




6. Exhibit D is a true and correct copy of the third Form 843 Texas filed with the Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it.
7. Since receiving the letter from the Internal Revenue Service (Exhibit B), HHSC has received no further written or other communication from the Internal Revenue Service pertaining to a Form 843 or refunding or otherwise returning all or any of the Health Insurance Providers Fees that Texas paid.
8. Since receiving the letter from the Internal Revenue Service (Exhibit B), HHSC has received no money from the U.S. Department of the Treasury that reflects a response to the filing of our Form 843 or otherwise refunding or returning all or any of the Health Insurance Providers Fees that Texas paid.
9. By and through this Declaration, I hereby incorporate by reference the attached exhibits and provide the same as if done so in open court, or otherwise under oath.
10. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 11th day of May, 2018.

  
Greta Rymal

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>		A. Signature <b>X</b> <div style="float: right;"> <input type="checkbox"/> Agent  <input type="checkbox"/> Addressee </div>	
1. Article Addressed to: <p style="text-align: center;">TEXAS</p> <p style="text-align: center;"><b>DEPARTMENT OF TREASURY</b>  <b>INTERNAL REVENUE SERVICE</b>  <b>1973 NORTH RULON WHITE BLVD</b>  <b>MAIL STOP 4916 IPF</b>  <b>OGDEN UT 84404</b></p>		B. Received by (Printed Name) _____ C. Date of Delivery _____ D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, enter delivery address below:	
2. Article Number (Transfer from service label) <p style="text-align: center;">October 19, 2015</p>		<p style="text-align: center;"><b>RECEIVED</b>  <b>OCT 28 2015</b>  <b>OGDEN, UT</b>  <b>IRS-OSC</b></p>	
3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	
PS Form 3811, February 2004		Domestic Return Receipt	
		102595-02-M-1540	

October 19, 2015

Department of Treasury  
Internal Revenue Service  
1973 North Rulon White Boulevard  
Mail Stop 4916 IPF  
Ogden UT 84404

via Certified Mail 7003 1680 0002 1989 8729

Re: Claim for Refund and Request for Abatement

Dear Sir/Madam:

Enclosed please find Texas Health and Human Services Commission's Claim for Refund and Request for Abatement.

Sincerely,



Dianne Purcell  
Legal Assistant  
512/424-6968

RH:dhp

Attachment

# Texas Exhibit A

7003 1680 0002 1989 8729

PS Form 3808, June 2002 See Reverse for Instructions	Sent To _____	<b>U.S. Postal Service™</b> <b>CERTIFIED MAIL™ RECEIPT</b> (Domestic Mail Only; No Insurance Coverage Provided) For delivery information visit our website at <a href="http://www.usps.com">www.usps.com</a> ® <b>OFFICIAL USE</b>
	Street, Apt. No., or PO Box No. _____	
	City, State, ZIP+4 _____	
	Postmark Here	
Total Postage & Fees \$ _____		Certified Fee _____ Return Receipt Fee (Endorsement Required) _____ Restricted Delivery Fee (Endorsement Required) _____

*Annual Fee on Health Insurance Providers*

Form **843**  
(Rev. August 2011)  
Department of the Treasury  
Internal Revenue Service

**Claim for Refund and Request for Abatement**

▶ See separate instructions.

OMB No. 1545-0024

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Texas Health and Human Services Commission</b>	Your social security number
Address (number, street, and room or suite no.) <b>4900 N. Lamar Blvd.</b>	Spouse's social security number
City or town, state, and ZIP code <b>Austin, Tx 78751</b>	Employer identification number (EIN) <b>742638006</b>
Name and address shown on return if different from above	Daytime telephone number <b>512-487-3355</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. <i>(Fee Year 2014)</i> From <b>January 1, 2013</b> to <b>December 31, 2013</b>	<b>2 Amount</b> to be refunded or abated: \$ <b>\$84,637,710.00</b>
---	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b Date(s) of payment(s) ▶** \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ **ACA sec. 9010 fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

**The Health Insurance Provider's Fee under the Affordable Care Act as applied to States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.**

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature (Title, if applicable. Claims by corporations must be signed by an officer.)  
*Greta Rymal, Deputy Executive Commissioner, Financial Services, Texas Health and Human Services Commission*     Date *Oct. 12, 2015*

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶			Firm's EIN ▶	
	Firm's address ▶			Phone no.	



1973 Rulon White Blvd M/S 4916  
OGDEN UT 84201-0038

In reply refer to: 0435227736  
Feb. 19, 2016 LTR 96C 0  
74-2638006 201409 79

00000037  
BODC: TE

HEALTH AND HUMAN SERVICES  
% MIKE MARKL  
1106 CLAYTON LN STE 101E  
AUSTIN TX 78723-1033

Received  
FEB 22 2016  
NB  
Payroll -  
Time Labor and Leave

000701

Employer identification number: 74-2638006

Dear Taxpayer:

We received your Form 843, Claim for Refund and Request for Abatement, for the 2014 Health Insurance Provider Fee (IPF) year.

If you have questions, you can call Claim Representative at 1-616-365-4617 between 8:00 a.m. and 4:00 p.m. ET.

If you prefer, you can write to us at the address at the top of the first page of this letter.

When you write, include a copy of this letter and provide in the spaces below, your telephone number and the hours we can reach you. Keep a copy of this letter for your records.

Telephone Number ( ) \_\_\_\_\_ Hours \_\_\_\_\_

Sincerely yours,

Ginni L. Redfern  
Program Manager, AM OPS 1

Texas Exhibit B

RECEIVED  
FEB 26 2016  
OFFICE OF CHIEF COUNSEL

A1182



Department of the Treasury  
Internal Revenue Service

Notice 1155 (CG/EN/SP)

## Disaster Relief from the IRS

If you have been impacted by the recent disaster in your area and are unable to meet your tax obligations, the IRS may be able to assist with payment and filing extensions, and if qualified, with an expedited tax refund for casualty losses. Please call the IRS Disaster Hotline at 1-866-562-5227 to find out what type of administrative tax relief is available.

For assistance in calculating any disaster loss, please call 1-800-829-3676 and order Publication 2194, Disaster Resource Guide for Individuals and Businesses. If you have access to the Internet you may log on to [www.irs.gov](http://www.irs.gov) and use the keyword "disaster" to view additional information.

Aviso 1155

## Alivio de Desastre por parte del IRS

Si usted ha sido impactado por el reciente desastre en su área y no ha podido cumplir con sus obligaciones tributarias, el IRS podría ayudarle a extender el término para el pago y la presentación, y si califica, con un reembolso rápido del impuesto por las pérdidas fortuitas. Por favor llame a la Línea de Emergencia del IRS al 1-866-562-5227, para averiguar qué tipo de alivio administrativo tributario está disponible.

