

2/18/26 6:40 PM

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Application Detail

License Type:

Home Medical Equipment: Licensed

Application:

Home Medical Equipment: Initial Application

Application Date:

02/18/2026 (mm/dd/yyyy)

Organization Detail

Organization Name:

Medically Modern (NS)

Organization Type:

Limited Liability Company

Addresses**Main Address**

Address:

2093 Wantagh Ave

NASSAU

Wantagh, NY

11793

US

Phone Number:

347-503-7148

Extension:

E-mail Address:

records@medicallymodern.com

Administrative

Name:

Medically Modern

Address:

2093 Wantagh Ave

NASSAU

Wantagh, NY

11793

US

Phone Number:

347-503-7148

Extension:

E-mail Address:

records@medicallymodern.com

Emergency Contact

Name:

Medically Modern

Address:

2093 Wantagh Ave

NASSAU

Wantagh, NY

11793

US

Phone Number:

347-503-7148

Extension:

E-mail Address:

records@medicallymodern.com

Ownership of Building

Name:

Mid-Island Medical Supply Co., LLC

Address:

2093 Wantagh Ave

NASSAU

Wantagh, NY

11793

US

Phone Number:

347-503-7148

Extension:

E-mail Address:

records@medicallymodern.com

Legal Entity

Name:

Mid-Island Medical Supply Co., LLC

Address:

2093 Wantagh Ave

NASSAU

Wantagh, NY

11793

US

Phone Number:

347-503-7148

Extension:

E-mail Address:

records@medicallymodern.com

Holding Company

Name:

CDBE HOLDINGS, LLC

Address:

2093 Wantagh Ave

NASSAU

Wantagh, NY

11793

US

Phone Number:

347-503-7148

Extension:

E-mail Address:

records@medicallymodern.com

License Attributes Selected

Qualification/Certification

All Counties

Out of State New York (NS)
For Profit (NS)

Basic License Data

If your facility has branch offices provide the number. If none, enter 00

00

Provide Administrator's Name:

Corey Deutsch (NS)
~~Brandon Ellis~~

Provide the Ownership's Name:

Mid-Island Medical

Ownership Name Continued:

Supply Co., LLC

Is your facility accredited by a federally approved accrediting body?

Yes

If answered yes accredited, must provide expiration date of accreditation.

10/10/2027 (mm/dd/yyyy)

What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?

Free Standing

Provide a Yes or No, if your facility is Chain Affiliated:

No

Provide a Yes or No, if your facility has a Holding Company:

Yes

Provide a Yes or No, if your facility has a Holding Company:

Do you have Other Licensed Facilities in the state of Tennessee and/or other states? **No**

Provide a Yes or No, if your facility has a parent company: **No**

Do you have a contract with a management firm to operate this facility? **No**

Have any owners ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state? **No**

Does your facility have a physical location in Tennessee?: **No**

Administrator Conviction Information

Administrator convicted of crime?: **No**

Individual Owners, Partners, Director or Head of Government Entity 1

The name of the individual owner, partner, director of the corporation or head of the government: **Corey Deutsch**

Street: **260 W 26th St, Apt 2U**

City: **New York**

State: **New York**

Zip: **10001**

Individual Owners, Partners, Director or Head of Government Entity 2

The name of the individual owner, partner, director of the corporation or head of the government: **Brandon Ellis**

Street: **260 W 26th St, Apt 6Q**

City: **New York**

State: **New York**

Zip: **10001**

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?: **No**

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?:

Have any of owners of the disclosing entity had a suspension of admissions? **No**

Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state? **No**

File Attachments

Bank Statement First Page.pdf

Fees

Initial License Fee	\$1404.00
Total Amount Due:	\$1404.00

Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Home Medical Equipment facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Home Medical Equipment facility. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.



State of Tennessee
Health Facilities Commission
Andrew Jackson State Building
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

April 10, 2026

Sent Via Email

Corey Deutsch
Medically Modern
2093 Wantagh Ave
Wantagh, New York 11793

Facility Type: Home Medical Equipment

Dear Corey Deutsch:

It is my pleasure to inform you that your application for licensure of Medically Modern located at 2093 Wantagh Ave, Wantagh, New York 11793 has been initially approved for providing DME/HME services in all counties in Tennessee effective April 10, 2026 . The license number shall be 1561. For this initial approval to become final and permanent, your application must be ratified by the Commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for May 27, 2026 . **You are hereby authorized to commence operation pending the final decision of the Commission.**

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The East Tennessee Regional Office phone number is 865-594-9396 .

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission's final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1561 County: Nassau

Initial Renovation _____ Satellite/Off Campus Location _____
Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: Medically Modern

Application and fee on file in Central Office (CO)? Yes No _____ CON #: _____ Project #: _____ Phase: _____ of _____
2093 Wantagh Ave Wantagh NY 11793

Facility approved for Home Medical Equipment (HME): Providing DME/HME services in all counties in Tennessee.

Sprinklered: _____ (Full 100%) Partial: _____ (%)
Licensed bed count from: _____ 0 to _____ 0 Number of beds increased/decreased: _____ 0

If secured unit, number of beds in unit: N/A If Alzheimer's unit, number of beds in unit: _____
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor: Nancy Mullins RN Date: 04/06/26

Fire Safety: See attached application Date: _____

CD Approved: Yes _____ No _____ N/A Health Survey Required: Yes No _____; if Yes, please indicate which region: EAST

Facility's Letter of Notification received in Licensure: Yes No CNS
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc.) approved and received in regional office: Yes _____ No NA CNS
(NOTE: With exception of Initial Licensure Approvals)

Effective date: April 10, 2026
(Completed by Central Office Licensure Staff)

Licensure is recommended: Yes No _____

Niraj S
Regional Administrator/Facilities Construction Director or Designee
Licensure Program Unit Staff

4/9/2026
Date
4/10/26
Date

Doc Browns Inc
Wantagh, NY

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Home Care Accreditation Program

October 10, 2024

Accreditation is customarily valid for up to 36 months.

Carlos A. Pellegrini, MD, FACS
Chair, Board of Commissioners

ID #143121

Print/Reprint Date: 12/13/2024

Jonathan B. Perrin, MD, PhD, MSHA, MACP,
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care services provided in accredited organizations. Information about accredited organizations may be provided through the Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

