**Supplemental Materials**

**Mixed AD and DLB Diagnosis as a Covariate**

Among those with clinician-rated cognitive fluctuations present, a mixed DLB and AD diagnosis (8%) was not significantly more common than those without clinician-rated cognitive fluctuations present (5%; *X2*= .26, Fisher’s Exact *p*-value = .68, Cramer’s *V* = .05). Among those with informant-rated daily cognitive fluctuations present, a mixed DLB and AD diagnosis (14%) was not significantly more common than those without informant-rated daily cognitive fluctuations present (3%; *X2*= .26, Fisher’s Exact *p*-value = .06, Cramer’s *V* = .21). Similarly, significant differences in those with and without mixed DLB and AD diagnoses were not observed for either the CoV (*t* = -.25; *p*-value = .81; Cohen’s *d* = -.10) or FAQ ratio score values (*t* = -.99; *p*-value = .32; Cohen’s *d* = -.42). As such, a mixed DLB and AD diagnosis was not a statistical covariate of the relationships between the primary dependent and independent variables for this study.

**Standard FAQ Scoring**

In order to communicate how the standard FAQ scoring procedure (rather than the FAQ ratio score) is related to the three indicators of cognitive fluctuations, the aforementioned multiple linear regression procedure was utilized with the standard FAQ score (ranging from 0 to 30) as the dependent variable. With this operationalization, “not applicable”/never did or “unknown” responses were scored as missing, though a FAQ total score was nevertheless calculated for each participant using the available data. This scoring procedure resulted in a range of scores from 0 to 30, with higher scores suggestive of greater impairment in daily functioning and lower scores suggestive of less impairment in daily functioning.

The multiple linear regression model predicting daily functioning (as indexed using the standard FAQ scoring procedure) using only clinician-rated cognitive fluctuations found that the presence of clinician-rated cognitive fluctuations significantly predicted (Beta = 4.77, standard error = 1.42, *b* = .33, *p* = .001) greater problems with daily functioning (*r*2 = .107). Adding the CoV to this model significantly improved model fit (*F* = 38.48, *p* < .001, *∆r*2 = .260), with both presence of clinician-rated cognitive fluctuations (Beta = 2.87, standard error = 1.24, *b* = .20, *p* = .023) and higher CoV (Beta = 32.14, standard error = 5.18, *b* = .53, *p* < .001) exhibiting statistically significant associations with high standard FAQ scores. Similarly, a significant improvement in model fit occurred when the dichotomous indicator of informant-rated daily cognitive fluctuations was added to the model (*F* = 6.22, *p* = .014, *∆r*2 = .040), with high CoV (Beta = 30.42, standard error = 5.09, *b* = .50, *p* < .001) and presence of informant-rated daily cognitive fluctuations (Beta = 3.48, standard error = 1.40, *b* = .22, *p* = .014) exhibiting statistically significant associations with higher standard FAQ scores. In contrast, presence/absence of clinician-rated cognitive fluctuations were not significantly associated with the standard FAQ scores in this model (Beta = 1.67, standard error = 1.30, *b* = .11, *p* = .202).

As with the FAQ ratio score, age, sex, and dementia status were identified as covariates of the relationships between the indicators of cognitive fluctuations and the standard FAQ score (*p*-values < .05), though no other statistical covariates were identified (*p*-values > .05). When age, sex, and dementia status were added in a fourth block, there was a significant improvement in model fit (*F* = 5.08, *p* = .003, *∆r*2 = .086). Higher CoV (greater intraindividual variability-dispersion) remained significantly associated with worse daily functioning (Beta = 20.04, standard error = 5.56, *b* = .33, *p* < .001), while presence/absence of informant-rated daily cognitive fluctuations no longer exhibited a statistically significant association (Beta = 2.49, standard error = 1.36, *b* = .16, *p* = .069). Clinician-rated cognitive fluctuations was also not significantly associated with daily functioning in this model (Beta = 0.95, standard error = 1.24, *b* = .07, *p* = .445).

**Moderating Role of Dementia Status**

We tested the potential moderating role of dementia status (MCI-LB versus DLB) on the relationship between the CoV and daily functioning using moderated regression that predicted the FAQ ratio score. This model was identical to the model that included the CoV, clinician-rated cognitive fluctuations, informant-rated daily cognitive fluctuations, age, sex, and dementia status, but also included an interaction term of dementia status and the CoV. In this model, the interaction term for the CoV and dementia group status was not a statistically significant predictor of daily functioning (Beta = 1.49, standard error = 1.13, *b* = .56, *p* = .190), suggesting that the association of CoV and daily functioning (as measured by the FAQ ratio score) is not significantly different for those with MCI-LB from those with DLB.

We also tested the potential moderating role of dementia status (MCI-LB versus DLB) on the relationship between the CoV and daily functioning using moderated regression that predicted the standard FAQ score. This model was identical to the model that included the CoV, clinician-rated cognitive fluctuations, informant-rated daily cognitive fluctuations, age, sex, and dementia status, but also included an interaction term of dementia status and the CoV. In this model, the interaction term for the CoV and dementia group status was not a statistically significant predictor of daily functioning (Beta = 20.19, standard error = 10.84, b = .82, p = .066), suggesting that the association of CoV and daily functioning (as measured by the standard FAQ score) is not significantly different for those with MCI-LB from those with DLB.