Para ayudarle a calcular cualquier pérdida fortuita, por favor llame al 1-800-829-3676, y ordene la Publicación 2194, Disaster Resource Guide for Individuals and Businesses (Guía de recursos en casos de desastres para personas y negocios), en inglés. Si usted tiene acceso al Internet conéctese con la página del IRS en [www.irs.gov](http://www.irs.gov), y use la palabra clave "desastre" (*disaster*), para ver la información adicional.



**IRS**

Department of the Treasury  
Internal Revenue Service

1973 Rulon White Blvd M/S 4916  
OGDEN UT 84201-0038

000701.485464.305178.22765 1 MB 0.439 699



HEALTH AND HUMAN SERVICES  
% MIKE MARKL  
1106 CLAYTON LN STE 101E  
AUSTIN TX 78723-1033



000701

CUT OUT AND RETURN THE VOUCHER AT THE BOTTOM OF THIS PAGE IF YOU ARE MAKING A PAYMENT,  
EVEN IF YOU ALSO HAVE AN INQUIRY.



The IRS address must appear in the window.  
0435227736

Use for payments

BODCD-TE

Letter Number: LTR0096C  
Letter Date : 2016-02-19  
Tax Period : 201409



\*742638006\*

INTERNAL REVENUE SERVICE  
1973 Rulon White Blvd M/S 4916  
OGDEN UT 84201-0038

HEALTH AND HUMAN SERVICES  
% MIKE MARKL  
1106 CLAYTON LN STE 101E  
AUSTIN TX 78723-1033





**TEXAS**  
Health and Human  
Services

May 11, 2018

Department of the Treasury  
Internal Revenue Service  
1973 North Rulon White Boulevard  
Mail Stop 4916 IPF  
Ogden, Utah 84404

Re: Claims for Refund and Request for Abatement

Dear Sir/Madam:

Enclosed please find Texas Health and Human Services Commission's Claims for Refund and Request for Abatement.

Sincerely,

Patricia Winkler  
Legal Assistant  
512/424-6530

LTP: tp

2 Attachments

7009 1680 0000 8374 7475

**CERTIFIED MAIL RECEIPT**  
For delivery information visit our website at www.usps.com

**OFFICIAL USE**

Postage	\$	Postmark Here
Certified Fee		
Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

Sent To: IRS  
Street, Apt. No., or PO Box No.: 1973 N. Rulon White Blvd  
City, State, ZIP+4: OGDEN, UT 84404

PS Form 3800, August 2006 See Reverse for Instructions

**Texas Exhibit C**



Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Texas Health and Human Services Commission</b>	Your social security number
Address (number, street, and room or suite no.) <b>4900 N. Lamar Blvd.</b>	Spouse's social security number
City or town, state, and ZIP code <b>Austin, TX 78751</b>	Employer identification number (EIN) <b>742638006</b>
Name and address shown on return if different from above	Daytime telephone number <b>512-487-3355</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. <i>(Fee year 2015)</i> From <b>January 1, 2014</b> to <b>December 31, 2014</b>	<b>2 Amount to be refunded or abated:</b> \$ <b>108,949,507.00</b>
---	---

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b Date(s) of payment(s) ▶** \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ **ACA Sec. 9010 Fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to the States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

*Gita Rymal, Deputy Executive Commissioner, Financial Services, Texas Health and Human Services Commission*     *May 11, 2018*  
 Signature (Title, if applicable. Claims by corporations must be signed by an officer.)     Date  
 \_\_\_\_\_  
 Signature (spouse, if joint return)     Date

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶	Firm's EIN ▶			
	Firm's address ▶	Phone no.			

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

## Claim for Refund and Request for Abatement

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

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- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Texas Health and Human Services Commission</b>	Your social security number
Address (number, street, and room or suite no.) <b>4900 N. Lamar Blvd.</b>	Spouse's social security number
City or town, state, and ZIP code <b>Austin, TX 78751</b>	Employer identification number (EIN) <b>742638006</b>
Name and address shown on return if different from above	Daytime telephone number <b>512-487-3355</b>

**1 Period.** Prepare a separate Form 843 for each tax period or fee year. *(Fee Yr 2016)*  
 From **January 1, 2015** to **December 31, 2015**

**2 Amount to be refunded or abated:**  
 \$ **111,143,391.00**

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

- Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

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- A penalty or addition to tax was the result of erroneous written advice from the IRS.
- Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b Date(s) of payment(s) ▶** \_\_\_\_\_

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706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ **ACA Sec. 9010 Fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

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**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature (Title, if applicable. Claims by corporations must be signed by an officer.) *Opita Rimal, Deputy Executive Commissioner, Financial Services, Texas Health and Human Services Commission* Date *May 11, 2018*  
 Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶			Firm's EIN ▶	
	Firm's address ▶			Phone no.	

Texas Exhibit D



My name is Matthew Van Patton and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Director of the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC). My job duties include overseeing all aspects of the administration of the medical assistance program generally known as Nebraska Medicaid. I have held this position since March 1, 2018.
2. A copy of documents maintained by DHHS MLTC regarding our application for a refund from the federal government regarding the Health Insurance Providers Fees paid by Nebraska for tax years 2014, 2015, and 2016 are attached hereto as Exhibits A, B, and C. We do not expect to ask for a refund of the Health Insurance Providers Fees for tax year 2017, as Congress withheld the application of the Health Insurance Providers Fee for 2017.
3. These documents are true and correct copies of records maintained by DHHS MLTC, which I am authorized to certify as true and correct. These records are kept by DHHS MLTC in the regular course of our business. Furthermore, it was in the regular course of the business of DHHS MLTC that employees of DHHS MLTC, with knowledge of the information recorded made, transmitted, received, or otherwise archived the information to be included in the record. Finally, these records were created, received, and/or archived at or near the time of the acts, events, conditions, or information recorded in the records.
4. Exhibit A is a true and correct copy of the Form 843 Nebraska filed with the Internal Revenue Service for tax year 2014. Exhibit B is a true and correct copy of the Form 843 Nebraska filed with the Internal Revenue Service for tax year 2015. Exhibit C is a true and correct copy of the Form 843 Nebraska filed with

the Internal Revenue Service for tax year 2016. Exhibit D is a true and correct copy of the cover letter that accompanied Exhibits A, B, and C.

5. By and through this Declaration, I hereby incorporate by reference the attached exhibits and provide the same as if done so in open court, or otherwise under oath.
6. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 14<sup>th</sup> day of May, 2018.



Matthew Van Patton

# NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

May 14, 2018

Department of Treasury  
Internal Revenue Service  
1973 North Rulon White Boulevard  
Mail Stop 4916 IPF  
Ogden, UT 84404

via Certified Mail 7018 0360 0001 4774 9173

RE: Claim for Refund and Request for Abatement

Dear Sir/Madam:

Enclosed please find Nebraska Department of Health and Human Services Commission's Claim for Refund and Request for Abatement.

