PROOF OF CLAIM

DEPT OF SOCIAL SERVICES is not listed as a creditor in the Debtor's Schedule of Liabilities

In re

Women First HealthCare, Inc ,
Debtor

Case Number

04-11278 (MFW)

NOTE This form should not be used to make a claim for an administrative expense arising after the commencement of the case A "request" for payment of an administrative expense may be filed pursuant to 11 U S C § 503

Name of Creditor and Address

06509896000892

DEPT OF SOCIAL SERVICES
RECOVERIES UNIT
700 GOVERNORS DR
PIERRE, SD 57501 2291

Creditor Telephone Number (605) 773-5909 or 3653

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim Attach copy of statement giving particulars

☐ Check box if you have never received any notices from the bankruptcy court in this case

☐ Check box if this address differs from the address on the envelope sent to you by the court

If you have already filed a proof of claim with the Bankruptcy Court or BMC you do not need to file again

THIS SPACE IS FOR COURT USE ONLY

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR

Labeler # 64248

Check here if this claim ☐ replaces or ☒ amends a previously filed claim dated 5/25/04

1 BASIS FOR CLAIM

☐ Goods sold
☐ Services performed
☐ Money loaned
☐ Personal injury/wrongful death
☐ Taxes
☒ Other (describe briefly) Drug Rebate
☐ Retiree benefits as defined in 11 U S C § 1114(a)
☐ Wages salaries and compensation (Fill out below)
Last four digits of SS # _____
Unpaid compensation for services performed from _____ (date) to _____ (date)

2 DATE DEBT WAS INCURRED 7/1/03-3/31/04

3 IF COURT JUDGMENT, DATE OBTAINED

4 TOTAL AMOUNT OF CLAIM AT TIME CASE FILED

$	$	$	$
(unsecured)	(secured)	498 00 (unsecured priority)	498 00 (Total)

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 7 below

☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim Attach itemized statement of all interest or additional charges

5 SECURED CLAIM

☐ Check this box if your claim is secured by collateral (including a right of setoff)

Brief description of collateral

☐ Real Estate ☐ Motor Vehicle
☐ Other _____

Value of Collateral $ _____

Amount of arrearage and other charges at time case filed included in secured claim if any $ _____

6 UNSECURED NONPRIORITY CLAIM $ _____

☐ Check this box if a) there is no collateral or lien securing your claim or b) your claim exceeds the value of the property securing it or if c) none or only part of your claim is entitled to priority

7 UNSECURED PRIORITY CLAIM

☒ Check this box if you have an unsecured priority claim

Amount entitled to priority $ 498 00

Specify the priority of the claim

☐ Wages salaries or commissions (up to $4 925) earned within 90 days before filing of the bankruptcy petition or cessation of the Debtor's business whichever is earlier 11 U S C § 507(a)(3)

☐ Contributions to an employee benefit plan 11 U S C § 507(a)(4)

☐ Up to $2 225* of deposits toward purchase lease or rental of property or services for personal family or household use 11 U S C § 507(a)(6)

☐ Alimony maintenance or support owed to a spouse former spouse or child 11 U S C § 507(a)(7)

☒ Taxes or penalties owed to governmental units 11 U S C § 507(a)(8)

☐ Other Specify applicable paragraph of 11 U S C § 507(a) (____)

Amounts are subject to adjustment on 4/1/07 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

8 CREDITS The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim

9 SUPPORTING DOCUMENTS *Attach copies of supporting documents,* such as promissory notes purchase orders invoices itemized statements of running accounts contracts court judgments, mortgages security agreements and evidence of perfection of lien DO NOT SEND ORIGINAL DOCUMENTS If the documents are not available explain If the documents are voluminous, attach a summary

10 DATE-STAMPED COPY To receive an acknowledgment of your claim, please enclose a self-addressed, stamped envelope and an additional copy of this proof of claim.

