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Second Circuit Revisits Mandatory Subordination Under Section 510(b)

By Adam H. Friedman and Jonathan T. Koevary

For the third time in six years, the Second Circuit visited mandatory subordination of claims under Title 11 of the United States Code (the Bankruptcy Code). In *CIT Grp. Inc. v. Tyco Int'l. Ltd.*, No. 12-1692-bk, the Second Circuit affirmed a bankruptcy court decision holding that claims arising under a tax-sharing agreement entered into as part of stock divestment restructuring was not subject to mandatory subordination under section 510(b) of the Bankruptcy Code. In this article, we discuss the history of mandatory subordination and the current state of the law.

History

Bankruptcy Code section 510(b) provides in pertinent part that: "a claim arising from rescission of a purchase or sale of a security of the debtor … for damages arising from the purchase or sale of such a security … shall be subordinated to all claims or interests that are senior to or equal the claim or interest represented by such security." 11 U.S.C. § 510(b). In short, the provision ensures that those who bargained to be treated as investors do not find themselves elevated to the priority status of

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Physician, Heal Thyself

Saint Vincent Catholic Medical Center, A Case Study

By Adam C. Rogoff and Anupama Yerramalli

A multi-debtor operating entity with over $1 billion of liabilities and thousands of employees and retirees is complicated enough; add to the mix: 1) one of New York City's historic hospitals, founded in 1849, which cared for survivors of the Titanic and later was a leader in confronting the AIDs crisis; 2) ongoing care for tens of thousands of patients throughout New York; and 3) preserving the non-profit, charitable mission of the city's last Catholic hospital, and you have the elements of a complex Chapter 11 case with nuances that are not part of the standard fare. This article addresses some of these complexities.

Background

Saint Vincent Catholic Medical Centers of New York and its debtor-affiliates (collectively SVCMC) filed Chapter 11 cases in 2010 in the Southern District of New York (the Chapter 11 Cases). *See In re Saint Vincent Catholic Med. Ctr. of N.Y. et al*, Lead Case No. 10-11963 (CGM) (Bankr. S.D.N.Y.). For a complete history of the events leading to the commencement of the bankruptcy cases, please refer to the *Declaration of Mark E. Toney*, found at Docket No. 18.

SVCMC operated a 727-bed inpatient Level 1 trauma care hospital serving Lower Manhattan. SVCMC's other services included a hospice, home health agencies, three nursing homes, a cancer care clinic, an inpatient behavioral health hospital, and numerous outpatient clinics. SVCMC relied primarily upon Medicare and Medicaid for its reimbursements, and provided substantial charity (uncompensated) care. Battered by the recession in 2009 and suffering dramatic cuts in government-payor reimbursements, SVCMC could not continue to operate on a stand-alone basis. In early 2010, working closely with New York State agencies and the Governor's office, SVCMC pursued (unsuccessfully) the search for a strategic alliance with a new sponsor.

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Unable to locate a new partner, and suffering over $1 billion of legacy obligations (including funded debt, medical malpractice claims and pension liabilities), SVCMC was constrained to close its Manhattan hospital and find new sponsors for its other services. Promptly following its decision to close the main hospital, in April 2010, SVCMC filed for bankruptcy to facilitate that closure and preserve and transfer patient care services. (Note, In 2005, SVCMC had filed for bankruptcy, emerging in August 2007 from its prior Chapter 11 case.)

Throughout the process, SVCMC and its professionals (which included crisis management provided by Mark E. Toney as CEO/CRO, Steven Korf as CFO, and professionals from Grant Thornton) were guided by: 1) preserving patient care and safety; while 2) maximizing asset values for creditors. At times, SVCMC faced the specter of administrative insolvency. Two years later, SVCMC confirmed a Chapter 11 plan that assured administrative solvency, paid priority claims, and recovered over a half billion dollars of proceeds for the benefit of creditors, including repayment of secured debt. This process also unlocked substantial value from the former Manhattan hospital campus while creating the first free-standing emergency department in New York City to provide comprehensive ongoing care for the community.