Sincerely,

Michael Michalski  
Chief Financial Officer  
DHHS Financial Services

## Nebraska Exhibit A

Attachment

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
<p>1. Department of Treasury Internal Revenue Service 1973 North Rulon White Boulevard Mail Stop 4916 IPF Ogden, UT 84404</p>	<p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®  <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™  <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery  <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Return Receipt for Merchandise  <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation™  <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery  <input type="checkbox"/> Insured Mail <input type="checkbox"/> Restricted Delivery</p>
<p>2. Article Number (Transfer from service label)</p> <p>9590 9402 2957 7094 3689 94</p> <p>7018 0360 0001 4774 9173</p>	

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. HOLD AT DOTTED LINE.

**CERTIFIED MAIL®**



7018 0360 0001 4774 9173  
7018 0360 0001 4774 9173

**U.S. Postal Service™  
CERTIFIED MAIL® RECEIPT**  
Domestic Mail Only

For delivery information, visit our website at [www.usps.com](http://www.usps.com)®.

**OFFICIAL USE**

Certified Mail Fee	\$	
Extra Services & Fees (check box, add fee as appropriate)		
<input type="checkbox"/> Return Receipt (hardcopy)	\$	
<input type="checkbox"/> Return Receipt (electronic)	\$	
<input type="checkbox"/> Certified Mail Restricted Delivery	\$	
<input type="checkbox"/> Adult Signature Required	\$	
<input type="checkbox"/> Adult Signature Restricted Delivery	\$	
Postage	\$	
<b>Total Postage and Fees:</b>	\$	

Postmark Here

Sent To: **Department of Treasury**  
 Street: **Internal Revenue Service**  
**1973 North Rulon White Boulevard**  
 City, ST: **Mail Stop 4916 IPF**  
 PS Fo: **Ogden, UT 84404**

See Reverse for Instructions

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Nebraska Department of Health and Human Services</b>	Your social security number
Address (number, street, and room or suite no.) <b>301 Centennial Mall South</b>	Spouse's social security number
City or town, state, and ZIP code <b>Lincoln, NE 68508</b>	Employer identification number (EIN) <b>47-0491233</b>
Name and address shown on return if different from above	Daytime telephone number

1 <b>Period.</b> Prepare a separate Form 843 for each tax period or fee year. <i>(Fee year 2014)</i> From <b>January 1, 2013</b> to <b>December 31, 2013</b>	2 <b>Amount</b> to be refunded or abated: \$ <b>12,438,107</b>
---	---

3 **Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment   
  Estate   
  Gift   
  Excise   
  Income   
  Fee

4 **Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

5a **Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

b Date(s) of payment(s) ▶ \_\_\_\_\_

6 **Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706     709     940     941     943     945  
 990-PF     1040     1120     4720     Other (specify) ▶ **ACA sec. 9010 fee**

7 **Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

**The Health Insurance Provider's Fee under the Affordable Care Act as applied to the States through their Medicaid and CHIP Managed Care Organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.**

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

*Michal D. Michalski*    *Chief Financial Officer*    5/14/2018  
 Signature (Title, if applicable. Claims by corporations must be signed by an officer.)    Date

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶	Firm's EIN ▶			
	Firm's address ▶	Phone no.			



Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11 C, 720, 730, or 2290.

Name(s) <b>Nebraska Department of Health and Human Services</b>	Your social security number
Address (number, street, and room or suite no.) <b>301 Centennial Mall South</b>	Spouse's social security number
City or town, state, and ZIP code <b>Lincoln, NE 68508</b>	Employer identification number (EIN) <b>47-0491233</b>
Name and address shown on return if different from above	Daytime telephone number

1 <b>Period.</b> Prepare a separate Form 843 for each tax period or fee year. <i>(Fee year 2014)</i> From <b>January 1, 2014</b> to <b>December 31, 2014</b>	2 <b>Amount</b> to be refunded or abated: \$ <b>12,075,744</b>
---	---

3 **Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment   
  Estate   
  Gift   
  Excise   
  Income   
  Fee

4 **Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

5a **Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

b Date(s) of payment(s) ▶ \_\_\_\_\_

6 **Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706     709     940     941     943     945  
 990-PF     1040     1120     4720     Other (specify) ▶ **ACA sec. 9010 fee**

7 **Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to the States through their Medicaid and CHIP Managed Care Organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

*Michael Michaelson, Chief Financial Officer* \_\_\_\_\_ Date **5/14/2018**  
 Signature (Title, if applicable. Claims by corporations must be signed by an officer.)

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed
	Firm's name ▶	Firm's EIN ▶	Phone no.	PTIN
	Firm's address ▶			

**Nebraska Exhibit B**

A1194

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545 0024

► See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Nebraska Department of Health and Human Services</b>	Your social security number
Address (number, street, and room or suite no.) <b>301 Centennial Mall South</b>	Spouse's social security number
City or town, state, and ZIP code <b>Lincoln, NE 68508</b>	Employer identification number (EIN) <b>47-0491233</b>
Name and address shown on return if different from above	Daytime telephone number

1 <b>Period.</b> Prepare a separate Form 843 for each tax period or fee year. <i>(See year 2016)</i> From <b>January 1, 2015</b> to <b>December 31, 2015</b>	2 <b>Amount</b> to be refunded or abated: \$ <b>11,725,067</b>
---	---

3 **Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment   
  Estate   
  Gift   
  Excise   
  Income   
  Fee

4 **Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

5a **Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

b Date(s) of payment(s) ► \_\_\_\_\_

6 **Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706     709     940     941     943     945  
 990-PF     1040     1120     4720     Other (specify) ► **ACA sec. 9010 fee**

7 **Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

**The Health Insurance Provider's Fee under the Affordable Care Act as applied to the States through their Medicaid and CHIP Managed Care Organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.**

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

*Michael Michaelis, Chief Financial Officer* \_\_\_\_\_ Date 5/14/2018

Signature (file, if applicable. Claims by corporations must be signed by an officer.)

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ►	Firm's EIN ►		Phone no.	
	Firm's address ►				

IN THE UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF TEXAS  
WICHITA FALLS DIVISION

STATE OF TEXAS §  
STATE OF KANSAS §  
STATE OF LOUISIANA §  
STATE OF INDIANA §  
STATE OF WISCONSIN §  
STATE OF NEBRASKA §

Plaintiffs, §

v. §

CIVIL ACTION NO. 7:15-CV-00151-O

UNITED STATES OF AMERICA, §  
UNITED STATES DEPARTMENT §  
OF HEALTH AND HUMAN §  
SERVICES, SYLVIA BURWELL, §  
in her Official Capacity as §  
SECRETARY OF HEALTH AND §  
HUMAN SERVICES, UNITED §  
STATES INTERNAL REVENUE §  
SERVICE, and JOHN KOSKINEN, §  
in his Official Capacity as §  
COMMISSIONER OF INTERNAL §  
REVENUE, §

Defendants. §

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DECLARATION OF HEATHER SMITH

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1. My name is Heather K. Smith, and I am over the age of eighteen, and am fully competent to make this Declaration.

