA OF ESCONDIDO

D Employer Identification Number (EIN)
95-3263258

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
COLONIAL LIFE & ACCIDENT 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
57-0144607	62049	E3058872	258	01/01/2009	12/31/2009

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 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
11723	1307

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
DAVID ARTHUR RACKLIFFE
35 DANBURY LANE
IRVINE, CA 92618

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MICHAEL FRANCIS FAHEY
411 ADOBE
SAN CLEMENTE, CA 92672

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

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

VIRGINIA ANN THORP
21931 BACALAR STREET
MISSION VIEJO, CA 92691

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2			3

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

PATRICK DANIEL KAPTERIAN
26895 ALISO CREEK RD
ALISO VIEJO, CA 92656

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
10	2	BONUS AND NON CASH INCENTIVES	3

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

STACIE DIMON
38 OUTRIGGER CT
LONG BEACH, CA 90803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
14			3

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

STEPHEN DENHAM
2652 COOLEY RD
IMPERIAL, CA 92251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
14			3

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

JORGE RIESTRA
2800 KELLER DR
TUSTIN CITY, CA 92782

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
17	1	BONUS AND NON CASH INCENTIVES	3

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

WERNER LANGER PHD
PO BOX 11582
SANTA ANA, CA 92711

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
34			3

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

JIM BARRETT
1356 MIRACIELO CT
SAN MARCOS, CA 92078

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
48			3

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

REBECCA RENEE WEBB
1928 TAFT AVE
LOS ANGELES, CA 90068

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
58			3

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

R HANSON
1575 VIA ENTRADA DEL LARGO LAKE
SAN MARCOS, CA 92078

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
135			3

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

CHARLES DUANE SMITH
4040 EAST PIEDMONT DR
HIGHLAND, CA 92346

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
383	24	BONUS AND NON CASH INCENTIVES	3

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

MICHAEL JOSEPH MCCORMICK
29811 SANTA MARGARITA PKWY
RANCHO SANTA MARGARITA, CA 92688

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
348	82	BONUS AND NON CASH INCENTIVES	3

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

BARBARA ROSE WOLARIK
805 PILLAR POINT WAY
OCEANSIDE, CA 92058

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
419	35	BONUS AND NON CASH INCENTIVE	3

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

GARY LOUDELL DIMON
31805 TEMECULA PARKWAY
TEMECULA, CA 92592

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
380	162	CASH AND NON CASH INCENTIVES	3

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

LESLIE BRUCE DIMON
26630 BARTON RD
LOMA LINDA, CA 92373

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
811	40	BONUS AND NON CASH INCENTIVES	3

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

RALPH F REA
84 VIA BARCELONA
RANCHO SANTA MARGARITA, CA 92688

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
766	198	CASH AND NON CASH INCENTIVE	3

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

DAVID ZAZUETA ALVERADO
2530 VISTA WAY
OCEANSIDE, CA 92054

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1061	59	BONUS AND NON CASH INCENTIVES	3

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

SUSIE ANN ESTRADA
31878 DEL OBISPO
SAN JUAN CAPISTRANO, CA 92675

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2207	240	BONUS AND NON CASH INCENTIVES	3

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

SCOTT CHRISTOPHER CASTEEL
23862 CALLE GANADOR
MISSION VIEJO, CA 92691

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2125	464	BONUSES AND NON CASH INCENTIVES	3

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

KINGHORN & ASSOCIATES
PO BOX 225
BONITA, CA 91908

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2891			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	

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**	
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)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
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)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 organization(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** [X] 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) ▶ ACCIDENT, DISABILITY, LIFE, CANCER

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	95385		
(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)**	95385
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)**	
(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)**	
(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 **c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 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

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
TOYOTA OF ESCONDIDO EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500.
TOYOTA OF ESCONDIDO

D Employer Identification Number (EIN)
95-3263258

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
HCC LIFE INSURANCE

(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
35-1817054	92711	HCL16350	258	01/01/2009	12/31/2009

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 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**	
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)**	
d	Total of balance and additions (add **b** and **c(6)**)			**7d**	
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)**	
f	Balance at the end of the current year (subtract **e(5)** from **d**)			**7f**	

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 organization(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** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [X] 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)**	184162		
(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)**	184162
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)**	
(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)**	
(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 **c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 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.**	**2009** **This Form is Open to Public Inspection.**

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
TOYOTA OF ESCONDIDO EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TOYOTA OF ESCONDIDO

D Employer Identification Number (EIN)
95-3263258

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).. . . . . ☐ 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

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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)

