Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2010** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 01/01/2008 and ending 12/31/2008

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
SUMMA HEALTH SYSTEM HOSPITALS TAX SHELTERED ANNUITY PROGRAM

1b Three-digit plan number (PN) ▶ 003

1c Effective date of plan 01/01/1997

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
SUMMA AKRON CITY AND ST. THOMAS HOSPITALS

P.O. BOX 2090
AKRON, OH 44309-2090

168 EAST MARKET STREET
AKRON, OH 44309-2090

2b Employer Identification Number (EIN) 34-0714755

2c Sponsor's telephone number 330-996-8523

2d Business code (see instructions) 622000

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.	03/19/2010	NINO CIRALDO
	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

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SUMMA AKRON CITY AND ST. THOMAS HOSPITALS

P.O. BOX 2090
AKRON, OH 44309-2090

3b Administrator's EIN
34-0714755

3c Administrator's telephone number
330-996-8523

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:
2M

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

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

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

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

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

February 22, 2010

SUMMA HEALTH SYSTEM HOSPITALS
SUMMA HEALTH SYSTEM HOSPITALS TAX SHELTERED ANNUITY PROGRAM
P.O. BOX 2090
AKRON, OH 443092090

Employer Identification Number: 340714755
Plan Number: 003

Dear Plan Administrator:

We are in receipt of the document submitted as your 2008 Form 5500 Series Annual Return/Report. At this time, the document is being returned to you because it was not filed in a government-approved format. **The content of your filing has not been reviewed.**

Section 109 of the Employee Retirement Income Security Act of 1974 (ERISA) provides that the Secretary of the Department of Labor may require that information submitted in an annual report under Title I of ERISA must be submitted on such forms as the Secretary may prescribe. Section 6058(a) of the Internal Revenue Code (IRC) and the regulations thereunder prescribe the manner in which information must be submitted by plans that have a filing requirement under the IRC. Section 4 of the 2008 Form 5500 and 5500EZ instructions entitled "How to File" provides detailed information on the approved formats for the submission of a Form 5500 Series Annual Return/Report under ERISA. The formats include:

Electronic Filing of the Form 5500 Series Annual Return/Report, see the DOL web site at www.efast.dol.gov for a list of approved software vendors, the Form EFAST-1, and additional information.

Hand print forms can be completed by hand, typewriter, or by EFAST approved software. Hand print forms may be ordered by calling the Internal Revenue Service 24 hours a day, 7 days a week at 1-800-TAX-FORM (1-800-829-3676). A list of EFAST approved software vendors is available at www.efast.dol.gov for filers wanting to file using computer generated hand print forms.

Machine print forms are completed using EFAST approved computer software. Machine print forms may be filed by mail or filed electronically. For more information on filing using machine print forms and a list of EFAST approved vendors, see www.efast.dol.gov.

ACTION TO BE TAKEN BY YOU

To avoid possible civil penalties, you must submit a Form 5500 Series Annual Return/Report in an approved format **within 45 days from the date of this letter** as follows:

By Mail

EBSA
P.O. Box 7043
Lawrence, KS 66044-7043

By Private Delivery Service

EBSA/Vangent, Inc
Attn: EFAST
3833 Greenway Drive
Lawrence, KS 66046-5502

By Electronic Transmission

(See the website www.efast.dol.gov for information on filing electronically.)

IMPORTANT: You must also include a copy of this letter with your corrected filing.

IF YOU TAKE NO ACTION

Failure to submit your filing in an approved format may subject you to civil penalties of up to $1,100 per day pursuant to ERISA section 502(c)(2) and $25 a day (up to $15,000) pursuant to IRC section 6652(d)(1) for failing to file a complete and accurate return/report.

If you have any questions regarding this letter or need assistance in preparing your filing, please contact EBSA toll-free at (866) 463-3278, Monday through Friday, except Federal holidays, from 8:00 A.M. to 8:00 P.M. Eastern Standard Time.

Sincerely,

Chief, EFAST Processing
Employee Benefits Security Administration
EFAST Program