2. Since January 8, 2018, I have served as the Administrator of the Division of Medicaid Services with the Wisconsin Department of Health Services (DHS) and also serve as the Wisconsin Medicaid Director. My current job duties include:

- a. Director of Wisconsin Medicaid program, providing health and long term care services to over 1.2 million members with a biennial budget of over \$18.6 billion.
- b. Administrator of the division responsible for delivery, administration and policy development of the Supplemental Nutritional Assistance Program (SNAP), providing assistance to over 800,000 Wisconsin residents with an annual budget of over \$1 billion.

3. A copy of documents maintained by DHS regarding our application for a refund from the federal government regarding the Health Insurance Providers Fees paid by Wisconsin for tax year 2014, 2015, and 2016 are attached hereto as Exhibits A, B, and C. We do not expect to ask for a refund of the Health Insurance Providers Fees for tax year 2017 as Congress withheld the application of the Health Insurance Providers Fee for 2017.

4. These documents are true and correct copies of records maintained by DHS, which I am authorized to certify as true and correct. These records are kept by DHS in the regular course of our business. Furthermore, it was in the regular course of the business of DHS that employees of DHS, with knowledge of the information recorded made, transmitted, received, or otherwise archived the information to be included in the record. Finally, these records were created, received, and/or archived at or near the time of the acts, events, conditions, or information recorded in the records.

5. Exhibit A is a true and correct copy of the Form 843 Wisconsin filed with the Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2014. Exhibit B is a true and correct copy of the Form 843 Wisconsin filed with the Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2015. Exhibit C is a true and correct copy of the Form 843 Wisconsin filed with the Internal


Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2016.

6. I am aware that Texas previously filed a Form 843 at the time the lawsuit was commenced and that Texas has heard nothing from IRS.

7. By and through this Declaration, I hereby incorporate by reference the attached exhibits and provide the same as if done so in open court, or otherwise under oath.

8. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 9 day of May, 2018

  
\_\_\_\_\_  
Heather K. Smith

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>State of Wisconsin - Department of Health Services</b>	Your social security number
Address (number, street, and room or suite no.) <b>1 West Wilson Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Madison, Wisconsin 53707</b>	Employer identification number (EIN) <b>47-457134</b>
Name and address shown on return if different from above	Daytime telephone number <b>(608) 266-1865</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2014</b> to <b>December 31, 2014</b>	<b>2 Amount to be refunded or abated:</b> \$ <b>27,098,549.00</b>
--	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b Date(s) of payment(s) ▶** \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ **ACA sec.9010 fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

# Wisconsin Exhibit A

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature (Title, if applicable. Claims by corporations must be signed by an officer.) <i>Matthew Smith</i> Administrator @ Dept of Medicaid Services	Date 5/14/18
Signature (spouse, if joint return)	Date

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶	Firm's EIN ▶			
	Firm's address ▶	Phone no.			

Form <b>843</b> (Rev. August 2011) Department of the Treasury Internal Revenue Service	<b>Claim for Refund and Request for Abatement</b>  ▶ See separate instructions.	OMB No. 1545-0024
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Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-G, 720, 730, or 2290.

Name(s) <b>State of Wisconsin - Department of Health Services</b>	Your social security number
Address (number, street, and room or suite no.) <b>1 West Wilson Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Madison, Wisconsin 53707</b>	Employer identification number (EIN) <b>47-457134</b>
Name and address shown on return if different from above	Daytime telephone number <b>(608) 266-1865</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2015</b> to <b>December 31, 2015</b>	<b>2 Amount</b> to be refunded or abated: \$ <b>\$29,007,046.00</b>
--	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment   
  Estate   
  Gift   
  Excise   
  Income   
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b Date(s) of payment(s) ▶** \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706     709     940     941     943     945  
 990-PF     1040     1120     4720     Other (specify) ▶ **ACA sec.9010 fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

# Wisconsin Exhibit B

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

<i>Halluk Smith</i> Signature (Title, if applicable. Claims by corporations must be signed by an officer.)	5/14/18 Date
Administration Dept. of Medicaid Services Signature (spouse, if joint return)	Date

<b>Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.

Form <b>843</b> (Rev. August 2011) Department of the Treasury Internal Revenue Service	<b>Claim for Refund and Request for Abatement</b>  ▶ See separate instructions.	OMB No. 1545-0024
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Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>State of Wisconsin - Department of Health Services</b>	Your social security number
Address (number, street, and room or suite no.) <b>1 West Wilson Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Madison, Wisconsin 53707</b>	Employer identification number (EIN) <b>47-457134</b>
Name and address shown on return if different from above	Daytime telephone number <b>(608) 266-1865</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2016</b> to <b>December 31, 2016</b>	<b>2 Amount</b> to be refunded or abated: \$ <b>\$32,833,255.00</b>
--	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment   
  Estate   
  Gift   
  Excise   
  Income   
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b Date(s) of payment(s) ▶** \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706     709     940     941     943     945  
 990-PF     1040     1120     4720     Other (specify) ▶ **ACA sec.9010 fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

# Wisconsin Exhibit C

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

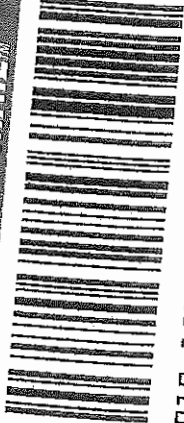
<i>[Signature]</i> Signature (title, if applicable. Claims by corporations must be signed by an officer.)	Date <b>5/14/18</b>
<i>Administrator Dept. of Medicaid Services</i> Signature (spouse, if joint return)	Date

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶	Firm's EIN ▶			
	Firm's address ▶	Phone no.			



PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE.

**CERTIFIED MAIL™**



7010 1870 0003 5264 9456  
7010 1870 0003 5264 9456

**U.S. Postal Service™**  
**CERTIFIED MAIL™ RECEIPT**  
*(Domestic Mail Only; No Insurance Coverage Provided)*

For delivery information visit our website at [www.usps.com](http://www.usps.com)

**OFFICIAL USE**

Postage	\$	
Certified Fee		
Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	00

Postmark Here

Sent To  
Street, Apt. or PO Box |  
City, State, |

Internal Revenue Service  
Mailstop 4921 IPF  
1973 Rulon White Blvd.  
Ogden, UT 84201

PS Form 3811, August 2003  
See reverse for instructions

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	<p>A. Signature <b>X</b> <span style="float: right;"><input type="checkbox"/> Agent <input type="checkbox"/> Addressee</span></p> <p>B. Received by (Printed Name) <span style="float: right;">C. Date of Delivery</span></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No</p>
<p>1. Article Addressed to:</p> <p style="text-align: center;">Internal Revenue Service Mailstop 4921 IPF 1973 Rulon White Blvd. Ogden, UT 84201</p>	<p>3. Service Type</p> <p><input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail  <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise  <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>
<p>2. Article Number (Transfer from service label)</p> <p style="text-align: right;">7010 1870 0003 5264 9456</p>	<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>PS Form 3811, February 2004 <span style="margin-left: 100px;">Domestic Return Receipt</span> <span style="float: right;">102595-02-M-1540</span></p>	

