

<div>Form 5500</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Annual Return/Report of Employee Benefit Plan</div> <div>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).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div>	<div>OMB Nos. 1210-0110 1210-0089</div> <div>2009</div> <div>This Form is Open to Public Inspection</div>
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Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning 01/01/2008 and ending 12/31/2008	
A	This return/report is for: <div><div><input type="checkbox"/> a multiemployer plan;</div><div><input type="checkbox"/> a multiple-employer plan; or</div><div><input type="checkbox"/> a single-employer plan;</div><div><input type="checkbox"/> a DFE (specify) ____</div></div>
B	This return/report is: <div><div><input type="checkbox"/> the first return/report;</div><div><input type="checkbox"/> the final return/report;</div><div><input type="checkbox"/> an amended return/report;</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months).</div></div>
C	If the plan is a collectively-bargained plan, check here. ▶ <input type="checkbox"/>
D	Check box if filing under: <div><div><input type="checkbox"/> Form 5558;</div><div><input type="checkbox"/> automatic extension;</div><div><input type="checkbox"/> the DFVC program;</div><div><input type="checkbox"/> special extension (enter description)</div></div>

Part II	Basic Plan Information—enter all requested information	
1a	Name of plan GRAJA INC 401 K PLAN	1b Three-digit plan number (PN) ▶ 001
		1c Effective date of plan 01/01/1999
2a	Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) GRAJA INC P O BOX 1827 1424 14TH LONGVIEW, WA 98632	2b Employer Identification Number (EIN) 91-1612236
		2c Sponsor's telephone number
		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			
	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 (if same as plan sponsor, enter "Same") GRAJA INC P O BOX 1827 1424 14TH LONGVIEW, WA 98632	3b Administrator's EIN 91-1612236 3c Administrator's telephone number <div style="background-color: #cccccc; height: 30px; width: 100%;"></div>
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
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
b Retired or separated participants receiving benefits.....	6b
c Other retired or separated participants entitled to future benefits.....	6c
d Subtotal. Add lines 6a , 6b , and 6c	6d
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e
f Total. Add lines 6d and 6e	6f
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:	

9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> 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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

Attachments Unavailable

Attachments for the selected filing cannot be publicly disclosed over the website as the Department of Labor determined that one or more attachments may contain sensitive personally identifiable information. Please contact the Department of Labor EBSA Public Disclosure Office as noted below in order to request a redacted copy of the document you need.

U.S. Department of Labor
Employee Benefits Security Administration
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