Peer Review File

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Comment 1: Because the authors performed multiple tests; the significant finding that nutrition adequacy is associated with duration of MV may be false positive; suggest to add dose response analysis to reduce the chance of FPs.

Reply 1: A post hoc multivariate analysis using "MV >= 7days" as the outcome measure shows that among the three nutritional subgroups, the adjusted OR for high nutritional adequacy was up to 7.26 and it was statistically significant (p = .03, 95% CI 1.24-42.57). Notice that the 95% CI is wide and this may favour the argument of a false positive result. However, a dose-response analysis would be technically difficult in this case considering the categorical nature of the variables and the small sample size of the study. The "Results" was updated and Table 7 was added to illustrate this.

Comment 2: The conclusion "the importance of nutritional assessment and the potential impacts of different nutritional strategies in patients who were nutritionally deprived." is not well supported by data; the data did not show nutritional adequacy is important; it seems have nothing to do with patient-important clinical outcomes.

Reply 2: The above was deleted from conclusion.

Comment 3: The hypothesis of the study should be clarified at the end of introduction.

Reply 3: The hypothesis of the study was amended as "in high-risk ICU patients (represented by an mNUTRIC score of 5 to 9), prescribing more of both calories and protein at two thirds or more of their respective target is associated with decreased mortality and morbidities."

Comment 4: Multivariable regression model must be performed to account for potential confounders, since the study design is non-randomization.

Reply 4: We acknowledge the non-randomisation nature of this study as being one of the limitations. In doing so, two models of cox regression each adjusted for different potential confounders were included (see Table 5). Cox is used instead of multivariate regression in this study since mortality is adopted as the primary outcome.

Comment 5: Low calorie intake may be beneficial for shock patients; they cannot tolorate high energy intake, thus I suggest to stratify patients with and without shock. This is an important factor to consider.

Reply 5: The mNUTRIC score itself includes parameters reflecting the severity of acute illness (APACHEII, SOFA). By recruiting patients with high nutritional risk (defined as mNUTRIC score of 5-9) in our study cohort, it would invariably select out majority of those who had shock (literally all subjects being analyzed scored at least 1 out of 4, meaning their mean arterial pressure was less than 70mmHg, for the cardiovascular component of SOFA score). While it was a thoughtful suggestion to

investigate the effects of nutritional intake among those with and without shock, we think this is a less relevant question in our study and would likely give a biased result.