**Certified Mail Provider**  
A mailing receipt

- A unique identifier for your mailpiece
- A record of delivery kept by the Postal Service for two years

**Important Reminders:**

- Certified Mail may ONLY be combined with First-Class Mail® or Priority Mail.
- Certified Mail is *not* available for any class of international mail.
- NO INSURANCE COVERAGE IS PROVIDED with Certified Mail. For valuables, please consider Insured or Registered Mail.
- For an additional fee, a *Return Receipt* may be requested to provide proof of delivery. To obtain Return Receipt service, please complete and attach a Return Receipt (PS Form 3811) to the article and add applicable postage to cover the fee. Endorse mailpiece "Return Receipt Requested". To receive a fee waiver for a duplicate return receipt, a USPS® postmark on your Certified Mail receipt is required.
- For an additional fee, delivery may be restricted to the addressee or addressee's authorized agent. Advise the clerk or mark the mailpiece with the endorsement "*Restricted Delivery*".
- If a postmark on the Certified Mail receipt is desired, please present the article at the post office for postmarking. If a postmark on the Certified Mail receipt is not needed, detach and affix label with postage and mail.

**IMPORTANT: Save this receipt and present it when making an inquiry.**

PS Form 3800, August 2006 (Reverse) PSN 7530-02-000-9047

UNITED STATES POSTAL SERVICE



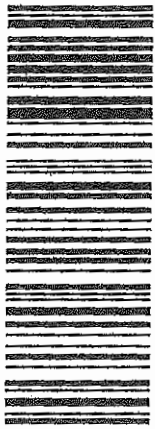
First-Class Mail  
Postage & Fees Paid  
USPS  
Permit No. G-10

• Sender: Please print your name, address, and ZIP+4 in this box •

DEPT. OF HEALTH SERVICES  
OFFICE OF LEGAL COUNSEL  
PO BOX 7850  
MADISON WI 53707-7850

F.M.

**CERTIFIED MAIL™**



7010 1870 0003 5264 9456  
 7010 1870 0003 5264 9456



Return Service  
 PF  
 White Blvd.  
 01

**U.S. Postal Service™**  
**CERTIFIED MAIL™ RECEIPT**  
*(Domestic Mail Only; No Insurance Coverage Provided)*  
 For delivery information visit our website at [www.usps.com](http://www.usps.com)  
**OFFICIAL USE**

Postage	\$	Postmark Here
Certified Fee		
Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

Sent To	
Street, Apt. or PO Box	Internal Revenue Service Mailstop 4921 IPF
City, State,	1973 Rulon White Blvd. Ogden, UT 84201

PS Form 3800, August 2006 See reverse for instructions

RETURN SERVICE REQUESTED

State of Wisconsin  
 DEPARTMENT OF HEALTH SERVICES  
 OFFICE OF LEGAL COUNSEL  
 1 WEST WILSON STREET  
 P. O. BOX 7850  
 MADISON, WI 53707-7850



F-83007

A1204

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> <li>■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>■ Print your name and address on the reverse so that we can return the card to you.</li> <li>■ Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	<p>A. Signature <span style="float: right;"><input type="checkbox"/> Agent <input type="checkbox"/> Addressee</span></p> <p><b>X</b></p>
<p>1. Article Addressed to:</p> <p style="text-align: center;">Internal Revenue Service Mailstop 4921 IPF 1973 Rulon White Blvd. Ogden, UT 84201</p>	<p>B. Received by (<i>Printed Name</i>) <span style="float: right;">C. Date of Delivery</span></p>
<p>2. Article Number <i>(Transfer from service label)</i></p>	<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No</p>
	<p>3. Service Type</p> <p><input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail  <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise  <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>
	<p>4. Restricted Delivery? (<i>Extra Fee</i>) <input type="checkbox"/> Yes</p>
<p>7010 1870 0003 5264 9456</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

**Certified Mail**

- A mailing receipt
- A unique identifier
- A record of delivery

**Important Reminders**

- Certified Mail must be delivered to the addressee.
- NO INSURANCE for valuables, please use Registered Mail for additional protection.
- For an additional fee, Endorsement for Return Receipt (PS Form 3811) is required. Endorsement for a duplicate return receipt is not required.
- For an additional fee, Endorsement for Return Receipt (PS Form 3811) is required.
- If a postmark on the mailpiece is not legible, the return receipt is not valid.

**IMPORTANT: Save**  
PS Form 3800, August 2003



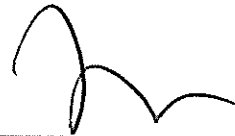
My name is Jen Steele and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Medicaid Director of the Bureau of Health Services Financing, Louisiana Department of Health (LDH). My job duties include oversight of the appropriations and spending for the Medicaid program, rate setting for Medicaid services, as well as the methodologies chosen by LDH for the delivery of health care services through Medicaid. I have held this position since January 2016.
2. A copy of documents maintained by LDH regarding our application for a refund from the federal government regarding the Health Insurance Providers Fees paid by Louisiana for tax years 2014, 2015, and 2016 are attached hereto as Exhibits A, B, and C. We do not expect to ask for a refund of the Health Insurance Providers Fees for tax year 2017, as Congress withheld the application of the Health Insurance Providers Fee for 2017.
3. These documents are true and correct copies of records maintained by LDH, which I am authorized to certify as true and correct. These records are kept by LDH in the regular course of our business. Furthermore, it was in the regular course of the business of LDH that employees of LDH, with knowledge of the information recorded made, transmitted, received, or otherwise archived the information to be included in the record. Finally, these records were created, received, and/or archived at or near the time of the acts, events, conditions, or information recorded in the records.
4. Exhibit A is a true and correct copy of the Form 843 Louisiana filed with the Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2014. Exhibit B is a true and correct copy of the Form 843 Louisiana filed with the Internal Revenue Service, along with a

true and correct copy of the cover letter that accompanied it, for tax year 2015. Exhibit C is a true and correct copy of the Form 843 Louisiana filed with the Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2016.

5. I am aware that Texas previously filed a Form 843 at the time the lawsuit was commenced and that Texas has heard nothing from IRS.
6. By and through this Declaration, I hereby incorporate by reference the attached exhibits and provide the same as if done so in open court, or otherwise under oath.
7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 11th day of May, 2018.



---

Jen Steele

John Bel Edwards  
GOVERNOR



Rebekah E. Gee MD, MPH  
SECRETARY

**State of Louisiana**  
Louisiana Department of Health  
Bureau of Health Services Financing

May 11, 2018

Internal Revenue Service  
Mail Stop 4921 IPF  
1973 Rulon White Blvd.  
Ogden, UT 84201

Dear Sir/Madam:

Enclosed please find the Louisiana Department of Health's Claim for Refund and Request for Abatement for fee years 2014, 2015, and 2016.