UNITED CLAIMS SOLUTIONS

10835 N 25TH AVE
SUITE 105
PHOENIX, AZ 85029

(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?
		13506	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

LEAF & COLE, LLP

2810 CAMINO DEL RIO SOUTH
SUITE 200
SAN DIEGO, CA 92108

95-2076568

(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	AUDITOR	7500	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PRE PAID LEGAL

321 EAST MAIN STREET
ADA, OK 74820-2629

(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	PREPAID LEGAL SERVICES	5266	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

FIRST HEALTH NETWORK

23291 NETWORK PLACE
CHICAGO, IL 60673-1233

(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	PPO-PREF PROV NETWORK	18155	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

COMMUNITY ADMINISTRATORS

740 BAY BLVD
CHULA VISTA, CA 91910

(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?
14	PLAN ADMINISTRATOR	73741	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

KINGHORN AND ASSOCIATES

2525 CAMINO DEL RIO SOUTH
SUITE 222
SAN DIEGO, CA 92108

(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	PLAN MANAGEMENT	41985	Yes [ ] No [X]	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 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

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan
TOYOTA OF ESCONDIDO EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TOYOTA OF ESCONDIDO

D Employer Identification Number (EIN)
95-3263258

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	25194	7494
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	74756	31199
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	540	2312
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(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)		
(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)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	100490	41005
	Liabilities			
g	Benefit claims payable	1g	98135	39920
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	2355	1085
k	Total liabilities (add all amounts in lines 1g through1j)	1k	100490	41005
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l		

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)	1487411	
	(B) Participants	2a(1)(B)	51150	
	(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)		1538561
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(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)		
	(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)		
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
	(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)		

		(a) Amount	(b) Total
2b (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)		
(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)		
c Other income	2c		1602
d Total income. Add all **income** amounts in column (b) and enter total	2d		1540163
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1063912	
(2) To insurance carriers for the provision of benefits	2e(2)	279547	
(3) Other	2e(3)	32105	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		1375564
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	164599	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		164599
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		1540163
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		
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] Unqualified (2) [ ] Qualified (3) [ ] Disclaimer (4) [ ] Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [ ] Yes [X] No

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

(1) Name: LEAF & COLE, LLP (2) EIN: 95-2076568

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, 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 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.

During the plan year:

		Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of 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	X		5000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan 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		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n		X	

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

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)

TOYOTA OF ESCONDIDO

EMPLOYEE BENEFIT TRUST

EMPLOYEE WELFARE PLAN

FINANCIAL STATEMENTS

DECEMBER 31, 2009 AND 2008



Leaf & Cole, LLP
Certified Public Accountants

TOYOTA OF ESCONDIDO
EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN
FINANCIAL STATEMENTS
DECEMBER 31, 2009 AND 2008

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Leaf & Cole, LLP
Certified Public Accountants
A Partnership of Professional Corporations

Steven W. Northcote, C.P.A.
Michael S. Schreibman, C.P.A
Michael J. Zizzi, C.P.A.
Julie A. Firl, C.P.A.
Nicholas M. Gines, C.P.A.

Members
American Institute of Certified Public Accountants
California Society of Certified Public Accountants

Independent Auditor's Report

To the Administrative Committee of
Toyota of Escondido
Employee Benefit Trust Employee Welfare Plan
231 Lincoln Parkway
Escondido, California 92026

We have audited the accompanying statements of benefit obligations and net assets available for benefits of Toyota of Escondido Employee Benefit Trust Employee Welfare Plan as of December 31, 2009 and 2008, and the related statements of changes in benefit obligations and net assets available for benefits for the years then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Plan as of December 31, 2009 and 2008, and the changes in its financial status for the years ended December 31, 2009 and 2008 in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplementary schedule of assets held for investment purposes as of December 31, 2009 is presented for the purpose of additional analysis and is not a required part of the basic financial statements, but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. The supplementary information is the responsibility of the Plan's management. The supplementary information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Leaf & Cole LLP
San Diego, California
August 8, 2010

2810 Camino Del Rio South, Suite 200, San Diego, California 92108-3820
619.294.7200, 619.294.7077 fax, www.leaf-cole.com, leafcole@leaf-cole.com

TOYOTA OF ESCONDIDO
EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN
STATEMENTS OF BENEFIT OBLIGATIONS AND
NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2009 AND 2008

	2009	2008
Benefit Obligations: (Note 1)		
Amounts currently payable to or for participants, beneficiaries and dependents:		
Health claims payable and claims incurred but not reported	$ 39,920	$ 98,135
Total Benefit Obligations	39,920	98,135
Net Assets:		
Assets: (Note 1)		
Receivables:		
Employer contributions	31,199	74,756
Health and drug claims	2,312	540
Cash	4,554	19,091
Flex plan cash	2,940	6,103
Total Assets	41,005	100,490
Liabilities:		
Flex plan	1,085	2,355
Total Liabilities	1,085	2,355
Net Assets Available for Benefits	39,920	98,135
EXCESS OF BENEFIT OBLIGATIONS OVER NET ASSETS AVAILABLE FOR BENEFITS	$ -	$ -

The accompanying notes are an integral part of the financial statements.

