



DISCLOSURE FOR HOUSING WITH SERVICES ESTABLISHMENTS
 State Form 49028 (R3 / 7-11)

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The Disclosure for Housing with Services Establishments form is to be submitted to comply with IC 12-10-15. All sections, except Section 8, Optional Information, shall be fully completed. Section 8 is optional and provides information that you may wish to answer for potential residents who may use this form when looking for services.

A copy of the contract to be executed between the Housing with Services Establishment and the resident is the ONLY attachment that will be accepted in addition to the disclosure form. Therefore, it is important to concisely answer the questions on the form.

Indicate whether this is an original, update, or a renewal and enter date:

Original Year 8 \ 15 \ 2024 Update Year _____ \ _____ \ _____ Renewal Year _____ \ _____ \ _____

SECTION 1 - ESTABLISHMENT INFORMATION

Name of facility HOLISTICARE HOMES		Facility Employer Identification Number (EIN) 86-3034380
On site manager's name SHELLEY PILLADO		
Address line 1 (number and street) 57711 COUNTY ROAD 9		
Address line 2 (number and street)		
City ELKHART	County Elkhart	ZIP code 46517
Telephone number (574) 360-8132	Fax number ()	E-mail address SHELLEY@HOLISTICAREHOMES.COM
Capacity (number of apartments) 7		Is your facility structure (select one): <input checked="" type="checkbox"/> freestanding? <input type="checkbox"/> part of a campus or complex? (select all that apply) <input type="checkbox"/> part of an independent apartment complex? <input type="checkbox"/> part of a nursing facility? <input type="checkbox"/> part of an independent living building? <input type="checkbox"/> part of a hospital? <input type="checkbox"/> part of a continuing care facility? <input type="checkbox"/> other: _____
Is the facility licensed as a residential care facility by the Indiana State Department of Health? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Does the facility participate in the Residential Care Assistance Program (RBA/ARCH)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Is the facility an Assisted Living Medicaid Waiver provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

SECTION 2 - OWNERSHIP / TYPE OF BUSINESS INFORMATION

Name of owner/company SHELLEY PILLADO		
DBA HOLISTICARE HOMES		
Address line 1 (number and street) 64180 BRICK CHURCH RD		
Address line 2 (number and street)		
City CASSOPOLIS	State Michigan	ZIP code 49031
Telephone number (574) 360-8132	Fax number ()	E-mail address SHELLEY@HOLISTICAREHOMES.COM
Name of managing agent (if not owner)		
Address line 1 (number and street)		
Address line 2 (number and street)		
City	State	ZIP code
Telephone number ()	Fax number ()	E-mail address
Type of business (select one): <input checked="" type="checkbox"/> For Profit <input type="checkbox"/> Not For Profit <input type="checkbox"/> Government <input type="checkbox"/> Other (please indicate)		Business ownership (select one): <input type="checkbox"/> Sole Owner <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Other (please indicate)
Month of the year that begins your fiscal (accounting) year? 1		

SECTION 3 - CORPORATE OFFICERS

Name SHELLEY PILLADO		
Title CEO	Telephone number (574) 360-8132	
Address line 1 (number and street) 64180 BRICK CHURCH RD		
City CASSOPOLIS	State Michigan	ZIP code 49031
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code

SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS

Name RAFAEL PILLADO		
Title VICE PRESIDENT	Telephone number: (574) 807-5430	
Address line 1 (number and street) 64180 BRICK CHURCH RD		
City CASSOPOLIS	State: Michigan	ZIP code: 49031
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code

SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS (continued)

Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1 (number and street)		
City	State	ZIP code

SECTION 5 - BASE RATE

Normal length of lease (contract):
 1 month 3 months 6 months 1 year

Other: _____

MONTHLY Per Person Base Rate Ranges for all that apply:
 (Note: If you convert a daily rate to a monthly rate please multiply your daily rate by 365 and then divide by 12.)

Studio	From: \$ _____ To: \$ _____	Semi-Private Occupancy:
One Bedroom	From: \$ _____ 6,360.00 To: \$ _____ 10,060.00	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Two Bedroom	From: \$ _____ To: \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Kitchenette:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Optional	
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Optional	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Optional	

Additional fees may be required (examples - admission fee, deposit fee, buy in fee, etc.)

Additional: **DEPOSIT 500** _____

SECTION 6 - CONTRACT INFORMATION

What is the criteria and process used to determine who may continue to reside in your facility?
 Each resident will receive an assessment upon admission to determine the appropriate level of care partnership prior to moving in. This assessment will allow us to develop a customized plan of care and train staff in specific strengths and needs. Every six months thereafter partnership needs assessment will be completed, or as conditions change. This assessment includes level of independence with BADLs, IADLs, mobility, safety, personal needs and wants and orientation.

SECTION 6 - CONTRACT INFORMATION (continued)

Can the contract be modified or terminated by the facility? Yes No If Yes, please explain under what conditions and the referral process.

Your right to occupy your unit and live at the Facility and to receive other services is contingent upon timely payment of all due amounts. The facility has the right to terminate the contract for lack of payment

Can the contract be modified or terminated by the resident? Yes No If Yes, please explain under what conditions and the referral process.