Sincerely,

A handwritten signature in black ink, appearing to read "Jen Steele".

Jen Steele  
Medicaid Director

Enclosures (3)

**Louisiana Exhibit A**



Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Louisiana Department of Health</b>	Your social security number
Address (number, street, and room or suite no.) <b>628 North Fourth Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Baton Rouge, LA 70802</b>	Employer identification number (EIN) <b>72-6011595</b>
Name and address shown on return if different from above	Daytime telephone number <b>(225) 342-3426</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2013</b> to <b>December 31, 2013</b>	<b>2 Amount</b> to be refunded or abated: \$ <b>331,342,739</b>
--	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment   
  Estate   
  Gift   
  Excise   
  Income   
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b** Date(s) of payment(s) ▶ \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706     709     940     941     943     945  
 990-PF     1040     1120     4720     Other (specify) ▶ **ACA sec. 9010 fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

**The Health Insurance Provider's Fee under the Affordable Care Act as applied to States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.**

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature (Title, if applicable. Claims by corporations must be signed by an officer.) Jen Steele, Medicaid Director Date 5/11/18

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶	Firm's EIN ▶			
	Firm's address ▶	Phone no.			

Form **843**  
(Rev. August 2011)  
Department of the Treasury  
Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Louisiana Department of Health</b>	Your social security number
Address (number, street, and room or suite no.) <b>628 North Fourth Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Baton Rouge, LA 70802</b>	Employer identification number (EIN) <b>72-6011595</b>
Name and address shown on return if different from above	Daytime telephone number <b>(225) 342-3426</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2014</b> to <b>December 31, 2014</b>	<b>2 Amount</b> to be refunded or abated: \$ <b>\$41,757,898</b>
--	---

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b** Date(s) of payment(s) ▶ \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ **ACA sec. 9010 fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

# Louisiana Exhibit B

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature (Title, if applicable. Claims by corporations must be signed by an officer.) Den Steele, Medicaid Director Date 5/11/18

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Louisiana Department of Health</b>	Your social security number
Address (number, street, and room or suite no.) <b>628 North Fourth Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Baton Rouge, LA 70802</b>	Employer identification number (EIN) <b>72-6011595</b>
Name and address shown on return if different from above	Daytime telephone number  <b>(225) 342-3426</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2015</b> to <b>December 31, 2015</b>	<b>2 Amount</b> to be refunded or abated: \$ <b>\$99,392,458</b>
--	---

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b** Date(s) of payment(s) ▶ \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ **ACA sec. 9010 fee**

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

# Louisiana Exhibit C

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature (Title, if applicable. Claims by corporations must be signed by an officer.) Jan Steele, Medicaid Director Date 5/11/18

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.



My name is Jon Hamdorf and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Kansas Medicaid Director and the Division Chief for the Division of Health Care Finance (DHCF) for the Kansas Department of Health and Environment. My job duties include supervision of the administration of the Kansas Medicaid and State Employee Health programs. I have held this position since December 2017.
2. During tax years of 2014, 2015 and 2016, Kansas Medicaid paid the following:
  - a. For tax year 2014, Kansas Medicaid paid \$32,837,960 as a Health Insurance Providers Fee (HIPF) payment;
  - b. For tax year 2015, Kansas Medicaid paid \$57,227,731 as a HIPF payment; and
  - c. For tax year 2016, Kansas Medicaid paid \$52,056,085 as a HIPF payment.
3. We do not expect to ask for a refund of the Health Insurance Providers Fees for tax year 2017, as Congress withheld the application of the Health Insurance Providers Fee for 2017.
4. Exhibit A is a true and correct copy of the Form 843 for Kansas that will be filing with the Internal Revenue Service for tax years 2014, 2015 and 2016.
5. I am aware that Texas previously filed a Form 843 at the time the lawsuit was commenced and that Texas has heard nothing from IRS.
6. By and through this Declaration, I hereby incorporate by reference the attached exhibits and provide the same as if done so in open court, or otherwise under oath.
7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 16 day of May, 2018.

  
Jon Hamdorf

STATE OF KANSAS



DEPARTMENT OF HEALTH AND ENVIRONMENT  
OFFICE OF LEGAL SERVICES  
CURTIS STATE OFFICE BUILDING  
1000 SW JACKSON ST., SUITE 500  
TOPEKA, KS 66612-1368

PHONE (785) 296-5334  
FAX (785) 559-4272  
WWW.KDHHS.GOV

GOVERNOR JEFF COLYER, M.D.  
JEFF ANDERSEN, ACTING SECRETARY

May 17, 2018

*Via Certified Mail 7014 0150 0000 2357 0173*

Department of Treasury  
Internal Revenue Service  
1973 North Rulon White Boulevard  
Mail Stop 4916 IPF  
Ogden, UT 84404

RE: Claim for Refund and Request for Abatement of Health Insurance Provider Fee

Dear Sir/Madam:

Enclosed please find the Kansas Department of Health and Environment's claims for refund and requests for abatement of the Health Insurance Provider Fee for fee years 2014, 2015, and 2016.

Sincerely,


A handwritten signature in blue ink, appearing to read "Brian M. Vazquez".

Brian M. Vazquez  
Associate Chief Counsel  
Kansas Dept. of Health & Environment  
[Brian.vazquez@ks.gov](mailto:Brian.vazquez@ks.gov)