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Creative Transactional Structures to Maximize Value for Creditors

While the closure of the Manhattan hospital received media, political and community attention, the other healthcare services rendered by SVCMC were relatively unknown to those outside of the immediate catchment areas. Upon filing the petitions, SVCMC sought to complete the safe transfer of all patients from the Manhattan hospital and implement the closure plan while simultaneously stabilizing the numerous other patient care services to ensure that they remained as going concerns. This process — which realized over $500 million of sales proceeds — was done through several independent sales transactions accomplished over an 18-month period. These transactions, because of the healthcare component, were subject to state regulatory approvals as well as the bankruptcy court. In Chapter 11, parties are accustomed to sales being approved quickly (30-60 days) and closing shortly thereafter. However, absent bankruptcy, the sale of a nonprofit's healthcare assets is subject to extensive regulatory approvals and could take a year or longer to obtain. SVCMC's crisis management team worked very closely with numerous state regulatory agencies to obtain — sometimes on an emergency basis — required nonbankruptcy approvals.

One key decision that was made early on was to undertake separate transactions and not pursue a global sale. This ensured that: 1) the best sponsor was located for each ongoing service; while 2) creating maximum marketing potential for the assets. For example, SVCMC operated its home health agency as a single unit. But, because there were separate operating licenses, in Chapter 11, this service was divided into the long-term home health care program (LTHHCP) and the certified home health agency (CHHA). A single stalking horse was selected for each service (using identical sales agreements) and separate auctions were conducted. The auctions themselves were done without having all of the bidders in the same room and, ultimately after multiple

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meetings with the bidders to improve their bids, each bidder submitted a final and highest bid. This bifurcated process, coupled with the final and highest bid approach, increased the aggregate purchase prices from $32.1 million to $47 million — a substantial increase.

No single sales approach was used in the case. One notable private sale concerned the inpatient behavioral health hospital, which served approximately 2,800 inpatients and had over 620,000 outpatient visits in clinics and residences throughout the New York City region. This service heavily relied upon Medicaid and, in order to retain the benefit of suitable reimbursement rates, optimal buyers needed an "Article 28" hospital license. Time was of the essence, too, due to rate changes that could adversely affect rates after October 2010.

Without preserving favorable reimbursement rates, the viability of the behavioral health hospital was uncertain. As if a limited pool of potential operators and looming deadlines wasn't enough, SVCMC also confronted claims by certain creditors with mortgages on 67 acres of developed and undeveloped real estate located in an affluent New York suburb that the facility should be closed to sell the land to a developer. SVCMC relied upon certain case law holding that when a debtor is a non-profit with a charitable healthcare mission (as here), the debtor and court were permitted to weigh the continuation of that mission as a sales factor. *See In re United Healthcare Sys., Inc.*, Civ. No. 97-1159, 1997 U.S. Dist. LEXIS 5090, *17-18 (D.N.J. Mar. 26, 1997).

Simply, price alone would not dictate the result. Working closely with New York State agencies, SVCMC showed that closure of the facility was untenable, as there was inadequate absorption for displaced patients. The bankruptcy court concurred; closure was not an option, allowing SVCMC to focus on what process would best preserve operations and value. SVCMC's crisis managers and professionals developed a two-prong sale: 1) the healthcare business was sold outright to St. Joseph's Hospital, which provided uninterrupted care at all of the inpatient and outpatient locations; and 2) SVCMC received an option to seek to repurchase and sell 37 acres of undeveloped real estate adjacent to the facility over the next year to a developer. Despite subsequent marketing, no developer emerged. However, the preservation of this optionality created the opportunity for an upside for mortgagees without disrupting the essential transfer of patient care. In total, SVCMC's marketing strategies resulted in approximately $255 million in sale proceeds from the non-hospital services.