TOYOTA OF ESCONDIDO
EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS AND
NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEARS ENDED DECEMBER 31, 2009 AND 2008

	2009	2008
Net Increase (Decrease) in Benefit Obligations:		
Change during the period attributable to:		
Health claims payable and claims incurred but not reported	$ (58,215)	$ 70,529
Net Increase in Net Assets Available for Benefits:		
Additions:		
Stop loss insurance reimbursements	1,602	21,408
Contributions:		
Employer	1,487,411	1,631,605
Employee	32,691	62,038
COBRA	18,459	13,146
Total Contributions	1,538,561	1,706,789
Total Additions	1,540,163	1,728,197
Deductions:		
Health and drug claims	1,122,127	1,025,248
Flex plan payments	32,105	64,827
Insurance premiums for the provision of benefits	279,547	404,912
Administrative expenses	164,599	162,681
Total Deductions	1,598,378	1,657,668
Net Increase (Decrease)	(58,215)	70,529
Increase (Decrease) in Excess of Benefit Obligations Over Net Assets Available for Benefits	-	-
Excess of Net Assets Over Benefit Obligations Available for Benefits:		
Beginning of year	-	-
End of year	$ -	$ -

The accompanying notes are an integral part of the financial statements.

TOYOTA OF ESCONDIDO
EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2009 AND 2008

Note 1 - Description of Plan and Significant Accounting Policies:

Description of Plan

The following description of Toyota of Escondido Employee Benefit Trust Employee Welfare Plan (the "Plan") provides only general information. Participants should refer to the summary plan description for a complete description of the Plan's provisions.

General

The Plan is a self-insured health and welfare benefit plan established by Toyota of Escondido (the "Company") on January 1, 2007 to provide health, disability and death benefits to full-time employees and to their beneficiaries and covered dependents. The Company self-insures these benefits from the general assets of the Company as well as through insurance contracts to pay certain benefits to employees whose claims exceed certain amounts during any plan year. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Eligibility

Those employees who are employed a minimum of thirty-two (32) hours a week are eligible to participate after ninety days of service. An employee will become a participant in the Plan on the first day of the month immediately following the date the employee satisfies the eligibility conditions.

Benefits

The Plan provides health benefits (medical, dental, vision and Rx) for eligible employees of the Company and their dependents. All covered employees also receive $10,000 of insurance coverage. The life insurance benefit is funded by a life insurance contract purchased by the Plan.

The Plan provides for continuation of benefits for certain terminated employees up to eighteen (18) months and certain dependents for a period of up to thirty-six (36) months depending upon eligibility. The cost of these benefits are paid by the terminated employees or their dependents.

The Plan includes a cafeteria arrangement maintained pursuant to Section 125 of the Internal Revenue Code in which employees can elect to reduce their taxable salary in favor of purchasing non-taxable benefits including reimbursements of medical expenses and dependent child care expenses. The Plan also provides the sponsorship of voluntary and supplemental benefits.

Contributions

The Company makes contributions to the plan administrator to fund the health claims payable, insurance premiums, commissions, administrative fees, prepaid legal and other voluntary supplemental benefits. Additional contributions are received from terminated employees to continue their benefits under the COBRA provisions. The Company receives funds from stop loss insurance carriers when claims exceed predetermined amounts, which are used to reduce the Company's current contribution.

Note 1 - Description of Plan and Significant Accounting Policies: (Continued)

Description of Plan (Continued)

Contributions (Continued)

The Plan receives contributions from the employer from it's employees per salary reduction arrangements as provided by Section 125 of the Internal Revenue Code. These reimbursements are used to fund employees' medical reimbursement accounts, dependent child care, pre-paid legal and supplemental voluntary policies.

Significant Accounting Policies

Basis of Accounting

The financial statements of the Plan have been prepared on the accrual basis of accounting which is in accordance with U.S. generally accepted accounting principles. Employee and employer contributions were recognized in the period that contributions are due.

In June 2009, the Financial Accounting Standards Board (FASB) Accounting Standards Codification (Codification) was issued. The Codification is the source of authoritative U.S. GAAP recognized by the FASB to be applied by nongovernmental entities. The Codification is effective for financials statements issued for interim and annual periods ending after September 15, 2009. The implementation of this standard did not have a material impact on the financial position and results of operations.

Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires the plan administrator to make estimates and assumptions that affect certain reported amounts of assets, benefit obligations and changes therein, IBNR, claims payable, liabilities and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Fair Value Measurements

The Plan has adopted the fair value standards for financial assets and liabilities that are required to be measured at fair value on a recurring basis. The Fair Value Measurement standards define fair value, establish a framework for measuring fair value, outline a fair value hierarchy based on inputs used to measure fair value and enhance disclosure requirements for fair value measurements. The fair value hierarchy distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Level 1 or 2 of the hierarchy) and the reporting entity's own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy). These standards do not change existing guidance as to whether or not an instrument is carried at fair value. The Plan had no financial instruments at December 31, 2009 and 2008.

Note 1 - Description of Plan and Significant Accounting Policies: (Continued)

Significant Accounting Policies (Continued)

Employer Contributions Receivable

Employer contributions receivable represent the total of the health claims payable and estimated claims incurred but not reported, net of any cash held in the Plan. Employer contributions receivable totaled $31,199 and $74,756 at December 31, 2009 and 2008, respectively.

Benefit Obligations

Plan liabilities for estimated health claims incurred but not reported is calculated using a "lag matrix formula' which calculates the average lag time between when a medical claim is incurred and when it is actually submitted to the Plan for payment. This lag time is then applied to the claims submitted to the Plan for payment during the year and the result is the estimated health claims incurred during the plan year that will be submitted for payment following the end of the plan year and when it is actually paid by the Plan. Health claims payable and claims incurred but not reported totaled $39,920 and $98,135 at December 31, 2009 and 2008, respectively.

Subsequent Events

In preparing these financial statements, the Plan has evaluated events and transactions for potential recognition or disclosure through August 10, 2010, the date the financial statements were available to be issued.

Note 2 - Income Taxes:

The Plan received a favorable determination letter from the Internal Revenue Service stating that the Plan meets the requirements for qualification under Section 501(c)(9) of the Internal Revenue Code and, as such, is exempt from taxation. The Plan has also received a determination letter from the Franchise Tax Board and is exempt under Section 23701(i).

Note 3 - Reconciliation of Financial Statements to Schedule H of Form 5500:

The following is a reconciliation of net assets available for benefits per the accompanying financial statements to the Schedule H of Form 5500 for the years ended December 31:

	2009	2008
Net assets available for benefits per the financial statements	$ 39,920	$ 98,135
Health claims payable and claims incurred but not reported	(39,920)	(98,135)
Net Assets Available for Benefits per Schedule H of Form 5500	$ -	$ -

Note 3 - Reconciliation of Financial Statements to Schedule H of Form 5500: (Continued)

The following is a reconciliation of health claims paid per the financial statements to Schedule H of Form 5500 for the years ended December 31:

	2009	2008
Health claims paid per the financial statements	$ 1,122,127	$ 1,025,248
Add: Amounts payable at end of year	39,920	98,135
Less: Amounts payable at beginning of year	(98,135)	(27,606)
Health Claims Paid Per Schedule H of Form 5500	$ 1,063,912	$ 1,095,777

Amounts currently payable to or for participants, dependents, and beneficiaries are recorded on Schedule H of Form 5500 for benefit claims that have been incurred prior to December 31, but not paid as of that date.

Note 4 - Termination of the Plan:

Under certain conditions, the Plan may be terminated. Upon termination, the assets then remaining shall be subject to the applicable provisions of the Plan then in effect and shall be used until exhausted to pay benefits to employees in the order of their entitlement.

TOYOTA OF ESCONDIDO
EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN
SCHEDULE OF ASSETS HELD FOR INVESTMENT PURPOSES
E.I.N.: 95-3263258
PLAN NUMBER: 501
DECEMBER 31, 2009

Identity of Issuer, Borrower Lessor or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Dates	Cost	Current Value
Wells Fargo Bank	Cash equivalents, interest varies	$ 7,494	$ 7,494

TOYOTA OF ESCONDIDO
EMPLOYEE BENEFIT TRUST EMPLOYEE WELFARE PLAN
SCHEDULE OF ASSETS HELD FOR INVESTMENT PURPOSES
E.I.N.: 95-3263258
PLAN NUMBER: 501
DECEMBER 31, 2009

Identity of Issuer, Borrower Lessor or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Dates	Cost	Current Value
Wells Fargo Bank	Cash equivalents, interest varies	$ 7,494	$ 7,494