Attach: KDHE Refund forms – HIPF for 2014, 2015 & 2016

**Kansas Exhibit A**

A1216

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY																
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	<p>A. Signature <b>X</b> <span style="float: right;"><input type="checkbox"/> Agent <input type="checkbox"/> Addressee</span></p> <p>B. Received by (<i>Printed Name</i>) <span style="float: right;">C. Date of Delivery</span></p>																
<p>1. Article Addressed to:  <b>Dept of Treasury                  Internal Revenue Service                  1973 North Rulon White Blvd                  Mail Stop 4916 IPF                  Ogden, UT 84404</b></p>  <p>9590 9402 3215 7196 7237 05</p>	<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes                  If YES, enter delivery address below: <input type="checkbox"/> No</p>																
<p>2. Article Number (<i>transfer from service label</i>)</p>	<p>3. Service Type</p> <table border="0"> <tr> <td><input type="checkbox"/> Adult Signature</td> <td><input type="checkbox"/> Priority Mail Express®</td> </tr> <tr> <td><input type="checkbox"/> Adult Signature Restricted Delivery</td> <td><input type="checkbox"/> Registered Mail™</td> </tr> <tr> <td><input type="checkbox"/> Certified Mail®</td> <td><input type="checkbox"/> Registered Mail Restricted Delivery</td> </tr> <tr> <td><input type="checkbox"/> Certified Mail Restricted Delivery</td> <td><input type="checkbox"/> Return Receipt for Merchandise</td> </tr> <tr> <td><input type="checkbox"/> Collect on Delivery</td> <td><input type="checkbox"/> Signature Confirmation™</td> </tr> <tr> <td><input type="checkbox"/> Collect on Delivery Restricted Delivery</td> <td><input type="checkbox"/> Signature Confirmation Restricted Delivery</td> </tr> <tr> <td><input type="checkbox"/> Insured Mail</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)</td> <td></td> </tr> </table>	<input type="checkbox"/> Adult Signature	<input type="checkbox"/> Priority Mail Express®	<input type="checkbox"/> Adult Signature Restricted Delivery	<input type="checkbox"/> Registered Mail™	<input type="checkbox"/> Certified Mail®	<input type="checkbox"/> Registered Mail Restricted Delivery	<input type="checkbox"/> Certified Mail Restricted Delivery	<input type="checkbox"/> Return Receipt for Merchandise	<input type="checkbox"/> Collect on Delivery	<input type="checkbox"/> Signature Confirmation™	<input type="checkbox"/> Collect on Delivery Restricted Delivery	<input type="checkbox"/> Signature Confirmation Restricted Delivery	<input type="checkbox"/> Insured Mail		<input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)	
<input type="checkbox"/> Adult Signature	<input type="checkbox"/> Priority Mail Express®																
<input type="checkbox"/> Adult Signature Restricted Delivery	<input type="checkbox"/> Registered Mail™																
<input type="checkbox"/> Certified Mail®	<input type="checkbox"/> Registered Mail Restricted Delivery																
<input type="checkbox"/> Certified Mail Restricted Delivery	<input type="checkbox"/> Return Receipt for Merchandise																
<input type="checkbox"/> Collect on Delivery	<input type="checkbox"/> Signature Confirmation™																
<input type="checkbox"/> Collect on Delivery Restricted Delivery	<input type="checkbox"/> Signature Confirmation Restricted Delivery																
<input type="checkbox"/> Insured Mail																	
<input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)																	
<p>PS Form 3811, July 2015 PSN 7530-02-000-9053 <span style="float: right;">Domestic Return Receipt</span></p>																	

U.S. Postal Service™ <b>CERTIFIED MAIL™ RECEIPT</b> (Domestic Mail Only; No Insurance Coverage Provided)											
For delivery information visit our website at <a href="http://www.usps.com">www.usps.com</a> <b>OFFICIAL USE</b>											
<table border="1"> <tr> <td>Postage</td> <td>\$</td> </tr> <tr> <td>Certified Fee</td> <td></td> </tr> <tr> <td>Return Receipt Fee (Endorsement Required)</td> <td></td> </tr> <tr> <td>Restricted Delivery Fee (Endorsement Required)</td> <td></td> </tr> <tr> <td>Total Postage &amp; Fees</td> <td>\$</td> </tr> </table>	Postage	\$	Certified Fee		Return Receipt Fee (Endorsement Required)		Restricted Delivery Fee (Endorsement Required)		Total Postage & Fees	\$	<p>Postmark Here</p>
Postage	\$										
Certified Fee											
Return Receipt Fee (Endorsement Required)											
Restricted Delivery Fee (Endorsement Required)											
Total Postage & Fees	\$										
<p>Sent To <b>Dept of Treasury, IRS</b>                      Street, Apt. No., or PO Box No. <b>1973 North Rulon White Blvd</b>                      City, State, ZIP+4 <b>Ogden, UT 84404</b></p> <p>PS Form 3800, August 2006 <span style="float: right;">See Reverse for Instructions</span></p>											

7014 0150 0000 2357 0173  
 PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE.  
**CERTIFIED MAIL™**



7014 0150 0000 2357 0173  
 7014 0150 0000 2357 0173



Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

### Claim for Refund and Request for Abatement

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) Kansas Department of Health and Environment	Your social security number
Address (number, street, and room or suite no.) 1000 SW Jackson	Spouse's social security number
City or town, state, and ZIP code Topeka, KS 66612	Employer identification number (EIN) <b>48-602992</b>
Name and address shown on return if different from above	Daytime telephone number

1 <b>Period.</b> Prepare a separate Form 843 for each tax period or fee year. <b>Fee yr - 2014</b> From <u>January 1, 2013</u> to <u>December 31, 2013</u>	2 <b>Amount to be refunded or abated:</b> \$ <u>32,837,960</u>
---	---

3 **Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

4 **Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

5a **Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

b Date(s) of payment(s) ▶ \_\_\_\_\_

6 **Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ ACA sec. 9010 fee

7 **Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

*Spencer J. Alford*, Director, Division of Health Care Finance     5/16/2018  
 Signature (Title, if applicable. Claims by corporations must be signed by an officer.)     Date

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

### Claim for Refund and Request for Abatement

OMB No. 1545-0024

▶ See separate instructions.

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- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

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- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) Kansas Department of Health and Environment	Your social security number
Address (number, street, and room or suite no.) 1000 SW Jackson	Spouse's social security number
City or town, state, and ZIP code Topeka, KS 66612	Employer identification number (EIN) 48-602992
Name and address shown on return if different from above	Daytime telephone number

1 <b>Period.</b> Prepare a separate Form 843 for each tax period or fee year. <u>Fee Year - 2015</u> From <u>January 1, 2014</u> to <u>December 31, 2014</u>	2 <b>Amount to be refunded or abated:</b> \$ <u>57,227,731</u>
---	---

3 **Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

- Employment   
  Estate   
  Gift   
  Excise   
  Income   
  Fee

4 **Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

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- Interest was assessed as a result of IRS errors or delays.
- A penalty or addition to tax was the result of erroneous written advice from the IRS.
- Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

b Date(s) of payment(s) ▶ \_\_\_\_\_

6 **Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706     709     940     941     943     945  
 990-PF     1040     1120     4720     Other (specify) ▶ ACA sec. 9010 fee

7 **Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

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Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Janet J. Blumley Director, Division of Health Care Finance 5/16/2018  
 Signature (Title, if applicable. Claims by corporations must be signed by an officer.) Date

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 10180R

Form **843** (Rev. 8-2011)

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

**Claim for Refund and Request for Abatement**

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
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- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

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- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>Kansas Department of Health and Environment</b>	Your social security number
Address (number, street, and room or suite no.) <b>1000 SW Jackson</b>	Spouse's social security number
City or town, state, and ZIP code <b>Topeka, KS 66612</b>	Employer identification number (EIN) <b>48-602992</b>
Name and address shown on return if different from above	Daytime telephone number

1 <b>Period.</b> Prepare a separate Form 843 for each tax period or fee year. <b>Fee Yr - 2016</b> From <b>January 1, 2015</b> to <b>December 31, 2015</b>	2 <b>Amount to be refunded or abated:</b> \$ <b>52,056,085</b>
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3 **Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

4 **Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

5a **Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

b Date(s) of payment(s) ▶ \_\_\_\_\_

6 **Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶ **ACA sec. 9010 fee**

7 **Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to States through their Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

*[Signature]* Director, Division of Health Care Finance 5/16/2018  
 Signature (Title, if applicable. Claims by corporations must be signed by an officer.) Date

Signature (spouse, if joint return) Date

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.