18. If you wish to leave the Facility you are required to give 30 days' notice of date you wish to terminate this Agreement. If you are leaving because of health emergency 30 days' notice is not required.

Outline the steps that should be taken by the resident to register a complaint and the process for resolving the complaints.

The resident should report their complaint to the supervisor who will investigate and attempt to resolve the issue, if the supervisor is unable to resolve the issue she will report it to the owner who will attempt to resolve the issue.

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (check all that apply)

MEALS: Extra meal fees are per: Month Bi-Week Week Day Other

Breakfast:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Lunch:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Dinner:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Snacks:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____

Comments:

HOUSEKEEPING: Extra housekeeping fees are per: Month Bi-Week Week Day Other

<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
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Comments:

LAUNDRY: Extra laundry fees are per: Month Bi-Week Week Day Other

Bed/Bath Linens:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Personal:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____

Comments:

PERSONAL ASSISTANCE: Extra personal assistance fees are per: Month Bi-Week Week Day Other

Dressing:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Toileting:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Transferring:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Mobility:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Bathing:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Eating:	<input checked="" type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____

Comments:

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (con't.) (check all that apply)

BLOOD PRESSURE TAKEN: Extra blood pressure fees are per: Month Bi-Week Week Day Other
 Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments:

EMERGENCY RESPONSE SYSTEM (ERS): Extra "ERS" fees are per: Month Bi-Week Week Day Other
 Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments:

24-HOUR NURSING RESPONSE: Extra 24 hr. fees are per: Month Bi-Week Week Day Other
 Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments: 24HR NURSING RESPONSE IS AVAIL TO RESIDENTS WHO USE COMMUNITY SERVICES, HOSPICE OR PALLIATIVE CARE

LICENSED NURSING SERVICES AVAILABLE: Extra fees are per: Month Bi-Week Week Day Other
 Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments: Contract with a service provider billed separately.

MEDICATIONS: Extra medication fees are per: Month Bi-Week Week Day Other
Reminders: Included Not Included Extra Fee, From: \$ _____ To: \$ _____
Set-up: Included Not Included Extra Fee, From: \$ _____ To: \$ _____
Dispensing: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments: We contract with a local pharmacy who bills set-up fees separately

ARRANGING OTHER MEDICAL SERVICES: Extra medical fees are per: Month Bi-Week Week Day Other
 Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments: We contract with home health agencies who bill separately for services

ASSISTING WITH PERSONAL FUNDS: Extra fund fees are per: Month Bi-Week Week Day Other
 Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments:

WANDER PROTECTION SYSTEM: Extra wander fees are per: Month Bi-Week Week Day Other
 Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments:

ACTIVITIES: Extra activity fees are per: Month Bi-Week Week Day Other
Day Outings: Included Not Included Extra Fee, From: \$ _____ 00.00 To: \$ _____ 30.00
In-House Activities: Included Not Included Extra Fee, From: \$ _____ To: \$ _____
Event Tickets: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments: As the event is scheduled

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (con't.) (check all that apply)

TRANSPORTATION: Extra transportation fees are per: Month Bi-Week Week Day Other

Facility Scheduled: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Unscheduled: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments: Contract with community service providers billed separately. We provide transportation for outings

UTILITIES: Extra utilities fees are per: Month Bi-Week Week Day Other

Heating: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Air Conditioning: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Electricity: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Water / Sewage: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Local Phone: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Cable TV: Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Comments: We have smart tvs and antennas

Services not listed on this form that are either included or available for an additional fee:

Service: _____

Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Service: _____

Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Service: _____

Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Service: _____

Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Service: _____

Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Service: _____

Included Not Included Extra Fee, From: \$ _____ To: \$ _____

Other Wellness / Health Related Services: Yes No If Yes, explain below:
 Any required service that can be contracted through community providers may be utilized

SECTION 8 - OPTIONAL INFORMATION

Do you offer wheelchair accessible units and / or common areas (check all that apply)? Units / Apartments Common Areas

Does each apartment have fire sprinklers? Yes No

Are pets allowed? Yes No If Yes, please describe any additional fees or special conditions below:

Do you have a nursing home / health care center at the same location? Yes No

Are rehabilitation services available on site? Yes No If Yes, please identify:

Provided through in home care service providers

SECTION 9 - INDIVIDUAL SUBMITTING THE DISCLOSURE / MAILING INSTRUCTIONS

Name of individual completing the form Shelley Pillado		Title CEO
Company / Affiliation HolisticCare Homes		
Address (number and street) 64180 Brick Church Rd		
City, state, ZIP code Cassopolis Indiana 49031		
Telephone number (574) 607-8120	Fax number ()	E-mail address shelley@holisticarehomes.com
Verified by (name) Shelley Pillado		Title CEO
Verified by (signature) Shelley Pillado		Date (month, day, year) 4/1/2026 9:43:08 AM
Send the completed form to the following address: <i>(Please do not FAX)</i>		
<p>Disclosure for Housing with Services Establishments FSSA Division of Aging 402 West Washington Street, Room W454, MS 21 Indianapolis, IN 46204</p> <p>For question call: 1-888-673-0002</p>		

DO NOT WRITE IN THIS SECTION
(For Official Use Only)