FORM B10 (Official Form 10) (4/01)

UNITED STATES BANKRUPTCY COURT _____ DISTRICT OF Delaware

PROOF OF CLAIM

Name of Debtor: Women First Healthcare, Inc

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 (The person or other entity to whom the debtor owes money or property)

Ohio Dept of Job & Family Services

Name and address where notices should be sent

Joseph T Chapman Esq
Attorney General s Office Collections Enforcement
150 East Gay Street 21st Floor
Columbus Ohio

Telephone number 614-466-6594

☐ 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 the address differs from the address on the envelope sent to you by the court

THIS SPACE IS FOR COURT USE ONLY

Account or other number by which creditor identifies debtor

Check here if this claim ☐ replaces ☐ amends a previously filed claim, dated _____

1 Basis for Claim

☐ Goods sold
☐ Services performed
☐ Money loaned
☐ Personal injury/wrongful death
☐ Taxes
X Other Medicaid Drug Rebate Invoice

☐ Retiree benefits as defined in 11 U S C § 1114(a)
☐ Wages, salaries, and compensation (fill out below)
Your SS # _____ _____ _____
Unpaid compensation for services performed
from _____ (date) to _____ (date)

2 Date debt was incurred 4th Q 03, 1st & 2nd Q 04

3 If court judgment, date obtained

4 Total Amount of Claim at Time Case Filed $ 2 501 47

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 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 Priority Claim

☐ Check this box if you have an unsecured priority claim

Amount entitled to priority

Specify the priority of the claim

☐ Wages salaries or commissions (up to $4 650) * 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 $2 100* 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 4/1/04 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment

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

8 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

9 Date-Stamped Copy To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim

THIS SPACE IS FOR COURT USE ONLY

FILED
OCT 2 6 2004
BMC

Women First Healthcare Inc
00197

Date: 10/25/04

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)
Joseph T Chapman, Esq (Atty for ODJFS)

Penalty for presenting fraudulent claim Fine of up to $500,000 or imprisonment for up to 5 years, or both 18 U S C §§ 152 and 3571

STATE OF OHIO
OHIO DEPARTMENT OF JOBS AND FAMILY SERVICES

RCE: STATE AGENCIES
GET: MANUFACTURERS

MEDICAID DRUG REBATE INVOICE

FACTURER: WOMEN FIRST HEALTHCARE, INC.
LER NUMBER: 64248
OD: Q104
OICE NUMBER: 6424810401

	TOTAL UNITS REIMB.	TOTAL REBATE AMT. CLAIMED	NO. OF SCRIPTS	TOTAL REIMB AMOUNT
TOTALS:	914	* $1,130.12	114	$3,783.18

* PLEASE REMIT THIS AMOUNT

****
** NOTE - CHANGE IN PAYEE AND REMITTANCE ADDRESS **
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PLEASE MAKE CHECK PAYABLE TO:

TREASURER OF STATE-STATE OF OHIO (ODJFS)

AND MAIL TO:

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
DEPT # 888
COLUMBUS, OHIO 43265

STATE OF OHIO
OHIO DEPARTMENT OF JOBS AND FAMILY SERVICES

SOURCE STATE AGENCIES
TARGET: MANUFACTURERS

MEDICAID DRUG REBATE INVOICE

MANUFACTURER 64248 WOMEN FIRST HEALTHCARE, INC
ADDRESS 1: 5355 MIRA SORRENTO PLACE
ADDRESS 2
CITY: SAN DIEGO STATE: CA ZIP: 92121

STATE CODE: OH INVOICE #: 6424840301
PERIOD COVERED: 42003

	NDC NUMBER	DRUG NAME	HCFA UNIT	REBATE AMT PER HCFA UNIT	ODJFS UNIT	TOTAL UNITS REIMB.	TOTAL REBATE AMT CLAIMED	NO OF SCRIPTS	TOTAL REIMB AMOUNT
#	64248031001	ESCLIM	TDP	0 000000	EA	144	117.65 EST	18	$534 76
	64248032001	ESCLIM	TDP	1 205300	EA	86	$103.66	12	$336 15
#	64248033001	ESCLIM	TDP	0 000000	EA	360	306.89 EST	45	$1,394 97
	64248034001	ESCLIM	TDP	0 351900	EA	96	$33 78	12	$382 56
#	64248035001	ESCLIM	TDP	0 000000	EA	240	209 37 EST	29	$951 70
							771.35 EST.		

These pages are support for the following claims.

Quarter 4, Year 2003 $ 771 35

Quarter 1, Year 2004 $ 1,130 12

There is also an unknown claim for Quarter 2, Year 2004 - We might have some #'s for this before Aug 31, but not much before Dec

STATE OF OHIO
OHIO DEPARTMENT OF JOBS AND FAMILY SERVICES

SOURCE: STATE AGENCIES
TARGET MANUFACTURERS

MEDICAID DRUG REBATE INVOICE

MANUFACTURER: 64248 WOMEN FIRST HEALTHCARE, INC
ADDRESS 1 5355 MIRA SORRENTO PLACE
ADDRESS 2:
CITY SAN DIEGO STATE CA ZIP 92121

STATE CODE. OH INVOICE # 6424820401
PERIOD COVERED: 22004

NDC NUMBER	DRUG NAME	HCFA UNIT	REBATE AMT PER HCFA UNIT	ODJFS UNIT	TOTAL UNITS REIMB	TOTAL REBATE AMT CLAIMED	NO OF SCRIPTS	TOTAL REIMB AMOUNT
# 64248031001	ESCLIM	TDP	0.000000	EA	72		9	$299.43
# 64248032001	ESCLIM	TDP	0.000000	EA	46		7	$193.84
# 64248033001	ESCLIM	TDP	0.000000	EA	296		37	$1,237.67
# 64248034001	ESCLIM	TDP	0.000000	EA	60		7	$258.33
# 64248035001	ESCLIM	TDP	0.000000	EA	236		29	$1,014.91

ESTIMATED LIABILITY = $600.00

Don't Send
Save for legal

STATE OF OHIO
OFFICE OF THE ATTORNEY GENERAL
JIM PETRO, ATTORNEY GENERAL

Collections Enforcement Section
150 E Gay St , 21st Fl
Columbus, OH 43215
Telephone (614) 466-8360
www ag state oh us

October 25, 2004

Via Overnight Delivery

Women First Healthcare, Inc
c/o BMC
1330 E Franklin Ave
El Segundo, CA 90245

Re. In re Women First Healthcare, Inc , Case No. 04-11278 (MFW) (Jointly Administered)
Proof of Claim for the Ohio Department of Job & Family Services

Dear Sir or Madam

Please find enclosed the original and two copies of a proof of claim for the Ohio Department of Job & Family Services Kindly acknowledge receipt via the enclosed self addressed, stamped envelope

Thank you for your attention to this matter Should you have any questions or concerns, my telephone number is below

Very truly yours,

Joseph T Chapman
Senior Assistant Attorney General
Collections Enforcement
150 East Gay Street, 21st Floor
Columbus, OH 43215
(614) 466-6594, fax (614) 752-9070
e-mail jchapman@ag state oh us