Once patient care services were stabilized, SVCMC pursued unlocking value from its substantial Manhattan real estate. This transaction required balancing numerous concerns — 1) obtain highest price; with 2) few to no contingencies; and 3) provide for

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a portion of the property dedicated to future healthcare to address the needs of the community. The sale of the real estate, which was subject to landmark and zoning restrictions, required a close collaboration among SVCMC, creditors and a potential purchaser, working closely with the regulatory agencies. The parties determined that the best path to address the three criteria was a revised sale with the Rudin family (which had entered into a sale contract with SVCMC as part of the prior Chapter 11 case, but which sale had not been consummated as of the later case). The original sale contract was amended to remove numerous closing contingencies, provide for payment in full upon closing — a $260 million purchase price — and provide for the development of a comprehensive care center owned and operated by North Shore-Long Island Jewish Health System to provide ambulatory and emergency health services, a treat and release facility, and diagnostic care in one of the buildings being sold.

A Single Forum: Using the Automatic Stay

Given the importance of SVCMC as a healthcare provider, the closure of the Manhattan hospital was understandably distressing for many. This distress led to attacks on the decision to close, including lawsuits filed in New York State courts. A key part of the Chapter 11 case was the concentration of these actions into the bankruptcy court. However, since various actions were lodged against the regulatory agencies directly — and not SVCMC — this required finding that non-debtor actions were disguised attacks against SVCMC or its property. This was aided by an early strategic decision to seek interim and final bankruptcy court approval to implement the hospital closure plan at the outset of the case.

Shortly after interim approval was obtained, a community group commenced a state court action to enjoin the New York State Department of Health (DOH) approval of the closure plan. Relying upon the interim closure order, SVCMC brought this action into the bankruptcy court asserting that the relief — while directed against DOH — interfered with SVCMC's property (the hospital). Simply, no hospital could continue without use of SVCMC's assets. The plaintiff group also objected to entry of the final order approving the closure process. The bankruptcy court entered the final closure order and enjoined the state court action, finding that: 1) the public health and safety exception to the automatic stay did not apply to private plaintiffs; 2) the plaintiffs (a community interest group only) lacked standing; and 3) although the plaintiffs did not specifically institute the action against SVCMC, the action affected estate property. *See In re SVCMC*, 429 B.R. 139 (Bankr. S.D.N.Y. 2010). Moreover, forced continued operations at the Manhattan hospital — without financial resources to operate effectively — would have threatened patient well-being and interfered with the orderly patient transfer process underway. *See Id*.

Several months later, another local constituent group commenced an action under New York's Freedom of Information Law (FOIL) against DOH, seeking documents related to the Manhattan Hospital closure. *See Erica Kagan v. New York State Department of Health*, Case No. 10110869 (N.Y. Sup. Ct.). That action was based upon a host of allegations against SVCMC. The bankruptcy court found that the FOIL action violated the stay by seeking improper discovery relating to allegations best investigated by the estate and, specifically, the Creditors' Committee. *In re SVCMC, Hr'g Tr.* at 46:9-19 (Sep. 2, 2010) (Docket No. 1131). The Committee ultimately determined that there was no misconduct. *In re SVCMC, Hr'g Tr.* 46:21-47:1 (Dec. 14, 2011) (Docket 2259). Again, the Chapter 11 case provided a centralized forum to address collateral attacks on the closure process directed against third parties (*e.g.*, DOH) but, in reality, targeting SVCMC's conduct.

Conclusion

The SVCMC Chapter 11 Cases were successful, despite the risk of administrative insolvency, based upon a process aimed at: 1) preserving patient care and respecting SVCMC's healthcare mission; 2) marketing and transferring healthcare services at a deliberate pace through a variety of private sales or auctions processes; and 3) achieving consensus to avoid significant litigation. When efforts arose to derail this process through collateral litigation, the automatic stay and the core jurisdiction of the bankruptcy court provided a single forum to monitor and resolve these issues. While SVCMC's historic provision of healthcare services came to an end, its rich legacy of patient care and integrity was preserved due to its ability to properly utilize the Chapter 11 process.

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