The original of this completed proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is received on or before 4 00 pm, Eastern Time on October 26, 2004 for Governmental Unit

BY MAIL TO
Women First HealthCare Inc
c/o BMC Group f/k/a Bankruptcy Management Corp
PO Box 983
El Segundo CA 90245-0983

BY HAND OR OVERNIGHT DELIVERY TO
Women First HealthCare Inc
c/o BMC Group f/k/a Bankruptcy Management Corp
1330 East Franklin Ave
El Segundo CA 90245

THIS SPACE FOR COURT USE ONLY

FILED
AUG 19 2004
BMC

Women First Healthcare Inc
00102

DATE SIGNED
8/17/2004

SIGN and print the name and title if any of the creditor or other person authorized to file this claim (attach copy of power of attorney if any)

Jodi Martell, Tedd Martell, Recoveries Investigator

Penalty for presenting fraudulent claim is a fine of up to $500 000 or imprisonment for up to 5 years or both 18 U S C §§ 152 AND 3571

FORM APPROVED
OMB NO 0938-0582

DATE 05/21/2004

STATE OF SOUTH DAKOTA
DEPARTMENT OF SOCIAL SERVICES MEDICAID AGENCY

SOURCE STATE AGENCIES
TARGET MANUFACTURERS

MEDICAID DRUG REBATE INVOICE

MANUFACTURER WOMEN FIRST HEALTHCARE, INC
ADDRESS 1 5355 MIRA SORRENTO PL STE 700
ADDRESS 2 STE 700
CITY SAN DIEGO STATE CA ZIP 92121-3825

STATE CODE SD INVOICE # 12004642480
PERIOD COVERED QTR 1 YR 2004

NDC NUMBER	DRUG NAME	REBATE AMT PER UNIT	TOTAL UNITS REIMB	TOTAL REBATE AMT CLAIMED	NO OF SCRIPTS	TOTAL REIMB AMOUNT	CORR FLG
64248009110	EQUAGESIC	577700	180 000	103 99	2	195 72	0
64248010201	ESTROPIPAT	065500	150 000	9 83	5	123 74	0
64248011710	BACTRIM DS	933800	20 000	18 68	1	8 35	0
64248031001	ESCLIM EST	1 459600	24 000	35 03	3	101 60	0
64248032001	ESCLIM EST	1 437900	40 000	57 52	5	166 95	0
64248033001	ESCLIM EST	1 331700	24 000	31 96	3	107 97	0
64248035001	ESCLIM EST	1 177300	32 000	37 67	3	138 02	0
64248041910	SYNALGOS	795000	80 000	63 60	3	115 89	0
64248041912	SYNALGOS P	795000	12 000	9 54	1	16 87	0
	TOTALS		562 000	367 82	26	975 11	

SEND REMITTANCE TO DEPT OF SOCIAL SERVICES
RECOVERIES UNIT
ADDRESS 700 GOVERNORS DRIVE
PIERRE, SD 57501
ATTN TEDDI MARTELL

FORM APPROVED
OMB NO 0938-0582

DATE 11/18/2003

STATE OF SOUTH DAKOTA
DEPARTMENT OF SOCIAL SERVICES MEDICAID AGENCY

SOURCE STATE AGENCIES
TARGET MANUFACTURERS

MEDICAID DRUG REBATE INVOICE

MANUFACTURER WOMEN FIRST HEALTHCARE, INC
ADDRESS 1 12220 EL CAMINO REAL
ADDRESS 2 SUITE 400
CITY SAN DIEGO STATE CA ZIP 92130-1303

STATE CODE SD INVOICE # 32003642480
PERIOD COVERED QTR 3 YR 2003

NDC NUMBER	DRUG NAME	REBATE AMT PER UNIT	TOTAL UNITS REIMB	TOTAL REBATE AMT CLAIMED	NO OF SCRIPTS	TOTAL REIMB AMOUNT	CORR FLG
64248009110	EQUAGESIC	281400	180 000	50 65	2	195 72	0
64248010201	ESTROPIPAT	052900	270 000	14 28	6	113 61	0
64248011710	BACTRIM DS	584100	20 000	11 68	1	6 35	0
64248031001	ESCLIM EST	610400	8 000	4 88	1	30 34	0
64248032001	ESCLIM EST	819100	56 000	45 87	7	214 27	0
64248033001	ESCLIM EST	000000	24 000	00	2	90 70	0
64248034001	ESCLIM EST	351900	8 000	2 82	1	31 67	0
64248035001	ESCLIM EST	000000	24 000	00	3	95 01	0
64248041910	SYNALGOS	000000	100 000	00	4	134 79	0
64248041912	SYNALGOS P	000000	39 000	00	2	55 40	0
	TOTALS		729 000	130 18	29	967 86	

SEND REMITTANCE TO DEPT OF SOCIAL SERVICES
RECOVERIES UNIT
ADDRESS 700 GOVERNORS DRIVE
PIERRE, SD 57501
ATTN HELEN ROKUSEK

HCFA-R-144