My name is Paul Bowling, and I am over the age of 18 and fully competent to make this declaration and state the following:

1. I am the Chief Financial Officer of Indiana Family and Social Services Administration (FSSA). My job duties include overseeing FSSA's budget. I have held this position since December of 2010.
2. Copies of documents maintained by FSSA regarding our application for a refund from the federal government regarding the Health Insurance Providers Fees paid by Indiana for fee years 2014, 2015, and 2016 are attached hereto as Exhibits A, B, and C. We do not expect to ask for a refund of the Health Insurance Providers Fees for fee year 2017, as Congress withheld the application of the Health Insurance Providers Fee for fee year 2017.
3. These documents are true and correct copies of records maintained by FSSA, which I am authorized to certify as true and correct. These records are kept by FSSA in the regular course of our business. Furthermore, it was in the regular course of the business of FSSA that employees of FSSA, with knowledge of the information recorded, made, transmitted, received, or otherwise archived the information to be included in the record. Finally, these records were created, received, and/or archived at or near the time of the acts, events, conditions, or information recorded in the records.
4. Exhibit A is a true and correct copy of the Form 843 Indiana filed with the Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2014. Exhibit B is a true and correct copy of the Form 843 Indiana filed with the Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2015. Exhibit C is a true and correct copy of the Form 843 Indiana filed with the

Internal Revenue Service, along with a true and correct copy of the cover letter that accompanied it, for tax year 2016.

5. By and through this Declaration, I hereby incorporate by reference the attached exhibits and provide the same as if done so in open court, or otherwise under oath.
6. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this the 21st day of May, 2018.

  
\_\_\_\_\_  
Paul Bowling

Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

### Claim for Refund and Request for Abatement

OMB No. 1545-0024

▶ See separate instructions.

Use Form 843 if your claim or request involves:

- (a) a refund of one of the taxes (other than income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding) or a fee, shown on line 3,
- (b) an abatement of FUTA tax or certain excise taxes, or
- (c) a refund or abatement of interest, penalties, or additions to tax for one of the reasons shown on line 5a.

Do not use Form 843 if your claim or request involves:

- (a) an overpayment of income taxes or an employer's claim for FICA tax, RRTA tax, or income tax withholding (use the appropriate amended tax return),
- (b) a refund of excise taxes based on the nontaxable use or sale of fuels, or
- (c) an overpayment of excise taxes reported on Form(s) 11-C, 720, 730, or 2290.

Name(s) <b>State of Indiana, Family and Social Services Administration</b>	Your social security number
Address (number, street, and room or suite no.) <b>240 Statehouse, 200 West Washington Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Indianapolis, IN 46204</b>	Employer identification number (EIN) <b>35-6000158</b>
Name and address shown on return if different from above	Daytime telephone number <b>317-233-4451</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2013</b> to <b>December 31, 2013 (Fee Year 2014)</b>	<b>2 Amount to be refunded or abated:</b> \$ <b>17,501,562.00</b>
--	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

**4 Type of penalty.** If the claim or request involves a penalty, enter the Internal Revenue Code section on which the penalty is based (see instructions). IRC section:

**5a Interest, penalties, and additions to tax.** Check the box that indicates your reason for the request for refund or abatement. (If none apply, go to line 6.)

Interest was assessed as a result of IRS errors or delays.  
 A penalty or addition to tax was the result of erroneous written advice from the IRS.  
 Reasonable cause or other reason allowed under the law (other than erroneous written advice) can be shown for not assessing a penalty or addition to tax.

**b Date(s) of payment(s) ▶** \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶

**7 Explanation.** Explain why you believe this claim or request should be allowed and show the computation of the amount shown on line 2. If you need more space, attach additional sheets.

The Health Insurance Provider's Fee under the Affordable Care Act as applied to the State of Indiana through its Medicaid and CHIP managed care organizations is an unconstitutional tax on a sovereign, is unconstitutionally coercive, and is an unconstitutional delegation to a private entity.

**Signature.** If you are filing Form 843 to request a refund or abatement relating to a joint return, both you and your spouse must sign the claim. Claims filed by corporations must be signed by a corporate officer authorized to sign, and the officer's title must be shown.

Under penalties of perjury, I declare that I have examined this claim, including accompanying schedules and statements, and, to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature (Title, if applicable. Claims by corporations must be signed by an officer.) CEO FSSA Date 5/21/18

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶	Firm's EIN ▶			
	Firm's address ▶	Phone no.			

**A1224**

Form **843**  
(Rev. August 2011)  
Department of the Treasury  
Internal Revenue Service

### Claim for Refund and Request for Abatement

OMB No. 1545-0024

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Name(s) <b>State of Indiana, Family and Social Services Administration</b>	Your social security number
Address (number, street, and room or suite no.) <b>240 Statehouse, 200 West Washington Street</b>	Spouse's social security number
City or town, state, and ZIP code <b>Indianapolis, IN 46204</b>	Employer identification number (EIN) <b>35-6000158</b>
Name and address shown on return if different from above	Daytime telephone number <b>317-233-4451</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2014</b> to <b>December 31, 2014 (Fee Year 2015)</b>	<b>2 Amount to be refunded or abated:</b> \$ <b>25,469,867.00</b>
--	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

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**b Date(s) of payment(s) ▶** \_\_\_\_\_

**6 Original return.** Indicate the type of fee or return, if any, filed to which the tax, interest, penalty, or addition to tax relates.

706      709      940      941      943      945  
 990-PF      1040      1120      4720      Other (specify) ▶

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Signature (Title, if applicable. Claims by corporations must be signed by an officer.) CFO FSA Date 5/21/18

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.



Form **843**  
 (Rev. August 2011)  
 Department of the Treasury  
 Internal Revenue Service

### Claim for Refund and Request for Abatement

OMB No. 1545-0024

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Name and address shown on return if different from above	Daytime telephone number <b>317-233-4451</b>

<b>1 Period.</b> Prepare a separate Form 843 for each tax period or fee year. From <b>January 1, 2015</b> to <b>December 31, 2015 (Fee Year 2016)</b>	<b>2 Amount to be refunded or abated:</b> \$ <b>51,830,054.00</b>
--	--

**3 Type of tax or fee.** Indicate the type of tax or fee to be refunded or abated or to which the interest, penalty, or addition to tax is related.

Employment    
  Estate    
  Gift    
  Excise    
  Income    
  Fee

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 990-PF      1040      1120      4720      Other (specify) ▶

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Signature (Title, if applicable. Claims by corporations must be signed by an officer.) CEO ESSA Date 5/21/18

Signature (spouse, if joint return) \_\_\_\_\_ Date \_\_\_\_\_

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.